



## **EVALUATION OF ROCHDALE OFFENDER HEALTH TRAINERS DEMONSTRATION PROJECT**

### **REPORT OF FINDINGS**

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## **HEALTHY SETTINGS DEVELOPMENT UNIT**

The Healthy Settings Development 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 programmes – including the Big Lottery funded Pan-Regional Prisons Programme, Health, Inclusion and Citizenship
- 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
- chairing the International Union of Health Promotion and Education’s Global Working Group on Healthy Settings
- contributing to the development and management of WHO’s Health in Prisons Project.

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# EXECUTIVE SUMMARY

## INTRODUCTION AND BACKGROUND

This report summarises learning captured through the process evaluation of the Offender Health Trainer (OHT) Demonstration Project, commissioned by the North West Health Trainer Partnership. It aims to inform the next stage implementation project and wider service roll-out.

The NHS Health Trainer service was launched in 2005 with the aim of tackling health inequalities through helping disadvantaged and hard to reach communities access local health services and make healthier lifestyle choices. Whilst the main focus was on disadvantaged geographical communities, the initiative also signalled an opportunity to develop services with target groups such as offenders in prison and probation settings.

Offenders and their families represent one of the most socially excluded groups, with considerable physical and mental health needs compared to the general population. Their problems are often complex and interrelated, as many have poor life and coping skills and have also experienced long term disengagement from services and a lack of education, training and employment. OHT services are already operating in some prisons, and there is growing interest in developing them in the probation setting.

## ROCHDALE OFFENDER HEALTH TRAINER DEMONSTRATION PROJECT

Rochdale is one of the most deprived boroughs in England and at any one time has approximately 1500 people subject to supervision by Greater Manchester Probation Trust (GMPT). The OHT Demonstration Project has built on previous pilot activity in other regions and the existing Community Health Trainer service at NHS Heywood, Middleton and Rochdale. Its goal is to improve the health of offenders subject to supervision by the Probation Service, through offering personalised support and improving access to appropriate health services. At the same time, it aims to tackle local health inequalities, empower offenders, improve the employment prospects of ex-offenders, improve community re-integration and reduce reoffending rates.

## PROCESS EVALUATION: OVERVIEW AND DESIGN

This process evaluation aims to capture the learning that has come from the development of the OHT partnership between Health and Probation Services in Rochdale Borough. Receiving ethical approval through UCLan, the study was designed to be flexible and responsive to the needs of the project as it evolved, and comprised three elements:

- **Rapid Appraisal of National Offender Health Trainer Programme:** Using literature review and informal conversations, this provided contextual information and summarised evidence of effectiveness of developments to date.
- **Qualitative Review of Rochdale Offender Health Trainer Demonstration Project:** This comprised seven interviews with staff involved in managing the project, ten interviews with service users, three interviews and one focus group with OHTs.
- **Joint Action Planning and Reporting:** Drawing on the above research, a workshop was held to present emergent findings, validate and expand data and enable action planning.

## PROCESS EVALUATION: FINDINGS

### A) INTERVIEWS WITH MANAGERS

Analysis of the evaluation data revealed a number of interconnected themes:

**Responding to Key Drivers:** Tackling Health inequalities and reducing reoffending were identified as the two key drivers that had catalysed and added legitimacy to the Rochdale OHT Demonstration Project, with interviewees revealing an evident willingness to develop a shared understanding of the interconnections between the two agendas:

**Developing the Partnership:** Whilst acknowledging the challenge of achieving effective partnership working between sectors with different agendas and priorities, interviewees highlighted the importance of previous collaborative work – and in particular the co-ordinating role of the Regional Offender Health Team – in paving the way for the OHT partnership. Interviewees identified a range of factors that facilitated successful partnership working: consensus; leadership; clarifying roles and responsibilities; securing mutual respect, developing a supportive culture and sharing expertise; building trust and openness.

**Recruiting the Offender Health Trainers:** A key task of staff managing the project was to recruit OHTs to deliver the service – on a part-time basis in order to avoid impacting negatively on receipt of benefits. Interviewees felt that the project had been successful in ‘walking the talk’, by facilitating rehabilitation of offenders through a sensitive recruitment process that offered employment and training opportunities to ex-offenders not regarded as being ‘high risk’. In order to avoid perceived problems with ex-offenders being employed by the NHS, the OHTs were employed through Probation.

**Providing Training and Building Skills:** As part of a commitment to ensuring equivalence and consistency with the Community Health Trainers initiative – as well as helping staff to a portfolio of accredited training – the Rochdale OHT Demonstration Project ensured that those recruited undertook the core City and Guilds Level 3 Health Trainers qualification. In addition, the recruits received thematic training on key topics and induction training to equip them to deal with the particular challenges of working within the Probation context – which interviewees felt could be strengthened in the future.

**Collecting Data:** An important part of the OHTs’ remit was to collect data, recording routine demographic information, generating a client group profile, understanding lifestyle challenges and associated behaviour changes, and helping build evidence of effectiveness – both in addressing health issues and reducing reoffending. Interviewees highlighted several hurdles including: delayed access to the Health Trainer Data Collection Recording System (DCRS); and poor literacy and skills levels. Looking to the future, they were concerned to track impacts on offending behaviour and health; explore how these impacts might be economically quantified; and compare areas with and without an OHT service in place.

**Judging Success:** From the ‘health’ perspective, key aims were for OHTs to facilitate access to services for offenders and to support them in making changes to their lives. Interviewees felt strongly that the project had been highly successful in terms of access but that it was too early to judge success in relation to lifestyle change. However, they felt that the service had been developed to take account of the complexity and chaotic nature of many offenders’ lives and in ways that appreciated the connections between health and other issues – and offered stories that powerfully illustrated how the project had moved

beyond service provision to empower individuals to make real changes to their lives. From the offender management perspective, the major success indicator was seen to be reduction in reoffending. Whilst acknowledging that it was unrealistic to expect to measure such changes within the project's lifetime, interviewees provided anecdotes indicating success.

**Communicating:** Within the project team, feedback mechanisms were seen to be important as a means of guiding future developments and improving service provision.. Those interviewed also emphasised the importance of raising awareness, to ensure that stakeholders within key organizations knew about and understood the remit of the OHT service – confirming that the Project Board had decided initially to limit external communication, in order to minimise the risk of negative media and public perceptions. However, a broader communication plan was developed that set out a step-by-step approach and looked to build on success stories emerging from the evaluative research – recognizing the need to move beyond the internal focus to ensure wider publicity.

**What's Helped?:** Interviewees highlighted the importance of the OHT 'concept' in providing a positive foundation by engaging people within the context of their own lives – as well as emphasizing the significance of favourable contextual factors in facilitating the project's establishment, development and implementation. They particularly drew attention to the pre-existing relationship between the NHS and the Probation Trust and the firm foundations that had already been put in place. Building on this, they also reflected on the value of good partnership working, enthusiasm, energy and a positive outlook.

**What's Hindered?:** Whilst the overwhelming feeling was that the project had successfully addressed challenges, interviewees identified a range of hindering factors at interpersonal and organisational levels – including different personalities and agendas; issues relating to governance, bureaucracy and joint decision-making; the economic context; stigma relating to offender-focused work; lack of established evidence base.

## **B) INTERVIEWS AND FOCUS GROUP WITH OFFENDER HEALTH TRAINERS AND SERVICE USERS**

**Service User Interview Findings:** Service users cited personal benefits such as feeling healthier, more energetic, being better informed and having more confidence. They felt that they had more control over their lives as a result, and were generally feeling more optimistic about the future. They were also appreciative of the OHT services that they were accessing and positive about the OHTs – considering them to be approachable, knowledgeable, helpful, supportive and good at listening.

**Offender Health Trainer Interview Findings:** The OHTs identified key issues as smoking cessation, exercise, diet and alcohol. Factors perceived to be impacting on the service users' progress included geographical area, family and peers, and lifestyle and social networks. The OHTs were passionate about their jobs, felt competent in their roles, were satisfied with systems in place and were keen for the project to develop further.

**Gaps Identified:** A small number of challenges were identified by the OHTs – including access to the Probation and DCRS databases; gaps in training; and the need for a senior role to be created to liaise between themselves and the Probation line manager.

## DISCUSSION

There was a consensus that the OHT model had been highly successful in facilitating access to services and had clearly prioritised 'starting where people are at' and supporting and empowering them to take small steps that could act as springboards to larger changes. It was also noted that the service has prioritised listening to clients and taking time to uncover the 'real' concerns that may lie behind presenting problems. The potential to bridge the two agendas of health and offending behaviour was recognised – with interviewees seeing no obvious tensions in prioritising 'non-health' targets related to reoffending and resettlement and believing that mainstream services had developed a sophisticated understanding of the links between health and offender management outcomes. However, it was acknowledged that Rochdale may not be typical of all locations – and that having a prison on site and a PCT-based Health Improvement Officer co-ordinating the Regional Healthy Prisons Network had been pivotal in preparing the ground for the project. It was felt that the forthcoming Implementation Project will serve as a testing ground and potentially help to future-proof the work – with key considerations highlighted including service infrastructure; training; data collection; and the appropriateness of the Probation Service as the host setting.

## CONCLUSION AND RECOMMENDATIONS

Locating a Health Trainer service in the Probation Service reflects and legitimises a socio-ecological 'settings' model of health, which prioritises the integration of health within the culture, structure, processes and routine life of the organization. It is clear that the Probation-based OHT model has been effective in terms of both the process of partnership working and wider impacts – and it is evident that Health Trainers in this setting are ideally placed to encourage offenders to improve their health and reduce reoffending. With further funding secured for the Implementation Project it is important to maximize the learning from this demonstration project to guide future decision-making, policy and practice.

In the light of the findings from this process evaluation, recommendations can be made in the following areas:

**Data Collection:** Whilst progress is being made to address challenges of paper-based data collection systems, additional consideration should be given to the challenges of accessing Probation databases and the DCRS system for the OHTs on a daily, operational basis.

**System-Level Sustainability:** A case needs to be made to mainstream the work in order to ensure sustainability. Commissioners need to recognize the value of joining up across the system and of aligning the health and reducing reoffending agendas – and also to appreciate the potential of the work to engage ex-offenders with meaningful employment.

**Evaluation:** Whilst there is a need to articulate long term impacts arising from Health Trainer services within the probation setting (particularly on rates of reoffending), it is important to balance this ambition with a realistic assessment of what is feasible during the next stage Implementation Project. Within the one year timeframe, it is unlikely to be possible to generate sufficient generalizable data on the reduction in reoffending rates across a relatively small number of service users. For this reason, it is recommended that a qualitative evaluation be undertaken that further focuses on user perspectives using an in-depth case study approach – thereby offering the potential to generate meaningful learning and highlight relevant factors that connect health, wellbeing, quality of life and likelihood of reoffending.

# **1. INTRODUCTION AND BACKGROUND**

## **1.1 OVERVIEW**

This report summarises the learning captured through the process evaluation of the Offender Health Trainer (OHT) Demonstration Project, commissioned by the North West Health Trainer Partnership. The evaluation focused on the OHT partnership between Health and Probation Services in Heywood, Middleton and Rochdale, with the intention of informing the next stage implementation project and wider service roll-out. It is anticipated that this evaluation will add to the current evidence base around OHTs and support future commissioning. Key issues are highlighted around organizational, service and role development.

## **1.2 NATIONAL CONTEXT**

### **1.2.1 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 White Paper, *Choosing Health* (H.M. Government, 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 the 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 Government 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 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. 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 currently have a Health Trainer service (Marmot, 2010).

Health Trainers support and encourage individuals on a one-to-one basis to make changes to their lifestyle, improve their health and wellbeing and minimise health risk. Broadly, the aims of Health Trainer services (DH, 2006) are to:

- build the workforce with the right skills to tackle health inequalities;
- work with individuals to carry out an initial health assessment, leading to the development of a personal health plan;
- provide one-to-one support to enable individuals to achieve a positive impact on their health by making changes in their behaviour;

- target individuals whose lifestyles carry a number of risks and help them to access and use local health services and personal health support.

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 (DCRS) is used to record information on Health Trainers and their clients, including health behaviour change outcomes. All NHS-funded services are required to provide information for a sub-set of the DCRS using the Minimum Data Set (MDS). 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.

Health Trainer core competencies and the national job description are being applied in a way that is compatible with the Public Health Skills and Career Framework and that Health Trainers recognise their place within this framework as a legitimate route into public health workforce in the NHS, local government and partner service providers (Public Health Resource Unit, 2008). Specifically:

- national occupational standards have been developed for Health Trainers
- an exemplar job description has been developed for local use and adaptation
- two national awards have been developed: Understanding Health Improvement award, Level 2 (Royal Society for Public Health) and provided recognition for Health Trainer Champions; and the City and Guilds Certificate for Health Trainers, Level 3 of the National Qualifications and Credit Framework
- NHS pay banding recognizes Health Trainers at Band 3.

### **1.2.2 Offender Health**

Offenders and their families represent one of the most socially excluded groups in our society, with considerable and 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).

Many prisoners have poor skills and little experience of employment (Social Exclusion Unit, 2002) – and over half of offenders have no qualifications at all; nearly half have experienced exclusion from school; and two thirds are unemployed prior to prison (Home Office, 2005). Indeed the single greatest factor behind offending is a lack of education, training and employment (Home Office, 2005). Therefore, being in sustainable employment is the single most important factor in preventing reoffending by ex-offenders – and it is estimated that employment can reduce the risk of reoffending by between a third and a half (Social Exclusion Unit, 2002)

The report on (adult) prisoners' basic skills (Social Exclusion Unit, 2002) suggests that 80 per cent have the writing skills, 65 per cent the numeracy skills and 50 per cent the reading skills at or below the level of an 11 year old child. The cross-government Green Paper *Reducing Reoffending Through Skills and Employment* (H.M. Government, 2005) prioritised: improving offenders' skills; reinforcing the emphasis on skills and jobs for all offenders; and encouraging more offenders into suitable employment.

Ensuring offenders have the underpinning skills for life and have developed work skills is fundamental to enabling them to meet the real needs of employers in the area where they will live or will settle after their sentence is complete. Getting and holding down a job is one of the key factors in reducing reoffending – and reducing reoffending benefits individuals, their children, their families, the communities in which they live and wider society (Department for Innovation, Universities and Skills, 2007). Employers' value basic skills, literacy and numeracy as well as generic 'employability' skills such as team working, problem-solving and self management (CBI, 2008).

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 recent Delivery Plan, *Improving Health, Supporting Justice* (H.M. Government, 2009) and the report *Reducing Reoffending by Ex-Prisoners* (Social Exclusion Unit, 2002) emphasizes 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.

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 well-being and drug and alcohol – 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.

### 1.2.3 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 needs of offenders. As such OHTs are playing an increasingly important role in delivering health messages to offenders. Health Trainers work with clients on a one to one basis assessing their health and lifestyle risks to facilitate behaviour change, provide motivation and practical support to individuals in their local communities. With the Health Trainers often coming from a similar background, living in the same community and having experienced some of the same health issues, they are more effective in working with the offenders in addressing their needs and empathising with their particular issues. The recent strategic review of health inequalities (Marmot, 2009) 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.

OHT services are already operating in some prison settings. Implementation through the Physical Education (PE) department in a prison has been the most popular choice. It has helped prison gyms to focus on broader aspects of health and has contributed to a broadening of focus to include 'health improvement' as well as 'working out'. It has also encouraged attendance by vulnerable and excluded prisoners. A strong partnership between PE, Education and Healthcare is vital, and a cohesive approach is needed in every setting.

There is less experience of developing the service in the probation setting, although interest here is growing. A service is operating in Portsmouth, within Hampshire Probation Service, and learning from this is being used to inform the development of other services around the country (Department of Health, 2009).

#### Case Study: Portsmouth

The first Health Trainers for offender health were commissioned in January 2007 by Portsmouth City Teaching Trust in recognition of the health inequalities experienced by people in touch with probation. The probation setting was identified as one where people could be reached who otherwise would not be in touch with or aware of services which could have a positive impact on their health.

The Health Trainers were based in the probation office, employed by a third sector organisation, Learning Links and working alongside probation staff. Their role is to give advice and guidance to offenders on how to access local services and to work with the offender to facilitate and motivate behaviour change to enable them to enjoy a healthier lifestyle. For most, being a Health Trainer is their first experience of employment.

In 2008/09 162 offenders accessed the Portsmouth Probation Health Trainer service addressing issues such as stopping smoking, alcohol reduction, diet and nutrition, physical activity and to register with NHS services. Other important tasks have included accompanying a client to the dentist (for the first time in 20 years) and another to the leisure centre to play badminton and meet new people.

Portsmouth City PCT and Hampshire Probation Service received the Butler Trust Health Improvement Award for Health Care and Health Promotion work in recognition of the effectiveness of their partnership work and innovation.

Source: Department of Health (2009)

## 1.3 LOCAL CONTEXT

Rochdale Borough is situated in the North West of England, North of Manchester and is part of Greater Manchester County. Using the Indices of Deprivation, it can be described as one of the most deprived areas in England. There are 20 wards in Rochdale Borough and 135 Lower Super Output Areas (LSOA), consisting of approximately 1500 people in each. The LSOAs are used to report statistics in small areas and are featured in the Indices of Deprivation. They are ranked according to Lower Level SOA with 1 being the most deprived and 32,482 being the least deprived in England. Seven of the Rochdale Borough Super Output Areas fall within the lowest 1% in the country and 19 with the lowest 1-5% (see Appendix A).

## 2. ROCHDALE OFFENDER HEALTH TRAINER DEMONSTRATION PROJECT

### 2.1 BACKGROUND

At any one time there can be approximately 1500 people subject to supervision by Greater Manchester Probation Trust (GMPT) across the Borough of Rochdale. The table below provides a snapshot analysis of those subject to supervision in the community (PID, 2009):

**Table 1: Probation Supervision in Rochdale: Snapshot Analysis (11 September 2009)**

<b>Total</b>	<b>1500</b>	<b>100%</b>
<b>Male</b>	<b>1356</b>	<b>90%</b>
<b>Female</b>	<b>144</b>	<b>10%</b>
<b>Ethnicity</b>	<b>Asian or Asian British</b>	<b>171</b>
	<b>Black or British</b>	<b>36</b>
	<b>Chinese</b>	<b>3</b>
	<b>Mixed</b>	<b>23</b>
	<b>Refusal</b>	<b>18</b>
	<b>White</b>	<b>1237</b>
	<b>Other</b>	<b>12</b>
<b>No disability</b>	<b>1149</b>	<b>77%</b>
<b>Disability</b>	<b>351</b>	<b>23%</b>
<b>Disability</b>	<b>Dyslexia</b>	<b>23</b>
	<b>Hearing impairment</b>	<b>13</b>
	<b>Learning difficulties</b>	<b>24</b>
	<b>Mental health issues</b>	<b>106</b>
	<b>Progressive condition</b>	<b>12</b>
	<b>Reduced mobility</b>	<b>45</b>
	<b>Reduced physical capacity</b>	<b>17</b>
	<b>Severe disfigurement</b>	<b>1</b>
	<b>Speech impairment</b>	<b>2</b>
	<b>Visual impairment</b>	<b>13</b>
<b>Drug problems</b>	<b>378</b>	<b>34 Female</b> <b>344 Male</b>
<b>Alcohol problems</b>	<b>274</b>	<b>22 Female</b> <b>252 Male</b>

This demonstration project has built on previous pilot activity in other regions (Hampshire, Yorkshire and Humber) and the existing Community Health Trainer service at NHS Heywood, Middleton and Rochdale.

## **2.2 AIMS AND REMIT**

The overall goal of the project is to deliver a service which will improve the health of offenders subject to supervision by the Probation Service in the Borough of Rochdale. It also aims to tackle local health inequalities by offering personalised support to offenders at risk of developing poor health; provide additional support to offenders who need it to enable them to make healthier choices; and facilitate better access for offenders to a range of health services that they require. In doing so, the project will enable the offender to take greater control over their health and wellbeing; promote a skill mix of health workers and OHTs who will thereby provide more flexible and responsive care for offenders; improve the employment prospects of ex-offenders through employment as Health Trainers; and improve community re-integration, thus reducing reoffending rates.

## **3. PROCESS EVALUATION: OVERVIEW AND DESIGN**

### **3.1 OVERVIEW AND AIMS**

The Project Board has aimed to produce an 'off the shelf' model of OHT practice that will be of benefit to others wanting to develop similar service provision in their area. In tandem with delivering a service to offenders in Rochdale, the Project Board is therefore concerned to provide learning outcomes in relation to partnership working. This process evaluation aims to capture the learning that has come from the development of the OHT partnership between Health and Probation Services.

### **3.2 STUDY DESIGN AND METHODOLOGY**

The study was designed to be flexible and responsive to the needs of the project as it evolved, and comprised three elements:

#### **3.2.1 Rapid Appraisal of National Offender Health Trainer Programme**

A rapid appraisal of the National OHT Programme was undertaken with a view to providing contextual information relevant to the development of Health Trainer services within Probation and summarising the evidence of effectiveness of developments to date. This appraisal comprised informal telephone interviews with key individuals involved in the development and implementation of the Rochdale OHT Demonstration Project together with a rapid review of relevant published and grey literature and wider documentation (as reported under Section 1.2 above).

#### **3.2.2 Qualitative Review of Rochdale Offender Health Trainer Demonstration Project**

A qualitative evaluative review of the Rochdale OHT Demonstration Project was undertaken in order to capture learning, inform future policy-related and commissioning decisions, and guide subsequent developments. The review comprised:

- seven semi-structured interviews with a purposeful sample of relevant staff involved in managing the project from NHS Heywood, Middleton and Rochdale and Rochdale Probation Service, using an interview schedule designed to explore stakeholders' perceptions of the demonstration project in terms of reach, delivery, processes, outputs and intended outcomes (see Appendix B);
- ten semi-structured interviews with service users (N.B. sample included male and female offenders aged between 20 and 50 years old from both Rochdale and Middleton), using an interview schedule designed to explore access to, their experience and their expectations of the service (see Appendix C);
- three interviews and one focus group with Health Trainers (N.B. sample included Health Trainers from both Rochdale and Middleton), using an interview schedule designed to explore their expectations, role and relationships with the wider project team, common issues they deal with and methods of delivery (see Appendix D).

Ethical approval was secured from UCLan's Faculty of Health Ethics Committee. Access to the Health Trainers and service users was undertaken by colleagues from GMPT as they are clients of their services more broadly. Consent was sought prior to all interviews with information sheets provided prior to engaging with the research. All participants were advised that they could leave the research at any time.

### **3.2.3 Joint Action Planning and Reporting**

Drawing on the above appraisal and evaluative review, a workshop was held towards the end of the pilot period. This enabled key findings to be presented; data to be validated, discussed and expanded; and multi-stakeholder action planning to take place.

## **4. PROCESS EVALUATION: FINDINGS**

The findings of the evaluation are presented in two sections: firstly, data from the interviews and workshop held with staff involved in managing the project; and secondly, data from the interviews and focus group held with Health Trainers and service users.

### **4.1 INTERVIEWS WITH MANAGERS**

Analysis of the evaluation data revealed a number of interconnected themes relating to the different stages involved in establishing and implementing the project, along with reflections on influencing factors: responding to key drivers; developing the partnership; recruiting OHTs; providing training and building skills; collecting data; judging success; communicating; facilitating and hindering factors.

#### **4.1.1 Responding to Key Drivers**

The key drivers identified by interviewees and seen to have catalysed and added legitimacy to the Rochdale OHT Demonstration Project strongly reflected the partnership approach, encompassing and bridging 'health' and 'offender management' agendas. An overarching policy driver was understood to be a commitment to health improvement and within this, to tackling health inequalities, a theme that had been high on the Labour Government's agenda and explicit within a range of its publications:

From a public health point of view, I think tackling health inequalities – and there's clearly a health inequality amongst offenders. So the polices, [Tackling] Health Inequalities, the Choosing Health white paper, Our Health, Our Care, Our Say. Those policies will all have an impact on this...So from the commissioning point of view, it should be something that's considered.

There was a strong sense that for NHS trusts, the project 'ticked boxes' relating to social inclusion targets and the need to access marginalised and excluded populations:

There's the social exclusion policy that's part of it...whenever you phone anybody up, like sexual health, they're desperate, it's always, 'we need your group of men and women, which is the hard to reach group'. And they've all got performance indicators to work with this group, so they're all desperate to come in and do as much work with them as possible, so they're meeting their targets.

More specifically, interviewees drew attention to *Choosing Health* as the key catalyst:

The Health Trainer initiative came originally from the *Choosing Health* white paper in 2004, that was where it was first kind of introduced as an idea...[The Rochdale OHT Demonstration Project] is definitely based on that, in that we've recruited people from the population in which they work and live.

In relation to health inequalities, one interviewee also mentioned the Coalition Government's White Paper, *Equity and Excellence: Liberating the NHS*, noting the continued priority given to health inequalities and suggesting that a number of the proposals could support the Offender Health Trainer agenda.

Alongside this emphasis on improving health and reducing health inequalities, the managers that were interviewed also understood the Rochdale OHT Demonstration Project to be driven by a parallel commitment to reduce reoffending:

I think probably from Probation in the first place it was more about reducing reoffending...

I mean the value of it, in terms of probation work, I mean obviously Probation is all about working with people to try and reduce risk and reduce the likelihood of reoffending.

Perhaps not surprisingly, those from an NHS background tended to emphasise the 'health' drivers whilst those from Probation tended to highlight the reduction of reoffending rates. However, the interviews revealed an evident willingness to engage with the parallel drivers and develop a shared understanding of the interconnections between the two agendas:

The Health Trainers are, in a sense, a good example of cutting across [the different drivers] looking at how it works out in individual situations.

Certainly the colleagues that we have in Probation, that we're working with now, understand those links between offending behaviour and poor health...[It's] very much about health inequalities.

I would say the criminal justice thing would be the priority and then the spin-off is the health.

In discussing the relationship between health and reoffending, one interviewee referred to a key Government report that had explicitly named health as an important pathway:

And there's evidence, well the health has been identified as one of the reducing reoffending pathways, you know the social exclusion report 2002, and that identified physical and mental health as one of the pathways. So it's obviously been identified that is an issue that can have a bearing upon people's behaviour and I guess through that, potentially in their offending behaviour.

## **4.1.2 Developing the Partnership**

As a partnership between the North West Health Trainer Partnership, Heywood, Middleton and Rochdale PCT, Greater Manchester Probation Trust and the Regional Offender Health Team, the Rochdale Demonstration Project faced the challenge of nurturing and achieving effective partnership working between sectors with different agendas and priorities. Whilst acknowledging the reality of this challenge, interviewees highlighted the importance of previous collaborative work – and in particular the co-ordinating role of the Regional Offender Health Team – in preparing the ground and paving the way for the OHT partnership:

There were good links between the local PCT and the prison [Buckley Hall], so they knew a lot about offender health, helped by Fran [Carbery]... So the PCT were warmed up – we had a probation district interested and a PCT that knew what the issues were, and we had the support of the management of Greater Manchester Probation Trust.

As with many partnerships, stakeholders were drawn from sectors with their own cultures, languages and targets, which inevitably required a willingness to work together and step outside of their comfort zone:

Initially it was quite difficult, we were all coming from different organisations...there were boundaries we were crossing that perhaps we hadn't done before...

In fact there are problems because you've got a number of different agencies potentially working together, and we know that they come with different agendas and we just have to make sure how it works.

Reflecting on the project, interviewees identified a range of factors that facilitated this boundary-crossing and resulted in successful partnership working:

### ***Consensus***

It is widely recognised that a level of consensus is necessary to effective partnership working. Although there were some different emphases from 'Health' and 'Probation' stakeholders, there was a strong consensus regarding the overall vision and values of the Rochdale OHT Demonstration Project:

We've all got on very well together and all shared the same vision really and everyone's bought into and acknowledged the importance of the project and what it's trying to achieve.

This consensus signalled a shared commitment to accessing 'hard-to-reach' people, improving access to mainstream services and tackling inequalities. It was clear that those involved in managing the project understood the importance of aligning agendas and of working together to improve health at the same time as providing work experience opportunities and improve employability. By beginning to embed health into probation activity, there was a sense that overall quality of life could be improved and that both NHS and offender management targets could be met.

### ***Clarifying roles and responsibilities***

Whilst consensus is important for effective partnership working, a major strength of inter-agency and inter-sectoral working lies in diversity. In any partnership, it is thus important to agree and make clear roles and responsibilities. Whilst there were initial teething problems

within the OHT Partnership, there was a strong sense that these had been quickly overcome:

I think originally, although we had this project board, we didn't sort of clarify people's roles. There were people who were trying to do things at the same time as other people were trying to do it in a different way. But we worked our way through it, I mean it took a while but I think eventually we got there and we came to some kind of mutual agreement as to what people's roles were. We had sort of task and finish groups and people volunteered themselves for those.

I think initially we clarified who was doing what, because we had different partners involved in the project and... sometimes agendas are pulled separate ways. However, we were able to bring it together...It developed really fast, we got people on board.

### ***Securing mutual respect, developing a supportive culture and sharing expertise***

Closely linked to the clarification of roles and responsibilities is a proactive approach to developing a mutually respectful and supportive culture and appreciating and sharing the expertise of different partners:

My experience is of working with the project team has been positive...They very quickly brought me up to speed and an awful lot of explanations of different terms, you know, for me and my lack of knowledge and expertise in this area! So just very kind, good use of emails, phone contact, constructive feedback, providing different training sources.

In addition to appreciating and harnessing the organisation-related skills and expertise of the different team members, interviewees highlighted the significance of interpersonal relationships and common vision and values:

It's been very positive, I think we've all worked incredibly well together and I think the key thing to that is, at a personal level, that we all got on very well together. That is obviously very significant when you're having to work together on a project that really is a new project and breaks new boundaries, as it were, in terms of partnership working.

### ***Building trust and openness***

Mutual respect and sharing of expertise can help to build trust, which underpins successful partnership working. Reflecting on the processes involved in developing the multi-agency team, interviewees felt that openness was an important factor:

I think we were all quite adult about it, you know, if it was something you didn't agree with then it was sort of brought to the table, I think probably through the project board, things were aired quite well.

In addition to building trust between the PCT and the Probation Trust, a number of the interviewees highlighted the particular challenge of securing a good working relationship between project managers and the Health Trainers, who – as offenders – had previously been in a very different relationship to the Probation Service:

The Probation staff are learning to trust the Health Trainers – I suppose that was part of the process, to get them to talking. Because we know at Portsmouth that there was some initial distrust, as you can imagine: somebody you might have supervised four years ago is sitting next to you as a staff member, it's things like that. So trust has developed between those two groups...

A key dilemma facing Probation managers related to levels of openness with ex-offenders – an issue that was resolved through ensuring consistency in confidentiality training:

I think there was a, you know, well if they're ex offenders might they know people that we're talking about? The resolution was to say to staff, 'our Health Trainers have had the same confidentiality training as you and they will keep information confidential'.

### **Leadership**

Alongside the mutuality and sharing of expertise and power that are so important for effective partnership working, interviewees also reflected on the importance of leadership. Whilst the Rochdale OHT Demonstration Project clearly functioned effectively as a partnership, bringing together stakeholders from different sectors to play different roles, the presence of a clearly identified project manager was understood to be fundamental to its success:

I think when it comes to partnership working it's not easy. It helps to have somebody who is sort of leading the group. So we've got John [Wheetman], who is the Project Manager.

#### **4.1.3 Recruiting the Offender Health Trainers**

A key initial task of the staff managing the project was to recruit the OHTs to deliver the service. Based within the Probation Service, it was decided that the posts should be part-time in order to avoid impacting negatively on receipt of benefits:

The Offender Health Trainers themselves are based in Probation and managed by Probation. That was a strategic decision because that's where your clientele is.

We adopted the Hampshire model and they employed initially four part-time Health Trainers. So these were people who were in receipt of benefit and looking for employment opportunities. So, in order not to affect their entitlement to the benefits but to give them an employment opportunity, they work part-time, they work just under 16 hours...We were keen to ensure that we provided the most advantageous situation to each individual.

Reflecting on this process, those interviewed were extremely positive and up-beat about how things had gone:

I think it's been brilliant. I think it's been set up well, we've had some 'can do' people. We recruited some good people who've been really enthusiastic and I think our staff have taken it on board.

Within the context of the project's overarching aims relating to social inclusion, health inequalities and reduction of reoffending, a key objective was to facilitate the rehabilitation of offenders through giving them employment and training opportunities. Whilst interviewees appreciated the challenges of employing ex-offenders, they felt strongly that the project should 'walk the talk':

It gives somebody who has been in trouble employment...If rehabilitation of offenders means anything, this is one way to test it.

However, there was also a real-world recognition of the need to manage risk across agencies, resulting in an early focus on reaching consensus about criteria for employment. These discussions resulted in a decision that the OHTs should be ex-offenders who were not regarded as being 'high risk':

And we were conscious...of the risk issues...[The OHTs] are ex-offenders, we decided that we'd have a criteria, that they'd been out of trouble for a while, a year or something, but they hadn't actually committed sex offences...or were subject to MAPA, multi agency public protection arrangements...So we would not touch those and we would not touch people who would be regarded as very high risk or high risk for other reasons...One example I know that we didn't employ was somebody who probably hadn't quite resolved their alcohol issues, still slightly out of control.

The discussions about managing risk also resulted in the decision to employ the OHTs through Probation, in order to overcome perceived problems with ex-offenders being employed by the NHS:

I think it was an issue for the NHS really, employing people who had convictions. It will be for many other organisations. So we thought they would be better sited within the Probation Trust because they could manage the risks better...It would have been nice to see it sitting within the Primary Care Trust or Community Health Trainer Service and I think that's work for the future, looking at how the NHS should be setting an example really for employing people who perhaps have got convictions in the past but, you know, we need to look at how we can manage risks better within the NHS.

The risk from [the NHS's] point of view was the fact that we don't have a full understanding of the background, whereas from an offender point of view, Probation understood the risk and how to provide support...With it being a pilot, we recognised that they would be supporting people within their own setting, but if they came to us it could become confused with the Community Health Trainers.

In terms of the actual recruitment process, participants in the data validation workshop clarified that whilst they had prioritised equivalence and consistency between community Health Trainers and OHTs, they had also appreciated that the recruitment process needed to take account of factors such as limited work experience and poor literacy levels. As a result, they had put in place a process that allowed people to be recruited to and undergo the training programme before being offered a job.

#### **4.1.4 Providing Training and Building Skills**

As part of a commitment to ensuring equivalence and consistency with the Community Health Trainers initiative – as well as helping staff to a portfolio of accredited training – the Rochdale OHT Demonstration Project ensured that those recruited undertook the core Health Trainers qualification:

They have the same training that the Community Health Trainers had, which was the City and Guilds Level 3, the Health Trainers qualification.

The City and Guilds includes things like awareness, engaging communities. It includes behaviour change, supporting people to change behaviour.

They have to be properly qualified to be Health Trainers...But they say, 'well I'm qualified Health Trainer, I have Level 3'. So it gives them a lot of satisfaction and support.

In addition, the recruits received thematic training focused on a number of topics, many identified by themselves as a priority:

Recently, very recently, they've had mental health awareness training, because one of them in particular was getting quite a few referrals from our mentally disorder defender specialist, and he

was a bit phased by the behaviour of some of the people. So that prompted us to organise some mental health awareness training. And he just fed back to me today actually that he found it really useful and felt much more confident about it.

They also did a lot of the local training such as stop smoking...hand washing and infection control, that kind of stuff. They've had training in Chlamydia screening and that was something that they identified as a need for themselves because they had quite a youngish client group – and that was nice for the PCT because they need to hit their targets around Chlamydia screening.

A number of interviewees also highlighted the importance of providing 'core' training that would equip the OHTs to deal with the particular challenges of working within the Probation context:

In addition, they've had induction training in Probation to help them orient into the workplace. And that dealt with things like confidentiality, access to the email system...And I think it actually covered a bit more about the purpose of Probation.

One concern that was raised early on by Probation managers related to confidentiality and concern about openness and disclosure in front of the OHTs, who were ex-offenders. As highlighted under 4.1.2, this was dealt with through ensuring that they received identical training to other Probation employees:

I think one of the early issues was with Probation staff, who weren't sure, because they were ex-offenders, they weren't sure how openly they could talk in front of them about other offenders, for example. But they'd had the same confidentiality training, Probation confidentiality training as they'd had, and they are our employees and so we were able to reassure them. But it was a learning point for us that we hadn't properly considered.

Reflecting on experience to date, interviewees felt that whilst it had been crucial to ensure equivalence and consistency with Community Health Trainers, the specific needs of the clients that the OHTs were seeing highlighted the need for additional specialist training to be built into the next phase of the project:

Our offenders are a bit different, a lot different in lots of ways to the general public, and it's that chaotic nature. And what you'll get thrown at you when they come in, they don't just talk about their health needs, they have talked about their needs, complex needs, their abuse as children, all sorts of things. And I think we need to work with this next set of training for the Health Trainers, the new ones coming in, and we're going to ensure that we do some work on our Probation offenders more. Because the health training we've just done out of house by some Health Trainers somewhere, but they need more in house training, so I'll approach our training unit for that to work specifically with our client group and some of the issues that do come up.

#### **4.1.5 Collecting Data**

An important part of the OHTs' remit has been to collect data, with a view to recording routine demographic information, generating a profile of the client group being reached, understanding the pattern of lifestyle challenges and associated behaviour changes, and helping to build evidence about the effectiveness of the approach – both in addressing health issues and reducing reoffending:

It was mainly demographic data plus what kind of health behaviour change they had committed to and whether or not they'd made that change. So whether they'd stopped smoking or whether they'd changed their eating habits. It was the basic Health Trainer data that's collected...They do a before and after interview. They collect data as they go along but they do an initial interview and

they determine what the health needs are and then they decide what targets they want to set. And then at the end of the time with the Health Trainer, they go through all that again, it's more or less the same questions they ask them.

There is data being collected...without the evidence we're not going to be able to support the continuation of the project.

We also are doing other bits of information, which we're exploring with the research department of the Probation Service, which in the longer term can demonstrate a lowering of risk behaviour.

The interviews with managers revealed several different hurdles that the Demonstration Project has had to contend with. The first of these concerned delayed access to the mainstream Health Trainer Data Collection Recording System (DCRS):

We are operating within the general standards of the Community Health Trainer service. Now all of their data is uploaded onto DCRS [the data collection recording system], which is the national Health Trainer database. So we use all the forms that the Community Health Trainer network uses...So we collect exactly the same information and that data will be uploaded onto the DCRS. Now that hasn't actually yet been achieved. We're virtually there but there's been a problem in trying to get the necessary hardware, so that we can access DCRS...getting authorisation through the local PCT because they, as part of the protocol, they have to give consent for the probation...So in the end, I approached it by going directly to the agency in Birmingham, that I believe the health service contract this work to...And eventually, Jane Thompson, who's on the project board and who's involved in the northwest Health Trainer partnership, was viewed as being acceptable, in terms of giving the authorisation for the Probation project to use the DCRS system... So we will shortly have that facility, whereby we can do all sorts of data, you know, we can draw down data from that system.

This delay necessitated an alternative temporary data collection system, which was developed by the project team to ensure that information could be captured and communicated internally – at the same time inevitably creating an accumulation of information for future transfer:

In the interim though, obviously the Project Board will have wanted basic headline monitoring information. So we devised a simple monitoring form for the Health Trainers to complete [with] headline information to do with the number of individuals seen, their ethnic origin, their sex, the key health issues that they were seeking assistance with, whether or not a personal health plan was established and whether or not the outcome was seen to be successful. So that was a very simple form that would just allow me to feedback to the project board on sort of basic headline data, whilst we were waiting for all the DCRS system issues to be resolved...So we have a backlog of data that will, once we've got the necessary hardware, will be uploaded onto the DCRS system. And we'll be able then to draw down all the various configurations that you can about use of the service.

Looking ahead and building on the data that has already been collected relating to behaviour change, there is also interest in evaluating the project in terms of cost effectiveness – by calculating the likely savings to the NHS and other services. Although this is inevitably extremely difficult to do, interviewees highlighted the importance of engaging with the agenda as a means of securing longer-term support for the OHT approach:

From the health service perspective...they were asking for data on the reductions of cost to the health service by what we were doing, so that's their measure of success...apparently there's something called a ready reckoner [and] this works out the reduction of costs to the NHS in the long term.

And to look within that evaluation to try and identify what the cost benefits are of this service, you know, how many beds do we save because we're doing this preventative work. And I think within the offender settings, again we need to begin to look at whether or not we can establish clearer links between improving individuals health and thereby reducing reoffending.

Participants in the data validation workshop were confident that the teething problems with DCRS were almost resolved and that this would greatly enhance data collection during the Implementation Project. There was a more general discussion about the range of data that would be needed and how this might be collected – with a particular concern to track impacts on offending behaviour and health; explore how these impacts might be quantified in economic terms; and compare and contrast geographical areas with and without the OHT service in place.

A further issue related to the poor literacy and skills levels of the ex-offender client group, which meant that it has been difficult to secure consistent service user feedback:

They're not very good at completing it, service users, for many reasons, one of which is their basic skills are usually fairly low.

#### **4.1.6 Judging Success**

Views about how the success of the Rochdale OHT Demonstration Project should be judged reflected the parallel 'health' and 'offender management' drivers identified under 4.1.1.

Within the context of health inequalities and social exclusion, it was widely recognised by interviewees that many offenders are 'hard-to-reach' and frequently do not access health-related services. In keeping with the overall ethos of NHS Health Trainers to train and employ people "in touch with the reality of the lives of the people with whom they work" (Department of Health, 2004: 106) and drawing on the experience of the Hampshire Probation Health Trainer Initiative, key aims and success criteria of the project were for OHTs to facilitate access to services for offenders and to support them in making changes to their lives:

The concept that Portsmouth have built up is that you have somebody that's been in trouble and turned their life around and can be used to do the same process but in a probation setting or in an offender health setting.

In terms of access, it was clear from the interviews that the project has already been extremely successful:

I can measure the success in the fact that it's actually happened. We've reached a point, we've got the staff in place, they've been trained and they're delivering a service and they're reaching the clients.

We have many offenders that have no GPs. They've either moved, are in transient lifestyle, or for whatever reason, have no dentist, no GP, and are not linked into services; and we've managed very successfully to get large numbers into a GP.

We know that some people aren't registered with a GP, they don't find it easy to access relevant services – and that a lot of services are good at gate keeping referrals and they would say that if they don't meet the threshold or if they don't keep appointments, well then they're not on the books. So it can be quite hard for people to get access to services... We've had nearly 300

[referrals]...So we've had stunning success with the numbers and, if nothing else, we're getting access to that number of people who have not had access to services before.

We were looking at the numbers of people who were actually accessing the service because that was one of the main things... So going off the first three months, I think we'd had double the amount that the Portsmouth project managed to do with a lot less people. So just purely looking at numbers who've accessed the service, that would deem it as a success.

In relation to lifestyle change, it is clearly too early to be able to judge success in a coherent way. However, it was recognised that whilst diet, exercise, smoking and alcohol have tended to be key foci for Community Health Trainers, the primary foci for OHTs have been alcohol and drugs. Within this frame of reference, the service has been developed to take account of the complexity and chaotic nature of many offenders' lives – appreciating that health and other issues are interrelated and that by working with people 'on a level' to address the issues of primary concern to them, it is also possible to make connections to other aspects of their lives and empower them to change:

From the health service point of view, [the OHTs] are actually seeing people that they don't normally see, i.e. under 25s, white, young people, from deprived areas. So actually they're filling a bit of a void...[It's using the] principle of peer interaction about health improvement. Because it's not a health model really, it's about other things, family, drugs and alcohol and how it affects your life and lifestyle. But it actually gets them to look at exercise, smoking, as well as drugs and alcohol, health issues but in a lifestyle way, not as a doctor saying to you...

The aims were slightly different, the focus in Probation was more on substance misuse, alcohol and sexual health, they were the three core things initially...whereas in the community our core was nutrition, physical activity and smoking – and then sexual health, substance misuse and alcohol were in addition, so there was a slight reverse...And the service is sold to tackle behaviour change around stop smoking, nutrition, physical activity but, like I said, we provide signposting and support in those other areas but that's not our core focus.

Interviewees provided a number of stories that powerfully illustrate how the project has begun to move beyond facilitating access to services, to empower individuals to make real changes to their lives – as summarised in the case study below:

#### **Alcohol Case Study**

Probation is all about working with people to try and reduce risk and reduce the likelihood of reoffending and health (physical and mental) has been identified as one of the pathways in the report *Reducing Reoffending of Ex-offenders* (Social Exclusion Unit, 2002). So it's obviously been identified health is an issue that can have a bearing upon people's behaviour and potentially their offending behaviour. We're beginning to acquire evidence now that the project is working, you know, that there are clear links or can be, links between reducing reoffending and dealing with people's health.

For example, one individual who's offending history was predominantly alcohol related was working with the Health Trainer on issues related to exercise. However, as this individual's health began to improve they began to reduce and eventually stop their alcohol intake. In a sense it was a bit of a by product or an achievement that came by way of the Health Trainer working with the individual on one issue that had a positive impact on another, very significant area of this person's life.

The obvious link here is that in reducing alcohol intake, there is the potential that their offending will reduce or will cease because initially a health issue was addressed, that had a knock on effect in terms of alcohol intake. So the overall impact is both on health behaviour *and* quite specifically, offending behaviour.

From the perspective of offender management, the major success indicator was understood to be a reduction in reoffending rates – with a concern being to demonstrate the potential and actual impacts and benefits of health-related work:

We also wanted to have a look at whether or not we could evidence any link, any impact on reoffending rates by focusing on health.

Some interviewees acknowledged that it was unrealistic to expect to be able to measure such changes within the project's lifetime, whilst others were more optimistic about progress:

I guess it's difficult to measure success in a short term with such a project, you'd need to look in the longer term at whether the reoffending rates go down.

And we're beginning to acquire evidence now that the project's working, you know, that there are clear links or can be links between reducing reoffending and dealing with people's health.

More generally, a number of people drew attention to the 'logic' of how the project would impact on reoffending, highlighting this with vignettes and examples:

There's the knock on affect on reoffending and the families and their lives.

For me it's successful because I like to see service users have as many different options available to them and that's being offered to them and it's something different than offending behaviour specifically...And, you know, if we get them linked into the gym, it's time taken away perhaps from offending and its use of their leisure time and it's free.

#### **4.1.7 Communicating**

In relation to communication within the project team, participants in the data validation workshop highlighted the importance of feedback as a means of guiding future developments and improving service provision. They confirmed that feedback mechanisms had been further developed and formalised over time – and that they included a dedicated feedback form for OHT clients to complete and a more general user group established by the Probation Service. The forthcoming Implementation Project was seen to offer an important opportunity to build on and further develop these mechanisms.

Those interviewed emphasised the importance of raising awareness, aimed at ensuring that stakeholders within key organizations knew about and understood the remit of the OHT service:

In terms of awareness raising activities, obviously at the point of recruitment and implementation, we raised the awareness of staff about the forthcoming service that would be available to them. We held a launch event...we invited key individuals from the courts or police or relevant local organisations, such as alcohol and drug services, really just to make them aware that the project was operating and what it was about.

We had open days at the beginning of the project in both offices, where we invited other agencies in, our staff and offenders, which were quite well attended.

Reflecting on their approach, interviewees confirmed that the Project Board had taken an explicit decision to limit external communication during the Demonstration Project. This decision reflected a concern that the investment of resources in working with offenders may be perceived negatively by both the media and the public – thereby hindering rather than helping the effective implementation and further development of the work.

Much of the communication as far as I'm aware has been done internally.

We were very conscious that in the public's eyes they would see £50K going to a relatively undeserving population.

We had to make sure those right messages were getting out...people realising we're reducing the amount of crimes that are committed through improving people's health and by doing that we're also reducing the amount of victims and people are sort of paying back what they've done... it's basically giving the slant that offenders have been employed to help reduce reoffending and to support behaviour change and to try and turn people's lives around so that they can make a better contribution to society..

However, this 'informed caution' operated within the context of a broader communication plan that set out a step-by-step approach and looked to build on success stories emerging from the evaluative research – recognizing the need to move beyond the internal focus to ensure wider publicity:

We set up what we called a Communications Task Group, and that really comprised of three members of the board initially. And within Probation we have a PR Manager [and there's a] PR lead for the Health Trust. So we devised a communications strategy within that sub-group...So, as I say, literally as we speak, we're in the midst of this PR strategy plan being delivered through local media and through the organisational publications.

And then more recently we invited John Boyington, who is the Director of Public Health in Bury, we invited him to come to the project and see what we were doing...And he met with us, he met with a couple of members of the board and he questioned a service user. And after he spent a couple of hours with us, it was at that point really that he fed back his views on the service and they were very positive views. And part of that feedback was that we really need to publicise and in a way shout about the service because his view was it was a good service and it hits a number of buttons.

#### **4.1.8 What's Helped?**

When asked what factors had been helpful and enabling, interviewees highlighted the importance of the OHT 'concept' in providing a positive foundation by engaging people within the context of their own lives – as well as emphasizing the significance of favourable contextual factors in facilitating the establishment, development and implementation of the Demonstration Project. They particularly drew attention to the pre-existing relationship between the NHS and the Probation Trust and the firm foundations that had already been put in place:

I think what's helped is the fact that there is a health lead within the Probation Service, so they do have a remit to improve the health of people on the Probation caseload. So that for us has helped a lot and the fact that Probation and Health are all partners in the Crime and Disorder Reduction Partnership.

Building on this, they also reflected on the value of good partnership working, as explored in detail under 4.1.2. Enthusiasm, energy and a positive outlook were all seen to be crucial to the collaborative approach:

I think it's worked very well. I think everybody's pulled together. We've learnt from each other and I think there's been very much a 'can do' approach by the board. It's been good.

[It's helped] that other agencies really want to work with us and a lot of the drivers for that are hard to reach groups. But there's more than that, there's an enthusiasm and a want to make it work.

The positive approach that all the agencies have had towards the project. And certainly, as far as I'm concerned, the very good partnership work, the collaborative approach that we've adopted in developing and implementing the project. And I say that at both, sort of a personal level, but also at an organisational level...So there's been a lot of support, there's been a lot of goodwill, enthusiasm, commitment and determination really to drive the project, to get it going and implement it. And, as I say, I think we're beginning to see some of the fruits of that work, some of the rewards of that work in having secured future funding.

#### **4.1.9 What's Hindered?**

When asked what had hindered the project, interviewees identified a range of factors. At an interpersonal level the overall feeling was that people had worked extremely well together and been enthusiastic to collaborate. However, inevitably, there had been a few difficulties to overcome:

We have found that there has been one or two clashes...it wasn't major, no falling out... We recognised that maybe, it's things like this that have got in the way in the past and have, not destroyed projects, but made them very slow.

There were other barriers...which no longer exist, like personalities and agendas.

At an organisational level, a number of people highlighted issues relating to governance, bureaucracy and joint decision-making that they perceived to have interfered with the smooth running of the project:

I would say, being quite frank, red tape from our point of view, meant that there were things that we should have been able to do and I would have liked to do (like the database), which meant we couldn't provide that, so it meant that it took quite a bit of time....[and there's certain governance issues in terms of who would take responsibility for what.

There were arguments over who was to manage that money...who would have the final say on how much was spent on which bit and how much was going to be spent on the evaluation and how much was going to be spent on actually recruiting people and resources and things. And I think it helped as well once we finally got John to project manage...

More widely, the economic context was viewed by many as a constraining factor:

We've struggled a little bit with some of the cutbacks...

Well I guess the funding issue has hindered, because we would have hoped we would have got funding from some means to sustain the life of the project, so it wasn't just a project, it was kind of mainstream, you know, it was a service within a service.

However, the news that follow-on funding had been secured to allow the project to continue and develop further had gone some way towards countering this pessimism:

I would have said the current economic climate but for the fact that Fran got the innovation bid. If she hadn't have got that, I think the project would have died a death because everybody's cutting back.

Reflecting on the nature of the project, it was clear that public perceptions and stigma relating to offender-focused work had presented some challenges. The overwhelming

feeling, though, was that these challenges had been responded to and that the project had been a clear success. However, those interviewed appreciated that the lack of an established evidence base for the work posed further challenges with regard to securing sustainability:

To be honest, the evidence isn't yet there...partly because, you know, some of the outcomes probably need a bit longer...it's still early days isn't it?

## **4.2 INTERVIEWS AND FOCUS GROUP WITH OFFENDER HEALTH TRAINERS AND SERVICE USERS**

### **4.2.1 Service User Interview Findings**

Service users cited personal benefits such as feeling healthier, more energetic, being better informed and having more confidence – for example as a result of losing weight creating a sense of personal achievement. They felt that they had more control over their lives as a result, and were generally feeling more positive about the future: one individual started exercising at gym due to receiving free passes, reported better moods and a better environment at home, and friendships with new (non-offending) peers whom he met at gym – suggesting that there had been knock-on effects through new and 'better' influences:

It made me realise I needed to look after myself because I am diabetic. She helped me realise I needed to drink more fluids to keep me hydrated and helped me to realise what were fatty and sugary foods. I feel a lot healthier when sticking to advice.

The service users were very positive about the OHTs, considering them to be approachable, knowledgeable, helpful and supportive and, good listeners. They reported developing good relationships with the OHTs, which proved beneficial in getting issues addressed that they may not have recognised themselves (e.g. needing counselling, improving diet to improve mood).

She's approachable, she's a good listener and she makes me feel comfortable.

My Health Trainer is fantastic, he's like a friend, someone to talk to. He's brilliant.

Generally, service users were appreciative of the OHT services that they were accessing, they acknowledged that these services were much needed, and also appreciated that they would not have sought out the help they needed by themselves. They reported little problem regarding attendance for their appointments and also no issues with the OHT seeing them in a probation environment.

### **4.2.2 Offender Health Trainer Interview Findings**

The OHTs identified the main issues that they were dealing with on a regular basis as smoking cessation, exercise, diet and alcohol. Factors that they perceived to be impacting on the service users' progress included the areas in which they live, family and peers, and lifestyle and social networks.

The OHTs felt competent in their roles and were relatively satisfied with the systems in place for carrying out their respective duties. They stated that they were passionate about their jobs – being trusted by the service users, making a positive impact on their well-being, and empowering and educating them on how to help themselves.

The OHTs were also keen for the project to develop further – both geographically beyond the current location and through adopting and maintaining further services such as chlamydia testing. They felt from their experiences so far that there was a significant need for the OHT service to expand, not just in the probation setting but also beyond by linking across the wider system. They felt that there was a lack of awareness of the OHT facility.

### **4.2.3 Gaps Identified**

A small number of gaps and challenges were identified by the OHTs. Access to both the Probation databases and the DCRS system presented some challenges. Gaps in training were considered, particularly in the context of the transition from initial training as a Community Health Trainer to being a Health Trainer in the probation setting. In addition, it was identified that there was a need for ‘psychological training’, ongoing refresher courses and more information on domestic violence and drug abuse to better assist the OHTs in practice. The OHTs also identified a need for a senior role as they felt there was a gap between themselves and the Probation line manager.

## **5. DISCUSSION**

Whereas data from interviews with managers suggested that, in contrast to Community Health Trainers, OHTs tended to focus primarily on issues such as alcohol and drugs (with discussions often providing a ‘lead-in’ to discussing other lifestyle issues), data from interviews and focus groups with OHTs and service users suggested that issues such as exercise, diet and smoking were seen to be key foci of the service. Participants in the data validation workshop reflected that the different emphases perhaps reflected the different perspectives of those being interviewed – with management staff knowing the huge impact that alcohol and drugs have on the lives of offenders and therefore prioritising these issues. There was a consensus that the OHT model clearly prioritised ‘starting where people are at’ and supporting and empowering them to take small steps that could act as springboards to larger changes. It was also noted that the service has prioritised listening to clients and taking time to uncover the ‘real’ concerns that may lie behind presenting problems. As with the alcohol case study, it is possible to work with a client on one issue and through this work have a positive impact in another equally important area of their life. The potential to bridge the two agendas of health and offending behaviour is clearly evident in the examples provided through this evaluation – supporting work by Maruna (2010) on understanding desistance from crime, which suggests that when personal and emotional issues are being taken care of, there may be a wider and longer-term impact on reoffending.

The opportunity afforded to people on probation to access ‘health’ related services clearly supports the idea that people want to make changes to their lifestyle but have perhaps not known how to access mainstream health services or not been aware what is available or whether they are eligible – stop smoking services, leisure facilities and primary care services are real examples drawn from this evaluation that highlights how Health Trainers have supported individuals to access these services.

Participants in the data validation workshop felt that there had been no obvious tensions in explicitly prioritising ‘non-health’ targets related to reoffending and resettlement – and that mainstream services had developed a reasonably sophisticated understanding of the links between health and offender management outcomes. However, they also acknowledged that Rochdale may not be typical of all locations and that having a prison (HMP Buckley Hall)

within the area and alongside having Fran Carbery in post (as a PCT-based Health Improvement Officer and Regional Healthy Prisons Coordinator) had been pivotal in laying a firm foundation for the work. Having a prison in the locality meant that issues of throughcare needed to be addressed and what had been identified was that the continuity of care for a prisoner being released could be weak. The introduction of Health Trainers within Buckley Hall prison provided the inaugural stimulus for joining up prison based Health Trainer activity with that of the community based Health Trainer work and thus, signposting offenders through the system rather than losing them at the point of release from prison. To maximize the potential for meeting the holistic needs of offenders the partnership with Probation and health evidently is acknowledged as having a great deal to offer not just the offender but the service providers across the system.

It was felt that the forthcoming Implementation Project, which will work across other geographical areas, will serve as a testing ground and potentially help to future-proof the work. In reflecting on the experience of the Demonstration Project and looking to the future, there are a number of considerations:

- **Service Organisation and Infrastructure:** Data from interviews and focus groups with OHTs and service users identified a need for a 'senior' OHT to bridge the perceived gap between the OHTs and their line manager. Participants in the data validation workshop responded positively to this suggestion, reflecting that a more developed structure may be appropriate now that the service is established and expanding. Whilst it was acknowledged that senior posts could be positive in offering the opportunity for career development, one participant voiced concern about potential costs. Another suggestion was that those OHTs already in post and with experience may naturally want to take on additional responsibilities – and that by facilitating a process mapping exercise, it may be possible to encourage appropriate development and ensure that specific concerns are addressed. It was also suggested that it may be positive to review the employment structure and mechanisms and to strengthen links to Community Health Trainers.
- **Training:** The gaps in training identified through the research with OHTs and service users were discussed during the data validation workshop – and participants confirmed that all of these were already being addressed and responded to. This swift progress could be attributed to the established broad partnership and good communication across the system. In addition, the breadth of this partnership lends itself to working to address the complexity of individual needs acknowledging that it is frequently difficult to work with one issue in isolation of others. Several additions to service provision and acknowledgement of ongoing training are testament to an evolving and responsive service.
- **Data Collection:** Participants in the data validation workshop were confident that the teething problems with DCRS were almost resolved and that this would greatly enhance data collection during the Implementation Project. There was a more general discussion about the range of data that would be needed and how this might be collected – with a particular concern to track impacts on offending behaviour and health; explore how these impacts might be quantified in economic terms; and compare and contrast geographical areas with and without the OHT service in place.
- **Setting:** Joining up systems across criminal justice agencies and health services can support people to access services that ordinarily they would not engage with. This can

range from being registered with a GP to accessing stop smoking, alcohol and drug services to utilising local leisure facilities. Whilst there was discussion about the potential value of locating OHT services within the NHS, there was a general consensus that locating Health Trainers in the probation setting helps to address the dilemma of how to access a group of people who are known to be difficult to reach when it comes to health services. The probation setting is a familiar, supportive environment for this group of people to take steps towards addressing key lifestyle issues that impact on their health and wellbeing.

## 6. CONCLUSION AND RECOMMENDATIONS

Locating a Health Trainer service in the Probation Service reflects and legitimises a socio-ecological 'settings' model of health, which prioritises the integration of health within the culture, structure, processes and routine life of the organization and investment in the social systems where people live their lives.

It is clear that the Probation-based OHT model has been effective in terms of both the process of partnership working and wider impacts – and it is evident that Health Trainers in this setting are ideally placed to encourage offenders to improve their health and reduce reoffending. With further funding secured for the Implementation Project it is important to maximize the learning from this demonstration project to guide future decision-making, policy and practice. This next phase of funding will offer more opportunity to further mainstream the work of Health Trainers in the probation setting, and inform the future sustainability of such services.

In the light of the findings from this process evaluation, recommendations can be made in the following areas:

- **Data Collection:** Whilst progress is being made to address the challenges of paper-based data collection systems, additional consideration should be given to the challenges of accessing Probation databases and the DCRS system for the OHTs on a daily, operational basis.
- **System-Level Sustainability:** As with all short-term funded projects and this one in particular, it is clear that a case needs to be made to mainstream the work in order to ensure sustainability across the system. It is essential that commissioners are engaged and recognize the value of working across and joining up the system and aligning the agendas of health and reducing levels of reoffending; and that emphasis is placed on the innovation and potential of the work to engage ex-offenders with meaningful employment. Equally, it is essential that different Health Trainer initiatives are joined up across the system and that links are made and maintained where possible, between Community Health Trainers and those in Probation.
- **Evaluation:** Whilst it is a challenging time, it is clear there is a need to articulate the longer term impacts arising from Health Trainer services within the probation setting. In planning how to evaluate the Implementation Project, it is important to balance this overarching ambition with a realistic assessment of what data and learning can be captured and used in a meaningful and valuable way. Within the one year timeframe offered by the Implementation Project, it is unlikely to be possible to capture sufficient meaningful and generalizable data on the reduction in reoffending rates across what may

be a relatively small number of service users. For this reason, it is recommended that there is a focus on what is feasible and achievable – and specifically that a qualitative evaluation be undertaken that further focuses on user perspectives using an in-depth case study approach – thereby offering the potential to generate meaningful learning and highlight relevant factors that connect health, wellbeing, quality of life and likelihood of reoffending. Such an evaluation would inform future service development and also provide learning that can inform the development of future impact and economic evaluation focused on demonstrating more convincingly whether OHT services contribute to reductions in levels of reoffending. However, it is suggested that this type of study will only be feasible when the programme is far more embedded with a large-scale cohort and when adequate funding is available to design and conduct a robust and meaningful evaluation that offers the potential for capturing the necessary data and generating findings that are valid and generalizable.

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# APPENDIX A: ROCHDALE HEALTH PROFILE 2010

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## **APPENDIX B: INTERVIEW SCHEDULE – KEY STAFF**

The overall aim of the interviews is to explore the nature of the offender health trainer demonstration project in terms of aims, delivery approach, target group(s) reached, workers and agencies involved, outputs and intended outcomes.

This will give insights into the impact of central policies and programme initiatives, and enabling factors and barriers to implementation, as well as identifying good practice.

Can you tell us about the project and your role within it?

*Prompt: what do they feel the goals of the project are?*

What is your experience of working with the project team?

*Prompt: How closely do you work with other project team members?*

What do you think the overall goals of this project are?

*Prompt: addressing health inequalities*

Can you tell us about any internal organisational policies or wider, external strategies that may support this work?

What sort of impact do external policies and targets have on this activity?

Can you tell us about an awareness raising activities that may have been used to inform more broadly about the project?

What training are you aware of that is available to support the development of offender health trainers?

Can you tell us about types of data that you know is routinely collected and how that data is collected?

*Prompts: who is responsible for collecting data; what methods are used to collect data; mechanisms for reporting; what helps or hinders this activity.*

How do you think success is being judged?

*Prompt: what indicators are you using to measure your success?*

How do you feel about where you and the project are at?

Do you receive any feedback from the project and if so, how has this informed your work with individuals?

Overall what parts of the project (including external policy) do you feel help or hinder provision of services and support for this project?

## APPENDIX C: INTERVIEW SCHEDULE – SERVICE USERS

### Key Themes / Question Areas for Service Users

#### Background

Introduction and informal discussion to get a sense of why individual is on probation and how long been involved with probation service. Prior to health trainer project perceptions of own health and access to health services.

#### Access

How did you access the project?

*How did you find out about the Health Trainer service?*

*Why did you decide to see a Health Trainer?*

*Were there issues you were unable to address with another agency?*

*Did the Health Trainer offer you a choice in how you used the service? (in terms of appointment times, best ways for communicating i.e. telephone/face to face/in writing)*

#### Experience

What has been your experience of the project?

*Did you feel comfortable speaking to your Health Trainer?*

*How would you describe your relationship with your Health Trainer?*

*What was it about your Health Trainer that you liked/disliked? (Ability to listen, takes an interest, understand your point of view/concerns, treat you with respect, does work that he/she say they will)*

*Were you asked by your Health Trainer what support/information you wanted to get from them?*

*Did you have contact with any other health staff? What was your experience of those staff? With one another? Did they communicate well with you?*

*What did you and your Health Trainer agree to focus on? (select multiple options if applicable)*

Self-esteem and general well-being  1

Sexual Health  2

Drug misuse  3

Blood borne viruses Hep B, C, HIV  4

Alcohol misuse  5

- Stop smoking  6
- Food and nutrition  7
- Sedentary/low levels of physical activity  8
- Medical/dental registration  9
- Disabilities  10
- Mental Health  11 mental well-being or illness – low/severe
- Healthy Eating  12
- Oral Health  13
- Other  14 Please specify.....

*How did you identify those issues? What prompted you to come e.g. self-identified or through discussion with the Health Trainer? If so was this a revelation to you?*

**Impact**

What does the project achieve?

*a) Do you feel you have made progress in the areas you and your Health Trainer agreed to focus on? If no, what were the obstacles? Check: was literacy one?*

*b) In what way? (Experiences of positive changes or no changes, Access to services, did they deliver on intervention?)*

*Has your Health Trainer been able to get you access to health services that you weren't previously using? (select multiple options if applicable)*

- Self-esteem and general well-being  1
- Sexual Health  2
- Drug misuse  3
- Blood borne viruses Hep B, C, HIV  4
- Alcohol misuse  5
- Stop smoking  6
- Food and nutrition  7
- Sedentary/low levels of physical activity  8
- Medical/dental registration  9
- Disabilities  10
- Mental Health  11 mental well-being or illness – low/severe

- Healthy Eating  12
- Oral Health  13
- Other  14 Please specify.....

*Have you been made aware of other health services that you intend to access? (select multiple options if applicable)*

- Self-esteem and general well-being  1
- Sexual Health  2
- Drug misuse  3
- Blood borne viruses Hep B, C, HIV  4
- Alcohol misuse  5
- Stop smoking  6
- Food and nutrition  7
- Sedentary/low levels of physical activity  8
- Medical/dental registration  9
- Disabilities  10
- Mental Health  11 mental well-being or illness – low/severe
- Healthy Eating  12
- Oral Health  13
- Other  14 Please specify.....

*Are there any health services that you would have liked to access or more information about but haven't been able to?*

*Through the support you got from a Health Trainer, what have you found to be particularly useful? Any non-health support access that's been facilitated?*

*Has there been any part of the Health Trainer service you have found to be disappointing?*

*Are there any improvements or changes that you think would improve the Health Trainer service?*

*Overall, do you feel that your health and/or quality of life will benefit as a result of the service you have received?*

*What is your personal definition of quality of life?*

*Do you feel you can achieve this? Through HT assistance or not?*

*Do you feel you have the capability to change your current way of life? What is in the way?  
(stigma, peers, cost, family, confidence, health etc)*

*If the description of quality of life you have provided is say a ten on a scale of well-being and zero is ill-being i.e. the worst state you could be in, where between one and ten would you place yourself now? Do you think the HT can help you get closer to a ten? What do you think can get you there?*

*Any further comments?*

**Thank you for your time.**

## **APPENDIX D: INTERVIEW/FOCUS GROUP SCHEDULE – HEALTH TRAINERS**

### **Key Themes / Question Areas for Health Trainers**

#### **Background**

Introduction and informal discussion to get a sense of how long individual has been involved with the project and how many clients worked with.

#### **Expectations**

*What were your expectations of this project?*

*Why did you get involved in the project?*

*How did you get involved?*

*What was the motivation to get involved?*

*[Check: Was it recommended or were they actively pursued]*

#### **Your Role**

What do you do/what is your role? How do you see your role in the project?

*What are the core tasks that you deliver?*

*Has this changed / developed through the course of the project? (if so how and why)*

*How are you asked to record what you do? (Familiarity with the systems, understanding of this process, aware what happens to this information?)*

#### **Training**

**What training did you have to deliver the role you defined above?**

*Check: Level 2 or Level 3 training (level 3 has grief intervention training – did it make a difference?)*

*What key topics?*

*What has been most useful about the training?*

*Have there been any gaps? Any instances where you have felt lacking in skills or confidence?*

*Is there a need for ongoing training/support? How would this be best delivered? What would it focus on?*

#### **Relationships**

What is your experience of working with the project team?

*Who else do you work alongside (probation, health, admin)?*

*How do you communicate with these colleagues?*

*How would you describe these relationships? (support/guidance/advice)*

*What are you involved in e.g. meetings?*

*How do you feel about this structure? Valued?*

*How does this affect how you feel about the role and opportunity to achieve?*

*How does this affect your work (positive and negative)?*

### **Health**

*What is your understanding of health?*

*What does health mean to you/your project?*

### **Impact**

**What do you think the overall goals of this project are? Is it meeting these?**

*What sorts of issues are you commonly working to address? (select multiple options if applicable)*

- Self-esteem and general well-being*  1
- Sexual Health*  2
- Drug misuse*  3
- Blood borne viruses Hep B, C, HIV*  4
- Alcohol misuse*  5
- Stop smoking*  6
- Food and nutrition*  7
- Sedentary/low levels of physical activity*  8
- Medical/dental registration*  9
- Disabilities*  10
- Mental Health*  11 *mental: well-being or illness – low/severe*
- Healthy Eating*  12
- Oral Health*  13
- Other*  14 *Please specify.....*

*Do you feel that the project is having an impact on the health well being of those using the service? [check this against each of the above listed issues]*

*In what way? (Experiences of positive changes or no changes) How? (brief intervention, sign-posting, onsite)*

*What other factors do you feel are interlinked to health complexities? Chaotic life, lifestyle, social structure. How much is being picked up?*

### **Partnerships**

*What do you think contributions of health/probation add to the project? [Specific services from PCT? And personal delivery?]*

*How much do you work with colleagues from all agencies?*

*Is there a clear role for you?*

*How do you/your role fit in this process?*

*What barriers are there to working effectively with probation/health e.g. structure, language, values...*

*In your experience is everything working well? If not why not, give examples...*

### **Future improvements/Issues**

[Revisit all barriers/obstacles mentioned thus far in more detail – check re funding]

*What might the project do to address these?*

*Can the partner agencies contribute to this?*

*Key lessons learned/do differently if funded?*

### **Methods of Delivery**

*How do you do what you do? E.g. information giving, signposting – do you use leaflets/written information or verbal?*

*What influences your choice in how you engage?*

*Any further comments?*

**Thank you for your time.**