# EVALUATION OF THE BURY, ROCHDALE AND OLDHAM OFFENDER HEALTH TRAINER IMPLEMENTATION PROJECT

# 2011-2012

## REPORT OF FINDINGS

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# EVALUATION TEAM

## HEALTHY SETTINGS UNIT

The Healthy Settings Unit was established in 2001 and aims to support and facilitate the holistic and integrated development of health – acknowledging that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO: Ottawa Charter for Health Promotion, 1986).

The Unit forms part of UCLan's School of Health. Its portfolio includes:

- development, delivery and management of externally-funded settings-focused health promotion and public health programmes
- research, evaluation and knowledge exchange
- training, CPD and consultancy
- contributing to the delivery of undergraduate and postgraduate public health teaching – including the specialist Healthy Settings module
- leadership and co-ordination of UCLan's Healthy University initiative
- co-ordination of the English National Healthy Universities Network
- co-ordination of the UK Healthy Cities Network, one of 20 WHO-accredited national networks within Europe
- contributing to the development and management of WHO's Health in Prisons Project.

## GMPT RESEARCH AND POLICY TEAM

The Research and Policy Team within the Greater Manchester Probation Trust's Performance and Policy Support Unit comprises a mix of researchers, statisticians, information officers and probation practitioners. The team's expertise lies in offender and Criminal Justice related issues and theory, with a strong background in researching and evaluating internal and externally contracted offender-related projects.

The team have demonstrable skills and experience working in partnership to deliver research projects for a range of organisations, including the Ministry of Justice, Greater Manchester Police, the NHS and charitable organisations such as Women in Prison. The team utilise a broad range of research methods, including qualitative methodologies, with offenders, their families, victims and other key stakeholders such as multi-agency operational and strategic staff.

The GMPT Research and Policy Team continually endeavours to maintain a high standard of research, whether internally or externally delivered, and moreover aim to combine a healthy mix of offender-related theory with evidence and policy in the criminal justice field.

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# EXECUTIVE SUMMARY

## OVERVIEW AND RECOMMENDATIONS

This evaluation, commissioned by NHS Bury, has explored the extent to which the OHT Implementation Project has been delivered as intended and examined the impact of the OHT Implementation Project on service users. Whilst there were shortcomings in the available data, the evaluation points to the overall success of the service in terms of meeting its aims, providing 'value for money' and impacting positively on the lives of individual offenders – helping them to tackle multiple interwoven problems and build hope and self-belief.

The following recommendations arise from the evaluation:

### Service continuation and sustainability

- **provide sustainable funding** to enable the service to continue and develop, building on its successes and further enhancing the features of design and delivery shown to have contributed to its success
- **disseminate evaluation findings** widely, particularly within Greater Manchester.

### Tailored service development

- **conduct a review of the current health trainer 'model'**, to ensure that it is not 'straight-jacketed' by narrowly-conceived primary issues – but clearly recognises and addresses the complexity of offenders' needs, thereby ensuring that resources are appropriately channelled
- **explore the viability of adapting and/or extending the capabilities of DCRS** to ensure it is 'fit for use' within the probation setting (in collaboration with the 'hub' in Birmingham)
- **provide further training for health trainers** focused on managing the tensions implicit in their role and equipping them to draw boundaries, promote independence and interface with other community-based services.

### Integration of the service within probation

- **explore with health trainers how the service can be better integrated** within probation in ways that enhance effectiveness, recognise delineation of roles and build employee satisfaction.

### Data collection and recording

- **develop and implement a DCRS advanced training programme** that increases understanding of and confidence in collecting and recording data (in collaboration with the 'hub' in Birmingham)
- **put in place supportive performance management mechanisms** to ensure that there is consistency and accuracy in data capture and entry, thereby increasing the ability to understand, monitor and evaluate the effectiveness of the service.

### Research and evaluation

- **integrate evaluative research on health, wellbeing and reoffending into future funding models and bids**, with a view to building on evaluations already undertaken – including a longitudinal study that can explore impacts of the service over time.

## INTRODUCTION AND BACKGROUND

This report presents findings from the evaluation of the Offender Health Trainer (OHT) service delivered during 2011-12 through probation settings in the Boroughs of Bury, Rochdale and Oldham – which are amongst the most deprived areas in the country.

The evaluation was conducted by a team of researchers from the University of Central Lancashire (UCLan) and Greater Manchester Probation Trust (GMPT) and comprised an interrogation and analysis of routinely collected quantitative data, a 'value for money' analysis and in-depth qualitative research.

The Health Trainer programme was launched by the Labour Government in 2004, as a response to persistent health inequalities. Although implemented initially in disadvantaged geographical communities, the programme has subsequently been piloted and implemented with other populations including offenders in prison and probation settings – who have been shown to represent one of the most socially excluded groups in our society, with considerable complex physical and mental health needs compared to the general population.

## OFFENDER HEALTH TRAINER IMPLEMENTATION PROJECT

Funded by NHS North West, the OHT Implementation Project developed from a demonstration project that took place in Rochdale from 2010-11 – and was extended to include Oldham and Bury in March 2011. The project has sought to deliver a service which will improve the health of offenders subject to supervision by the Probation Service in the Boroughs of Bury, Rochdale and Oldham and also improve their access to mainstream services.

## EVALUATION: OVERVIEW AND DESIGN

The aims of this evaluation are to:

- explore the extent to which the OHT Implementation Project has been delivered as intended
- examine the impact of the OHT Implementation Project on service users.

The study took a mixed-methods approach, using the following techniques

- interrogation and analysis of OHT data routinely collected using the National Health Trainer Data Collection Recording System (DCRS)
- use of the Health Trainer Value for Money Assessment Tool
- interviews with eight clients enabling the construction of five qualitative case studies exploring and documenting service users' experiences and journeys
- semi-structured interviews and a focus group interview with health trainers.

## FINDINGS

### INTERROGATION AND ANALYSIS OF ROUTINELY COLLECTED 'DCRS' DATA

An interrogation/analysis of routinely collected 'DCRS' data was undertaken. This proved challenging due to gaps in the data, seemingly the result of collection and entry inconsistencies and errors. However, recognising that it is not possible to generalise beyond the evaluation context, a number of key findings can be highlighted:

### Client profile

During the period 01 April 2011 to 31 March 2012, the service reached a total of 633 clients – 150 in Rochdale, 256 in Bury and 227 in Oldham – representing 21.7% of the offender population subject to probation supervision during this time period; and conducted 682 initial assessments (due to a small number of clients exiting and re-entering the service). Of these clients, 82% were male, 85% identified as White British, 67% were aged 18 to 35 years and 20% were not registered with a GP. Additionally, 95% were recorded as having contra-indications and 94% as having multiple wellbeing risks.

## Progress through the service

Of the 633 clients undertaking a first initial assessment, 474 proceeded to the stage of undergoing wellbeing assessments and setting a personal health plan (PHP) – although of these, 88 had no PHP set and more than 120 had no health/wellbeing scores recorded.

## Primary issue

For the 514 full assessments carried out, the recorded primary issue was alcohol (8%), diet (14%), exercise (19%), emotional wellbeing (15%) and smoking (31%). A substantial number of full assessments (12%) had no primary issue recorded.

## Motivation

With regard to clients' motivation, 83.3% of clients rated the importance of addressing their primary issue at 8-10 (out of 10), whereas 63.3% rated their confidence to address the issue at 8-10 (out of 10) – with the 'guaranteed support of a health trainer' being viewed as the single most important factor (47%) in increasing their confidence.

## Personal health planning completion

Adjusting for data entry errors affecting sign-off, the estimated percentage of clients reaching the wellbeing/PHP stage fully or partially completing their PHP was 26% and 2% respectively. The analogous values by primary issue were: alcohol – 28%, 4%; diet – 21%, 2%; exercise – 28%, 3%; smoking – 23%, 2%; emotional wellbeing – 49%, 2%; other issue or not stated – 2%, 0%.

## Changes in health, wellbeing and health-related behaviours

The available pre- and post- 'intervention' data pointed to improvements in health and wellbeing (although data collection and entry errors meant that relatively few pairs of pre- and post- measures were available and that these were strongly biased towards clients who completed their PHP). Specifically:

- mean **fruit and vegetable consumption** per day increased from 2.1 to 7.6
- mean **alcohol consumption** declined from 38.1 to 26.2 units per week
- mean **moderate exercise** sessions increase from 3.3 to 4.2 per week
- mean **cigarettes smoked** per day declined from 14.7 to 8.1
- mean **self-efficacy** score increased by 20 (from 69 to 89) for clients who had completed their PHP and by 14 (from 66 to 80) for those who had not completed their PHP
- mean **general health** score increased by 43 (from 37 to 80) for clients who had completed their PHP and by 27 (from 43 to 70) for those who had not completed their PHP
- mean **WHO-5 wellbeing** score increased by 36 (from 41 to 77) for clients who had completed their PHP and by 30 (from 34 to 64) for those who had not completed their PHP.

## Signposting/referral

A total of 58 clients were recorded as having been signposted to other services, 59% of these to a GP or other primary care service (however, this does not include referrals and registrations among clients proceeding to develop PHPs).

### VALUE FOR MONEY

Using input values estimated from the DCRS alongside other data and inequality weightings agreed with the commissioner, the Health Trainer Value for Money Tool predicted a net public sector saving of £823,266. However, the net cost/savings were shown to be highly dependent on assumptions about reduction in reoffending as a result of clients' engagement with the service. The assumption that re-offending would decrease from 50% to 40% was based on secondary evidence and would obviously be much stronger if based on primary research.

## QUALITATIVE RESEARCH

Analysis of the data from the interviews conducted with service users and the focus group and interviews held with health trainers highlighted five key themes which were further complemented by five case studies illuminating service users' experiences:

### Reasons for accessing the Offender Health Trainer service

Most interviewees had accessed the service on the recommendation of their offender manager or having heard about it in the probation office. Whilst clients may have initially had one clear aim (or 'primary issue'), they reported that the health trainers frequently uncovered a complexity of inter-related needs, enabling them to view things more holistically and recognise other issues that they would benefit from addressing. However, the health trainers tended to break clients' goals down into smaller 'chunks' to make challenges seem more surmountable. Whilst some clients entered the service in order to be signposted or referred to a GP or other health professional, the majority of interviewees were keen to make significant changes to their lifestyle with the OHT service acting as an important catalyst. The main areas highlighted were: diet and healthy eating; smoking cessation/reduction; confidence, self-esteem and emotional wellbeing; and fitness and gainful occupation of time.

### Relationships and engagement with the service

The interviews highlighted a number of themes concerned with relationships and continued engagement with the Health Trainer service, which included:

- **Accessibility and flexible approach:** Those interviewed appreciated the accessibility and convenience of the OHT service and tended to be more at ease with health trainers than with 'traditional' health professionals, feeling comfortable talking though issues which they felt GPs and other health professionals may not have time for and would not take seriously. A number spoke of forming a strong relationship with their health trainer, creating a firm commitment to goal achievement based on not wanting to disappoint.
- **Non-judgmental approach and relationship of trust:** The fact that the health trainers had former experience of the criminal justice system resonated with clients. This promoted a feeling of being understood and 'on a level playing field' – and acted as a source of inspiration, providing motivation to 'turn their lives around'. The non-judgemental approach and ability to understand service users was important in creating a relationship of trust. Echoing DCRS data, which highlighted the importance of clients having the 'guaranteed support of a health trainer', the interview findings indicated an association between progress and quality of the health trainer-client relationship.
- **Support, commitment and dependence:** Whilst the support and commitment of the health trainers was crucial to clients' engagement, the interview findings highlighted the danger of possible over-dependence and points to the need for the service to prioritise the promotion of independence and self-coping mechanisms alongside intensive support.

### Services accessed and evidence of change

With regard to services and evidence of change, the interviews highlighted several themes:

- **Services accessed and activities undertaken:** Most interviewees benefited from weekly appointments (often coinciding with probation appointments), supported by telephone contact. The main services accessed were signposting, information provision, dietary assistance, smoking cessation and support/motivation. Whilst the DCRS data suggests that diet was the fourth most commonly identified primary issue, interviewees identified healthy eating advice as their most common 'primary issue'.
- **Evidence of change and positive health outcomes:** In discussing the results of their engagement with the OHT service, those interviewed identified a range of outcomes as evidence of positive health, wellbeing and lifestyle changes – including weight loss/gain, healthy eating, increased confidence, stopping smoking, GP registration and gym membership. The service was deemed successful in relation to both soft and tangible

outcomes – with the latter proving particularly important to many clients (particularly young men). By achieving one goal, service users tended to feel empowered to achieve other life goals, such as starting work – reflecting a new-found 'can do' approach.

- **Impacts on offence-focussed work:** The interviews also suggested that the service may impact positively on re-offending. Clients interviewed reported feeling more motivated to attend their probation appointments and confident to avoid falling back into their 'old ways'
- **Increase in wellbeing:** Clients responded well to the approach of setting and achieving small goals which could be built on – and all those interviewed reported an increase in perceived quality of life as a direct result of their involvement with the OHT service.

### Future Plans

In terms of future plans, the interviews highlighted three main themes:

- **Building on success to address other health and wellbeing issues:** Interviewees indicated feeling positive about their future and their wellbeing. Having achieved significant progress in addressing one problematic area of their life, they now planned to expand this to improve their health and general wellbeing further.
- **Building on success to move on with their lives:** Most individuals were committed to utilising the 'skills for life' that they had attained as a result of accessing the OHT service to complete their probation orders successfully and move on with their lives – where possible transferring this knowledge onto their friends, families and children.
- **Fear at signing off from Health Trainer service:** By their second interview (held in February 2012), most participants had signed off or were planning to sign off. However, several reported their intention to continue their involvement, clearly apprehensive about signing off, not feeling ready to 'go it alone' and anxious about the future of the service.

### Current Issues with Implementation

The focus group and interviews with the health trainers highlighted themes relating to:

- **Recording of information:** The health trainers felt that there are significant issues with DCRS and its ability to capture all information required to demonstrate value and measure the true impact of the service. They also felt that the emphasis on recording 'primary issue' did not encourage an holistic model, which they felt was crucial to the success of the service in the probation setting. However, interviewees also acknowledged different levels of competency and pointed to inconsistencies in how different health trainers use the system – resulting in data entry errors.
- **Delivery of the service in the probation setting:** The health trainers felt that it would be advantageous to have access to the probation case management system, Delius. They also felt that this lack of access was symbolic of their position within probation.
- **Hopes for the future of the service:** The health trainers hoped for three main outcomes – guaranteed funding for the service and their jobs; widened access to the (voluntary) service; and a specific 'health trainer room' in each probation office.

## DISCUSSION

The findings from the interrogation and analysis of DCRS data, the Value for Money Tool and the interviews and focus groups with service users and health trainers provide a wealth of valuable information, which can be usefully considered under three headings:

### HOW SUCCESSFUL HAS THE OHT SERVICE BEEN?

Although the evaluation was not designed to measure all the aims specified for the OHT service, findings point to its overall success, the main shortcoming being the percentage of those attending for an initial assessment going on to complete a PHP. In summary:

- **Service reach:** The service reached 633 clients, one fifth of the offender population subject to probation supervision during this time period 01 April 2011 to 31 March 2012

- **Annual trend:** There was an upward trend in number of clients accessing the service and having an initial assessment – from 133 in the first quarter to 192 in the fourth quarter.
- **Client progression:** 61% of these clients went on to set at least one PHP, although the achievement rate for completing their PHP among this sub-group was estimated to be only 26% – approximately 16% of all clients compared to a specified aim of 50%.
- **Behaviour change:** The data point to promising trends in behaviour change, with an increase in measures of healthy eating and exercise and a decrease in smoking and alcohol intake.
- **Self-perceived health and wellbeing:** Mean scores for self-efficacy, general health and WHO-5 wellbeing all increased.
- **Client referral:** The data suggest that the service resulted in a substantial number of clients being referred to GPs and other health and leisure services.
- **Client satisfaction:** Whilst no user satisfaction survey has been undertaken, the qualitative research findings point to high levels of satisfaction and illuminate through case studies the usefulness of the Health Trainer service within the probation setting.
- **Probation order compliance:** The qualitative data indicate that for some interviewees, engagement with the service increased attendance at appointments and general compliance with probation orders.
- **Value for money:** Assuming a 10% reduction in re-offending rates as a result of the OHT service, the Health Trainer Value for Money Tool predicted a net public sector saving of £823,266.
- **Impact on individuals' lives:** Beyond the specified aims, the qualitative data point to the power of the probation-based OHT service to make a profound difference to individuals' lives and hopes – empowering clients to build on small successes and go on to address other more substantial goals.

### WHAT HAS CONTRIBUTED TO THE SUCCESS OF THE SERVICE?

The qualitative data suggest that features of both service design and service delivery have been important in contributing to the success of the OHT service:

## Service design

- **Location within the probation setting:** Findings highlighted the importance of the service's location – with the interwoven nature of clients' problems providing a clear rationale for the co-location of services that address offending-related and health and wellbeing issues, with local probation offices offering a natural 'home'.
- **Inclusivity:** The inclusivity of the service was deemed important, offering access to all offenders on probation, irrespective of age, gender or type of offence.
- **Referral and registration with GPs and other health services:** A further key feature of the OHT service was its focus on assisting offenders to register with local health services, such as doctors and dentists – of particular significance given the evidence that offenders typically do not access mainstream health services effectively.

## Service delivery

The delivery of the OHT service was understood to be particularly effective because it applied learning from offender engagement and desistance theory – as highlighted by examining six key aspects:

- **Change of lifestyle and outlook:** The OHT service supported and motivated individuals to change their lives and transform their personal circumstances for the better.
- **Social links:** The focus on increasing 'social capital' through links to the community and non-offending social networks can be seen to contribute to the desistance process.
- **Belief and support:** The clients felt 'believed in' and able to rely on the support of the health trainers in achieving change.
- **Identity and role models:** By employing ex-offenders, the service offered a motivational 'tool' and offered hope to clients that it is possible to change.

- **Strengths focussed:** The service set small goals and marked achievements, thus focusing on clients' strengths and helping to empower them.
- **Practical support:** The service incorporated a strongly practical focus linked to agreeing tangible goals, which proved important to clients' continued engagement.

### WHAT ARE THE KEY AREAS FOR IMPROVEMENT IN SERVICE DESIGN AND DELIVERY?

Whilst the research findings were positive, they also point to potential routes for enhancing the design and delivery of the OHT service.

- **Data collection and recording:** It was clear from the interrogation and analysis of the DCRS data that there are serious shortcomings in data collection and recording – and that these shortcomings have important implications for understanding and robustly evaluating the effectiveness of the OHT service.
- **Drawing boundaries and guarding against over-dependence:** The qualitative research highlighted potential dangers of over-dependence and blurring of boundaries, suggesting the value of further training.
- **Further tailoring the Health Trainer model to the probation context:** It is important to reflect on the experiences of running the service within the probation setting and considering how it can be further tailored to ensure that the model clearly addresses the complexity of offenders' needs.
- **Further integrating the Health Trainer service into probation:** The interviews and focus group with the health trainers raised several issues concerning the integration of the Health Trainer service into probation – specifically the physical location and space provision; and the separation of information management systems.

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# 1. INTRODUCTION AND BACKGROUND

## 1.1 OVERVIEW

This report presents findings from the evaluation of the Offender Health Trainer (OHT) service delivered in Probation settings in Bury, Rochdale and Oldham during 2011-12 as an implementation project funded by NHS North West. It follows an earlier report on the evaluation of the OHT Demonstration Project. The evaluation was conducted by a team of researchers from the University of Central Lancashire (UCLan) and Greater Manchester Probation Trust (GMPT) and comprised an interrogation and analysis of routinely collected quantitative data, a 'value for money' analysis and in-depth qualitative case study research.

The report starts by outlining the national and local contexts; goes on to introduce the OHT Implementation Project and provide an overview of the evaluation study design and methods; and details and discusses findings before concluding.

## 1.2 NATIONAL CONTEXT

### 1.2.1 Health and wellbeing

Health and wellbeing vary significantly across England, despite people living longer than ever before. People in disadvantaged areas experience a shorter life expectancy and a greater burden of ill-health that is driven by underlying social factors that affect people's health and wellbeing (Department of Health, 2010).

The implications of health inequalities are set out in Sir Michael Marmot's independent review *Fair Society, Healthy Lives* (The Marmot Review, 2010) which makes clear that material circumstance, social environment, psychosocial factors, behaviours and biological factors are all important influences on health. The review advocates for greater consideration of the broader context of people's lives in order to tackle health inequalities, highlighting that low income and deprivation are particularly associated with higher levels of obesity, smoking, mental illness and harms arising from drug and alcohol misuse. It goes further by arguing that some vulnerable groups and communities – for example, people with learning difficulties or travellers – have significantly poorer life expectancy than would be expected based on their socioeconomic status alone, suggesting broader complexities that interact to shape people's lives.

The Coalition Government's long term vision and strategy for the future of public health in England is set out in the White Paper *Healthy Lives, Healthy People* (Department of Health, 2010) – which serves as its response to *Fair Society, Healthy Lives* (The Marmot Review, 2010) and seeks to strengthen both national and local leadership. While the strategy clearly recognises the wider determinants of health, it is also apparent that it is "driven by a philosophy of individual responsibility" (Parish, 2011). Highlighting Britain as the most obese in Europe, with among the worst rates of sexually transmitted infections recorded, a relatively large population of problem drug users and rising levels of harm from alcohol, the White Paper argues that healthier people tend to be happier, tend to play an active role and contribute to society and the economy through their families, local communities and workplaces. It also contends that poor health and wellbeing put a huge strain on individuals, the NHS, the economy and society – particularly as many deaths and illnesses can be avoided by adapting healthier lifestyles, particularly through reducing smoking rates, improving diet and increasing physical activity. The strategy set out supports the Government's localism agenda by advocating an approach that empowers individuals to make healthy choices and gives communities the tools to address their own particular needs.

Wellbeing has become increasingly important in recent government policy and the term is used in tandem with 'health' within *Healthy Lives, Healthy People* (Department of Health, 2010). It is useful to reflect on the term and its meaning by considering the following

common understanding for policy-makers developed by the UK government's Whitehall Working Group set up in 2005 (Steur & Marks, undated: 8):

> *'Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, security, rewarding employment and a healthy and attractive environment.*
>
> *Government's role is to enable people to have fair access now and in the future to the social, economic and environmental resources needed to achieve wellbeing. An understanding of the combined effect of policies on the way people experience their lives is important for designing and prioritising them'.*

This statement illustrates the complexity and breadth of the term, which is perhaps most usefully thought of as the dynamic process that gives people a sense of how their lives are going through the interaction between their circumstances, activities and psychological resources or 'mental capital' (Michaelson et al, 2009) Research over recent years has suggested that some of the key components of wellbeing are: family relationships, financial situation, community and friends, health and personal freedom (Layard, 2005). Subjective wellbeing suggests that as well as experiencing good feelings, people need: a sense of individual vitality; to be able to undertake activities that are meaningful, engaging and which make them feel competent and autonomous; and a stock of inner resources to help them cope when things go wrong and be resilient to changes beyond their immediate control. It is also crucial that people feel a sense of relatedness to other people, and in addition to the personal, internally-focused elements, it is clear that people's social experiences – the degree to which they have supportive relationships and a sense of connection with others – form a vital aspect of wellbeing.

### 1.2.2 Health trainers

Wanless (2002) made a powerful argument for the need to 'invest in reducing demand by enhancing the promotion of good health and disease prevention' and suggested that some interventions and services may not have been reaching those most disadvantaged. The Labour Government's White Paper, *Choosing Health* (Department of Health, 2004), argued that much illness and disease could be prevented if people made appropriate changes to lifestyles in order to reduce risks to their health – its underpinning principle being that of informed choice. One of the flagship initiatives heralded by this White Paper was the NHS Health Trainer service, targeted at people living in deprived communities or experiencing other forms of disadvantage or exclusion. Launched in 2005, the Health Trainer programme was designed to tackle health inequalities through helping disadvantaged and hard to reach communities access local health services and make healthier lifestyle choices.

As emphasized by the former Government 's review of health inequalities (Department of Health, 2008), "a fair society means helping people to make healthier choices in many different aspects of their lives," acknowledging that "some people live in circumstances that make it much harder for them to choose healthy lifestyles." Health trainers continue to represent a visible link between professionals and disadvantaged communities. Their selection is based not only on their abilities, but also on their knowledge and understanding of the communities with which they work – many living in the same geographical areas or being from the same population group. Recognising the value of workers having a similar background to those they are working with in terms of connecting with and exerting influence (North West Public Health Observatory, 2011), the aim of the Health Trainer service is to provide 'support from next door' rather than 'advice from on high'. Half of clients are drawn from the most deprived 20 per cent of local authority areas and nearly 90 per cent of Primary Care Trusts had a Health Trainer service in 2009 (The Marmot Review, 2010).

Health trainers are ambassadors for healthy lifestyles – they increase the capacity for the delivery of health improvement and the prevention of poor health by supporting and encouraging individuals on a one-to-one basis to make changes to their lifestyle by improving their knowledge and skills in relation to health and wellbeing thus assisting the local population in helping them to live healthier lifestyles and access the support they need (North West Public Health Observatory, 2011).

Local evaluations suggest that health trainers can provide the type of support necessary to help individuals make desirable lifestyle changes. Health trainers offer a way of facilitating information between service and PCTs and fill a gap in disadvantaged communities while providing personal fulfilment and career development (Ball et al, 2008).

Whilst the main focus within Choosing Health was on community health trainers working within disadvantaged geographical areas, the commitment to health trainers was reaffirmed in *Health Inequalities: Priorities and Next Steps* (Department of Health, 2008) where it stated that "amongst other initiatives the Department of Health will roll out health trainers to every community". This signalled an opportunity to develop Health Trainer services to prioritise particular target groups and thus, engage with offenders in prison and probation settings.

A national Data Collection and Reporting System is used to record information on health trainers and their clients, including health behaviour change outcomes and to monitor the impact of the services (Wills and Cook, 2011). The Department of Health has also commissioned a national evaluation, an analysis of health trainers' case stories and annual End of Year Reports from all Health Trainer services – and early indications are that the Health Trainer programme has had a direct and positive impact on its workforce and clients.

### 1.2.3 Offender health

> *"The health status of many people caught up in the criminal justice system falls lamentably below that of the general population, and drug and alcohol dependency, learning disabilities and mental health can and do have a profound impact upon the criminality of some offenders" (Pearson, 2010: 5).*

Offenders and their families represent one of the most socially excluded groups in our society, with considerable complex physical and mental health needs compared to the general population. Some 90% of prisoners have a diagnosable mental health or substance misuse problem or both and more than 80% of prisoners smoke – and these patterns are reflected amongst those on probation. In addition, offenders experience high levels of poor literacy, numeracy and comprehension, and have great difficulties accessing employment, accommodation and health services (Social Exclusion Unit, 2002). Offenders are not a homogenous group: they are differentiated by ethnicity, age, gender, family background, geographic location and the nature, circumstances and frequency of crime they commit. Their problems are often complex and inter-related, as many have poor life and coping skills. Offenders have also experienced long term disengagement from services, and have histories of poor relationships with those who might help them (Home Office, 2004).

The needs of released prisoners are complex with many interlinked issues from mental health, gaining and keeping employment, and maintaining accommodation. Therefore ensuring that people who come out of prison have access to a range of services that tackle these issues is an imperative (Bradley, 2009). High levels of health needs among offenders are recognized in the Delivery Plan, *Improving Health, Supporting Justice* (H.M. Government, 2009) and the report *Reducing Reoffending by Ex-Prisoners* (Social Exclusion Unit, 2002) emphasises the extent to which people with chaotic lives and those from deprived backgrounds fall into crime as a consequence of unemployment and a lack of skills and qualifications. The National Offender Management Service's (NOMS's) *National Reducing Reoffending Action Plan* (Home Office, 2004) identifies improving health as one pathway out of reoffending. Health Trainer services in an offender setting can impact on four of NOMS's resettlement pathways (Home Office, 2004):

- Skills and employment
- Health
- Drugs and alcohol
- Attitudes, thinking and behaviour

The link between offending, reoffending and wider factors such as health is widely recognised. *Improving Health, Supporting Justice* (H.M. Government, 2009) highlights that adults and young people who are socially excluded and in contact with the criminal justice systems are more likely to experience mental health problems or learning disabilities and can struggle to access appropriate care and all too often have to reach crisis point to do so. Therefore this delivery plan advocates for care pathways, continuity of care and ensuring equity of access to services. Thus, the case for health and criminal justice services working in partnership is clear – supporting offenders to choose and maintain a healthier lifestyle can have a significant, positive impact on the health service in areas such as mental wellbeing and drug and alcohol[1].

### 1.2.4 Offender health trainers

The development of OHT programmes is a great example of health and criminal justice coming together to provide a service specific to the broad health and wellbeing needs of offenders. As such OHTs are playing an increasingly important role in engaging offenders with their health and wellbeing in a unique and non-health setting. Health trainers work with clients on a one to one basis assessing their health and lifestyle risks to facilitate behaviour change, provide motivational guidance and offer practical support to individuals in their local communities. With the OHTs often coming from a similar background, living in the same community and having experienced some of the same health and social issues, they can be more effective in working with the offenders in addressing their specific needs and empathising with their particular issues. Whilst OHT services are already operating in some prison settings, the recent strategic review of health inequalities (The Marmot Review, 2010) identified that the Health Trainer programme was ready to be expanded to new settings and different age groups, thereby supporting the further roll-out across the wider offender system.

It is widely recognised that people living in more deprived areas or those who come from more vulnerable groups, have more risky behaviours and make poorer health choices – mirrored in the epidemiological evidence relating to the health of offenders. Thus, the accessible provision of advice, education and signposting to services in more deprived areas and towards populations considered 'harder to reach' will be of more benefit to those who most need the service, and thereby having the potential to reduce health inequalities (Attree et al, 2012). Attention to the broader issues affecting offenders in culturally acceptable settings and environments is likely to bring about social benefits, including a potential reduction in reoffending, in addition to anticipated health benefits in terms of health improvement and life expectancy. Moreover there is a compelling argument to take the opportunity to engage with offenders while they are within the criminal justice system as it may be more difficult to do so after release/discharge (DH, 2011).

## 1.3 LOCAL CONTEXT

Bury, Rochdale and Oldham are situated in Greater Manchester. Using Indices of Deprivation they are amongst the most deprived areas in the country, as illustrated by the map below (see Figure 1). Rochdale has a population of approximately 205,000; Oldham approximately 220,000; and Bury approximately 184,000. [2]

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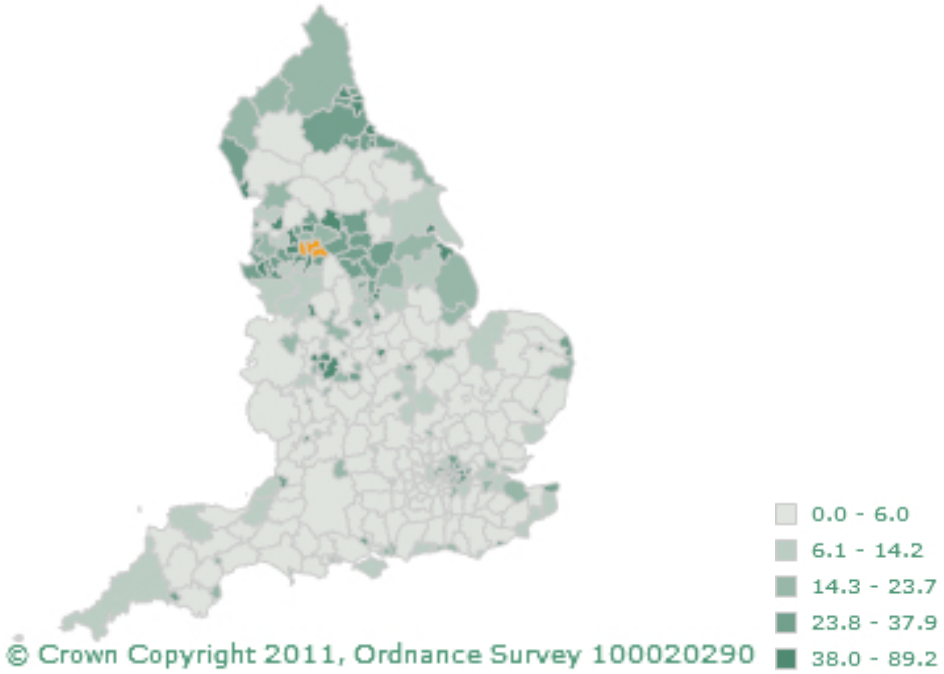
[1] This is highlighted in number of former Public Service Agreements (18; 23; 25) and National Indicators (15; 16; 20; 28; 30; 38; 39; 40) which emphasised the merging of health and criminal justice agendas.

[2] Table 8a Mid-2010 Population Estimates: Selected age groups for local authorities in the United Kingdom; estimated resident population. *Population Estimates for UK, England and Wales, Scotland and Northern*

**Figure 1.1: Deprivation in 'Our Communities' across England and Wales** (Department of Health, www.apho.org.uk – based on 2007 data)




As stated in the *Improving Health, Supporting Justice* strategy (2009: 11), the North West of England is characterised by poor social indicators, significant health inequalities and lower than average life expectancy. Department of Health data from 2007 (available on www.apho.org.uk) demonstrates that Rochdale, Bury and Oldham experience poorer outcomes than the national average for four key areas:

- Community social factors
- Children and young people's health
- Adults' health and lifestyle
- Life Expectancy and causes of death

This suggests that this is a region with deeply engrained social, health and poverty issues (for more specific information on health outcomes and deprivation factors for each of three boroughs, see Appendix 1.)

# 2. OFFENDER HEALTH TRAINER IMPLEMENTATION PROJECT

## 2.1 BACKGROUND

Table 2.1 presents information on those individuals subject to probation supervision in Bury, Rochdale and Oldham between April 2011 and March 2012, showing that during the evaluation time period, there were 681 offenders supervised in Bury, 1,119 in Rochdale and 1,121 in Oldham – a total of 2,921. Moreover, it highlights that many of the individuals were assessed as having substance misuse problems and emotional wellbeing issues. This confirms the rationale for investing in the OHT service in these boroughs for this cohort of individuals.

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*Ireland, Mid-2010*. Office for National Statistics. 3 June 2011. http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847. Retrieved 1 June 2012.

In addition, the *Improving Health, Supporting Justice* strategy (2009: 11) highlights that the North West of England has the second highest volume of crime and the third highest crime rate in England and Wales. This suggests that the region is not just experiencing high levels of deprivation and poor health but also difficulties with crime-related issues.

**Table 2.1: Individuals on Probation in Bury, Rochdale and Oldham (April 2011-March 2012): Overview and Needs.**

| | **Bury** | **Rochdale** | **Oldham** |
|---|---|---|---|
| **Gender** | | | |
| Male | 87% (n=553) | 89% (n=991) | 87% (n=978) |
| Female | 13% (n=128) | 11% (n=128) | 13% (n=143) |
| Total | 100% (n=681) | 100% (n=1119) | 100% (n=1121) |
| **Ethnicity** | | | |
| White British | 85% (n=543) | 79% (n=880) | 74% (n=803) |
| BAME | 15% (n=88) | 21% (n=233) | 26% (n=279) |
| **Age** | | | |
| 18-25 | 38% (n=241) | 36% (n=401) | 41% (n=456) |
| 26-35 | 26% (n=168) | 32% (n=363) | 31% (n=343) |
| 36-45 | 24% (n=152) | 21% (n=231) | 19% (n=209) |
| 46+ | 12% (n=76) | 11% (n=124) | 10% (n=113) |
| **Disability** | | | |
| None | 88% (n=559) | 85% (n=952) | 81% (910) |
| Physical | 3% (n=20) | 3% (n=35) | 3% (n=31) |
| Learning | 1% (n=3) | 2% (n=20) | 1% (n=11) |
| Other | 5% (n=32) | 10% (n=112) | 12% (n=132) |
| **OASys Criminogenic Assessed Needs** | | | |
| Drugs | 52% (n=97) | 57% (n=256) | 55% (n=240) |
| Alcohol | 59% (n=153) | 63% (364) | 55% (n=327) |
| Emotional Wellbeing | 34% (n=88) | 38% (n=212) | 35% (n=209) |
| Attitude | 69% (n=224) | 74% (n=516) | 68% (n=482) |
| Thinking and Behaviour | 95% (n=312) | 95% (n=662) | 97% (n=683) |
| Employment, Training and Education | 33% (n=107) | 46% (n=321) | 40% (n=285) |
| Tier | | | |
| 1-2 | 50% (n=317) | 46% (n=514) | 49% (n=549) |
| 3-4 | 50% (n=316) | 54% (n=605) | 51% (n=571) |
| **Offender Group Reconviction Score** | | | |
| 0-50 | 60% (n=382) | 50% (n=558) | 53% (n=597) |
| 51-100 | 40% (n=255) | 50% (n=561) | 47% (n=524) |

**Source: Greater Manchester Probation Trust**

## 2.2 PROJECT DEVELOPMENT

The OHT Implementation Project developed from a demonstration project[3], initially funded by the NHS North West Health Trainer Partnership. It was established in Greater Manchester Probation Trust's Rochdale local delivery unit in February 2010. The service was then extended beyond Rochdale to include Oldham and Bury in March 2011, funded by the NHS North West. The service is now delivered alongside NHS Community Health Trainer services already established in those districts and is funded until autumn 2012.

The service has increased staffing to two full-time and six part-time health trainers together with one part-time project manager. The service has also increased the breadth of its provision: for example health trainers are now able to offer Chlamydia testing, in addition to extending delivery beyond the local delivery unit offices – for example by offering services to women's centres, approved premises and Spotlight teams.

## 2.3 AIMS AND REMIT

The aim of the OHT Implementation Project has been to deliver a service which will improve the health of offenders subject to supervision by the Probation Service in the Boroughs of Bury, Rochdale and Oldham and also improve their access to mainstream services.

It has sought to tackle local health inequalities by offering personalised support to offenders at risk of developing poor health; providing additional support to offenders who need it to enable them to make healthier choices; and facilitating better access for offenders to a range of health services that they require. In doing so, the project has endeavoured to:

- enable offenders to take greater control over their health and wellbeing
- promote a skill mix of health workers and probation-based health trainers, able to provide more flexible and responsive care for offenders
- promote health and wellbeing within the offender population attending probation local delivery units in Bury, Rochdale and Oldham
- improve the employment prospects of ex-offenders through employment as health trainers
- improve community re-integration thereby reducing reoffending rates.

# 3. EVALUATION: OVERVIEW AND DESIGN

## 3.1 AIMS AND RESEARCH QUESTIONS

The aims of this evaluation study are to:

- explore the extent to which the OHT Implementation Project has been delivered as intended
- examine the impact of the OHT Implementation Project on service users.

It is intended that the data will allow the following research questions to be answered:

- With which individuals has the project engaged and to whom have services been delivered?
- Which health and wellbeing issues as the project addressed?
- To what extent has the project delivered its anticipated health and wellbeing benefits – and what additional benefits have there been?
- To what extent has the project offered value for money?
- How have service users perceived the service?
- What has the experience of delivering the service been for health trainers?

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[3] See Dooris and Baybutt (2011) for an evaluation of this demonstration project

## 3.2 STUDY DESIGN AND METHODS

### 3.2.1 Introduction

The evaluation study took a mixed-methods approach, using the following quantitative and qualitative techniques:

- interrogation and analysis of OHT data routinely collected using the National Health Trainer Data Collection Recording System (DCRS)
- use of the Health Trainer Value for Money Assessment Tool
- semi-structured interviews with clients enabling the construction of qualitative case studies exploring and documenting service users' experiences and journeys
- semi-structured interviews and a focus group interview with health trainers.

The use of multiple methods is valuable not least because it allows *triangulation*, facilitating the validation of data through cross verification from more than two sources.

### 3.2.2 Interrogation and analysis of routinely collected data

This component of the research had the primary aim of providing a quantitative evaluation of the activities undertaken within and the operation of the OHT service in the Boroughs of Rochdale, Bury and Oldham, Greater Manchester. It sought to determine the characteristics of the clients who were referred to the service, their journeys through the programme and their outcomes; and to assess the magnitude of change due to the intervention by drawing on pre- and post-intervention data relating to health assessments and perceived measures of health, wellbeing and self-efficacy. A related aim was to estimate the percentage of clients who achieved certain goals for a number of primary health issues to inform input estimates for the 'Portsmouth Ready Reckoner' Health Trainer Assessment Tool (see section 3.2.3).

Two additional aims were envisaged at the outset of the DCRS evaluation. One was to a assess clients' expectations and experiences of the Health Trainers service and clients' degree of motivation to make change. However, as the DCRS does not capture clients' aims and expectations, a quantitative evaluation of the DCRS was unable to address this issue as a whole, although some minor evaluation of motivation was feasible. The other envisaged aim was to identify factors which were associated with successful and unsuccessful outcomes. However, certain shortcomings of the current extracted data suggest that this aim is too ambitious and that the data would be unlikely to support an analysis of this type.

Data were extracted from the DCRS system for clients who attended for an initial assessment appointment between 01 April 2011 and 31 March 2012. These data were extracted into Excel spread sheets with a separate sheet for each of the DCRS data tables extracted. The table spread sheets were imported into the statistical package SPSS and sheets were linked using the linkage identifiers from each DCRS table so that types of information could be connected across sheets. Some clients had accessed the programme up to three times by undertaking more than one initial assessment. This was evident from the assessments spread sheet because the client identifier was replicated up to three times. Therefore considerable care was taken to ensure that data was correctly linked and that data were not replicated when merged to create large SPSS data files which contained information from more than one DCRS table.

A mainly descriptive analysis of the DCRS data was carried out which ascertained the clients' journeys through the programme, as captured by DCRS. In order to contextualise the analysis, it is useful to describe the 'typical' journey (see Box 3.1) – although it should be noted that there was substantial variation between the journeys taken by different clients as well as considerable attrition, with clients dropping out at all stages through the programme.

**Box 3.1: The Client Journey through the Health Trainer Service**

Clients attended for an initial assessment with a health trainer and client demographics and source of referral were recorded. If a client was found to have no contraindications and wished to continue then the client proceeded to full assessment. If not proceeding then the client might be signposted at this stage and then signed off. The full assessment recorded diet, alcohol consumption, smoking habit and exercise, height and weight. After full assessment the client could then proceed to the drawing up of a personal health plan (PHP) and measures of self-efficacy, wellbeing and general health were taken. The PHP was identified by the primary issue to be addressed. If the client did not want to proceed to the PHP then the client may have been signposted elsewhere and then signed off. Clients attempted to carry out the plan and, at a later date DCRS recorded whether the client had fully, partially or not completed the plan. Clients attended for a post assessment where diet, alcohol consumption, smoking habit and exercise, height and weight were reassessed and measures of self-efficacy, wellbeing and general health were recorded again. Clients were then signed off.

The descriptive analyses determined the numbers of clients entering the programme, numbers exiting the programme at each stage, numbers moving from one stage to the next, the reasons for exit, the numbers achieving success for a selected primary health issue and the magnitude of change in health and wellbeing achieved by those moving through the programme. The analyses did not use formal statistical tests of significance because these were felt to be inappropriate in this context. Statistical testing is appropriate when inferences need to be made about a population from which the given data can be considered a sample and which has a random element in generating the sample from the population. Testing is not about the given data but about the populations that gave rise to it. In order to make valid inferences, a clear conceptual understanding is required about what comprises the population and this understanding is not explicit in this context.

### 3.2.3 Assessing value for money using the 'Portsmouth Ready Reckoner' Health Trainer Assessment Tool

Drawing on relevant DCRS data, an assessment of the Value for Money of the OHT service provided during this 2nd Stage Implementation Project was carried out using the 'Portsmouth Ready Reckoner' Health Trainer Assessment Tool, which has already been piloted with a range of health trainer services including those working with offenders. This entailed importing relevant data into the Ready Reckoner Excel spread sheet and agreeing with commissioners and stakeholders certain estimates and weightings, in order to allow an estimate of cost and/or cost savings to the NHS, Local Authorities and Criminal Justice System. As the tool relies on these estimates and weightings, several different entries were made in order to explore the impact on cost/cost savings.

### 3.2.4 Qualitative research

In order to supplement the descriptive analysis of the quantitative OHT data, in-depth case study research was conducted. The purpose of this research was to develop a rich picture and detailed understanding of the journeys that individuals take during their time as users of the OHT service – with a critical theme being the wider benefits (e.g. to the offender's lifestyle and family, exploring possible links to reoffending).

Case studies of eight service users were undertaken. The evaluation team engaged a cohort of service users who were able to reflect on their experiences of a variety of health-related interventions (e.g. relating to diet; smoking; exercise). A sampling framework was developed, informed by profiling carried out via DCRS in October 2011[4] and based on both demographic and experiential variables. The priorities for stratifying the sample included variables such as age, gender, presenting health need, district, and length of community sentence and offending profile (see Table 3.1).

[4] In September 2011, there were 368 individuals on the health trainer caseload. The sampling was therefore based on these available 368 service users across the three districts.

**Table 3.1: Sample of service users interviewed in October 2011 and February 2012**

| Gender[5] | Age | REM | Health Need[6] |
|---|---|---|---|
| Female | 36+ | White British | Diet, lifestyle |
| Female | 18-25 | White British | Smoking |
| Male | 26-35 | Mixed – White & Black British | Smoking, drug abuse |
| Male | 26-35 | White British | Diet |
| Male | 36+ | White British | Diet, lifestyle |
| Male | 26-35 | White British | Exercise, diet |
| Male | 18-25 | Asian/British - Pakistani | Smoking, diet, dentist |
| Male | 18-25 | White British | Exercise, smoking |

In order to build the case studies, face-to-face interviews were used (n=16 – a sample of eight repeated). Face-to-face interviews are appropriate where the data required relate to individual experiences and the intention is to explore in some depth the opinions and expectations of individuals and their understanding of their actions. Interviews are also more appropriate for sensitive or confidential subjects.

Taking into account the duration of the evaluation (August 2011-July 2012), a longitudinal aspect to the project was possible and desirable, evaluating and assessing the opinions of the key stakeholders at different points in time. This allowed for contrasts and comparisons over time, but also allowed the individuals in the second phase of interviews to reflect on their experiences of the project over the recent months and to evaluate what they had achieved (or remained to be achieved). There is a risk when only conducting one series of interviews early in the service user's engagement that it may focus too much on commencement issues. The longitudinal approach therefore eliminated this issue, and allowed the service user to discuss any emerging issues but also to reflect on his or her experience wholly over a period of several months. As a result of this, two face-to-face in-depth semi-structured interviews were conducted with each individual service user – one in October 2011 and a follow-up interview five months later in their journey in February 2012.

In addition to the interviews with the service users, interviews and a focus group were also undertaken with the health trainers. This was to gain an understanding of the issues affecting those individuals delivering the service day-to-day. The two senior health trainers were interviewed in February 2012 and a focus group with all health trainers was conducted in early July 2012. These interviews and focus group allowed the health trainers to provide further information on the journeys of service users as well as highlighting the issues faced by the health trainer team, particularly in relation to the utilisation of the DCRS system. A summary of stakeholders involved in the qualitative research is shown in Table 3.2.

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[5] All the service users interviewed had to have a minimum of six months left on their orders in order to be considered for the sample (i.e. if they were interviewed in October 2011, they had to be available for their follow-up interview five months later in February 2012). The above table does not include information on offence type and risk; however this information was collated purely for diversification of the sample.

[6] It ought to be noted many of these service users also stated that they attended for 'listening' as well as 'diet' and 'smoking' etc. For some, their lifestyle had deteriorated due to bereavement or imprisonment and so 'talking about' their issues as well as their lifestyle and diet, such as alcohol intake to cope, were also factors.

**Table 3.2: Stakeholders involved in the qualitative research process**

| Stakeholder | Method |
|---|---|
| Offenders (n=8) | 16 interviews (8 in October, 8 in February) |
| Health Trainers (n=2) | 2 interviews (February) |
| Health Trainers (n=8) | 1 focus group (July) |

All of the interviews were audio recorded, transcribed verbatim and anonymised. Thematic analysis was used to categorise the data and organise the findings into different topics. Thematic analysis is an approach to dealing with data that focuses on the creation and application of 'codes' relating to identifiable themes and patterns within the data (Aronson, 1994). The initial task of thematic analysis is to extract a list of the patterns of experience and themes from the data. This involved reading the entire data pool several times and listing the common strands that emerged. From this, an initial coding frame was developed and applied to further data. Once the coding frame was completed, it was used to identify, in each transcript, all data relating to the themes and sub-themes. Importantly, texts could have had more than one code allocated to it. Each theme was then analysed and written up to present the findings. In addition, where previous related literature exists, the team have interwoven this with the thematic findings from the fieldwork.

# 4. FINDINGS

## 4.1 INTERROGATION AND ANALYSIS OF ROUTINELY COLLECTED 'DCRS' DATA

### 4.1.1 Introduction

This section reports the findings from the interrogation and analysis of data collected and recorded routinely by health trainers using DCRS.

The DCRS extraction was for all clients who were added to the database from 01/04/2011 to 24/04/2012 and these numbered 663. However the criterion for inclusion was to include all clients with a first assessment between 01/04/2011 and 31/03/2012 – and so those clients (totalling 30) who were first assessed prior to 01/4/2011 but added later or first assessed after 31/03/2012 were removed leaving 633 clients remaining for the evaluation (representing 21.7% of the offender population subject to probation supervision in Bury, Rochdale and Oldham during this time period).

The results of the DCRS analysis are presented using tables and where appropriate graphs, supported with explanatory text. Where percentages are used, it should be noted that they will not always add up to 100, due to the impact of rounding up or down. A number of statistical terms are used, including:

- **Mean:** the average calculated by dividing the sum of all the given elements by the total number of elements
- **Standard deviation:** a measure of variability of individual observations around the mean of the observations
- **Standard error:** a measure of the precision of the mean.

A summary flow chart of clients through the Health Trainer service is provided in Box 4.1, which also indicates which tables contain more detailed information.

**Box 4.1: Flow of clients through the Health Trainer service**


### 4.1.2 Recruitment of Clients

Table 4.1 shows the month of first assessment and the month the client was added to the database. Whilst clients were usually added to the DCRS database during the month of their first assessment, some were added earlier or later – and for this reason, the April 2011 value of 31 clients may be a slight underestimate (as the extracted data only relates to clients added to DCRS from 01 April 2011). Table 4.2 details recruitment of clients by probation office caseload – there being 23.7% in Rochdale, 40.4% in Bury and 35.9% in Oldham. Based on the data provided by GMPT, this suggests that, during this time period, those recruited represented approximately 37.6% of the offender population subject to probation supervision in Bury; 13.4% in Rochdale; and 20.2% in Oldham.

**Table 4.1: Recruitment of clients who were included in the evaluation**

| | | Date client added to database | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2011 | | | | | | | | | 2012 | | | | |
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | Total |
| Date of 1st assessment | 2011 | | | | | | | | | | | | | | |
| | Apr | 21 | 8 | 1 | | | | | | | | | 1 | | *31 |
| | May | | 40 | 4 | | | | | | | | 1 | | | 45 |
| | Jun | | 5 | 41 | 10 | | | | | | | 1 | | | 57 |
| | Jul | | 2 | 4 | 43 | 4 | | | | 1 | | 2 | | | 56 |
| | Aug | | 2 | | 5 | 60 | 9 | | | | | | | | 76 |
| | Sep | | | | | | 20 | 16 | 1 | | | | | | 37 |
| | Oct | | 1 | | | 1 | | 41 | 9 | 1 | | | | | 53 |
| | Nov | | | | | 1 | | 1 | 49 | 10 | 4 | | 1 | | 66 |
| | Dec | | | | | | | | | 19 | 1 | | | | 20 |
| | 2012 | | | | | | | | | | | | | | |
| | Jan | | | | | | | | 1 | | 56 | 13 | 1 | | 71 |
| | Feb | | | | | | | | | | | 64 | 2 | | 66 |
| | Mar | | | | | | | | | | | | 52 | 3 | 55 |
| Total | | 21 | 58 | 50 | 58 | 66 | 29 | 58 | 60 | 31 | 61 | 81 | 57 | 3 | 633 |

* Likely to be an underestimate.

**Table 4.2: Numbers of clients by probation office caseloads**

| | | Caseload: | | | |
|---|---|---|---|---|---|
| | Boroughs of: | Rochdale | Bury | Oldham | Total |
| Date of 1st assessment | 2011 | | | | |
| | Apr | 9 | 18 | 4 | *31 |
| | May | 12 | 22 | 11 | 45 |
| | Jun | 25 | 17 | 15 | 57 |
| | Jul | 13 | 27 | 16 | 56 |
| | Aug | 12 | 32 | 32 | 76 |
| | Sep | 9 | 14 | 14 | 37 |
| | Oct | 13 | 23 | 17 | 53 |
| | Nov | 14 | 25 | 27 | 66 |
| | Dec | 1 | 10 | 9 | 20 |
| | 2012 | | | | |
| | Jan | 19 | 25 | 27 | 71 |
| | Feb | 9 | 22 | 35 | 66 |
| | Mar | 14 | 21 | 20 | 55 |
| Total | | 150 (23.7%) | 256 (40.4%) | 227 (35.9%) | 633 (100%) |

* Likely to be an underestimate.

Clients heard about the Health Trainer service via a number of routes, as shown in Table 4.3. Over half had been referred and one third had heard about the service by word of mouth.

**Table 4.3: Where the clients heard about the Health Trainers' Service**

| Source | | |
|---|---|---|
| At work | 6 | (0.9%) |
| By being referred | 365 | (57.7%) |
| Community services | 13 | (2.1%) |
| Other care services | 2 | (0.3%) |
| Poster / leaflet | 22 | (3.5%) |
| Promotional event | 4 | (0.6%) |
| Word of mouth | 221 | (34.9%) |
| Total | 633 | (100%) |

### 4.1.3 Client Demographics

Details of clients' age, gender, ethnicity, disability status and GP registration are given in Table 4.4.

This shows that 82% of clients were male and 18% female (a gender ratio of 4.6 to 1) – compared to a distribution of 86% male and 14% female in the overall offender population for Bury, Rochdale and Oldham.[7] The age of clients spanned all groups and the average age for men was 31.7 years and for women 31.2 years.

Whilst the majority (85%) of clients reported their ethnicity as White British, a diversity of ethnic groups were represented. Black and Minority Ethnic groups thus comprised 15% of the Health Trainer service clients compared to 21% of the offender population[8] and 17% of the overall population[9] of Bury, Rochdale and Oldham. For the majority of clients (60%) the disability status was not recorded and only 2% of clients were known to have a disability.

One fifth (20%) of clients were not registered with a GP – which compares starkly with just 1% of the population as a whole.[10] Data on employment status is not available as a decision was taken by Greater Manchester Probation Trust part way through the year not to collect this information.

[7] Source: Greater Manchester Probation Trust, 2012

[8] Source: Greater Manchester Probation Trust, 2012

[9] Source: www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-50029

[10] Source: HM Government, 2010

**Table 4.4: Client demographics**

| **Gender** | | | **Disability** | | |
|---|---|---|---|---|---|
| Men | 521 | (82.3%) | Disabled | 13 | (2.1%) |
| Women | 112 | (17.7%) | Not disabled | 241 | (38.1%) |
| Not stated | 0 | (0.0%) | Not stated | 379 | (59.9%) |
| Total | 633 | (100%) | Total | 633 | (100%) |
| **Ethnicity** | | | **Age (years)** | | |
| White | | | Men | | |
| British | | (84.7%) | 16-17 | 1 | (0.2%) |
| Irish | 2 | (0.3%) | 18-25 | 180 | (34.5%) |
| Other | 2 | (0.3%) | 26-35 | 166 | (31.9%) |
| Mixed | | | 36-45 | 99 | (19.0%) |
| White & Black Caribbean | 22 | (3.5%) | 46+ | 61 | (11.7%) |
| White & Black African | 5 | (0.8%) | Not known | 14 | (2.7%) |
| White & Asian | 6 | (0.9%) | Total | 521 | (100%) |
| Mixed | 1 | (0.2%) | Mean age 31.7 (n=507) | | |
| Asian or Asian British | | | SD 10.5 (n=507) | | |
| Indian | 6 | (0.9%) | Women | | |
| Pakistani | 27 | (4.3%) | 16-17 | | |
| Bangladeshi | 7 | (1.1%) | 18-25 | 41 | (36.6%) |
| Other | 1 | (0.2%) | 26-35 | 40 | (35.7%) |
| Black or Black British | | | 36-45 | 20 | (17.9%) |
| Caribbean | 5 | (0.8%) | 46+ | 10 | (8.9%) |
| African | 4 | (0.6%) | Not known | 1 | (0.9%) |
| Other | 2 | (0.3%) | Total | 112 | (100%) |
| Other ethnic group | 2 | (0.3%) | Mean age 31.2 (n=111) | | |
| Not stated | 5 | (0.8%) | SD 9.7 (n=111) | | |
| Total | 633 | (100%) | All | | |
| | | | 16-17 | 1 | (0.2%) |
| **GP Registration** | | | 18-25 | 221 | (34.9%) |
| Registered | 505 | (79.8%) | 26-35 | 206 | (32.5%) |
| Not registered | 128 | (20.2%) | 36-45 | 119 | (18.8%) |
| Not stated | | | 46+ | 71 | (11.2%) |
| Total | 633 | (100%) | Not known | 15 | (2.4%) |
| | | | Total | 633 | (100%) |
| | | | Mean age 31.6 (n=618) | | |
| | | | SD 10.4 (n=618) | | |

### 4.1.4 Clients' initial assessments:

Most clients (588 out of 633) made just one 'journey' through the Health Trainer service. However, a minority completed this first journey, were signed off and then accessed the service once more (41); and four clients accessed the service three times (N.B. a total of 45 clients accessed the service twice because those who assessed it three times also had a second assessment). This resulted in a total of 682 initial assessments for the 633 clients, as shown in Table 4.5.[11]

**Table 4.5: Number of initial assessments of clients**

| Initial assessments | Clients | | Initial assessments | |
|---|---|---|---|---|
| 1 | 588 | (90.4%) | 588 | (81.1%) |
| 2 | 41 | (7.9%) | 82 | (14.2%) |
| 3 | 4 | (1.7%) | 12 | (4.6%) |
| Total | 633 | (100%) | 682 | (100.0%) |

The assessment spread sheet extracted from DCRS required some cleaning due to repeated entry of some initial assessments. This resulted in a very small mismatch between date of first initial assessment given in the assessments spread sheet and the date of initial assessment given in the clients' spread sheet – but this mismatch is too small to be of any consequence for the evaluation (See Appendix – Table A1).

The dates of the first, second and third initial assessments are shown in Table 4.6 and the source of referral for this assessment is shown in Table 4.7 The large majority of clients were referred either by the probation service (48%) or were self-referred (39%) – and feedback from the Health Trainer service has confirmed that these two referral routes are now the only two options that can be entered onto DCRS.

**Table 4.6: Dates of up to three initial assessments**

| | | Initial assessments | | | |
|---|---|---|---|---|---|
| | | First | Second | Third | All |
| 2011 | Apr | 30 | | | 30 |
| | May | 46 | 1 | | 47 |
| | Jun | 57 | 4 | | 61 |
| | Jul | 56 | | | 56 |
| | Aug | 76 | 8 | | 84 |
| | Sep | 36 | 8 | 1 | 45 |
| | Oct | 54 | 5 | | 59 |
| | Nov | 66 | 2 | | 68 |
| | Dec | 20 | 1 | | 21 |
| 2012 | Jan | 71 | 6 | | 77 |
| | Feb | 66 | 3 | 1 | 70 |
| | Mar | 55 | 4 | 2 | 61 |
| | Apr | | 3 | | 3 |
| | Total | 633 | 45 | 4 | 682 |

[11] In the tables that present data showing the first, second and third initial assessments, percentages are sometimes given for the first assessment only (when the data is primarily describing the clients) and sometimes for the total number of assessments (when the data is primarily describing the assessments).

**Table 4.7: Source of referral for initial assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Advice and guidance | 4 | | | 4 | (0.6%) |
| Community / voluntary services | 7 | | | 7 | (1.0%) |
| Emotional wellbeing services | 14 | | | 14 | (2.1%) |
| GP or other primary care service | 3 | | 1 | 4 | (0.6%) |
| Health Trainer services | 41 | 1 | | 42 | (6.2%) |
| Lifestyle risk management services | 1 | | | 1 | (0.1%) |
| Local authority services | 16 | | | 16 | (2.3%) |
| Probation | 312 | 15 | | 327 | (47.9%) |
| Self | 235 | 29 | 3 | 267 | (39.1%) |
| Total | 633 | 45 | 4 | 682 | (100%) |

At the initial assessment, over 95% of clients had clinical contra-indications, more than 94% had multiple wellbeing risks and almost 95% stated that they wanted assistance (Tables 4.8-4.10).

**Table 4.8: Clinical contraindications at initial assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| Clinical contraindications | First | | Second | Third | All |
| Not stated/blank | 15 | (2.4%) | 2 | | 17 |
| No | 15 | (2.4%) | 1 | | 16 |
| Yes | 603 | (95.3%) | 42 | 4 | 649 |
| Total | 633 | (100%) | 45 | 4 | 682 |

**Table 4.9: Multiple wellbeing risks at initial assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| Multiple wellbeing risks | First | | Second | Third | All |
| Not stated/blank | 15 | (2.4%) | 1 | | 16 |
| No | 20 | (3.2%) | 0 | | 20 |
| Yes | 598 | (94.5%) | 44 | 4 | 646 |
| Total | 633 | (100%) | 45 | 4 | 682 |

**Table 4.10: Assistance wanted at initial assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| Assistance wanted | First | | Second | Third | All |
| Not stated/blank | 17 | (2.7%) | 1 | | 18 |
| No | 15 | (2.4%) | 0 | | 15 |
| Yes | 601 | (94.9%) | 44 | 4 | 649 |
| Total | 633 | (100%) | 45 | 4 | 682 |

A range of topics were discussed at initial assessment, as shown in Table 4.11 – with the most common being smoking (26%) followed by exercise (21%). Feedback from the Health Trainer service has confirmed that 'local issue' was used for a diversity of topics including sexual health and GP registration.

**Table 4.11: Topics discussed at initial assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Blank/Not stated | 53 | 5 | | 58 | (8.5%) |
| Alcohol | 61 | 1 | | 62 | (9.1%) |
| Diet | 88 | 2 | | 90 | (13.2%) |
| Emotional wellbeing | 80 | 8 | | 88 | (12.9%) |
| Exercise | 136 | 5 | 1 | 142 | (20.8%) |
| Local issue | 60 | 2 | 1 | 63 | (9.2%) |
| Smoking | 155 | 22 | 2 | 179 | (26.2%) |
| Total | 633 | 45 | 4 | 682 | (100%) |

Following initial assessment, an outcome was recorded. Of the 633 clients who went for their first initial assessment, 527 were deemed eligible to proceed to full assessment. However, some decided not to proceed at this stage and a total of 496 actually progressed to full assessment (see Appendix: Table A2).

### 4.1.5 Full Assessments

In presenting data relating to the 496 clients who proceeded to the full assessment stage, some tables are concerned with the journey following the first initial assessments, whilst others combine information from first, second and third initial assessments.

Table 4.12 shows the primary issue selected at full assessment – and in addition to smoking, exercise, emotional wellbeing, diet and alcohol, 16% of clients did not have a primary issue recorded. Following full assessment, an outcome was recorded (see Appendix: Table A3). At this stage, 22 clients did not proceed further and 474 progressed to the next stage of undertaking wellbeing assessments and developing personal health plans (PHPs). The primary issue for these 474 clients is shown in Table 4.13, from which it is clear that the 22 not proceeding were among those for whom no primary issue had been recorded. Figure 4.1 shows the composition of primary issues at the wellbeing/PHP stage: as can be seen, the most frequent primary issue was smoking and the least frequent was alcohol – but these and all other issues were well represented in the client data.

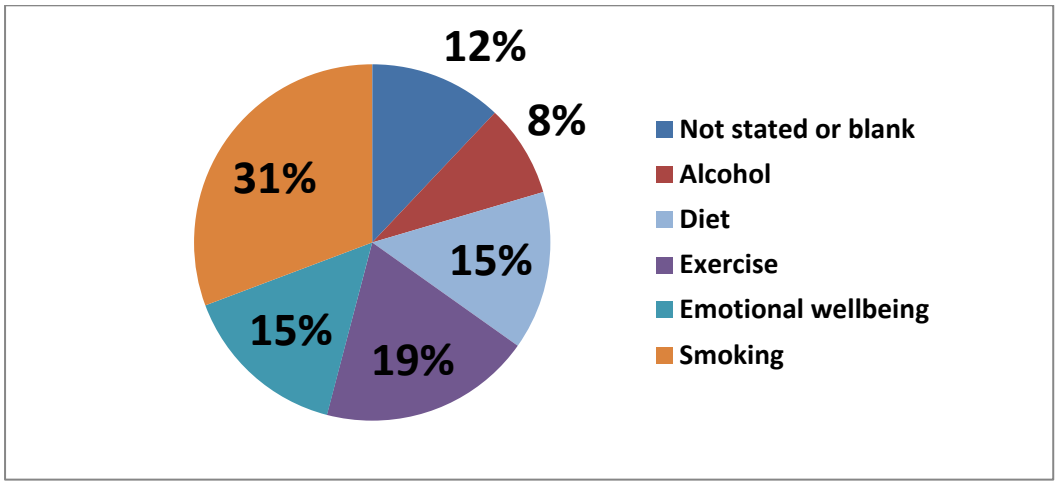
**Table 4.12: Primary issue at full assessments**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Blank/Not stated | 80 | 6 | 1 | 87 | (16.1%) |
| Alcohol | 42 | 1 | | 43 | (8.0%) |
| Diet | 73 | 1 | | 74 | (13.7%) |
| Exercise | 95 | 3 | 1 | 99 | (18.4%) |
| Emotional wellbeing | 73 | 5 | | 78 | (14.5%) |
| Smoking | 133 | 23 | 2 | 158 | (29.3%) |
| Total | 496 | 39 | 4 | 539 | (100%) |

**Table 4.13: Primary issue for those proceeding to wellbeing/PHP stage**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Not stated/blank | 58 | 4 | | 62 | (12.1%) |
| Alcohol | 42 | 1 | | 43 | (8.4%) |
| Diet | 73 | 1 | | 74 | (14.4%) |
| Exercise | 95 | 3 | 1 | 99 | (19.3%) |
| Emotional wellbeing | 73 | 5 | | 78 | (15.2%) |
| Smoking | 133 | 23 | 2 | 158 | (30.7%) |
| Total | 474 | 37 | 3 | 514 | (100%) |

**Figure 4.1: Primary issue for clients who proceeded to wellbeing/PHP**




PHPs were drawn up for clients following full assessment and the number recorded per client for all initial assessments is shown in Table 4.14. It can be seen that of the 474 clients progressing to this stage, 88 had no PHP set.

**Table 4.14: Numbers of personal health plans (PHPs) made for the clients proceeding to the wellbeing/PHP stage (first initial assessments)**

| PHPs | Clients | % |
|---|---|---|
| 0 | 88 | (18.6%) |
| 1 | 245 | (51.7%) |
| 2 | 74 | (15.6%) |
| 3 | 30 | (6.3%) |
| 4 | 16 | (3.4%) |
| 5-9 | 16 | (3.4%) |
| 10-14 | 4 | (0.8%) |
| 15-19 (maximum number = 15) | 1 | (0.2%) |
| Total | 474 | (100%) |

Health and wellbeing were measured at the commencement of the PHP process using three tools used widely in Health Trainer services and integrated into the DCRS data collection system – although not for all of the clients proceeding to the wellbeing/PHP stage (the reason for the missing scores in unknown). The mean scores were as follows (see Appendix: Table A4):

- self-efficacy (feeling able to take more control of lifestyle): 72% based on 333 assessments
- general health: 40% based on 351 assessments
- WHO-5 wellbeing: 43% based on 315 assessments.

For the primary issues of alcohol, diet, exercise and smoking, measures of activity and consumption were recorded before commencement of the PHP and these are given in Tables 4.15 to 4.18.

**Table 4.15: Alcohol as primary issue for those clients who proceeded to wellbeing/PHP stage (first initial assessment)**

| | Clients | % |
|---|---|---|
| Alcohol status at full assessment: | | |
| Blank/not stated | 2 | (4.8%) |
| No | 1 | (2.4%) |
| Yes, less than once weekly | 1 | (2.4%) |
| Yes, more than once weekly | 38 | (90.5%) |
| Total | 42 | (100%) |
| Total alcohol units per week: | | |
| Blank/not stated | 2 | (4.8%) |
| 0 | 2 | (4.8%) |
| 1-49 | 11 | (29.2%) |
| 50-99 | 15 | (35.7%) |
| 100-149 | 5 | (11.9%) |
| 150-199 | 3 | (4.1%) |
| 200-249 | 2 | (4.8%) |
| 250-300 | 2 | (4.8%) |
| Total | 42 | (100%) |
| Mean | 88.5 | |
| SD | 69.1 | |

**Table 4.16: Diet as primary issue for those clients who proceeded to wellbeing/PHP stage (first initial assessment)**

| | Sample size (missing values) | Mean (SD) |
|---|---|---|
| Consumption per day: | | |
| Fruit | 68 (5) | 1.0 (1.2) |
| Vegetables | 68 (5) | 1.3 (1.6) |
| Fried foods | 67 (6) | 1.2 (1.2) |
| Fat foods | 67 (6) | 1.6 (1.2) |
| Snacks | 66 (6) | 2.1 (3.7) |

**Table 4.17: Exercise as primary issue for those clients who proceeded to wellbeing/PHP stage (first initial assessment)**

| | Sample size (missing values) | Mean (SD) |
|---|---|---|
| Number of sessions per week: | | |
| 30 minute moderate exercise | 89 (6) | 3.4 (3.3) |
| 20 minute intensive exercise | 88 (7) | 1.3 (2.4) |

**Table 4.18: Smoking as primary issue for those proceeding to wellbeing/PHP stage (first initial assessment)**

| | Clients | % |
|---|---|---|
| Consumption cigarettes per day: | | |
| 0 | 4 | (3.0%) |
| 1-5 | 6 | (4.5%) |
| 6-10 | 28 | (21.1%) |
| 11-15 | 29 | (21.8%) |
| 16-20 | 41 | (30.8%) |
| 21-30 | 16 | (12.0%) |
| 31-40 | 7 | (5.3%) |
| More than 40 | 2 | (1.5%) |
| Total | 133 | (100%) |
| Mean[1] 17.7 | | |
| SD 9.2 | | |

[1] Includes the four zero values.

Health trainers and clients kept in touch and contacts were recorded (see Appendix: Table A5). The majority of the clients (454) had between 1 and 4 contacts with their health trainer, 6 had no contacts, 110 had between 5 and 9 contacts, and the remaining 63 had more than 10 contacts – the maximum being 32. Clients' progress was also reviewed at intervals (see Appendix: Table A6). In total, only 142 clients had at least one review following their first initial assessment – meaning that 332 of the 474 clients proceeding to the wellbeing/PHP stage were recorded as having no reviews.

### 4.1.6 Clients' Motivation

Clients who proceeded to the wellbeing/PHP stage were asked about their motivation to make changes in their health. In terms of the importance of addressing the primary issue, 83% of clients gave a rating of 8 or more out of 10 and in terms of their confidence in achieving change, 63% gave a rating of 8 or more out of 10 (see Appendix: Table A7).

Table 4.19 records why clients felt that it was important to address their primary issue and what would increase its importance. 'Risk to health' was the most often expressed reason (46%), followed by 'own beliefs about changing behaviours' (22%). In relation to increasing the importance of addressing the primary issue, among those answering the question or seeing it as applicable, 'knowing that support is available' was the most often expressed factor (20%), followed by 'being willing to take necessary action' (10%). Table 4.20 records what clients felt would increase confidence to achieve their primary goal, with the 'guaranteed support of a health trainer' being seen as by far the most important factor (47%).

**Table 4.19: Client-stated reason for importance and what would increase importance**

| Why is it important to address this issue? | Clients | (%) | What would increase its importance? | Clients | (%) |
|---|---|---|---|---|---|
| Another's influence | 2 | (0.4%) | Being willing to take necessary action | 47 | (9.9%) |
| Family and friends belief about current behaviours | 40 | (8.4%) | Support of family and friends | 25 | (5.5%) |
| Health risks of continuing current behaviours | 220 | (46.4%) | Risk of getting worse | 25 | (5.3%) |
| Likely response of other people | 10 | (2.1%) | Knowing that support is available | 94 | (19.8%) |
| Own beliefs about changing behaviours | 106 | (22.4%) | Believing achieving goal is possible | 29 | (6.1%) |
| Previous experience of addressing issue | 8 | (1.7%) | Knowing what to do to achieve goal | 24 | (5.1%) |
| Seriousness of issue | 18 | (3.8%) | Desire to achieve goal | 14 | (3.0%) |
| | | | Prioritising behaviour change | 16 | (3.4%) |
| Other | 14 | (3.0%) | Other | 9 | (1.9%) |
| Not stated | 56 | (11.8%) | Not stated | 52 | (11.0%) |
| | | | Not applicable | 139 | (29.3%) |
| Total | 474 | (100%) | Total | 474 | (100%) |

**Table 4.20: Client-stated assistance that would increase confidence**

| What would increase your confidence? | Clients | (%) |
|---|---|---|
| Assurance of a confidential service | 1 | (0.2%) |
| Being satisfied with progress | 39 | (8.2%) |
| Clear realistic goals | 16 | (3.4%) |
| Guaranteed support of family and friends | 8 | (1.7%) |
| Guaranteed support of health trainer | 223 | (47.0%) |
| Overcoming fear of failure | 8 | (1.7%) |
| Not applicable | 107 | (22.6%) |
| Not stated | 72 | (15.2%) |
| Total | 474 | (100%) |

### 4.1.7 Client sign off

In principle, clients were signed off when they exited the programme, either at completion or abandonment of the PHP – or beforehand if they did not progress to the wellbeing/PHP stage. The reasons for sign-off for the 474 clients proceeding to the wellbeing/PHP stage are shown in Table 4.21 – the most commonly recorded being 'completed the PHPs' (34.6%), 'did not attend'(30%), 'did not follow plan' (7.3%) and 'was not contactable' (7.0%). Details of sign-off reasons for all 633 clients are shown in Table A8 (see Appendix) – which suggests that 'was signposted only' and 'only wanted some information' were the most common sign-off reasons for those clients not proceeding to the wellbeing/PHP stage.

**Table 4.21: Sign off reason for clients proceeding to wellbeing/PHP stage (all clients)**

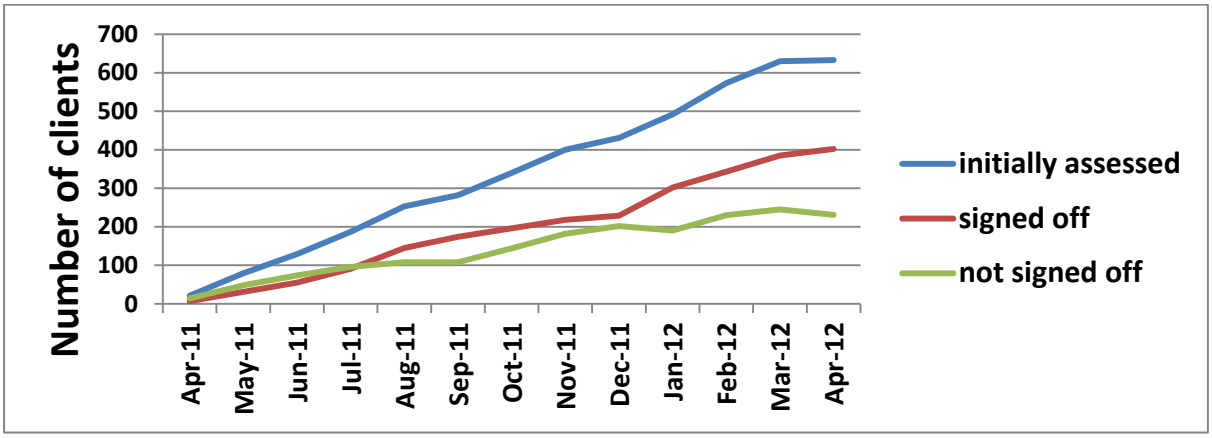
| | Initial assessments | | | | |
|---|---|---|---|---|---|
| Client…… | First | Second | Third | All | |
| chose an alternative service | 3 | | | 3 | (1.0%) |
| did not attend | 82 | 4 | | 86 | (30.1%) |
| could not afford desired activities | 2 | | | 2 | (0.7%) |
| was not contactable | 18 | 2 | | 20 | (7.0%) |
| did not follow plan | 19 | 2 | | 21 | (7.3%) |
| did not realised commitment required | 13 | 2 | | 15 | (5.2%) |
| insufficient support from significant others | | 1 | | 1 | (0.3%) |
| was disappointed with rate of progress | 1 | | | 1 | (0.3%) |
| was unable to continue | 13 | | 1 | 14 | (4.9%) |
| had mini-health MOT only | 1 | | | 1 | (0.3%) |
| was not eligible | 2 | | | 2 | (0.7%) |
| was not ready to make changes | 3 | 1 | | 4 | (1.4%) |
| only wanted some information | | 1 | | 1 | (0.3%) |
| had another reason | 6 | 1 | | 7 | (2.4%) |
| completed the PHPs | 87 | 12 | | 99 | (34.6%) |
| partially completed the PHPs | 7 | 1 | | 8 | (2.8%) |
| was recommended to primary care | | 1 | | 1 | (0.3%) |
| Total signed off | 257 | 28 | 1 | 286 | (100%) |
| Total not signed off | 217 | 9 | 2 | 228 | |
| Total | 474 | 37 | 3 | 514 | |

Whilst it would be expected that clients recruited later in the year would still be working through their PHP and therefore still be 'in the system', only 402 of the 633 clients had been signed off by the date of the DCRS data extraction (see Appendix: Table A9) – leaving 231 not signed off. As this number was felt to be far larger than should reasonably be anticipated, it was decided to investigate further in order to gain insight into whether this figure was correct or the result of data entry problems or errors. This was necessary in order to estimate as accurately as possible the percentage of clients who fully or partially completed their PHPs – parameters which are required to gain insight into the success of the service and to use the value for money tool (see 4.2).

The Health Trainer service was contacted for further clarification and feedback confirmed that there had been some problems with data entry that had affected clients being signed off on DCRS. Further analysis was therefore undertaken. By comparing the date of first initial assessment to the date of sign off and whether the clients were signed off or not signed off (Tables A10 and A11), it can be seen that many clients who entered the programme towards the beginning of the evaluation year were still not signed off at the end of the year – with 80 clients who had their initial assessment between April and September 2011 still in the system in April 2012. To look at this in more detail, the contacts spread sheet was accessed to obtain the final contact date for each client who had not been signed off and thus obtain an indication of whether they were still 'active clients' and should have been signed off (see Appendix: Table A12 for all clients; Table A13 for clients who proceeded to the wellbeing/PHP stage). For all clients, 99 out of the 231 who had not been signed off (43%) had not been contacted since the end of 2011 (nearly four months prior to data extraction); and for clients who proceeded to the wellbeing/PHP stage, 97 out of 217 (45%) had not been contacted since the end of 2011. Using the assumption that 'active clients' would have had contact with their Health Trainer within the previous four months, these figures strongly

support the supposition that there have been data entry problems or errors and that approximately 45% of clients who were not signed off should have been signed off. Further confirmation is provided by viewing graphically the number of clients entering, exiting and remaining in the Health Trainer service during the evaluation year (see Figure 4.2). This likewise points to inaccuracies in data entry with insufficient clients being signed off, since the expectation would be that the numbers not signed off would reach an equilibrium value and not continue to rise.

**Figure 4.2: The numbers of clients entering the programme by initial assessment and exiting the programme by being signed off in the evaluation year**




By using the assumption that 45% of those not signed off should have been signed off (but had not been due to data entry problems or errors), it is possible to make an adjustment to the sign-off figures – as illustrated in Figures 4.3 and 4.4. These use the data from Table 4.21 to show the sign-off reason diagrammatically, the first showing percentages for all signed off clients without an adjustment, the second showing the percentages with an adjustment (i.e. assuming that the total number of signed off clients should be 389 instead of 286 – including an additional 103 clients).

**Figure 4.3: Sign off reason for clients who proceeded to the wellbeing/PHP stage (all assessments)**

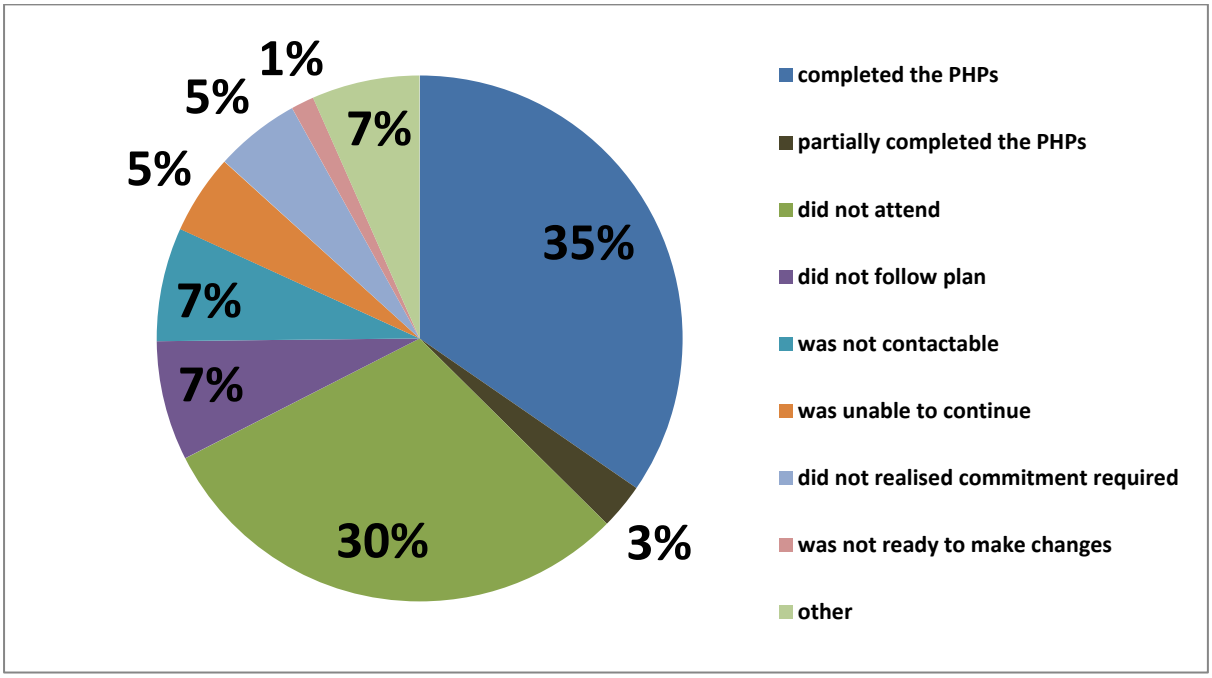
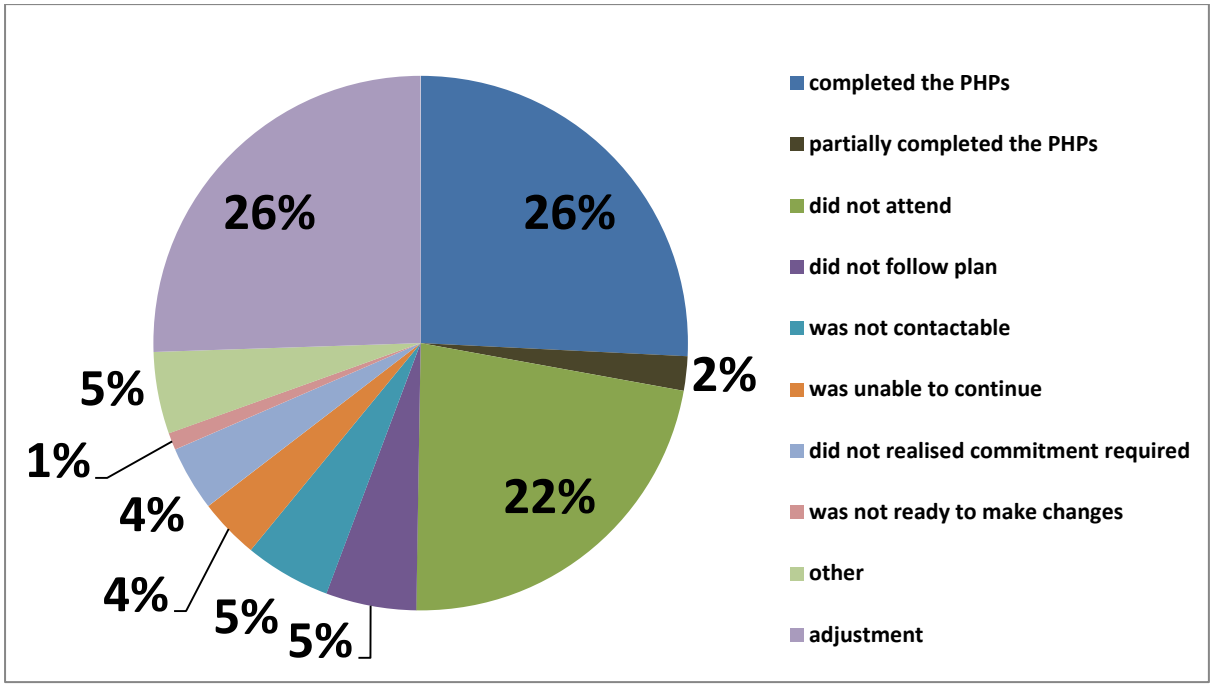


**Figure 4.4: Sign off reason for clients who proceeded to the wellbeing/PHP stage (all assessments) adjusted using the assumption that 45% of those not signed off should have been signed off**




### 4.1.8 Achievement of Personal Health Plan goals

In analysing the data relating to achievement of PHP goals, the same adjustment was used, based on the assumption that 45% of clients not signed off should have been signed off (but had not been due to data entry problems or errors). In addition, recognising that these clients have had no contact with the Health Trainer service for a number of months, a further assumption was made that these clients had not completed their PHP.

The numbers of clients who fully or partially achieved their PHPs for each primary issue is shown in Table 4.22. Using the above adjustment, it was possible from these values to estimate the percentages of clients who achieved or partially achieved their PHP goal for each primary issue – using the following calculations:

% fully achieving goal = 100N2 / (0.45N1+N2+N3+N4)

% partially achieving goal = 100N3 / (0.45N1+N2+N3+N4)

where:

N1 = number of clients not signed off

N2 = number of clients signed off having fully completing their PHP

N3 = number of clients signed off having partially completing their PHP

N4 = number of clients signed off having not completely their PHP.

For alcohol as primary issue, 28.4% fully and 3.6% partially completed their PHP; for diet the values were 20.7% and 1.9% respectively; for exercise 27.8% and 2.8%; for smoking 23.4% and 2.3%, for emotional wellbeing 48.5% and 1.7%; and for 'other or not stated' 2.1% and 0.0%.

**Table 4.22: Percentage achieving goals for each primary issue for those clients who proceeded to wellbeing/PHP stage (adjusted to allow for data entry problems/errors – all assessments)**

| | Initial assessments | | | | Goal achievement |
|---|---|---|---|---|---|
| | First (adjusted) | Second | Third | All (adjusted) | % (adjusted) |
| **Primary issue Alcohol:** | | | | | |
| Not signed off | 27 | | | 27 (14.8) | |
| Signed off PHP completed | 8 | | | 8 | 28.4% |
| Signed off PHP partially completed | 1 | | | 1 | 3.6% |
| Signed off PHP not completed | 6 | 1 | | 7 (19.2) | 68.0% |
| Total | 42 | 1 | | 43 | |
| **Primary issue Diet:** | | | | | |
| Not signed off | 38 | | | 38 (20.9) | |
| Signed off PHP completed | 10 | 1 | | 11 | 20.7% |
| Signed off PHP partially completed | 1 | | | 1 | 1.9% |
| Signed off PHP not completed | 24 | | | 24 (41.1) | 77.4% |
| Total | 73 | 1 | | 74 | |
| **Primary issue Exercise** | | | | | |
| Not signed off | 49 | | | 49 (27.0) | |
| Signed off PHP completed | 17 | 3 | | 20 | 27.8% |
| Signed off PHP partially completed | 2 | | | 2 | 2.8% |
| Signed off PHP not completed | 27 | | 1 | 28 (50) | 69.4% |
| Total | 95 | 3 | 1 | 99 | |
| **Primary issue Smoking** | | | | | |
| Not signed off | 44 | 8 | 2 | 54 (29.7) | |
| Signed off PHP completed | 23 | 7 | | 30 | 23.4% |
| Signed off PHP partially completed | 3 | 0 | | 3 | 2.3% |
| Signed off PHP not completed | 63 | 8 | | 71 (95.3) | 74.3% |
| Total | 133 | 23 | 2 | 158 | |
| **Primary issue Emotional wellbeing** | | | | | |
| Not signed off | 32 | 1 | | 33 (18.2) | |
| Signed off PHP completed | 28 | 1 | | 29 | 48.5% |
| Signed off PHP partially completed | 0 | 1 | | 1 | 1.7% |
| Signed off PHP not completed | 13 | 2 | | 15 (29.8) | 49.8% |
| Total | 73 | 5 | | 78 | |
| **Primary issue Other or not stated** | | | | | |
| Not signed off | 27 | | | 27 (14.8) | |
| Signed off PHP completed | 1 | | | 1 | 2.1% |
| Signed off PHP partially completed | 0 | | | 0 | 0.0% |
| Signed off PHP not completed | 30 | 4 | | 34 (46.2) | 97.9% |
| Total | 58 | 4 | | 62 | |

### 4.1.9 Changes in health-related behaviours – pre-assessment and post-assessment measures

When the PHP had been completed or abandoned, clients who had been signed off undertook a post-assessment which evaluated their health and wellbeing at the end of their programme. The number of post assessments in the DCRS data was lower than expected. Post-assessments on fruit and vegetable consumption were available for 26 clients only, alcohol total for 34 clients, moderate exercise for 50 clients and smoking for 158 clients. Table 4.23 shows these totals broken down by signed off status.

**Table 4.23: Availability of post assessments by signed off status at first assessment (all primary issues)**

| | Post assessments on: | | | |
|---|---|---|---|---|
| | Fruit and veg per day | Alcohol total | Moderate exercise | Smoking total |
| Signed off status: | | | | |
| Not signed off | 0 | 0 | 0 | 0 |
| Signed off PHP completed | 14 | 14 | 24 | 37 |
| Signed off PHP partially completed | 3 | 2 | 4 | 5 |
| Signed off PHP not completed | 9 | 18 | 22 | 116 |
| Total | 26 | 34 | 50 | 158 |

In order to compare fairly the measures at the start and end of the programme, a measure was required both before and after the PHP on the same client. Table 4.24 shows the numbers of clients who had a measure both before and after the PHP and for each measure the numbers are separated into those who had the primary issue relevant to that measure and those clients who did not have that primary issue. The mean and SD are given for the before and after measures based on the same individual clients.

A comparison of Tables 4.23 and 4.24 indicate that post-assessments were undertaken for a number of clients for whom pre-assessments had not been undertaken: there are 34 post-assessments for alcohol but only 25 before-after pairs, implying that 9 clients had a post-assessment but no pre-assessment; 158 post-assessments for smoking but only 80 before-after pairs, implying that 78 had post-assessments but no pre-assessment; and 26 post-assessments for fruit and vegetable intake but only 22 before-after pairs, implying that 4 had post-assessments but no pre-assessment. In these instances, the usefulness of the post-assessment is questionable as its purpose is to measure change – which cannot be done without a pre-assessment.

**Table 4.24: Before and after measures showing health-related lifestyle changes**

| Number of before-after pairs | | Before | | After | | Change | |
|---|---|---|---|---|---|---|---|
| | | Mean (SD) | Range | Mean (SD) | Range | Mean (SD) | |
| **Fruit & Vegetables (portions/day)** | | | | | | | |
| All before& after pairs | 22 | 2.1 (1.6) | 0-5 | 4.0 (2.0) | 0-8 | 1.8 (2.4) | ↑ |
| Primary issue Diet | 8 | 1.6 (1.5) | 0-4 | 4.5 (2.3) | 2-8 | 2.9 (2.1) | ↑ |
| Primary issue not Diet | 14 | 2.4 (1.7) | 0-5 | 3.6 (1.9) | 0-6 | 1.2 (2.4) | ↑ |
| **Alcohol (units/week)** | | | | | | | |
| All before & after pairs | 25 | 38.1 (37.9) | 2-154 | 26.2 (36.0) | 0-154 | -11.9 (21.4) | ↓ |
| Primary issue Alcohol | 4 | 51.3 (18.9) | 26-70 | 12.3 (8.7) | 0-20 | -39.0 (17.5) | ↓ |
| Primary issue not Alcohol | 21 | 35.6 (40.4) | 2-154 | 28.9 (38.7) | 0-154 | -6.7 (18.2) | ↓ |
| **Moderate Exercise (sessions/week)** | | | | | | | |
| All before & after pairs | 50 | 3.3 (3.4) | 0-14 | 4.2 (3.1) | 0-14 | 0.9 (2.3) | ↑ |
| Primary issue Exercise | 17 | 3.9 (3.3) | 0-8 | 5.3 (2.9) | 0-10 | 1.4 (2.9) | ↑ |
| Primary issue not Exercise | 33 | 3.0 (3.5) | 0-14 | 3.7 (3.1) | 0-14 | 0.7 (1.9) | ↑ |
| **Smoking (cigarettes/day)** | | | | | | | |
| All before & after pairs | 80 | 14.7 (10.6) | 0-40 | 8.1 (10.0) | 0-60 | -6.6 (14.2) | ↓ |
| Primary issue Smoking | 39 | 19.2 ( 8.8) | 3-40 | 5.8 ( 7.8) | 0-25 | -13.4 (11.4) | ↓ |
| Primary issue not Smoking | 41 | 10.4 (10.4) | 0-40 | 10.3 (11.4) | 0-60 | -0.1 (13.7) | ↓ |

Figures 4.5-4.8 use the data from Table 4.24 to illustrate the changes in the mean values for the fruit and vegetable intake, alcohol consumption, moderate exercise and smoking – for all clients who had before-after measures and separately for those for whom the measure related or did not relate to their primary issue. It can be seen that:

- there was a substantial mean increase in fruit and vegetable portions per day for all clients (1.8), this being greater for those whose primary issue was diet (2.9) compared to those whose primary issue was not diet (1.2)
- there was a substantial decrease in mean total weekly alcohol consumption for all clients (11.9 units), this being relatively large (39 units) for those whose primary issue was alcohol and relatively small (6.7 units) for those whose primary issue was not alcohol
- there is a moderate increase in the mean weekly number of moderate exercise sessions for all clients (0.9), this being twice as great (1.4) for those whose primary issue was exercise compared to those whose primary issue was not exercise (0.7)
- there is a decrease in number of cigarettes per day for all clients (6.6), this being substantial for clients whose primary issue was smoking (13.4) and negligible for those clients whose primary issue was other than smoking (0.1).

**Figure 4.5: Mean number of portions fruit and vegetables per day before and after the PHP (bars show the standard error of the mean)**

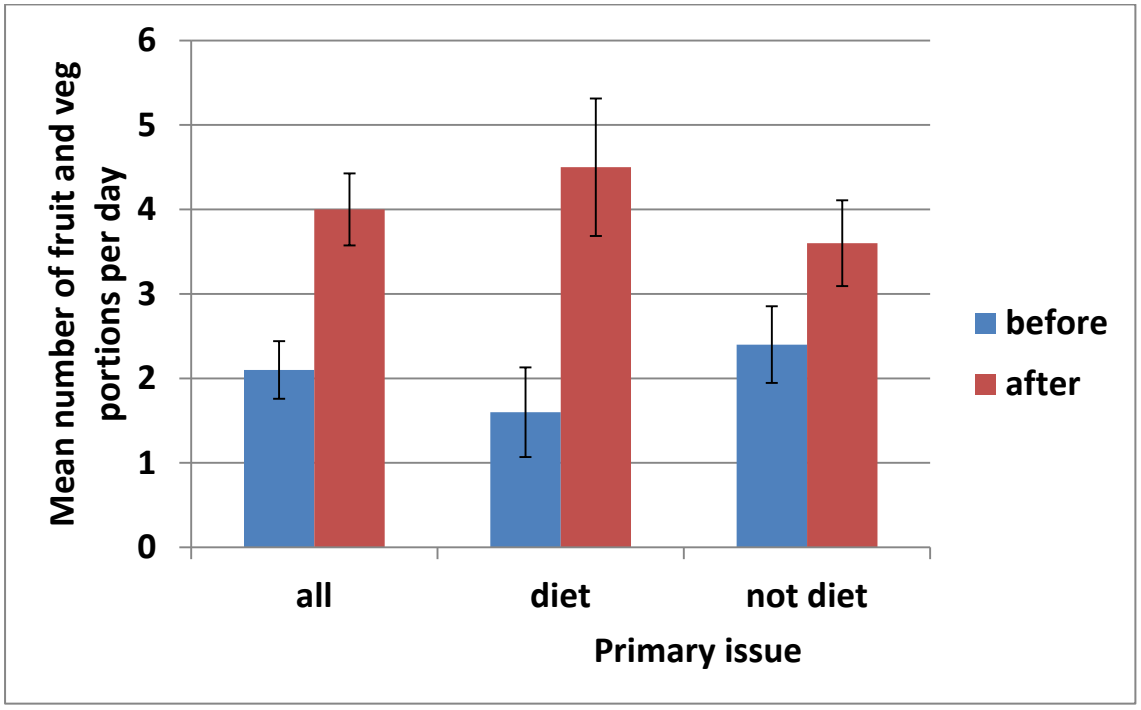



**Figure 4.6: Mean total number of alcohol units per week before and after the PHP (bars show the standard error of the mean)**

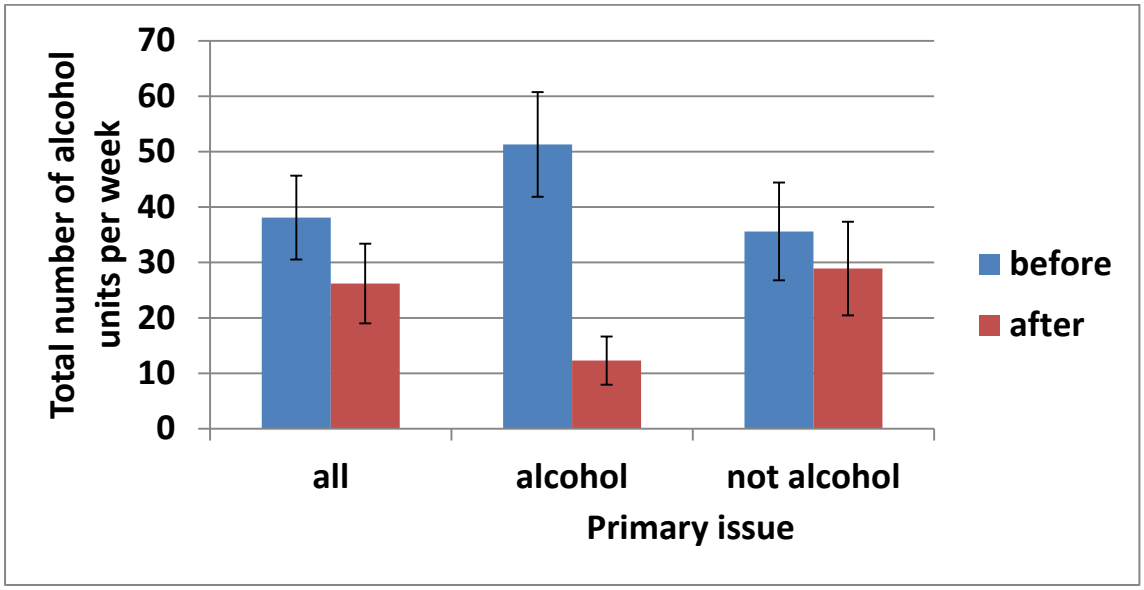


**Figure 4.7: Mean number of moderate exercise session per week before and after the PHP (bars show the standard error of the mean)**

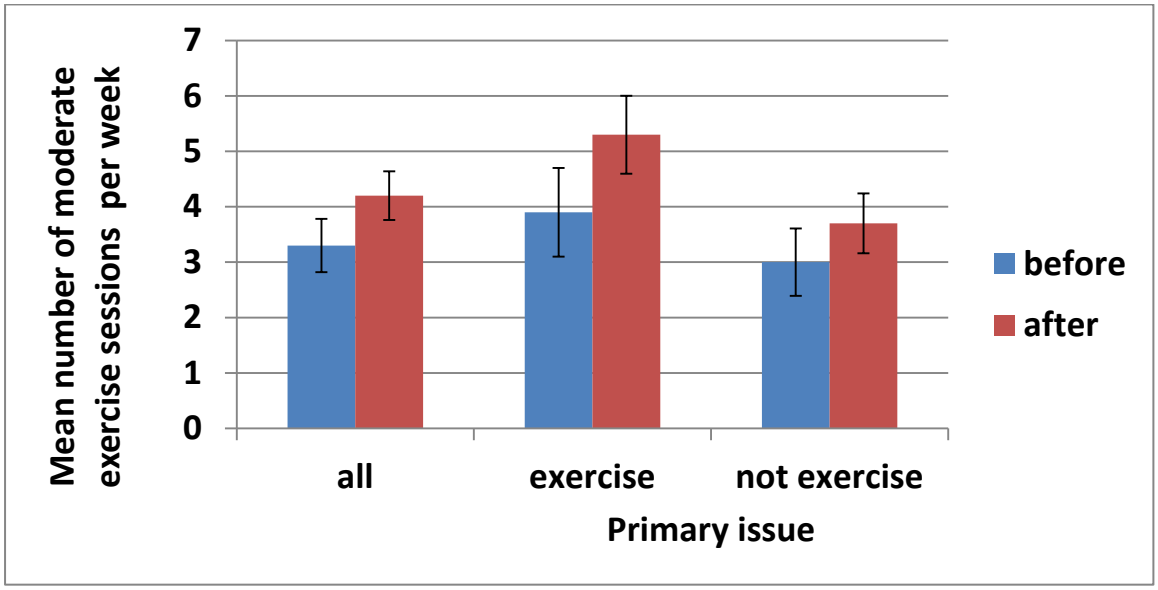
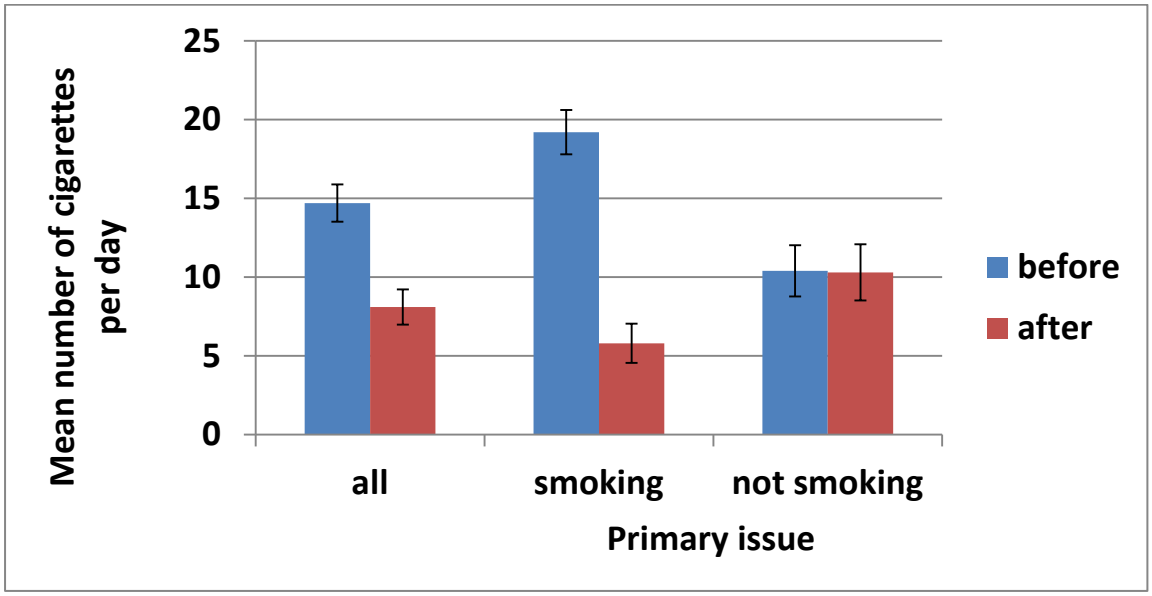



**Figure 4.8: Mean number cigarettes smoked per day before and after the PHP (bars show the standard error of the mean)**




### 4.1.10 Changes in health and wellbeing scores

As discussed earlier (see Appendix: Table A4), 'pre-assessment' health and wellbeing measures (self-efficacy, general health and WHO-5 wellbeing) were available for between 315 and 351 clients – far short of the full 474 who proceeded to the wellbeing/PHP stage. However, the numbers of 'post-assessment' measures of health and wellbeing provided after completion or abandonment of the PHP were substantially lower than this, resulting in 66-67 before-after pairs of measures (Table 4.25) with which to assess change in health and wellbeing.

**Table 4.25: Average measures of health and wellbeing (all measures from all assessments)**

| | Number of before-after pairs | Mean before score (SD) | Mean after score(SD) | Change |
|---|---|---|---|---|
| Self-efficacy | 67 | 68.3 (14.2) | 86.4 (10.3) | 18.1 (13.9) ↑ |
| General health | 66 | 38.3 (18.9) | 77.1 (13.6) | 38.8 (18.8) ↑ |
| WHO-5 wellbeing | 67[1] | 40.3 (25.1) | 73.8 (19.0) | 33.5 (26.9) ↑ |

[1] Contains 3 before scores of zero

These raw values show a substantial mean increase in self-efficacy score, in general health score and in WHO-5 wellbeing score, but it is not clear to which of the 474 clients who proceeded to the wellbeing/PHP stage the pairs of values refer. By analysing the information further (see Appendix: A14), it can be seen that data collection for health and wellbeing scores was inconsistent and that the vast majority of paired before-after scores are available for clients who fully completed their PHP. This bias makes it necessary to consider the data in the context of whether the mean values are for clients who had or had not completed their PHP.

The mean changes in health and wellbeing scores for those clients who completed, partially completed or who did not complete their PHP are therefore shown in Table 4.26. These mean values are shown graphically in Figure 4.9 for self-efficacy score, in Figure 4.10 for general health score and in Figure 4.11 for WHO-5 wellbeing score. The data shows that:

- there was an improvement is self-efficacy for clients who completed their PHP (20.1), somewhat larger than for those who did not (14.0)
- there was an improvement of between 27 and 43 in score for general health for all groups and an improvement of between 24 and 36 for WHO score for all groups.

The results do suggest that the health trainers' intervention is effective in improving these measures of health and wellbeing. However it needs to be remembered that the number of clients for whom pairs of data are available is comparatively small and that those who benefit from the intervention are probably more likely to be willing to give post-assessment scores, which will bias any estimate of the effectiveness of the intervention.

**Table 4.26: Mean measures of health and wellbeing (first assessment only) and separately for clients who completed, partially completed and did not complete their PHP.**

| | PHP completed | | | | PHP partially completed | | | | PHP not completed | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. before-after pairs | Mean before (SD) | Mean after (SD) | Change | No. before-after pairs | Mean before (SD) | Mean after (SD) | Change | No. before-after pairs | Mean (SD) | Mean after (SD) | Change |
| Self-efficacy | 46 | 68.9 (15.6) | 89.0 (9.2) | 20.1 ↑ (14.6) | 3 | 68.3 (2.9) | 74.3 (9.8) | 6.0 ↑ (6.9) | 14 | 66.1 (12.8) | 80.2 (10.9) | 14.0 ↑ (11.5) |
| General health | 42 | 36.7 (18.3) | 80.2 (11.4) | 43.6 ↑ (16.5) | 3 | 30.0 (20.0) | 66.7 (11.5) | 36.7 ↑ (11.5) | 16 | 42.5 (21.7) | 70.0 (16.3) | 27.5 ↑ (21.1) |
| WHO-5 wellbeing | 45 | 41.3 (27.0) | 77.4 (17.4) | 36.1 ↑ (28.8) | 3 | 33.3 (4.6) | 57.3 (28.1) | 24.0 ↑ (24.0) | 15 | 34.1 (20.8) | 64.3 (20.3) | 30.1 ↑ (24.2) |

**Figure 4.9: Mean self-efficacy score before and after engagement with Health Trainer service (bars show standard error of the mean)**

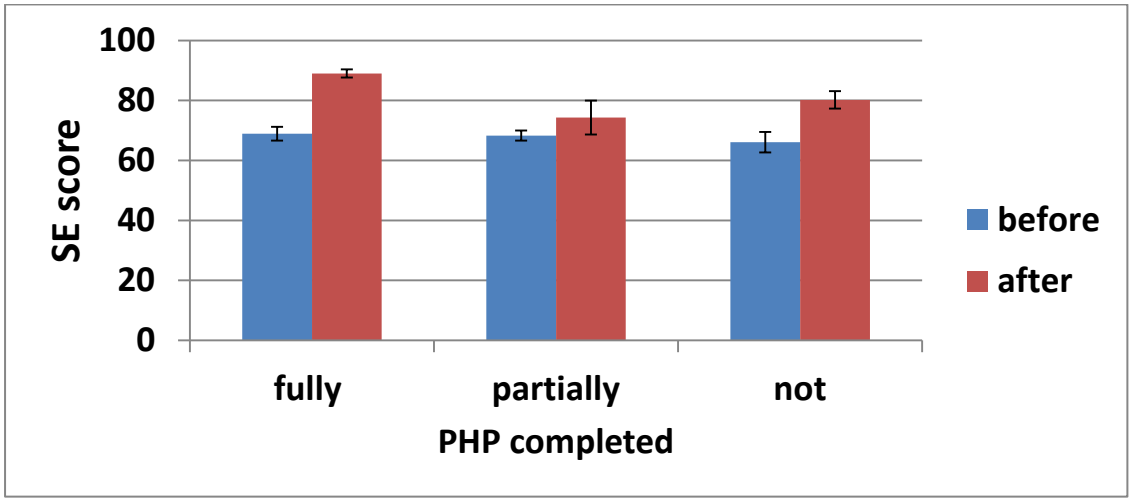



**Figure 4.10: Mean general health score before and after engagement with Health Trainer service (bars show standard error of the mean)**

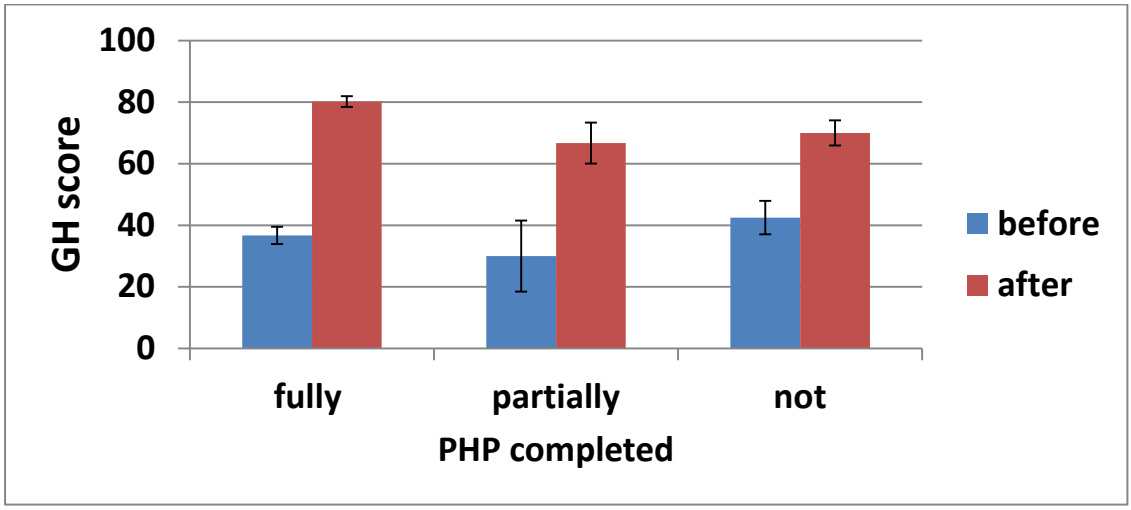
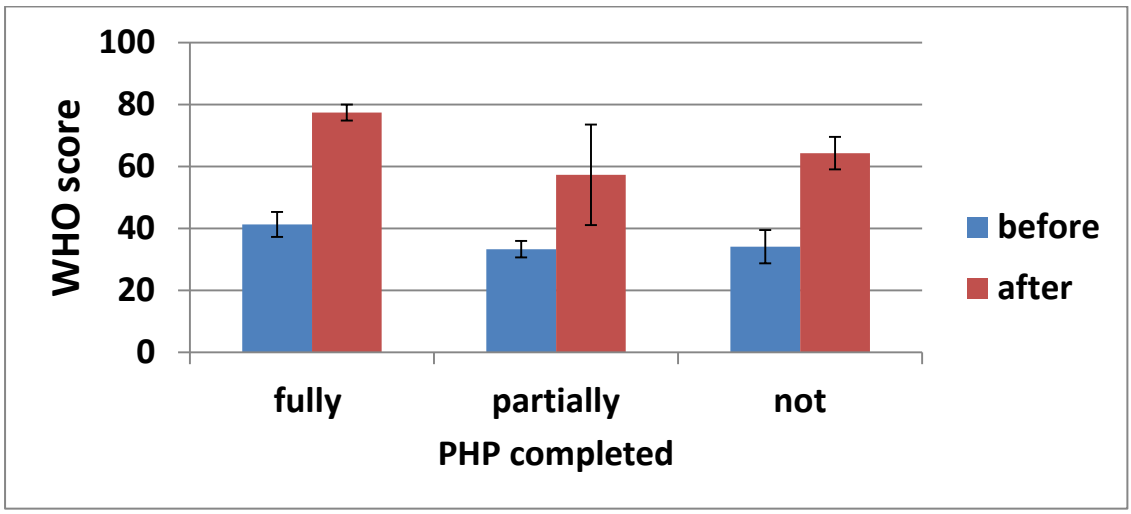


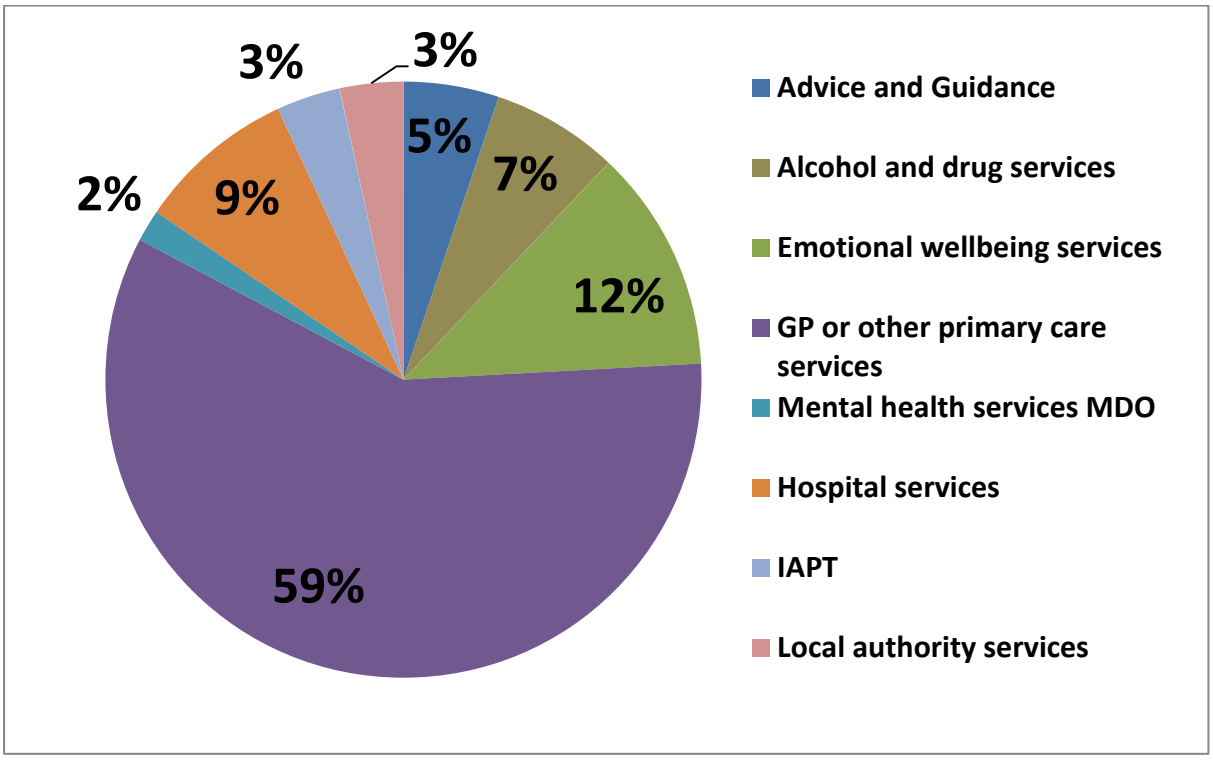

**Figure 4.11: Mean WHO-5 wellbeing score before and after engagement with Health Trainer service (bars show standard error of the mean)**



### 4.1.11 Signposting

A number of clients exited the programme having sought help and advice – with a total of 58 being signposted elsewhere for assistance (see Appendix: Table A15). Most of these were signposted after their initial assessment, but a small number proceeded to full assessment and were then signposted. Figure 4.12 shows the breakdown of signposting, the majority being to GP or primary care services. It has been argued that signposting must be recognised as a valuable aspect of the Health Trainer service – with the Portsmouth Health Trainer Ready Reckoner Value for Money Tool valuing such participation at £120 per event or meeting (Lister, 2010).

**Figure 4.12: Signposting of clients**




**Note:** IAPT refers to the Improving Access to Psychological Therapies Programme; MDO refers to Mentally Disordered Offenders

### 4.1.12 Returners

As discussed above (see section 4.1.4), the data shows that some clients received more than one initial assessment. From the total of 633 clients, 588 only had one initial assessment, 41 clients had two initial assessments and 4 clients had three initial assessments. This resulted in 633 first initial assessments, 45 second initial assessments and 4 third initial assessments.

In order to understand whether those who came for a second initial assessment were returning to address the same or a different primary issue, the data was further analysed. Table 4.27 shows the primary issue for those who returned for a second initial assessment, broken down by the outcome of their first initial assessment and if appropriate, their primary issue. Of the 45 clients who had a second initial assessment, 21 had not proceeded to the wellbeing/PHP stage at their first initial assessment and a further 4 had not proceeded at the second assessment. Hence only 20 clients had proceeded to PHP and wellbeing at both assessments. A further 5 out of these 20 clients had 'other or not stated' as their primary issue for the first, second or both of their full assessments. Hence only 15 clients had an identified first and second primary issue. Of these 15, 8 clients had smoking as their primary issue at both assessments. The remaining 7 had alcohol then smoking (1), diet then

smoking (3), exercise then smoking (1), smoking then exercise (1) and smoking then emotional wellbeing (1). Apart from the 8 clients who returned for the primary issue of smoking, no other pattern is discernible.

Four clients had a third initial assessment. One of these was signposted only at the third assessment. One had a primary issue of exercise at the third assessment but blank/other for primary issue at both their first and second assessment. One had smoking as the issue at their third assessment, blank/other at their second assessment and smoking as primary issue at their first assessment. The final one of the four had blank/other at the third assessment, smoking at the second assessment and smoking at the first assessment. There would seem to be no discernible conclusion which can be drawn about returners.

**Table 4.27: Primary issue for those undertaking a second initial assessment and the primary issue for their first initial assessment.**

| | 2nd initial assessment | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1st initial assessment | Not proceeding | Alcohol | Diet | Exercise | Emotional Wellbeing | Smoking | Other or not stated | Total |
| Not proceeding | 4 | 1 | 1 | 2 | 4 | 9 | | 21 |
| Alcohol | | | | | | 1 | | 1 |
| Diet | 1 | | | | | 3 | | 4 |
| Exercise | | | | | | 1 | | 1 |
| Emotional Wellbeing | 1 | | | | | | | 1 |
| Smoking | 2 | | | 1 | 1 | 8 | 2 | 14 |
| Other or not stated | | | | | | 1 | 2 | 3 |
| Total | 8 | 1 | 1 | 3 | 5 | 23 | 4 | 45 |

### 4.1.13 Community engagement

Community engagement represented a further activity undertaken by the Health Trainer service. The DCRS data indicates that health trainers attended or participated in 61 events. This type of activity has been judged to be important in terms of improved communications and enhanced social capital and it has been argued that this must be acknowledged by commissioners and other stakeholders – with the Portsmouth Health Trainer Ready Reckoner Value for Money Tool valuing such participation at £120 per event or meeting (Lister, 2010).

## 4.2 VALUE FOR MONEY

### 4.2.1 Introduction

The Portsmouth Health Trainer Ready Reckoner Value for Money Tool was developed in response to demand for an easily-usable tool that could be used to assess the value for money of Health Trainer services. Based on a set of assumptions agreed by a Stakeholder Panel of 12 people with practical experience of commissioning and providing Health Trainer services and an independent Chair and Secretary, the tool applies the logic of health economics to routinely collected data (together with weightings and other data provided locally) to produce an indication of value for money in terms of net cost or saving – both overall and per unweighted total Disability Adjusted Life Years (DALYs) and Quality Adjusted Life Years (QALYs). Following its development, the tool was tested by application to a small number of established Health Trainer services.

Importantly for this evaluation, the tool includes data concerning number of offender clients and impact on reoffending.

### 4.2.2 Applying the tool

The Portsmouth Health Trainer Ready Reckoner Value for Money Tool was initially run with the estimates given in Table 4.28, which are largely derived from DCRS data (see section 4.1). Additionally, the tool required:

- **An estimate of reoffending rates:** A rate of 50% for propensity to reoffend was agreed in liaison with the commissioner and drawing on the guidance document accompanying the Value for Money Tool (Lister, 2010). As the evaluation was neither longitudinal nor designed to explore rates of reoffending, a rate of 40% actual reoffending was used, drawing on the guidance document accompanying the Value for Money Tool (Lister, 2010), which – drawing on a range of evidence (e.g. Social Exclusion Unit, 2002; Frontier Economics, 2010) – suggests that OHT services can be expected to reduce reoffending behaviour by at least 10% above the predicted level for its clients.
- **Equity weighting:** It was agreed in liaison with the commissioner and the author of the guidance document accompanying the Value for Money Tool (Lister, 2010) that it was reasonable to assume that 100% of clients were from the lowest Index of Multiple Deprivation quintile. It was also agreed that a weighting for disadvantage of 150% should be applied.

Using these estimates, the tool predicts that the net public sector saving would be £823,266 for the year. As with any model, it is important to run the tool with several different scenarios in order to explore the implications of changing variables. In Table 4.28, the estimates from the DCRS evaluation were kept constant and the figure for offender clients actually reoffending was varied from 40.0% to 50.0%. It can be seen that the net public sector cost/saving is highly dependent on the assumption made about the percentage of clients who will actually reoffend – with a cost of £45,394 incurred when there is no reduction in reoffending rates (i.e. both propensity to reoffend and actual reoffending rates are set at 50%). Using the DCRS estimates for goal achievement, the figures suggest that the service would be cost neutral if actual reoffending is reduced from 50% to 49.48%.

The tool was re-run with the estimates for achievement of both behaviour change goals and overall offenders' goals being halved (see Table 4.29) and doubled (see Table 4.30). This shows that when goal achievement is halved, net savings are reduced to £342,689 assuming a 10% reduction in reoffending rates and that if there is no reduction in reoffending rates, the net cost of the service rises to £91,641. When goal achievement is doubled, net savings increase to £1,784,561 assuming a 10% reduction in reoffending rates and that even with no reduction in reoffending rates, there would be a cost saving from the service of £47,241.

Figure 4.13 shows the results of running the Portsmouth Health Trainers tool for the scenarios in Tables 4.28-4.30. This illustrates clearly that the cost savings resulting from the programme are most strongly influenced by the percentage of clients who actually reoffend.

**Table 4.28: Results of running the Value for Money Tool using 'percentage of clients achieving goals' figures estimated from DCRS**

| | | | | | |
|---|---|---|---|---|---|
| **Estimates from DCRS** | | | | | |
| Total service cost | £150,221 | £150,221 | £150,221 | £150,221 | £150,221 |
| Annual number of clients:[1] | | | | | |
| At pre-assessment stage | 682 | 682 | 682 | 682 | 682 |
| At assessment stage | 514 | 514 | 514 | 514 | 514 |
| No. behaviour change clients[2] | | | | | |
| Smoking | 158 | 158 | 158 | 158 | 158 |
| Alcohol | 43 | 43 | 43 | 43 | 43 |
| Diet and activity[3] | 173 | 173 | 173 | 173 | 173 |
| Emotional wellbeing | 78 | 78 | 78 | 78 | 78 |
| Other | 62 | 62 | 62 | 62 | 62 |
| % fully achieving goals[2] | | | | | |
| Smoking | 23.4% | 23.4% | 23.4% | 23.4% | 23.4% |
| Alcohol | 28.4% | 28.4% | 28.4% | 28.4% | 28.4% |
| Diet and activity[3] | 24.8% | 24.8% | 24.8% | 24.8% | 24.8% |
| Emotional wellbeing | 48.5% | 48.5% | 48.5% | 48.5% | 48.5% |
| Other | 2.1% | 2.1% | 2.1% | 2.1% | 2.1% |
| % partially achieving goals[2] | | | | | |
| Smoking | 2.3% | 2.3% | 2.3% | 2.3% | 2.3% |
| Alcohol | 3.6% | 3.6% | 3.6% | 3.6% | 3.6% |
| Diet and activity[3] | 2.4% | 2.4% | 2.4% | 2.4% | 2.4% |
| Emotional wellbeing | 1.7% | 1.7% | 1.7% | 1.7% | 1.7% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| No. signposted clients[4] | 58 | 58 | 58 | 58 | 58 |
| No. events attended[5] | 61 | 61 | 61 | 61 | 61 |
| **Other estimates** | | | | | |
| Offender-specific data: | | | | | |
| No. offender clients[1] | 514 | 514 | 514 | 514 | 514 |
| % achieving goals[6] | 26% | 26% | 26% | 26% | 26% |
| No. signposted offender clients[4] | 58 | 58 | 58 | 58 | 58 |
| Propensity to reoffend[7] | 50% | 50% | 50% | 50% | 50% |
| Actual reoffending rate[7] | 40.0% | 42.5% | 45.0% | 47.5% | 50.0% |
| Equity weighting:[8] | | | | | |
| % clients in lowest IMD quintile | 100% | 100% | 100% | 100% | 100% |
| Weighting for disadvantage | 150% | 150% | 150% | 150% | 150% |
| **Results** | | | | | |
| Net public sector cost/savings | **-£823,266** | **-£606,101** | **-£388,936** | **-£171,771** | **£45,394** |

1 As the DCRS analysis looked at all assessments (including where a small number of clients re-entered the system and were recorded as having a further 2-3 initial assessments and journeys through the service), it is these combined figures that are used here (see Table 4.22).
2 See Table 4.22
3 Calculated by combining diet and exercise data, which were recorded separately in DCRS
4 See Table A15
5 See section 4.1.13
6 See Figure 4.4
7 Agreed in liaison with commissioner and drawing on information from guidance document
8 Agreed in liaison with commissioner and author of the guidance document

**Table 4.29: Results of running the Value for Money Tool using 'percentage of clients achieving goals' figures halved (set at 50 per cent of those estimated from DCRS)**

| | | | | | |
|---|---|---|---|---|---|
| **Estimates from DCRS** | | | | | |
| Total service cost | £150,221 | £150,221 | £150,221 | £150,221 | £150,221 |
| Annual number of clients: | | | | | |
| At pre-assessment stage | 682 | 682 | 682 | 682 | 682 |
| At assessment stage | 514 | 514 | 514 | 514 | 514 |
| No. behaviour change clients | | | | | |
| Smoking | 158 | 158 | 158 | 158 | 158 |
| Alcohol | 43 | 43 | 43 | 43 | 43 |
| Diet and activity | 173 | 173 | 173 | 173 | 173 |
| Emotional wellbeing | 78 | 78 | 78 | 78 | 78 |
| Other | 62 | 62 | 62 | 62 | 62 |
| % fully achieving goals | | | | | |
| Smoking | 11.7% | 11.7% | 11.7% | 11.7% | 11.7% |
| Alcohol | 14.2% | 14.2% | 14.2% | 14.2% | 14.2% |
| Diet and activity | 12.4% | 12.4% | 12.4% | 12.4% | 12.4% |
| Emotional wellbeing | 24.3% | 24.3% | 24.3% | 24.3% | 24.3% |
| Other | 1.1% | 1.1% | 1.1% | 1.1% | 1.1% |
| % partially achieving goals | | | | | |
| Smoking | 1.2% | 1.2% | 1.2% | 1.2% | 1.2% |
| Alcohol | 1.8% | 1.8% | 1.8% | 1.8% | 1.8% |
| Diet and activity | 1.2% | 1.2% | 1.2% | 1.2% | 1.2% |
| Emotional wellbeing | 0.9% | 0.9% | 0.9% | 0.9% | 0.9% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| No. signposted clients | 58 | 58 | 58 | 58 | 58 |
| No. events attended | 61 | 61 | 61 | 61 | 61 |
| **Other estimates** | | | | | |
| Offender-specific data: | | | | | |
| No. offender clients | 514 | 514 | 514 | 514 | 514 |
| % achieving goals | 13% | 13% | 13% | 13% | 13% |
| No. signposted offender clients | 58 | 58 | 58 | 58 | 58 |
| Propensity to reoffend | 50% | 50% | 50% | 50% | 50% |
| Actual reoffending rate | 40.0% | 42.5% | 45.0% | 47.5% | 50.0% |
| Equity weighting: | | | | | |
| % clients in lowest IMD quintile | 100% | 100% | 100% | 100% | 100% |
| Weighting for disadvantage | 150% | 150% | 150% | 150% | 150% |
| **Results** | | | | | |
| Net public sector cost/savings | **-£342,689** | **-£234,106** | **-£125,524** | **-£16,941** | **£91,641** |

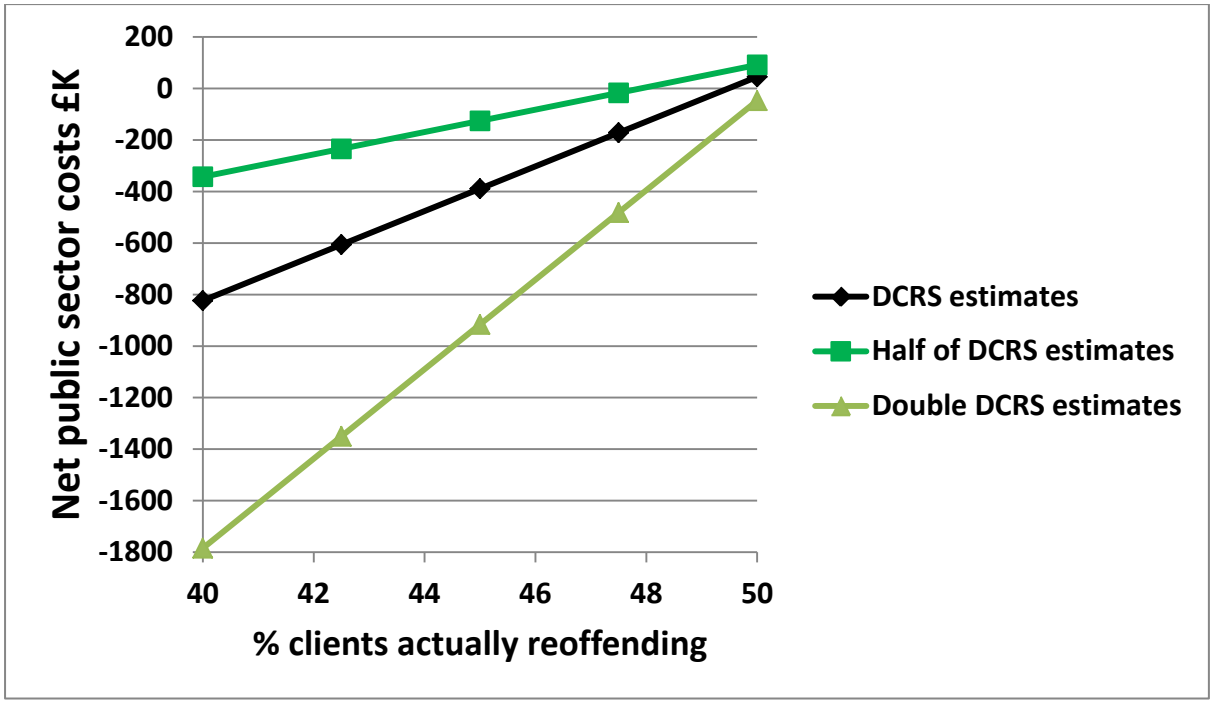
**Note:** Data sources as detailed in footnotes to Table 4.28 but estimates of percentage goal achievement halved.

**Table 4.30: Results of running the Value for Money Tool using 'percentage of clients achieving goals' figures doubled (set at 200 per cent of those estimated from DCRS)**

| | | | | | |
|---|---|---|---|---|---|
| **Estimates from DCRS** | | | | | |
| Total service cost | £150,221 | £150,221 | £150,221 | £150,221 | £150,221 |
| Annual number of clients: | | | | | |
| At pre-assessment stage | 682 | 682 | 682 | 682 | 682 |
| At assessment stage | 514 | 514 | 514 | 514 | 514 |
| No. behaviour change clients | | | | | |
| Smoking | 158 | 158 | 158 | 158 | 158 |
| Alcohol | 43 | 43 | 43 | 43 | 43 |
| Diet and activity | 173 | 173 | 173 | 173 | 173 |
| Emotional wellbeing | 78 | 78 | 78 | 78 | 78 |
| Other | 62 | 62 | 62 | 62 | 62 |
| % fully achieving goals | | | | | |
| Smoking | 46.8% | 46.8% | 46.8% | 46.8% | 46.8% |
| Alcohol | 56.8% | 56.8% | 56.8% | 56.8% | 56.8% |
| Diet and activity | 49.6% | 49.6% | 49.6% | 49.6% | 49.6% |
| Emotional wellbeing | 97.0% | 97.0% | 97.0% | 97.0% | 97.0% |
| Other | 4.2% | 4.2% | 4.2% | 4.2% | 4.2% |
| % partially achieving goals | | | | | |
| Smoking | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% |
| Alcohol | 7.2% | 7.2% | 7.2% | 7.2% | 7.2% |
| Diet and activity | 4.8% | 4.8% | 4.8% | 4.8% | 4.8% |
| Emotional wellbeing | 3.4% | 3.4% | 3.4% | 3.4% | 3.4% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| No. signposted clients | 58 | 58 | 58 | 58 | 58 |
| No. events attended | 61 | 61 | 61 | 61 | 61 |
| **Other estimates** | | | | | |
| Offender-specific data: | | | | | |
| No. offender clients | 514 | 514 | 514 | 514 | 514 |
| % achieving goals | 52% | 52% | 52% | 52% | 52% |
| No. signposted offender clients | 58 | 58 | 58 | 58 | 58 |
| Propensity to reoffend | 50% | 50% | 50% | 50% | 50% |
| Actual reoffending rate | 40.0% | 42.5% | 45.0% | 47.5% | 50.0% |
| Equity weighting: | | | | | |
| % clients in lowest IMD quintile | 100% | 100% | 100% | 100% | 100% |
| Weighting for disadvantage | 150% | 150% | 150% | 150% | 150% |
| **Results** | | | | | |
| Net public sector cost/savings | -£1,784,561 | -£1,350,231 | -£915,901 | -£481,571 | -£47,241 |

**Note:** Data sources as detailed in footnotes to Table 4.28 but estimates of percentage goal achievement doubled.

**Figure 4.13: Results of running the Value for Money Tool using a range of 'percentage of clients achieving goals' figures and for a range of actual reoffending rates (negative values of net public sector cost represent cost savings and positive values represent spend incurred)**




## 4.3 QUALITATIVE RESEARCH

### 4.3.1 Introduction

This section reports the findings from the 16 interviews conducted with the eight service users in October 2011 and February 2012 and the focus group and interviews held with health trainers. As explained in the methodology section, the eight individuals were sampled according to age, gender, health need, district/probation office and length of time on probation order. The sample only included those individuals who had completed their sessions with the Health Trainer service or were engaging successfully with the service. It did not, therefore, include those individuals who may not have engaged with the health trainer project or those who 'dropped out' of the service.

The findings are presented across five thematic sections – reasons for accessing the OHT service; relationships and engagement with the service; services accessed and evidence of change; future plans; and current issues with implementation. Within this structure, five case studies are interwoven which illuminate service users' experiences of the Health Trainer service.[12]

### 4.3.2 Reasons for accessing the Offender Health Trainer service

Most of the interviewees stated that they accessed the service on the recommendation of their offender manager or by being approached and informed about the service by a health trainer, for example whilst in the probation office waiting area. One of the participants accessed the service after a visit to his hostel by the health trainers. All of the participants agreed that these approaches were effective and that 'all of us on probation everywhere should have this service'. This in part supports the DCRS findings, but does not highlight the importance of self-referral as highlighted in Table 4.7.

[12] Please note all participants have been assigned pseudonyms.

The profile of those service users interviewed demonstrated that individuals who accessed the Health Trainer service presented with a wide variety of complex needs. Therefore, whilst they may have initially entered the service with one clear aim in mind (i.e. their 'primary issue'), often the intervention of the health trainer would uncover a variety of needs which the service user would then benefit from addressing. This demonstrates that the health trainers were therefore able to broaden service users' perspectives and enable participants to recognise other issues that they would benefit from addressing. In this sense, it is important to appreciate that most needs were inter-related, whereby for example a change in lifestyle or increase in confidence often incorporated healthy eating, taking up exercise and/or reducing smoking. Therefore, although service users may access the service for one (documented) primary reason they tend to receive a more holistic service with more than one outcome. [13]

Given that there tended to be more than one need, the health trainers would tend to help clients break their goals down into smaller 'chunks' to make challenges seem more surmountable. This was considered by service users to be the most practical approach and one which ensured they continued to engage and attend.

Whilst it was clear that some clients entered the service in order to be signposted or gain a referral to a GP or other health professional, the majority of interviewees were keen to make significant changes to their lifestyle, and in some cases, the service user had been considering a lifestyle change for some time. The OHT service was considered the instigator that they needed to undertake these changes in a more proactive way.

The main reasons for accessing the Health Trainer service as reported by the eight participants interviewed can be readily explored under the following headings:

- Diet, nutrition and healthy eating
- Smoking cessation/reduction
- Confidence, self-esteem and emotional wellbeing
- Fitness and gainful occupation of time

**Diet, nutrition and healthy eating**

> *Before I went into jail, I lost a hell of a lot of weight. I was size six; you could see my ribs and everything. I was very bad. I knew I needed to do something about it. (Zara)*

Whilst the DCRS data suggests that around 14% of clients identified diet as their primary issue (see Tables 4.12 and 4.13), the interviews revealed healthy eating and nutritional guidance as a more common concern, with half of the participants stating that they had very poor diets or eating habits (e.g. eating sporadically, eating food with little nutritional value, eating at wrong times) and many either wanting to lose/gain weight and/or receive healthy eating advice. Two of the individuals were considerably under-weight and were accessing the service to gain weight and address their malnutrition through education about healthy eating. One participant was drinking 50 cans of Pepsi a week and was unaware of the impact of this on his health.

> *She [health trainer] did a diet plan with me when I started and then she told me what foods to eat. I'd eat a load at one time, whereas she said you can eat the same amount but set it out in the day and split it up into like five different stages, then obviously your body is eating at the right times. Whereas I wouldn't eat in the morning and I'd just eat a tonne at night. (Alex)*

> *She's been helping me and telling me 'eat more vegetables and fruit'. I never used to eat them at all before I started seeing her. But now I'm eating them. Everyday too. I know I've lost weight already 'cos of it. I feel better too. (Tony)*

[13] However, there are implications here for targeting, recording and assessment for the project. These are discussed later in the section on 'Current Issues with Implementation'.

It seems evident that before these individuals accessed the Health Trainer service, they had not been well informed regarding what a balanced diet entailed, how to maintain such a diet and what the impacts of a healthier lifestyle would be. Therefore, by accessing the Health Trainer service, these individuals were learning (as adults) how to look after themselves. Understandably, the practical sessions on 'cook and taste' were particularly well liked by participants, as they were acquiring a skill and also learning how to 'help themselves' and their families.

**Smoking cessation/reduction**

As suggested by the DCRS data (see Tables 4.12 and 4.13), smoking cessation was another key reason for the service users interviewed to access the Health Trainer service. Two of the participants presented with a worryingly high level of nicotine intake – with one participant admitting that she smoked at least 150 roll-ups a week. By attending the service, participants stated they felt more focussed and motivated to undertake the challenge of reducing or stopping their smoking habits.

In this area, the health trainers are particularly well equipped to instil immediate practical measures and incorporate a variety of alternative methods, for instance patches, inhalers, carbon monoxide testing, which can keep service users engaged and motivated and assist in their smoking cessation. This is explained to service users from the outset and participants stated that they felt 'able' to reduce their smoking, given the numerous provisions the health trainers had access to, to help them reduce their smoking. As a result, this 'enticed' them to continue engaging to achieve their goals.

> *I didn't expect to have a carbon monoxide test from my own lungs. It's great though to have that piece of equipment 'cos you can keep track of how well you're doing. It's another one of those things which is an incentive in a way to beat each score week on week and think 'next week I'm going to reduce that, definitely smoking less this week'. (Les)*

**Confidence, self-esteem and emotional wellbeing**

The majority of the interviewees identified themselves as having low self-esteem and low confidence. For these interviewees, the Health Trainer service was seen to be particularly important in terms of offering the benefit of simply having someone to talk to. This appeared to be a significant issue for the older individuals and female participants, who typically entered the service seeking 'healthy lifestyle' advice, but soon uncovered their need for greater assistance regarding self-esteem. This 'layering' of problems perhaps explains why the DCRS data indicates that only 15% of clients identified emotional wellbeing as their primary issue (see Tables 4.12 and 4.13).

Two individuals had diagnosed mental health issues, notably self-harm and mild depression. Both of these participants felt that they needed someone to talk to or receive support from (one participant was on a waiting list for further counselling sessions).

> *Chatting with [health trainer] has given me a lot more confidence because like I say I've got clinical depression and sometimes I think 'I just can't', but they make you see, 'Well yeah you can!' They attended our women's group and nearly all of us signed up – we just knew this is what we needed – that support and understanding. (Belinda)*

Some of the participants also cited 'stress' as a reason for accessing the Health Trainer service. This 'stress' was usually due to family problems (for example, following release from prison and living back in the home environment) or frustration with a lack of options 'out there' (e.g. difficulties finding jobs, accommodation, social networks).

**Fitness and gainful occupation of time**

A further focus highlighted by interviewees was that many service users needed something to occupy their time having been diverted from criminal involvement. This was understood to link to fitness and exercise, with the possibility of obtaining gym membership and/or swimming passes often serving as a key motivation for this group. These interviewees cited

that they wanted a 'positive channel for their energies' to support their new non-offending lifestyles. This was particularly true for young male interviewees and those who were unemployed. Consequently, exercise – a primary issue for around 19% of clients (see Tables 4.12 and 4.13) – was seen as key for these individuals as well as for those who wished to lose weight or adopt healthier lifestyles.

> *I just thought you know …I'd been in jail quite a long time, come out here…it's been stressful man. I had nothing going on, was proper bored. I thought 'you know what. I'll go back to what I know best. Get back into the training and that.' (Gerry)*

**Box 4.2: Lance's story – case study**

Lance has a troubled history of mental health issues and self-harming and is on probation for a sexual offence. He first came across the Health Trainer service at his hostel, while the health trainers were visiting to conduct cooking demonstrations. He had wanted to make positive changes to his life 'in every way possible' for quite some time and saw this as his 'ideal opportunity'.

Lance found making changes to his lifestyle challenging. However, through the support of his health trainer, he felt encouraged and motivated to persevere. Lance sought assistance with altering his diet and eating habits, joining a gym, registering with both a dentist and a GP, signing up to see a counsellor again, opening up about his hopes and fears and learning how to cook (nutritional meals) for himself. Lance described his health trainer as like 'a mother figure' who 'pushes me a bit' but has his 'best interests at heart'. He recognised that he needed to make changes and alter his lifestyle; but more importantly that he needed the regular intensive encouragement and oversight, particularly when he was having 'a low week'.

Through the small steps his health trainer set out for him, Lance felt able to undertake each challenge as it presented itself but also felt motivated to attend each week, particularly at the beginning. Lance highlighted the informal and positive approach taken by the health trainers in supporting him to tackle his needs practically and also emphasised the convenience of the service being located in the same building as his weekly probation appointment.

### 4.3.3 Relationships and engagement with the service

The interviews highlighted a number of themes concerned with relationships and continued engagement with the Health Trainer service, which are explored under the following headings:

- Accessibility and flexible approach
- Non-judgmental approach and relationship of trust
- Support, commitment and dependence

#### Accessibility and flexible approach

The perceived qualities of the health trainers appeared to have a direct correlation with the success of the intervention. Participants seemed to respond well to the communication skills of the practitioner and felt them to be warm and accessible. They appreciated the fact that the health trainers had time for them, were empathetic and would follow up issues raised. Many participants felt more comfortable with the health trainers than with their own GP and/or other health practitioners (such as dietician or dentist) and could talk though issues which they felt their GP may not have time for and would not take seriously.

> *My doctor were rubbish. I wanted to put weight on, all they did was told me to go to some health thing and it weren't anything to do with your weight, it was just like going to the gym. So that didn't benefit, whereas since I've seen [health trainer], I've put two pound on in the short space of time that I've seen her. (Alex)*

> *Well with the GPs they just try and push medication and you've got like a 5 minute appointment with them…you're just a time slot… With the health trainers it's like they tell you all the options and say, 'What do you think?' It's more supportive. She's not like watching the clock or…like if she's busy, she will just text and say, 'Listen I haven't forgotten.' Because otherwise I'd be thinking, 'What's the point? She's not bothered so why should I be bothered?' (Belinda)*

As highlighted by the case study in Box 4.2, interview participants appreciated the accessibility and convenience of the OHT service, as well as the flexibility of appointments. For those who cemented a strong relationship with their health trainer, there was a feeling of friendship and a firmer commitment to goal achievement, based on not wanting to disappoint. This level and scope of engagement provides a rich picture of the experience of those interviewed – and is commendable given how challenging a group offenders can be to engage, particularly young male offenders (see GMPT, 2012). However, it is important to place these findings within the context of the DCRS data, which suggested that alongside the intensive engagement and commitment of certain clients (see Table A5), there was a relatively high level of attrition and disengagement at each stage in the service users' journey. Not surprisingly, many of the interviewees compared the openness and flexibility of the Health Trainer service with the rigidity of and mandatory nature of attendance at the probation office. However, they were arguably not recognising the difference in requirements, such as offender managers' reduced flexibility with the delivery of a mandatory court order.

**Non-judgmental approach and relationship of trust**

When asked what they had thought when the Health Trainer service was mentioned to them, participants indicated that they had conjured up images of 'people in white coats'. The participants were 'relieved' and 'relaxed' when they accessed the service and realised that the service was flexible, 'informal' and voluntary.

> *I thought she was going to be like dead snobby, uppity, telling me that I had to do this, and this, and this. It's a lot different from what I expected. (Zara)*

The fact that the health trainers had former experience of the criminal justice system resonated with participants, promoting a feeling of being understood and 'on a level playing field'. The ability of the health trainers to understand the participants was important in creating a relationship of trust between service users and the health trainers. The non-judgemental approach was considered by the participants to be fundamental to their investment in the service.

Moreover, this previous experience of the criminal justice system acted as a source of inspiration for the participants interviewed as they saw these trainers as being able to 'turn their lives around'. It acted as a motivational tool to spur on service users that if these health trainers can make successes of their lives, be respected professionals and can help people in their communities then 'so can I'. This is demonstrated in the quote below (but also in Belinda's story in Box 4.6).

> *I just think about both of the health trainers and where they were four years ago and where they are now. So it's that personal touch knowing that yeah you can do it. Look what they've been through. They can do it, and that's what keeps you positive thinking, 'well yeah if they can do it, so can I.' (Belinda)*

The DCRS data suggests that the single most important factor that would increase the importance of addressing their issue was 'knowing that support is available' – and that the 'guaranteed support of a health trainer' was the most important perceived factor that would increase confidence in achieving their goals (see Tables 4.19 and 4.20). The interview findings support this, indicating an association between progress (as defined by the service user) and quality of relationship between the health trainer and participant. The health trainers were often viewed as 'like a friend' with clients feeling that 'they could tell them anything'. This familiarity allowed the participants to 'trust' and to feel able to be completely honest about their lifestyle and their problems, a feeling they expressed they do not display towards other medical professionals, because of embarrassment, shyness or fear of being judged. Although in some cases this may present the potential for 'over-familiarisation', there did not appear (in the small number of cases reviewed in this research) to be any significant crossing of boundaries – although issues of over-dependence and out-of-hours contact are discussed below.

**Support, commitment and dependence**

Linked to this, there are some inherent dangers in such a flexible and engaging service. So whilst the service users report referring to the health trainers as 'always having time for me', possible over-dependence was an emerging issue. These service users stated 'I don't know what I would do without her' or that their health trainer 'always goes above and beyond for me'. Two of the participants indicated that they contact the health trainers out of hours and sometimes the health trainers respond to these out of hour's contacts.

These findings point to the need for caution in how the service continues to develop and be implemented, in order to ensure that it promotes independence and self-coping mechanisms, rather than a dependence on health trainers. (see Section 5.4.2). Nonetheless, the committed and supportive approach, when implemented with clear boundaries, appears to be well-received and appreciated by those who need it. Moreover, many of the approaches adopted by the health trainers are consistent with desistance theory (i.e. taking a practical and strength's focussed approach and encouraging attendance by providing a 'warm welcome') – as explored further in Section 5.3.2.

**Box 4.3: Zara's story – case study**

Zara, a young white pregnant female who had served a variety of community and custodial sentences, was referred to the Health Trainer service via a probation-run women's contact centre. Zara had serious issues with her health: she was malnourished, pale, a heavy smoker and had no self-confidence. She built a strong relationship with her health trainer and responded well to the personal approach – she was particularly moved by her health trainer's commitment, even telephoning her on a weekend during a particularly difficult time. Through the project, Zara was able to gain weight, stop smoking and address her distorted body image. She reported feeling more confident and developing a more positive attitude which helped her even at times when her resolve was tested: 'I'd never thought I could quit smoking – I've been smoking 11 year. My granddad passed away [last week] and I've still quit smoking because she [health trainer] pulled me through it... she just helped me so much'.

Through the support of the project, she was able to widen her support network and her increased confidence meant that she was empowered to access other services, for example gaining accommodation through talking to a housing provider which she would never had considered before accessing the service: 'I've now got myself a house. I wouldn't have gone to the council and had my interview because I wouldn't have had the confidence to speak to the other man over the other end of the table. I wouldn't have been able to do this before I met her [health trainer]. Zara is much more positive about her future and plans to now see a counsellor so she can further address her past. She continues to abstain from smoking and remains in regular contact with her health trainer.

### 4.3.4 Services accessed and evidence of change

With regard to services accessed and evidence of change, the interviews highlighted a range of themes, which are explored under the following headings:

- Services accessed and activities undertaken
- Evidence of change and positive health outcomes
- Impacts on offence-focussed work
- Increase in wellbeing

**Services accessed and activities undertaken**

Most participants benefited from weekly appointments, supported by telephone contact when deemed necessary by the health trainer. These appointments tended to coincide with their probation (enforceable) appointments.

The main services accessed and activities undertaken as a result of engagement with the Health Trainer service (as reported by the eight participants) are listed below:

- **signposting:** dentist, GP, dietician, exercise scheme/gym, counselling, drugs services, job-club
- **information provision:** health information, guidance and explanations
- **dietary assistance:** healthy eating, food diaries, diet plan, cooking demonstrations
- **smoking cessation:** TASK, patches, inhaler, carbon monoxide testing, nasal spray
- **support/motivation:** change lifestyle/improve confidence, increase exercise, reduce smoking, complete applications/programmes, attain employment, think positively.

Whilst the DCRS data suggests that diet was the fourth most commonly identified primary issue, after smoking, exercise and emotional wellbeing, (see Tables 4.12 and 4.13), the interview participants identified healthy eating advice as their most common 'primary issue' – and one which encapsulated a range of support from diet sheets, recipes, weigh-ins, cooking sessions, portion control advice and healthy food swaps. One severely malnourished participant gained a stone in weight, another put on 2lb within a few weeks, and another lost a stone in weight through healthy eating and exercise.

Stopping smoking was also a key need, which had inputs which included the provision of nicotine patches and carbon monoxide testing. As highlighted in Zara's story in Box 4.2, one participant who had smoked for eleven years went from smoking 150 roll-ups a week to complete cessation.

> *I have cut down a lot. I smoke normally sort of one in the morning and one before I go to bed or something. I used to smoke about a packet of fags a day, like twenty fags a day. But now with the patches and everything I've cut down to just like two a day. (Matt)*

Exercise was almost as popular amongst the participants, but tended to be related to healthy eating/lifestyle. However, as stated earlier some participants wished to undertake exercise for different reasons such as support to reduce stress and lead a non-offending lifestyle (see Gerry's story in Box 4.4).

**Box 4.4: Gerry's story – case study**

Gerry accessed the Health Trainer service upon his release from custody for a robbery offence, via a referral from his Offender Manager. Gerry was quite proactive and knew what he wished to change about his lifestyle – 'I just needed the help and support to go about doing it'. Gerry openly discussed his drug addiction (mainly cannabis), his dependence on cigarettes and his desire to take up exercise as a method of occupying his time while on licence in the community.

Gerry, as an enthusiastic youth in his twenties, had lots of energy and wished to use it for better purposes such as going to the gym. He felt this would reduce his 'stress' and get him out of the family home for a while. He also thought it would keep him from wanting to smoke cannabis 'I'm a bad weed head – for a lot of lads this will help stop reoffending 'cos it takes time off their hands'.

Gerry's health trainer encouraged Gerry's positive ambition regarding reducing his drugs misuse and taking up the gym. She referred him to various local exercise clubs, applied for a gym pass, signposted him to a drugs agency and spent time explaining how cannabis can affect your body. She explained the importance of maintaining a balanced diet and not smoking all day and "getting the munchies".

The approach the health trainer used was effective as Gerry stated 'I need a kick up the behind and for someone to say come on, snap out of it'. Gerry responded well to the health trainer's suggestions and felt he was gradually getting his life back on track due to the positive inputs of his health trainer.

### Evidence of change and positive health outcomes

In discussing the results of their engagement with the OHT service, those interviewed identified the following outcomes as evidence of positive health, wellbeing and lifestyle changes:

- Lost weight /gained weight
- Maintained healthy diet
- Quality of life improved / increased confidence / positive outlook
- Reduced/stopped smoking, reduced substance misuse

- GP/Dental/dietician registration and treatment
- Gym/exercise scheme membership
- Ability to change and overcome barriers
- Widened support network.

For the participants in Bury, Rochdale and Oldham, the Health Trainer service was successful in attaining a mix of both soft and tangible outcomes for its clients. As expected, however, some outcomes are more easily quantified and recognised than others. Tangible outcomes (e.g. weight gain, gym membership, smoking reduction) enabled service users to feel that they got some*thing* valuable from the intervention (i.e. rather than just 'talk' or 'listening'). This is particularly salient in the context that offenders often tend to fail to see the value unless they can 'see' it. Therefore, for many of the clients, the most important outcome was often the most tangible one.

It was interesting to note that the three service users who placed a greater value on the softer outcomes, such as listening, increased confidence and wellbeing, were older and that two of these three were female. This could be explained by Bottoms' (2001) Compliance Theory. This theory allows for different types of engagement to be explained by traits, such as gender and age. We know from Bottoms' theory that women tend to have normative compliance, whereby they invest in the norms of the service they are engaging with and thus the support they receive, whether tangible or not, will be valued. This would also stand to reason for older service users. This is in contrast to, for instance, young male offenders who could be categorised under instrumental compliance, whereby they 'see' or weigh up what benefits engaging with a service will provide them. This would explain the tendency therefore to emphasise the tangible outputs and outcomes they had attained.[14]

As stated earlier, through the progress achieved on one goal, many participants stated they felt empowered to achieve other life goals, such as starting work. One participant (who had clinical depression) was delighted to report that her GP 'could not believe the change' in his patient and the input of the health trainers was deemed to have directly enabled the removal of anti-depressant medication (see Belinda's story in Box 4.6). Most of the participants spoke of their newly formed ability to overcome barriers and fears, supported by an attitudinal change towards a 'can do' approach.

**Impacts on offence-focussed work**

The ability of the health trainers to increase service users' motivation whilst they are on probation has the potential to have some positive impacts for their progression on their court orders. As demonstrated by two individuals interviewed, the encouragement they received from their health trainer and the visible benefits they were attaining from the service, for both themselves and their families, made them more motivated to attend their probation appointments. This has direct transference to assisting with offence-focused work of offender managers and potentially impacts positively on future patterns of offending – which supports the assumption that the Health Trainer service may reduce rates of reoffending, which informed the use of the Value for Money Tool (see 4.2).

One participant stated that he avoided going back to prison because of the support and motivation of the health trainer.

> *I was really, really down when I first started seeing [health trainer]…it's got a lot better. I was nearly back in prison to tell you the truth. They was going to send me back to prison because I wasn't doing everything I should be, but thankfully I got myself back on track with her [health trainer] support and motivation. (Lance)*

Moreover, several participants also indicated that they were more willing to attend probation as a result of the Health Trainer service.

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[14] However, this sample group was too small to draw any significant inferences regarding age and gender.

*It's giving me a bit more of a willingness to come into probation as well. Usually you'd be feeling down, you wouldn't want to come to probation, whereas 'cos [health trainer's] picking you up and giving you the incentive to like sort your health and that out, it makes you feel a lot happier then you want to come in. So it's helping you with both. (Alex)*

*I didn't have the confidence to talk to anyone else. She [health trainer] brought the confidence out in me. I couldn't even talk to my probation officer when I first started. (Zara)*

**Box 4.5: Alex's story – case study**

Alex was on probation for a burglary offence and was referred to the Health Trainer service by his Offender Manager. Alex had concerns about his weight for a long time and was worried about his appearance and being 'thin'. He had originally tried the route of going through his doctor and getting referred to a dietician, but he had little success with this. He felt they weren't 'listening' and 'didn't really understand'. Alex felt the Health Trainer service was more practical. He received advice on nutrition and has been referred to a nutritionist; he completes a food diary; balances his meals out over five stages throughout the day; and learned how to make nutritious meals. As a result of this, Alex has gained 2lb in weight and is extremely motivated to gain more weight as a result of this success and by being able to adapt to the method of 'achieving small goals'. Alex has also reduced his smoking. Through the provision of nasal spray and nicotine patches he has been able to significantly reduce his nicotine intake and hopes to continue this progress to be able to cease smoking entirely.

Most importantly, Alex feels he has increased his confidence 'loads' and improved his overall wellbeing. He now has the confidence to socialise more and go to the gym as he is less worried about his appearance. Alex also felt that having the Health Trainer service in the probation setting made him more 'willing' to attend his probation appointments, as he was less likely to 'feel down' and therefore less reluctant regarding engagement.

**Increase in wellbeing**

Participants seemed to respond well to the approach of setting and achieving small goals which could then be built on. All participants were questioned as to their perceived quality of life based on a scorecard from 1 (low) to 10 (high)[15]– and all reported an increase, with one respondent moving from 1 to 10 in only a few months, as a direct result of their involvement with the Health Trainer service. This participant stated that not only had their health benefitted from the input of the OHT service but that their outlook and general self-esteem had completely altered as a result. They now felt their barriers and fears were receding and for the first time their 'future seemed brighter'. This trend supports the DCRS data, which shows that self-efficacy, general health and WHO-5 wellbeing scores all increased over the period of engagement with the Health Trainer service (See Tables 4.25 and 4.26).

*I've changed emotionally as well as physically. Like 'cos I've put the weight on, I'm feeling more confident… and because I'm feeling better about myself I'm not so paranoid about going to the gym you know 'cos I was scared because there's all these big guys and because you're slim you think they'll look at you funny. But now I've got the confidence to just go. (Alex)*

### 4.3.5 Future plans

In terms of future plans, the interviews highlighted a range of themes, which are explored under the following headings:

- Building on success to address other health and wellbeing issues
- Building on success to move on with their lives
- Fear at signing off from Health Trainer service

[15] During their interviews in both October and February, the participants were asked to place themselves on a scale of 1-10 regarding their well-being – 1 very low and 10 very high. It was found that most responses tended to be low before they accessed the Health Trainer service and considerably higher afterwards.

**Building on success to address other health and wellbeing issues**

Most individuals indicated feeling very positive about their future and their wellbeing. For many, having achieved significant progress in addressing one problematic area of their life, they now planned to expand this to improve their health and general wellbeing further, whether this was through the Health Trainer service or of their own volition.

> *If it weren't for my health trainer I'd probably still be smoking, still be underweight eating nothing. I'd probably still have no confidence. It's made a hell of a difference. I'm a lot happier in myself and I don't intend to stop here. (Zara)*

**Building on success to move on with their lives**

Most individuals had the aim of completing their orders with probation successfully too and moving on with their lives, utilising the skills they had attained as a result of accessing the Health Trainer service. Overall, participants were looking forward to completing their probation orders and maintaining their positive progress made. Several participants acknowledged that they had learned skills for life and that they would be transferring this knowledge onto their friends, families and children.

> *From when I first started probation, I was going round doing whatever I could, and now everybody's helped me and obviously like I've got my flat and all that. So if I go out and do something then obviously I'm going to lose everything, and that's what I don't want to do. I've got more things that I want now. (Matt)*

> *Like I've learned loads around nutrition. I know now to try and eat more eggs for protein and switch me white broad for brown. I know about fibre and vitamins. I knew none of that stuff. I'm telling me mates about it too, you know for energy for the gym and all that. (Alex)*

**Fear at signing off from Health Trainer service**

Most of the individuals who were interviewed as part of their second interview in February 2012 were either finished with the Health Trainer service or were about to finish in the upcoming weeks. However, two of the participants interviewed reported their intention to continue to be involved with the service. These two individuals were apprehensive about signing off and displayed concern when this topic was raised during the interview. For them, this was mainly due to not yet feeling ready to move on or to guard against relapse.

> *I was in a state when Sam was like, 'I'm not sure how long the funding will be for.' And I was like [slams table] 'No you can't. That's it I'm starting a campaign and everything to keep you all here'. (Belinda)*

The health trainers acknowledged during their focus group that only those individuals who are 'ready' to change fully and maintain that change will be most likely to utilise their learning fully and sustain their good progress. Moreover, they felt their progress also depends entirely on the issue they presented with (i.e. the less serious the issue, the better equipped the individual will be to change for the better and maintain progress on their own after some assistance and guidance from the Health Trainer service).

### 4.3.6 Current issues with implementation

This section explores the most salient findings from the focus group with the health trainers, conducted in early July 2012 and interviews with both senior health trainers, conducted in February 2012. This research highlighted some key findings regarding:

- Recording of information
- Delivery of the service in the probation setting
- Hopes for the future of the service.

**Box 4.6: Belinda's story – case study**

Belinda was on release from custody for an offence of arson. She started accessing the Health Trainer service after a visit by the trainers to a probation women's group she was attending. Belinda has a history of clinical depression and had been a victim of domestic violence for many years. Belinda had previously been a professional substance misuse counsellor but has since lost that post due to her offence. Belinda is now accessing the Health Trainer service mainly for wellbeing and self-esteem related support.

Belinda was able to assess her own situation critically (due to her training as a counsellor). This led to additional personal difficulties when accessing counselling services for herself as she felt uncomfortable and that she 'just needed support and understanding'. Belinda felt the Health Trainer provision was ideal for her needs as she found the trainers to be flexible, approachable and 'did not watch the clock'. Moreover, the fact that the health trainers were women who had previous experience of the criminal justice system was key for Belinda. She felt this was a source of inspiration and a motivation when she was feeling low, that 'if [health trainer] could do it then I can do it'. Belinda felt having the health trainers was preferable to attending the GP regularly as she felt they were dismissive and also a more suitable option than discussing personal and emotional issues with a probation officer.

Belinda had considerable success with the Health Trainer service, and stated for her she had two main outcomes. One was that her health trainer had encouraged her to apply for a volunteer post at a local substance misuse agency, which she successfully acquired; the other was that her doctor had been able to withdraw her anti-depressant medication due to the positive progress she has been achieving personally. However, one aspect of concern is the over-dependence Belinda may have developed on her health trainer. She felt she 'needed' the Health Trainer service and knew that if anything went wrong she could call. When the possibility of funding and limitations of the service were mentioned Belinda said she felt 'very upset' at the thought of not having the service available.

### Recording of information

The health trainers felt there are significant issues with DCRS and its ability to capture all information required to effectively demonstrate the tasks undertaken by the OHTs and therefore illustrate outcomes and value. One such difficulty is the lack of ability to be specific about why clients are accessing the service. For instance, if a service user wishes to see a dentist, doctor or sexual health worker or requires drugs advice, such services must be categorised as 'local issue'. This, they state, is ineffective as it does not accurately capture what they do and the services they provide. It also does not effectively capture the on-going work with these individuals for 'motivational purposes'.

Moreover, given the various different needs for which those interviewed accessed the Health Trainer service, it is clear there are some responses which have not been and are not able to be captured on DCRS, such as 'listening'. This indicates that the health trainers provide a service which is greater than that suggested by the data collected – and suggests that in order to demonstrate value and measure the true impact of the service, a data collection system is needed that incorporates and records the total work (i.e. input, outputs and outcomes) carried out with service users.

Another issue raised during the focus group and interviews with the health trainer staff was the inability of DCRS to record more than one 'primary' need. As highlighted above and reflecting the life experience of offenders in the impoverished region of the North West, the interview data suggested that most clients present with complex inter-related needs – maybe two to four needs of equal priority. Whilst DCRS does allow lifestyle changes to be captured even when not related to the stated primary issue (see Table 4.24) and offers the possibility of capturing changes in health and wellbeing scores for all clients, the health trainers interviewed felt strongly that the system is geared up to look at defined issues in isolation. They felt that this emphasis on recording 'primary issue' did not encourage an holistic model to be adopted, which they felt was crucial to the success of the service in the probation setting – and they also feared that it only allowed success to be measured against primary issues.

Alongside these perceived shortcomings of DCRS, those interviewed did acknowledge that there are also different levels of competency among employees and inconsistencies in how different health trainers use the system – resulting in data entry errors. Whilst some health trainers clearly use the system to the best of its ability, others prioritise client liaison and place less emphasis on quality of computer-based recording and reporting. This is not unusual and tends to be found in client-facing services such as voluntary and community sector agencies (see, for example, GMPT, 2011). The health trainers stressed that they need to work with handwritten notes as they require the service users to sign their notes as 'written consent' before they can then record and input this information into DCRS, which can be used for central analytical purposes.

**Delivery of Health Trainer service in probation setting**

The health trainers highlighted the difficulties they face as a result of the probation case management system, Delius, being inaccessible to them. They considered this to be problematic to service delivery (i.e. they were unable to have a full understanding of the individual and their circumstances, including risk). Moreover, health trainers felt they were duplicating their work as they are unable to input information about their appointments with the offenders onto Delius; rather they email a summary to the Offender Manager who then uploads this into Delius. The health trainers felt this was all unnecessary and that they should be granted access to the probation case management and assessment systems. They felt it was also a source of embarrassment when told by Offender Managers 'to just look on Delius' and they then must explain once more that they are ex-offenders and do not have access to this system.

This raises fundamental issues regarding the position of OHTs – as ex-service users – within probation, their access to sensitive information and their ability to become 'equal' professionals in probation (and health service) settings, receiving the necessary training and support required similar to other professional employees. These issues are explored further in Chapter 5.

**Hopes for future service delivery**

Alongside the issues raised above, the health trainers hoped for three main outcomes. First, they expressed their hopes that they could have guaranteed funding to reduce their job insecurities. Second, they hoped that access could be increased by the service being extended beyond the current remit to deliver in the courts, prisons and all local delivery units on a full-time basis. The health trainers were adamant however, that the Health Trainer service should not be 'mandatory' for all offenders, but that it should be offered to all offenders 'as an initial health check' during their induction (i.e. initial probation appointment).

Lastly, the health trainers hoped for a specific 'health trainer room' in each probation office, not just for ease of carrying materials around but also to encourage a 'drop-in' approach for offenders who may not have the courage to inquire about the service despite their curiosity.

# 5. DISCUSSION

## 5.1 INTRODUCTION

The findings from the interrogation and analysis of DCRS data, the Value for Money Tool and the interviews and focus groups with service users and health trainers provide a wealth of valuable information about:

- How successful has the OHT service been?
- What has contributed to the success of the service?
- What are the key areas for improvement in service design and delivery?

This chapter explore these themes, considering to what extent the service has worked; how and why it has worked; and what could potentially be done better.

## 5.2 How Successful has the Offender Health Trainer Service Been?

Insight into the success of the service in promoting health, tackling health inequalities and meeting its agreed aims was provided by both the interrogation and analysis of the DCRS data and the findings from the interviews and focus groups.

### 5.2.1 Overview

The interrogation and analysis of the DCRS data points to the overall success of the OHT service, with the following headline findings:

- **Service reach:** During the period 01 April 2011 to 31 March 2012, the service reached a total of 633 clients – 150 in Rochdale, 256 in Bury and 227 in Oldham – and conducted 682 initial assessments (due to a small number of clients exiting and re-entering the service).
- **Client demographics:** Of these clients, 82% were male, 85% identified as White British, 67% were aged 18 to 35 years and 20% were not registered with a GP. Additionally, 95% were recorded as having contra-indications and 94% as having multiple wellbeing risks.
- **Client progression:** Of the 633 clients undertaking a first initial assessment, 474 proceeded to the stage of undergoing wellbeing assessments and setting a PHP – although of these, 88 had no PHP set and more than 120 had no health/wellbeing scores recorded.
- **Personal health planning:** Adjusting for data entry errors affecting sign-off (see section 5.4.1), the estimated percentage of clients reaching the wellbeing/PHP stage who fully completed or partially completed their PHP was 26% and 2% respectively. The analogous values by primary issue were: alcohol – 28%, 4%; diet – 21%, 2%; exercise – 28%, 3%; smoking – 23%, 2%; emotional wellbeing – 49%, 2%; other issue or not stated – 2%, 0%.
- **Changes in health, wellbeing and health-related behaviours:** The available pre- and post- 'intervention' data pointed to improvements in health and wellbeing (although data collection and entry errors meant that relatively few pairs of pre- and post- measures were available and that these were strongly biased towards clients who completed their PHP). Specifically:
  - mean fruit and vegetable consumption per day increased from 2.1 to 7.6
  - mean alcohol consumption declined from 38.1 to 26.2 units per week
  - mean moderate exercise sessions increase from 3.3 to 4.2 per week
  - mean cigarettes smoked per day declined from 14.7 to 8.1
  - mean self-efficacy score increased by 20 (from 69 to 89) for clients who had completed their PHP and by 14 (from 66 to 80) for those who had not completed their PHP
  - mean general health score increased by 43 (from 37 to 80) for clients who had completed their PHP and by 27 (from 43 to 70) for those who had not completed their PHP
  - mean WHO-5 wellbeing score increased by 36 (from 41 to 77) for clients who had completed their PHP and by 30 (from 34 to 64) for those who had not completed their PHP.
- **Client referral:** A total of 58 clients were recorded as having been signposted to other services, 59% of these to a GP or other primary care service (however, this does not include referrals and registrations among clients proceeding to develop PHPs).
- **Value for money:** Using input values estimated from the DCRS alongside other data and inequality weightings agreed with the commissioner, the Health Trainer Value for Money Tool predicted a net public sector saving of £823,266. However, it is important to note that the net cost/savings were shown to be highly dependent on assumptions about

reduction in reoffending as a result of clients' engagement with the service. The assumption that re-offending would decrease from 50% to 40% was based on secondary evidence (Lister, 2010) and would obviously be much stronger if based on a longitudinal study exploring the actual impact of the service on re-offending in Bury, Rochdale and Oldham.

### 5.2.2 Reflections on aims of service

The funding bid submitted by NHS Bury set out a number of aims for the OHT service – and it is useful to reflect on the extent to which these have been met:

- **Increased numbers accessing mainstream health and leisure service (including GP registration):** It is evident from the DCRS signposting data that a number of clients were referred to GPs and other primary care services. Additionally, the qualitative research findings suggested that many of those undergoing PHPs also registered with GPs and other health and leisure services (e.g. dentist, gym, swimming).
- **50% or more of those attending a first appointment complete a PHP:** The DCRS data highlighted above shows that 386 of the 633 clients (61%) went on to set at least one PHP – but suggests that the achievement rate for completing their PHP among this sub-group was only 26% (approximately 16% of all clients).
- **Upward trend over the 12 months in numbers accessing the service and completing a PHP:** The DCRS data shows a general upward trend over the four quarters in clients accessing the service and having their initial assessment (from 133 in the first quarter to 192 in the fourth quarter) – with a dip in the third quarter, possibly reflecting closure over the Christmas and New Year period. Errors and time lag in data entry made it impracticable to analyse data for completion of PHP on a quarterly basis.
- **Greater than 90% satisfaction rate with service:** The evaluation was not designed to assess the satisfaction rate, although the qualitative research findings suggest high levels of satisfaction.
- **Usefulness of the intervention in the probation setting:** Whilst no user satisfaction survey has been undertaken, the qualitative research findings point to and illuminate the particular usefulness of the Health Trainer service within the probation setting.
- **Reduced health inequalities and improved access to services:** The particular characteristics of the offender population and the high levels of multiple wellbeing risks and contra-indications recorded on DCRS suggest that the service has indeed tackled health inequalities. As discussed above, it has also increased clients' access to other health and leisure services.
- **Increased capacity to deliver preventative interventions:** The evaluation has not sought to measure the service's capacity.
- **Reduction in smoking and in smoking-related disease:** Whilst recognising the shortcomings in data entry, the DCRS data show a reduction in smoking (a decrease among clients from 14.7 to 8.1 in mean number of cigarettes smoked per day). This finding was supported by the qualitative research data – but it has obviously not been possible to measure reduction in smoking-related disease.
- **Reduction in alcohol specific and related hospital admissions**: Whilst the DCRS data suggest a reduction in alcohol consumption among clients from 38.1 to 26.2 units per week, the evaluation has not focused on hospital admissions or sought to evaluate the impact of the health trainer in this regard.
- **Improved mental wellbeing:** Similarly, whilst the DCRS data suggest substantial increases in self-efficacy, general health and WHO-5 wellbeing scores among clients, the evaluation has not sought to or been able to measure longer-term impacts of the service on mental wellbeing.
- **Rates of compliance with orders are higher for those receiving a health trainer intervention than overall rates for the three probation districts:** The evaluation was not designed to explore or evaluate impact on compliance with orders. However, the qualitative data indicate that for some of the individuals interviewed, engagement with

the Health Trainer service did increase attendance at appointments and general compliance.

- **Rates of re-offending are lower for those receiving a health trainer intervention than overall rates for the three probation districts:** Again, the evaluation was not designed to explore impact on re-offending rates – although evidence from other studies suggests that this type of intervention can be expected to decrease re-offending rates by around 10% (Lister, 2010).

### 5.2.3 Wider and deeper impacts on offenders' lives

In considering how successful the service has been, it is important to appreciate that interventions often achieve impacts that are not predicted or captured in initial aims. The qualitative research findings provide important complementary data that needs to be considered alongside the DCRS data – pointing to the power of the probation-based service to make a profound difference to individuals' lives and hopes (captured particularly in the case studies recorded in section 4.2). In particular, the service was felt to be delivered in ways that served to empower clients to build on small successes and go on to address other more substantial goals.

### 5.2.4 Wider development of service

Whilst the evaluation has not specifically focused on the wider development of the OHT service, it is evident that its value and importance has been recognised by both probation and NHS trusts – resulting in an extension beyond March 2012 (currently to autumn 2012).

## 5.3 What has Contributed to the Success of the Service?

In understanding what it was that contributed to the success of the OHT service, it is important to reflect on the findings from the qualitative research which in contrast to the quantitative data is able to provide a 'rich picture' not just of whether the service worked, but of why and how – generating powerful case studies that illustrate how people's lives have changed.

### 5.3.1 Service design

The qualitative research findings suggest that the overall design of the OHT service has contributed to its effectiveness – and a number of key features were highlighted in the interviews and focus groups:

- **Location within the probation setting:** The interviews, and in particular the resulting case studies, highlighted the importance of the Health Trainer service being located within probation offices (and health trainers being employed by the Probation Trust) – with clients commenting on the convenience and the knock-on effects in terms of also attending probation appointments. Evidence shows that drugs and alcohol, learning disabilities and poor health can all have a profound impact on criminality and that a high proportion of offenders have or can expect to have long-term health problems (Pearson, 2010). Furthermore, health has been identified as an important but neglected factor in understanding and addressing criminal behaviour – with nutritional intervention and positive dietary change having a particularly strong influence on cognitive processes and behaviours associated with offending (Bennet and Bradley; 1997; Dickerson, 1998; Ramsbottom and Gesch, 2009). The interwoven nature of clients' problems provides a clear rationale for the co-location of services that address offending-related and health and wellbeing issues, with local probation offices offering a natural 'home'.
- **Inclusivity:** A further important feature of the OHT service design is its inclusivity – enabling access to all offenders on probation, irrespective of age, gender or type of offence. In their interviews, service users made it clear that they valued having a service available to them and tailored to them.

- **Referral and registration with GPs and other health services:** The focus on assisting offenders to register with local health services, such as doctors and dentists was seen as a key feature of service design that enhanced its overall effectiveness. This is of particular significance given the evidence that offenders typically do not access mainstream health services effectively (see Pearson 2010) – a finding supported by the DCRS data, which indicates that 20% of clients having their initial assessment are not registered with a GP, contrasting with just 1% of the overall population.[16]

### 5.3.2 Service delivery: implementing desistance theory

The qualitative research findings not only highlighted the importance of service design as a contributor to the success of the Health Trainer project, but also demonstrated that the service applied learning from offender engagement and desistance theory (Maruna, 2010) throughout its delivery – suggesting that its impacts may go beyond health and encourage clients to abstain from crime. This section examines how this has contributed to the success of the initiative and the positive outcomes achieved, by considering six key aspects:

- **Change of lifestyle and outlook:** The OHT service clearly supported and motivated individuals to change their lives and feel confident that they could transform their personal circumstances for the better. It stands to reason that any increase in motivation, confidence and/or hope engendered by engagement with and participation in the Health Trainer service should assist the desistance process (Maruna, 2010; LeBel et al, 2008). Furthermore, those who have higher life satisfaction tend to be less likely to commit offences, most notably violent offences (MacDonald et al, 2005).
- **Social links:** Desistance theory indicates that having 'social capital' helps people to understand and connect to others (Farrall, 2004) and that those who feel part of and contribute to society appear to be more successful in giving up crime (McNeill, 2006, Laub et al, 1998; Maruna, 2010). Hence, the focus of the Health Trainer service on increasing links to the community and to non-offending social networks (e.g. through gym membership) can be understood to contribute to the desistance process.
- **Belief and support:** Being 'believed in' is key in desistance theory (McNeill et al, 2005) and it is clear from the research that the health trainers do indeed have faith in the clients and that this is important to the service users. The Sheffield Desistance Study (Maruna, 2010) found that support was critical to offenders' engagement and that 'desisters' who believe that the criminal justice system helped them usually associate this help with a particular member of staff. This echoes findings from both the DCRS analysis, which identified the 'guaranteed support of a health trainer' as the most important factor that would increase clients' confidence in achieving their goals (identified by 47% of service users); and the qualitative research, which highlighted the importance of the relationship with health trainers and the extent to which clients rely on and identify with them as individuals.
- **Identity and role models:** Not being labelled as a 'criminal' is fundamental to achieving and maintaining desistance (Maruna, 2010). The qualitative research highlighted the value of a service that employs ex-offenders – not only for the health trainers themselves, but also for the service users. The fact that the health trainers have moved on from their previous offences into responsible and professional positions clearly served as a motivational 'tool' and reinforced the positive message that it is possible to move beyond the offender label and achieve personal goals.
- **Strengths focussed:** Giving strong optimistic messages and focusing on individuals' strengths is central to desistance (McNeill et al, 2005). The Health Trainer service applied this approach by encouraging clients to set small goals that felt achievable, helping them to remain optimistic. Recognising and marking achievements is also important, and clients evidently felt rewarded when their health trainers praised them for their achievements.

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[16] Source: www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-50029

- **Practical focus:** In desistance research, offenders are reported to value practical support more than any other type of intervention – and this is also understood to be important in encouraging progress to be sustained (Laub and Sampson, 2001). The Health Trainer service is designed and delivered to incorporate this aspect of practicality, as evidenced by the qualitative findings – which highlighted the perceived value of practical provision (e.g. cook and taste sessions) and tangible outcomes.

In summary, it appears that the Health Trainer service has successfully implemented learning from desistance theory research around 'what works' within its day-to-day delivery, contributing to the achievement of personal goals and overall project outcomes.

## 5.4 What are the Key Areas for Improvement in Service Design and Delivery?

Whilst the research findings were positive, they also point to potential routes for enhancing the design and delivery of the OHT service.

### 5.4.1 Data collection and recording

The interrogation and analysis of the DCRS data highlighted serious shortcomings in data collection and recording – and also showed that these shortcomings have important implications for understanding and robustly evaluating how effectively the OHT service is working (see sections 4.1 and 5.1). Examples include:

- no primary issue was recorded for many of those proceeding to the wellbeing/PHP stage
- no post-assessments were conducted and/or recorded for many clients who set PHP goals
- a number of post-assessments were conducted for clients for whom no pre-assessment had been undertaken, making the usefulness of the post-assessment questionable
- 'pre' health and wellbeing scores (self-efficacy, general health and WHO-5 wellbeing) were not provided for many of those proceeding to the wellbeing/PHP stage – and far fewer 'post' scores were available
- a large number of clients appeared to have not been signed off even though they had had no contact with the service for many months.

Although there have clearly been some logistical challenges relating to how the NHS-designed system interfaces with the probation system and some concerns among health trainers about the adequacy of DCRS for capturing the necessary breadth and depth of the data, it remains that it *is* the national data system for Health Trainer services and that even with shortcomings, it offers a valuable means of recording information that can be used to assess the value and impact of the service. As with any professional organisation, accountability and responsibility need to be embraced by all employees – and as such it is the duty of the health trainers to record their data in as robust a way as possible utilising the facilities they have available. Of particular concern is the lack of sign-off for many clients, which raises the question of whether this is a data entry issue alone or reflects clients being 'lost' and not followed up.

The interviews with the health trainers revealed dissatisfaction with DCRS and a sense that the system was not capable of comprehensively capturing the full range of inputs, outputs and impacts relating to the service. These findings suggest that it may be valuable to explore the appropriateness of the system and to ensure full understanding of how the system works (e.g. there was a strong belief that DCRS can only demonstrate success based on clients' achievements against the primary issue – but as is apparent from the analysis in section 4.1, this is not the case).

### 5.4.2 Drawing boundaries and guarding against over-dependence

It was evident from the interviews with service users that whilst they greatly valued the flexibility of the service and the dedication of the health trainers and their willingness to forge close and trusting relationships, there are indications of over-dependence of some vulnerable clients and risks of boundaries becoming blurred.

This suggests that there may be a need to conduct further training with the health trainers to ensure that the service not only provides one-to-one support for behaviour change, but also proactively supports the development of independence and self-coping mechanisms. This is particularly important in the context of current funding uncertainties and the potential for the service to be discontinued – and it is vital that the service guards against vulnerable individuals being left feeling isolated or under-valued and at risk of returning to offending and/or self-harm.

### 5.4.3 Further tailoring the Health Trainer model to the probation context

By its very nature, the client base for the OHT service is vulnerable with complex needs and a disproportionate level of mental health problems (Social Exclusion Unit, 2002). The qualitative research data confirmed this, suggesting that even when the primary 'presenting' issue was smoking, diet, exercise or alcohol rather than emotional wellbeing, the health trainers were working with the service users to address issues relating to stress, anxiety and lack of self-esteem.

Whilst the Health Trainer model was developed to work with individuals experiencing disadvantage, there would seem to be value in reflecting on the experiences of running the service within the probation setting and considering how it can be further tailored to ensure that the model clearly addresses the complexity of offenders' needs, thereby ensuring that resources are appropriately channelled.

### 5.4.4 Further integrating the Health Trainer service into probation

The interviews and focus group with the health trainers raised several issues concerning the integration of the Health Trainer service into probation – specifically the physical location and space provision; and the separation of information management systems.

In terms of physical location, the health trainers felt that a dedicated 'health trainer room' in each probation office would enable them to work more effectively as a team and manage their resources better, but also encourage a 'drop-in' approach for offenders. With regard to information management systems, they felt that it would be beneficial to have access to Delius, the offender case management system – partly because they felt that this would enable them to address their clients' needs in a more holistic way and partly because they felt that this would signal a fuller acceptance of their position as 'proper' members of staff. Whilst there may well be data protection issues that mitigate against providing access to Delius, these findings suggest that it will be important to discuss the issue in a transparent way and respond to the health trainers' concerns.

# 6. CONCLUSION AND RECOMMENDATIONS

## 6.1 CONCLUSION

*Fair Society, Healthy Lives* (The Marmot Review, 2010) powerfully highlighted the importance of tackling inequalities in health and addressing the wider determinants of health and wellbeing. The Government's response, set out in *Healthy Lives, Healthy People*, (Department of Health, 2010) emphasises the need to address the root causes of poor health and wellbeing and to reach out to the individuals and families who need the most support.

Offenders and their families represent one of the most socially excluded groups in society, with considerable physical and mental health needs compared to the general population (Social Exclusion Unit, 2002). Furthermore, it is evident that their problems are often complex and inter-related, pointing to the need for a co-ordinated approach to service delivery. The development of OHT programmes located within probation settings represents such an approach. Building on learning from Community Health Trainer programmes, OHT services have employed and trained ex-offenders to engage and work with offenders on a one-to-one basis. Following on from the Rochdale demonstration project, the OHT Implementation Project has been delivered through local probation offices in Bury, Rochdale and Oldham – assessing offenders' health and lifestyle risks, providing motivational guidance, offering practical support to facilitate behaviour change, and signposting to a range of health services.

This evaluation, commissioned by NHS Bury, has explored the extent to which the OHT Implementation Project has been delivered as intended and examined the impact of the OHT Implementation Project on service users – through analysing routinely collected DCRS data; using the Health Trainer Value for Money Assessment Tool; undertaking interviews with health trainers; and conducting interviews and focus groups with health trainers. The research findings show that the service recruited 633 clients, representing 21.7% of the offender population subject to probation supervision across the three boroughs (and approximately 37.6% in Bury; 13.4% in Rochdale; and 20.2% in Oldham). Whilst a disappointingly low percentage of these clients (16% compared to a specified aim of 50%) progressed to and successfully completed PHPs, the data available points to encouraging trends in behaviour change (relating to diet, alcohol intake, exercise and smoking) and self-perceived health and wellbeing scores. Furthermore, whilst the changes in 'before' and 'after' measures are greater for those clients that did successfully complete their PHPs, the directional trends remain for those who did not. Additionally, it appears that a substantial number of clients were referred to a GP and/or other health and leisure service.

In terms of 'value for money', the Health Trainer Assessment Tool predicts that – based on estimates derived from the DCRS data together with an estimate of reoffending rates and an equity weighting agreed in liaison with the commissioner and drawing on the guidance document accompanying the Value for Money Tool (Lister, 2010) – the service would result in a net public sector saving of £823,266 for the year. However, it must be noted that the net cost/savings were shown to be highly dependent on assumptions about reduction in reoffending as a result of clients' engagement with the service, which were not based on empirical research (which would require a longitudinal follow-up).

Alongside the quantitative analysis and 'value for money' modelling, the qualitative research provided a rich insight into how the service has worked and what contributed to its success – pointing to features of its design (location within probation, inclusivity, referral to GPs and other health services) and delivery (application of desistance theory – providing a practical strengths-focused highly supportive service concerned to encourage change of outlook, forge social links, and motivate through role modelling). Moreover, this research generated in-depth stories or case studies illustrating how the OHT service had made a real and tangible difference to offenders' lives – not merely focusing on one 'primary' issue, but helping them to tackle multiple interwoven problems and build hope and self-belief.

## 6.2 RECOMMENDATIONS

Drawing on the research findings, a number of recommendations can be made:

### 6.2.1 Service continuation and sustainability

Whilst there were shortcomings in the evaluation data (see 6.2.2), the quantitative and qualitative research findings suggest that the OHT service has been successful in terms of engaging offenders, building confidence-building, enhancing self-perceived wellbeing and facilitating behaviour change. Recommendations are to:

- **provide sustainable funding** to enable the service to continue and develop, building on its successes and further enhancing the features of design and delivery shown to have contributed to its success
- **disseminate evaluation findings** widely, particularly within Greater Manchester.

### 6.2.2 Tailored service development

Recognising the multiple and inter-connected complex needs of many offenders, it is important to ensure that the OHT service is appropriately tailored to the probation context and that health trainers are competent to provide intensive one-to-one support but at the same time to guard against over-dependence. Recommendations are to:

- **conduct a review of the current health trainer 'model'**, to ensure that it is not 'straight-jacketed' by narrowly-conceived primary issues – but clearly recognises and addresses the complexity of offenders' needs, thereby ensuring that resources are appropriately channelled
- **explore the viability of adapting and/or extending the capabilities of DCRS** to ensure it is 'fit for use' within the probation setting (in collaboration with the 'hub' in Birmingham)
- **provide further training for health trainers** focused on managing the tensions implicit in their role and equipping them to draw boundaries, promote independence and interface with other community-based services.

### 6.2.3 Integration of the service within probation

The evaluation highlighted issues regarding the integration of the OHT service within probation. Recommendations are to:

- **explore with health trainers how the service can be better integrated** within probation in ways that enhance effectiveness, recognise delineation of roles and build employee satisfaction.

### 6.2.4 Data collection and recording

It was clear from the evaluation that there are serious shortcomings in data collection and recording – and that these shortcomings have important implications for understanding and robustly evaluating how effectively the OHT service is working. Recommendations are to:

- **develop and implement a DCRS advanced training programme** that increases understanding of and confidence in collecting and recording data (in collaboration with the 'hub' in Birmingham)
- **put in place supportive performance management mechanisms** to ensure that there is consistency and accuracy in data capture and entry, thereby increasing the ability to understand, monitor and evaluate the effectiveness of the service.

### 6.2.5 Research and evaluation

In order to demonstrate the effectiveness of the service and understand and learn from what works or doesn't work well, it is essential to build evaluative research into any future programme. Recommendations are to:

- **integrate evaluative research on health, wellbeing and reoffending into future funding models and bids**, with a view to building on evaluations already undertaken – including a longitudinal study that can explore impacts of the service over time.

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# APPENDIX 1: PROFILES OF BURY, ROCHDALE AND OLDHAM

**Bury at a glance**

The health of people in Bury is mixed compared with the England average. Deprivation is lower than average, however about 7,000 children live in poverty.

Life expectancy for both men and women is lower than the England average.

Life expectancy is 10.8 years lower for men and 8.0 years lower for women in the most deprived areas of Bury than in the least deprived areas.

Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is worse than the England average.

About 20.2% of Year 6 children are classified as obese. Levels of teenage pregnancy, breast feeding England average. The level of GCSE attainment is initiation and smoking in pregnancy are worse than the better than the England average.

The estimated level of adult smoking is worse than the England average. The estimated level of adult obesity is better than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average. The rate of road injuries and deaths is better than the England average.

Priorities in Bury include reducing smoking prevalence, reducing alcohol intake and promoting self-care.

For more information see www.burypct.nhs.uk

**Rochdale at a glance**

The health of people in Rochdale is generally worse than the England average. Deprivation is higher than average and about 12,800 children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 11.6 years lower for men and 9.9 years lower for women in the most deprived areas of Rochdale than in the least deprived areas.

Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.

About 20.7% of Year 6 children are classified as obese, higher than the average for England. Levels of hospital stays among those under 18, breast feeding teenage pregnancy, GCSE attainment, alcohol-specific initiation and smoking in pregnancy are worse than the England average.

Estimated levels of adult 'healthy eating' and smoking are worse than the England average.

Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are worse than the England average.

The rate of road injuries and deaths is better than the England average.

The rate of statutory homelessness is lower than average.

Priorities in Rochdale include reducing all age all-cause mortality, tobacco, alcohol and obesity.

For more information see www.hmr.nhs.uk

**Oldham at a glance**

The health of people in Oldham is generally worse than the England average.

Deprivation is higher than average and about 14,400 children live in poverty.

Life expectancy for both men and women is lower than the England average.

Life expectancy is 11.1 years lower for men and 10.3 years lower for women in the most deprived areas of Oldham than in the least deprived areas.

Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.

About 17.3% of Year 6 children are classified as obese, lower than the average for England.

Levels of hospital stays among those under 18, breast feeding teenage pregnancy, GCSE attainment, alcohol-specific initiation and smoking in pregnancy are worse than the England average.

Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average.

The rate of road injuries and deaths is better than the England average. The rate of statutory homelessness is lower than average.

Priorities in Oldham include smoking, alcohol related harm and increasing physical activity.

For more information see www.oldham.nhs.uk

# APPENDIX 2: INTERROGATION AND ANALYSIS OF ROUTINELY COLLECTED 'DCRS' DATA – SUPPLEMENTARY TABLES

**Table A1: Date of first initial assessment; mismatch shown in bold type**

| | | Clients' spread sheet | Assessments' spread sheet |
|---|---|---|---|
| 2011 | Apr | **31** | **30** |
| | May | **45** | **46** |
| | Jun | 57 | 57 |
| | Jul | 56 | 56 |
| | Aug | 76 | 76 |
| | Sep | **37** | **36** |
| | Oct | **53** | **54** |
| | Nov | 66 | 66 |
| | Dec | 20 | 20 |
| 2012 | Jan | 71 | 71 |
| | Feb | 66 | 66 |
| | Mar | 55 | 55 |
| | Total | 633 | 633 |

**Table A2: Initial assessments outcomes**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Eligible – did not want to proceed | 17 | 1 | | 18 | (2.6%) |
| Eligible – proceed to assessment | 496 | 39 | 4 | 539 | (79.0%) |
| Eligible –service not wanted at this time | 14 | | | 14 | (2.1%) |
| Information only | 48 | 1 | | 49 | (7.2%) |
| Not eligible | 2 | | | 2 | (0.3%) |
| Recommended to primary care | 7 | 2 | | 9 | (1.3%) |
| Referral to accredited health trainer | 1 | | | 1 | (0.1%) |
| Signpost only | 48 | 2 | | 50 | (7.3%) |
| Total | 633 | 45 | 4 | 682 | (100%) |

**Table A3: Full assessment outcome**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| | First | Second | Third | All | |
| Not stated/blank | 13 | | | 13 | (2.4%) |
| Could not make contact with client | 1 | | | 1 | (0.2%) |
| Mini health MOT only | 2 | | | 2 | (0.4%) |
| Not ready for change at this time | 1 | | | 1 | (0.2%) |
| Proceed to wellbeing / PHP | 474 | 37 | 3 | 514 | (95.4%) |
| Signpost only | 5 | 2 | 1 | 8 | (1.5%) |
| Total | 496 | 39 | 4 | 539 | (100%) |

**Table A4: Average measures of health and wellbeing before commencement of PHP (all initial assessments)**

| Score | Sample Size (missing values) | Mean (SD) |
|---|---|---|
| Self-efficacy | 333 (181) | 71.6 (14.1) |
| General health | 351[1] (163) | 39.9 (22.6) |
| WHO-5 wellbeing | 315[2] (199) | 43.3 (25.7) |

[1]Contains 6 zero values
[2]Contains 16 zero values

**Table A5: Numbers of contacts with clients (all initial assessments)**

| Contacts per client | Clients | % |
|---|---|---|
| 0 | 6 | (0.9%) |
| 1-4 | 454 | (71.7%) |
| 5-9 | 110 | (17.4%) |
| 10-14 | 42 | (6.6%) |
| 15-19 | 10 | (1.6%) |
| 20-24 | 7 | (1.1%) |
| 25-29 | 3 | (0.5%) |
| 30-32 (maximum number =32) | 1 | (0.2%) |
| Total | 633 | (100%) |

**Table A6: Number of reviews of the clients (first initial assessments)**

| Reviews | | |
|---|---|---|
| 0 | 491 | (77.6%) |
| 1 | 81 | (12.8%) |
| 2 | 31 | (4.9%) |
| 3 | 18 | (2.8%) |
| 4 | 9 | (1.4%) |
| 5 | 2 | (0.3%) |
| 6 | 0 | (0.0%) |
| 7 (maximum number = 7) | 1 | (0.2%) |
| Total | 633 | (100%) |

**Table A7: Client stated importance of the primary issue and confidence in achieving change**

| | How important is it to address this issue? | | How confident are you in achieving change? | |
|---|---|---|---|---|
| Out of 10 | Clients | (%) | Clients | (%) |
| 1 | | | 4 | (0.8%) |
| 2 | | | 1 | (0.2%) |
| 3 | 1 | (0.2%) | 5 | (1.1%) |
| 4 | | | 8 | (1.7%) |
| 5 | 7 | (1.5%) | 37 | (7.8%) |
| 6 | 14 | (3.0%) | 26 | (5.5%) |
| 7 | 31 | (6.5%) | 52 | (11.0%) |
| 8 | 77 | (16.2%) | 89 | (18.8%) |
| 9 | 44 | (9.3%) | 30 | (6.3%) |
| 10 | 274 | (57.8%) | 181 | (38.2%) |
| Not stated | 26 | (5.5%) | 41 | (8.6%) |
| Total | 474 | (100.0%) | 474 | (100.0%) |

**Table A8: Sign off reason for all clients**

| | Initial assessments | | | | |
|---|---|---|---|---|---|
| Client…… | First | Second | Third | All | |
| chose an alternative service | 6 | 1 | | 7 | (1.6%) |
| did not attend | 82 | 4 | | 86 | (19.5%) |
| could not afford desired activities | 5 | | | 5 | (1.1%) |
| was not contactable | 19 | 2 | | 21 | (4.8%) |
| did not follow plan | 19 | 2 | | 21 | (4.8%) |
| did not realised commitment required | 15 | 2 | | 17 | (3.9%) |
| insufficient support from significant others | | 1 | | 1 | (0.2%) |
| was disappointed with rate of progress | 1 | | | 1 | (0.2%) |
| was unable to continue | 13 | | 1 | 14 | (3.2%) |
| had mini-health MOT only | 4 | | | 4 | (0.9%) |
| was not eligible | 4 | | | 4 | (0.9%) |
| was not ready to make changes | 25 | 1 | | 26 | (5.9%) |
| only wanted some information | 48 | 2 | | 50 | (11.4%) |
| had another reason | 6 | 1 | | 7 | (1.6%) |
| completed the PHPs | 87 | 12 | | 99 | (22.5%) |
| partially completed the PHPs | 7 | 1 | | 8 | (1.8%) |
| was recommended to primary care | 7 | 3 | | 10 | (2.3%) |
| was referred to an accredited health trainer | 1 | | | 1 | (0.2%) |
| was signposted only | 53 | 4 | 1 | 58 | (13.2%) |
| Total signed off | 402 | 36 | 2 | 440 | (100%) |
| was not signed off | 231 | 9 | 2 | 242 | |
| Total | 633 | 45 | 4 | 682 | |

**Table A9: Sign off date**

| | | Initial assessments | | | |
|---|---|---|---|---|---|
| | | First | Second | Third | All |
| 2011 | Apr | 7 | | | 7 |
| | May | 24 | | | 24 |
| | Jun | 24 | | | 24 |
| | Jul | 36 | 1 | | 37 |
| | Aug | 54 | 4 | | 58 |
| | Sep | 29 | 5 | | 34 |
| | Oct | 22 | 4 | | 26 |
| | Nov | 22 | 2 | | 24 |
| | Dec | 11 | | | 11 |
| 2012 | Jan | 73 | 8 | 1 | 82 |
| | Feb | 41 | 4 | 1 | 46 |
| | Mar | 42 | 5 | | 47 |
| | Apr | 17 | 3 | | 20 |
| | Total signed off | 402 | 36 | 2 | 440 |
| | Not signed off | 231 | 9 | 2 | 242 |
| | Total | 633 | 45 | 4 | 682 |

**Table A10: Sign off date by initial assessment date for all clients (first initial assessment only)**

| 1st initial assessment | Date client signed off | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2011 | | | | | | | | | 2012 | | | | | |
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | Not signed off | Total |
| 2011 | | | | | | | | | | | | | | | |
| Apr | 7 | 6 | 4 | 4 | 2 | | 1 | | | 2 | 1 | | 2 | 1 | *30 |
| May | | 18 | 8 | 5 | 5 | 1 | | | | 1 | 1 | | | 7 | 46 |
| Jun | | | 12 | 11 | 11 | 3 | 1 | | | 1 | 1 | | | 17 | 57 |
| Jul | | | | 16 | 4 | 7 | 3 | 4 | | 5 | | | | 17 | 56 |
| Aug | | | | | 32 | 6 | 1 | | | 7 | 3 | 2 | 1 | 24 | 76 |
| Sep | | | | | | 12 | 3 | 2 | 1 | 3 | 1 | | | 14 | 36 |
| Oct | | | | | | | 13 | 3 | 1 | 13 | 8 | | | 16 | 54 |
| Nov | | | | | | | | 13 | 1 | 16 | 5 | 4 | 2 | 25 | 66 |
| Dec | | | | | | | | | 8 | 5 | 2 | | | 5 | 20 |
| 2012 | | | | | | | | | | | | | | | |
| Jan | | | | | | | | | | 20 | 7 | 11 | 1 | 32 | 71 |
| Feb | | | | | | | | | | | 12 | 7 | 4 | 43 | 66 |
| Mar | | | | | | | | | | | | 18 | 7 | 30 | 55 |
| Total | 7 | 24 | 24 | 36 | 54 | 29 | 22 | 22 | 11 | 73 | 41 | 42 | 17 | 231 | 633 |

* Likely to be an underestimate.

**Table A11: Signed off and not signed off by month of first initial assessment**

| 1st initial assessment | All clients Status on DCRS at 24th April 2012 | | | | Clients whose full assessment outcome was 'proceed to wellbeing/PHP' Status on DCRS at 24th April 2012 | | | |
|---|---|---|---|---|---|---|---|---|
| | Not signed off | Signed off | % signed off | Total | Not signed off | Signed off | % signed off | Total |
| 2011 | | | | | | | | |
| Apr | 1 | 29 | (96.7%) | 30 | 1 | 26 | (96.3%) | 27 |
| May | 7 | 29 | (63.0%) | 46 | 7 | 26 | (78.8%) | 33 |
| Jun | 17 | 40 | (70.2%) | 57 | 17 | 32 | (65.3%) | 49 |
| Jul | 17 | 39 | (69.6%) | 56 | 17 | 24 | (58.5%) | 41 |
| Aug | 24 | 52 | (68.4%) | 76 | 24 | 22 | (47.8%) | 46 |
| Sep | 14 | 22 | (61.1%) | 36 | 14 | 11 | (44.0%) | 25 |
| Oct | 16 | 38 | (70.4%) | 54 | 16 | 28 | (63.6%) | 44 |
| Nov | 25 | 41 | (62.1%) | 66 | 22 | 29 | (56.9%) | 51 |
| Dec | 5 | 15 | (75.0%) | 20 | 4 | 7 | (63.6%) | 11 |
| 2012 | | | | | | | | |
| Jan | 32 | 39 | (54.9%) | 71 | 31 | 26 | (45.6%) | 57 |
| Feb | 43 | 23 | (34.8%) | 66 | 42 | 16 | (27.6%) | 58 |
| Mar | 30 | 25 | (45.5%) | 55 | 22 | 10 | (31.3%) | 32 |
| Total | 231 | 402 | (63.5%) | 633 | 217 | 257 | (54.2%) | 474 |

**Table A12: Clients who were not signed off by month of initial assessment and last contact for any assessment – all clients (first initial assessment)**

| | | Month of last contact with client | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2011 | | | | | | | | | | 2012 | | | | | |
| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Dec |
| **2011** | Total | | | | | | | | | | | | | | | | |
| Apr | 1 | | | | | | | | | | | | 1 | | | | |
| May | 7 | | | 3 | 2 | 1 | 1 | | | | | | | | | | |
| Jun | 17 | | | | 6 | 3 | 6 | | | | | 1 | | | 1 | | |
| Jul | 17 | | | | | 8 | 6 | | | | | 2 | 1 | | | | |
| Aug | 24 | | | | | | 21 | | | | | 2 | 1 | | | | |
| Sep | 14 | | | | | | | 8 | 1 | 2 | | 1 | 2 | | | | |
| Oct | 16 | 1 | | | | | | | 11 | | | 3 | 1 | | | | |
| Nov | 25 | | | | | | | | | 16 | 1 | 3 | 4 | 1 | | | |
| Dec | 5 | | | | | | | | | | 2 | 1 | 1 | | | | 1 |
| **2012** | | | | | | | | | | | | 19 | | | | | |
| Jan | 32 | | | | | | | | | | | | 8 | | 3 | 2 | |
| Feb | 43 | | | | | | | | | | | | 38 | 3 | 1 | 1 | |
| Mar | 30 | | | | | | | | | | | | | 17 | 12 | 1 | |
| Total | 231 | 1 | | 3 | 8 | 12 | 34 | 8 | 12 | 18 | 3 | 32 | 57 | 21 | 17 | 4 | 1 |

* The data extracted in April 2012 included figures for May and December 2012 – and whilst it is presumed that these reflect data entry errors, the data is presented as found.

**Table A13: Clients who were not signed off by month of initial assessment and last contact for any assessment – clients who proceeded to wellbeing/PHP stage (first initial assessment)**

| | Month of last contact with client | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1st initial assessment | | 2011 | | | | | | | | | | 2012 | | | |
| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
| 2011 | Total | | | | | | | | | | | | | | |
| Apr | 1 | | | | | | | | | | | | 1 | | |
| May | 7 | | | 3 | 2 | 1 | 1 | | | | | | | | |
| Jun | 17 | | | | 6 | 3 | 6 | | | | | 1 | | | 1 |
| Jul | 17 | | | | | 8 | 6 | | | | | 2 | 1 | | |
| Aug | 24 | | | | | | 21 | | | | | 2 | 1 | | |
| Sep | 14 | | | | | | | 8 | 1 | 2 | | 1 | 2 | | |
| Oct | 16 | 1 | | | | | | | 11 | | | 3 | 1 | | |
| Nov | 22 | | | | | | | | | 14 | 1 | 3 | 3 | 1 | |
| Dec | 4 | | | | | | | | | | 2 | 1 | 1 | | |
| 2012 | | | | | | | | | | | | | | | |
| Jan | 31 | | | | | | | | | | | 18 | 8 | | 3 |
| Feb | 42 | | | | | | | | | | | | 37 | 3 | 1 |
| Mar | 22 | | | | | | | | | | | | | 11 | 10 |
| Total | 217 | 1 | | 3 | 8 | 12 | 34 | 8 | 12 | 16 | 3 | 31 | 55 | 15 | 15 |

**Table A14: Clients contributing self-efficacy scores to the database (first initial assessment)**

| | Clients with… | Clients without… | Total |
|---|---|---|---|
| | before score | before score | |
| Proceed to PHP/wellbeing | 306 | 168 | 474 |
| Not proceed to PHP/wellbeing | 12 | 147 | 159 |
| Total | 318 | 315 | 633 |
| | after score | after score | |
| Proceed to PHP/wellbeing | 64 | 410 | 474 |
| Not proceed to PHP/wellbeing | 6 | 153 | 159 |
| Total | 70 | 563 | 633 |
| | both before and after score | both before and after score | |
| Proceed to PHP/wellbeing | 63 | 411 | 474 |
| Not proceed to PHP/wellbeing | 7 | 152 | 159 |
| Total | 70 | 563 | 633 |
| | both before and after score | both before score and after score | |
| Proceed to PHP/wellbeing then: | | | |
| Not signed off | 0 | 217 | 217 |
| Signed off PHP completed | 46 (73%) | 41 | 87 |
| Signed off PHP part completed | 3 (5%) | 4 | 7 |
| Signed off PHP not completed | 14 (22%) | 149 | 163 |
| Total signed off | 63 | 194 | 257 |
| Total | 63 (100%) | 411 | 474 |

**Table A15: Where clients were signposted to after initial assessment and if not proceeding after full assessment**

| | Did not proceed after initial assessment | Did not proceed after full assessment | Assessments: First | Second | Third | All |
|---|---|---|---|---|---|---|
| Advice and Guidance | 3 | | 3 | | | 3 |
| Alcohol and drug services | 2 | 1 | 3 | 1 | | 4 |
| Emotional wellbeing services | 4 | 1 | 5 | 2 | | 7 |
| GP or other primary care services | 30 | 2 | 32 | 1 | 1 | 34 |
| Hospital services | 4 | 1 | 5 | | | 5 |
| IAPT[1] | 2 | | 2 | | | 2 |
| Local authority services | 2 | | 2 | | | 2 |
| Mental health services MDO[2] | 1 | | 1 | | | 1 |
| Total | 48 | 5 | 53 | 4 | 1 | 58 |

[1] Improving Access to Psychological Therapies Programme
[2] Mentally Disordered Offenders