



**A report on the
Healthy Eating Healthy Living Project
for adults with Learning Disabilities
in six Scottish pilot sites**

June 2011

Dorothy A. Morrison

Healthy Living Project Lead



**community
food and health**
(scotland)



Contents:

| | | |
|-------------|---|---------|
| 1. | Introduction/Summary | Page 3 |
| 2. | Background | Page 3 |
| 3. | Main Aims of the Project | Page 5 |
| 4. | The Pack and How it was Delivered | Page 6 |
| 5. | Pilot sites | Page 7 |
| 6. | Project Aims, Objectives and Outcomes | Page 9 |
| 7. | Development of Training Manual to support delivery | Page 14 |
| 8. | Additional Outcomes | Page 16 |
| 9. | Key issues that emerged | Page 16 |
| 10. | Recommendations | Page 18 |
| 11. | Appendices | Page 19 |
| Appendix 1 | Weekly Session Evaluation Sheet | Page 19 |
| Appendix 2 | Salt Quiz | Page 21 |
| Appendix 3 | Flavour of Weekly Evaluations | Page 23 |
| Appendix 4 | Start and End Weight of Participants | Page 25 |
| Appendix 5 | Pre-course focus group questions | Page 27 |
| Appendix 6 | Pre-course Focus Group sample | Page 28 |
| Appendix 7 | Post-Course Focus Group Questions | Page 33 |
| Appendix 8 | Post-course Focus Group sample | Page 34 |
| Appendix 9 | Post-Course Questionnaire for Carers | Page 37 |
| Appendix 10 | Observation of impacts on participants and staff | Page 39 |
| Appendix 11 | Case Studies | Page 44 |
| Table 1: | Knowledge of service users pre and post | Page 22 |
| Table 2: | Mental Health and Well-being – Pre- and Post-project | Page 51 |

Healthy Eating Healthy Living Project Evaluation Report

June 2011

1. Introduction / Summary

1.1. This is a report on the development of an innovative educational resource pack about healthy eating developed for delivery to adults with learning disabilities, in view of the considerable health inequalities they experience and the large gap in the provision of accessible resources that exists.

1.2. A Scottish Government grant funded a project team to be employed to support six pilot sites (five in the Greater Glasgow area and one in Tayside), to deliver the pack. Creation and production of a DVD was funded, as one of several multi-media resources that make up the pack, and designed to be of particular use at home.

1.3. A two day training course was commissioned in recognition of the importance of supporting carers to support adults with learning disabilities to be able to make healthy and informed choices in their daily lives about the foods they eat. This course for carers is tailored to the specific health and nutrition issues more commonly experienced by adults with learning disabilities. The course is accredited by the Royal Environmental Health Institute of Scotland (REHIS), like the Elementary Food and Health one-day course on which it is modelled.

1.4. The report describes the elements of the pack and how it is innovative. The process by which staff delivered the pack and how they were equipped to do this is reported. The experience, results and impact of delivering the pack, together with highlights and learning for future roll-outs of the materials are further key features of this document.

2. Background

2.1 A review of Learning Disability Services, *The Same As You?*, was published in 2000. It estimated that in Scotland, about 20 people in every 1,000 have mild or moderate learning disabilities and 3 – 4 people in every 1,000 have severe or profound learning disabilities. In Scotland, this is around 120,000 of whom about 5000 live in Glasgow. About 18,000 adults with learning disabilities are currently known to Local Authorities in Scotland. This means there are over 100,000 people with a learning disability who have no formal support. Recent studies from other geographical areas using differing methodologies report a prevalence varying from 2 to 85 people with learning disabilities per 1,000 of the population. (Health Scotland Health Needs Assessment Report 2004).

2.2. People with learning disabilities have a shorter life expectancy and increased risk of early death when compared to the general population. Coronary heart disease is the second most common cause of death after respiratory disease among people with a learning disability.

2.3. They are more at risk of certain illnesses and conditions: 35% of men with a learning disability are likely to be obese; epilepsy; gastro-intestinal cancer rates are proportionately higher (48% - 59% vs 25% cancer deaths in the general population)

(Emerson & Baines, 2010). The authors cite other common issues including: non-mobility; poorer oral (mouth) health; dysphagia i.e. difficulties with eating, drinking and swallowing; increased rate of diabetes; gastro-oesophageal reflux disorder; constipation and osteoporosis.

2.4. Added to these, visual impairment is also 8 –200 times more likely among people with a learning disability compared to the general population. Forty per cent are reported to have a hearing impairment and people with Down's syndrome are at particularly high risk of developing vision and hearing loss (Emerson & Baines, 2010).

2.5. Emerson and Baines go on to report that carers perceive the health of their children with learning disabilities to be better than it is, from childhood onwards. Yet, health screening of adults with learning disabilities registered with GPs reveals high levels of unmet physical and mental health needs. Evaluations of in-depth health checks among patients with learning disabilities in NHS Greater Glasgow and Clyde and collated in 2011 bear this out. Previously unrecognised conditions most commonly detected by the health check were: impacted wax (26%), gastro-oesophageal reflux (15.6%), mental ill-health (13.9%), obesity (13.8%), dry skin conditions (10.0%), visual impairment (8.6% & possibly a further 13.0%), constipation (7.4%).

2.6. In terms of literacy, many people with learning disabilities do not read or write well and some not at all. While many useful resources exist already with information and tips on healthy eating, these assume levels of literacy, numeracy, comprehension, and sometimes, IT skills. Thereby, a further inequality in opportunity exists for people with learning disabilities to make informed choices about foods, drinks and diet.

2.7. It was therefore important to design an accessible training resource, tailored to people's needs and using an appropriate variety of media and teaching and learning styles.

2.8. Considerable gaps have been identified in terms of the provision of accessible health information for people with learning disabilities. *The Same As You?* Implementation Group (SAYIG) is working to implement the recommendations of the review of services for people with learning disabilities. The Group has agreed, as part of its current focus, to address the health inequalities faced by people with learning disabilities. This project is in line with Scottish Government's current focus.

2.9. A bid for Change Fund monies allocated by the Adult Care and Support Division of the Scottish Government Primary and Community Care Directorate was submitted by Mary Laidlaw, Specialist Dietitian in Learning Disabilities, South West Glasgow CHCP. The Healthy Eating Healthy Living Project (named after the Healthy Living national campaign at that time) received three year grant-funding from March 2009 to March 2011.

2.10. The Scottish Government agreed the proposal submitted to them for £90,000 funding to further develop an educational resource to promote healthy eating with adults with learning disabilities and their carers. The grant funded three part-time staff; a project lead and a food-support worker (December 2009 – June 2011) and an admin assistant (May 2010 – June 2011).

3. Main aims of the Healthy Eating Healthy Living Project

The project had two main aims:

Aim 1 - To develop an educational pack - within this aim, there were five objectives:

- 3.1.1 Assess whether the current educational resources and format of delivery were sufficiently robust to be able to be replicated with similar results to the running of the course earlier at Berryknowes Resource Centre, by a range of workers in other organisations/locations.
- 3.1.2 Adapt the current educational resources to include additional health issues such as weight management.
- 3.1.3 Develop and incorporate new ways of influencing carers and reinforcing the main messages at home.
- 3.1.4 Build a final version of the pack ready to be reproduced and made available widely.
- 3.1.5 Continue to involve service users in the process of developing resources adapted to their needs and evaluate changes in their knowledge as well as confidence and self esteem.

Aim 2 - To develop a Training Manual to support delivery of the Healthy Living Pack – to meet this aim, there were four objectives:

- 3.2.1 Explore what training for carers of adults with learning disabilities was available on food, health and nutrition.
- 3.2.2 Specify and commission a course tailored to the needs of carers for adults with learning disabilities
- 3.2.3 Pilot this course, refine and make available
- 3.2.4 Ensure that champions delivering the Healthy Eating Healthy Living Course is adequately supported with information on health and nutrition to deliver the Healthy Eating Healthy Living Course while this commissioned course is under construction.

4. The Pack and How it was Delivered

4.1. A group of dietetic staff and a support worker from Berryknowes, led by Mary Laidlaw, Specialist Dietitian in Learning Disabilities, South West Glasgow CHCP, wrote the initial training pack. They delivered it twice, prior to this current pilot, funded by a combination of strands consisting of the Health Promoting Health Service, the Glasgow Learning Disability Partnership, and health improvement. It received positive evaluations both times and the materials were refined in line with feedback, evaluations and observations.

4.2. The pack takes 26 sessions of approximately half a day to deliver, taking participants through seven topics: sugar, fruit and veg, fat, fibre, salt, healthy bones and labelling. The delivery is modelled on the spiral curriculum theory - meaning that several key messages are taught, relating to the subject; practical elements follow, such as comparative tasting of healthier and less healthy versions of foods and drinks, observing what is available in the market, shopping; preparing and cooking healthy foods and, of course, tasting them.

4.3. For each session, the trainer's manual lists the activities, learning outcomes, table of activities and the resources required. Trainers (champions) are prompted to enable the service-users to re-cap on the previous week, often using photo-minutes as an aide-memoir. There are key messages, a mix of practical and group activities, a short input of physical activity and at the end of each session and each topic, there is a return to the key messages, to reinforce learning.

4.4. To make the messages of the pack more accessible, these were kept uncomplicated, the topic headlines being:

- Say No to Sugar
- Say Yes to Fruit and Veg
- Say No to Fat
- Say Yes to Fibre
- Say No to Salt
- Say Yes to Healthy Bones
- Food Labelling

4.5. As well as the trainer's manual, each pilot received a large Eatwell mat –this shows the colour-coded sections of foods and the proportions that make up a healthy meal. Even if people have speech and language issues, they can place the foods, replicas, packets etc on the section where they think it belongs.

4.5.1. A set of 180 commissioned photos of foods and drinks, in user-friendly format (i.e. plain crockery, single-colour backgrounds, encapsulated with matt lamination in line with RNIB guide-lines). The project commissioned and now own these digital images; they can be easily copied for future production runs.

4.5.2. Powerpoint presentations of animated characters are supplied with the pack, demonstrating the benefits of healthier foods and the harms of less healthy ones using graphics, journey of food through the body (sugar, fat, fibre sections). Other powerpoint presentations include skeleton images in a variety of poses (healthy bones) section.

4.5.3. Visual props that trainers used included: 15 metre lengths of plastic tubing to simulate the length of the alimentary tract; blood pressure gauge and the use of it.

4.5.4. Sensory appraisal of foods was an important practical aid, such as touching, feeling, tasting, smelling herbs, lemon, Tabasco sauce, garlic (salt topic). An effective exercise is for champions to buy some more unusual fruits and vegetables then covering them with straw or shredded paper in a cardboard box and inviting service-users to feel and guess the items.

4.5.5. Tasting sessions form another sensory activity e.g. comparing both sugar-free or unsweetened and sweetened versions. Having tasters sometimes also provides service users with opportunities to taste new foods, flavours and textures like cottage cheese.

4.5.6. In 26 sessions, there were five cookery sessions. These involve: a shopping list check using a laminated pictorial sheet in the pack; food hygiene and handling re-cap (pack contains a laminated page of Cook's Rules); preparation and of course, testing the finished product. Sometimes comparisons can be made with shop-bought equivalents, e.g. making scones sweetened with dried fruit instead of sugar, and scones from a supermarket.

4.5.7. Champions were asked to complete a brief weekly evaluation and these were collated, quickly growing to an overall picture of each pilot's experience.

4.5.8. Service users received certificates of attendance and participation for each topic, a popular practice enjoyed by all.

5. Pilot sites

5.1. Six pilot sites were identified. The project team was keen to be as inclusive as possible in the span of settings in which the pack was delivered. Each pilot had at least two champions for the Healthy Eating Healthy Living course and a manager from each pilot was on the Project Steering Group which met quarterly. Altogether, 34 service users or patients participated in the project.

5.2. The first two times that the pack was delivered at Berryknowes, there was input by three dietitians and a dietetic assistant, although not all at once, in addition to a day support worker. In the six-site project phase, there was regular input and support by the project food support worker to the five sites in the Greater Glasgow sites, the Tayside pilot had input from a health improvement practitioner employed through the LD dietetic service and a small amount of input from the Project Lead. After the project is over, it is hoped that staff could deliver the pack by referring to trainers' notes

5.3. Berryknowes Adult Resource Centre, South West Glasgow, in partnership with the Wedge Centre, Pollok formed the first pilot in a day-service setting run by local authority - Glasgow City Council. By summer 2010, the pack had been delivered three times at Berryknowes. The centre there has the advantage of having an adapted bungalow with a purpose-designed kitchen and other rooms. A new development was proposed to pilot the course jointly with The Wedge centre at Pollok where people with learning disabilities also attend. In the course that ran from September 2010, three group members were from Berryknowes and four from The

Wedge. The two champions were support workers, one from Berryknowes and one from the Wedge.

5.4. Summerston Adult Resource Centre, in partnership with the Killearn and Hinshaw Street Centres, all in the North Glasgow CHCP area at the time of the pilot, constituted the second local authority day service setting. Service users in the group were in a mixture of supported tenancies, living with family members. Summerston was the largest centre and had the best facilities, a kitchen and a group room. There were six members in the group, three who attended Summerston regularly, two from Killearn and one from Hinshaw Street. The two champions were both support workers at Summerston Resource Centre.

5.5. Thornliebank Adult Resource Centre, East Renfrewshire involved partnership working with another local authority, adding to the richness of the partnership. Five men and one woman made a group of six. Some lived in their own tenancies, one lived alone in the family home, two in the group shared a flat. Meals at the centre are made in-house; the catering department has the Healthy Living Award Plus that is to say, 70% of all that is offered is healthier than usual. The two champions were day support officers at the Resource Centre.

5.6. The team also wanted to pilot the pack in a health service setting, and so two low-secure forensic wards, Campsie and Whitehouse, in Leverndale Hospital, South West Glasgow were the fourth site. Each ward accommodates four patients (all male), most men are there for years rather than months. These wards are, by design, highly self-sufficient, patients doing the cleaning, personal laundry, general and personal shopping and preparing and eating meals with staff, so there are many opportunities for application and re-inforcement of healthy eating messages. There were seven men in the Leverndale Healthy Eating Pilot. The three champions were staff nurses between the two wards.

5.7. Sense Scotland at Touchbase, Kinning Park, Glasgow represented the piloting of the materials to people with more complex and profound learning disabilities. There were only two in the group, one man and one woman, mainly because the kitchen used for practical sessions is quite small and could not accommodate more than this number plus support staff. This pilot demonstrates links with providers organisations in the voluntary sector. The two champions were support workers based at Sense Scotland.

5.8. The project was of considerable interest to the Scottish Learning Disabilities Dietetic Clinical Network. The request from NHS Tayside members to host a pilot at the Kinnoull Day Opportunities local authority provision - the sixth pilot - gave the project more of a national flavour. Being in a location serving a much more widely scattered population, than for example, Glasgow, this pilot gave the project some other perspectives which may help other such settings nationally. Again, the champions were two day support workers and there was also valuable input from a health improvement practitioner based in Tayside's learning disabilities specialist dietetic department.

5.9. Some discussions had also taken place with Cardonald College as a further education setting but this could not go ahead as hoped. Approaching providers of supported accommodation had also been discussed. Many of the messages from Leverndale's experience as a residential setting could be transferred elsewhere.

6. Project Aims, Objectives and Outcomes-

The development of an educational pack - five objectives:

6.1. Assess whether the current educational resources and format of delivery were sufficiently robust to be able to be replicated with similar results to Berryknowes by a range of workers in other organisations/locations.

6.1.1. This objective was met in that firstly, both the educational resources and the delivery format were assessed by a range of evaluation tools: weekly evaluation sheets; attendance; quizzes and individual evaluations for the four major topics (sugar, fruit and veg, fat, fibre) and other measures for the smaller ones (salt, healthy bones, food labelling). Thus, knowledge pre- and post- topic delivery could be measured. See Appendices 1, 2.

6.1.2. Knowledge increased from scores of 40% to 76% for sugar, 62% to 74% about fruit and veg and 73% to 78% about fat. A flavour of the comments from each week is shown in Appendix 3 and an indication of the increases in knowledge is shown in Table 1. People's learning continues as shown by the case-studies pilots conducted.

6.1.3. Participants can choose to demonstrate their enjoyment or otherwise of the course by their attendance; of the 34 service users or patients who began the course, only one dropped out due to post surgery recuperation.

6.1.4. Assessment of resources and their delivery was also a process evaluation of the on-going experiences, learning and reflection of champions and service-users as they delivered and received the pack in the six pilot sites. The project lead co-ordinated training on the pack's topics and delivering the pack at the two resource hand-over sessions in May and July 2010.

6.1.5. The project lead conducted two development sessions with champions and managers in February and March 2011 and led the group through the pack, taking feedback on each topic and how its delivery had gone, where and how improvements might be made.

6.1.6. These measurements go a considerable way to capturing the results and experience that pilots had. Quantitative and qualitative feedback showed that many people in the six pilots were learning and internalising what they were being taught and experiencing. The enjoyment of the learning was also captured. The DVD which was produced and complements the pack's messages, portrays some of this enjoyment.

6.2. Adaptation of the current educational resources to include additional health issues such as weight management

6.2.1. Overweight and obesity rates are of concern for the general population and even more so for people with learning disabilities. The bid submitted for funding, accordingly, envisaged a project in which year two would include development of the current educational resources and their delivery to include additional health issues such as weight management.

6.2.2 There are implications for health and social care regarding the costs of overweight and obesity in terms of treatment, increased disposition to other conditions such as diabetes, heart disease, cancers, high blood pressure, stroke; costs of bariatric equipment and procedures. There are increased costs of medication, anaesthetics etc, generally increased risks during and after surgery for people who are overweight or obese. Mobility is reduced by overweight and obesity, joints may be affected and require replacement and ultimately, people can become physically disabled by the excess weight they carry.

6.2.3. It should be borne in mind that the pack is primarily an educational resource rather than a course in weight management, while not wishing to miss opportunities to support weight loss where this would benefit a service user. Also, some service users are underweight and a healthy diet for them is high in calories and energy.

6.2.4. In a research study led by Dr Craig Melville et al, the Glasgow Weight Management Scheme was adapted to meet the needs of adults with learning disabilities. This study began after the project bid was submitted and before the project started. The Healthy Eating Healthy Living project was delayed in getting underway, such that a second year was not feasible and a further run of the pilot proved impossible within the funding period.

6.2.5. In the light of this, pilots were asked to weigh participating service users pre and post delivery so that any weight loss or gain could be recorded. "Slow" scales were purchased with project funds ie ones which enable accurate weights to be taken of people who may find it difficult to stand still. Overall, there was little weight loss, although a couple of notable successes. This may have been due to several of the pilots running during such a cold winter when regular exercise was difficult. The start and end weights and gains or losses are given in Appendix 4. It is important to note that not all pilots completed the course and it is difficult to say anything about weight gain or loss that is conclusive.

6.2.6. The findings of the research by Dr Melville et al will be of interest and learning to future weight management elements of the pack and its delivery. Anecdotally, several staff have mentioned overweight or obese clients to the project staff, who they feel would benefit from going through the course and wanted to know how the course could be accessed.

6.3. The develop and incorporation of new ways of influencing carers and reinforcing the main messages at home

6.3.1. Previous roll-out of the project had showed that it would have been helpful to gather views prior to the delivery of the pack as well as afterwards, and so pre-focus groups were arranged. Many people with learning disabilities are likely to be dependent to some degree on the food choices and preferences of their carers, whether family carers or staff carers live with/support them or not. This also affects food eaten out-with the home an increasing proportion of meals eaten by all groups. Finding out what involvement service users had already in food choices, menu-planning and food-preparation service users further shaped the project. In addition the pre focus groups helped to prompt carers to reflect on their own habits and choices.

6.3.2. This objective was partly achieved in that carers were invited to pre- and post-course focus groups at pilot sites. The attendance at these was mixed, although the pre-focus groups conducted by the project lead at both Perth and Thornliebank were very well attended. At the Leverndale (forensic wards) pilot, patients are resident for years rather than months, so the pre-course focus group consisted of ward staff who were much less/not involved in the delivery of the course by way of proxy carers. Efforts were made to make focus groups at time that suited carers, and pilot staff phoned round to encourage attendance after letters went out. It was hoped that the pre-course focus groups, while acting as a base-line for future feedback, might also plant seeds of thought and change in the carers participating.

6.3.3. The pre-focus groups yielded plenty of information which is detailed as Appendices 5 and 6.

Carers conveyed some of their own uncertainty about what was healthy. Some were doubtful about how well those they cared for would progress in terms of healthier eating. Several sought clarity about what foods really were healthy; some were confused by apparently conflicting media messages.

6.3.4. The post-focus groups conducted in March / April 2011 were less well-attended. The Perth one gave the most feedback and was a particular highlight. One post-focus group transcript is attached. The food support worker phoned round family and staff carers in the NHS Greater Glasgow & Clyde pilots who had not managed to attend and conducted some short interviews. See Appendices 7, 8, & 9.

6.3.5. Available post focus feedback was positive. Carers spoke with surprise of weight loss in an overweight relative when it had not been thought likely. Although designed for carers, service users sometimes also attended groups and joined in, re-enforcing the key messages they had learned.

6.3.6. The Healthy Eating Healthy Living DVD was made as part of the project in partnership with the Scottish Consortium for Learning Disabilities, filmed at three of the six pilots sites. It features three chapters of around ten minutes each, on fruit and vegetables, fat and sugar. It took longer to complete than either the project team or the production company anticipated, only becoming available in June 2011. Therefore its impact is yet to be captured and this would be a worthwhile exercise.

6.3.7. While ensuring the key messages, shopping, preparation, cooking and eating activities are all captured, the Healthy Eating Healthy Living DVD doubles as a documentary of the groups as they really happened, filmed in day centres and supermarkets. It also complements The Food For Thought DVD, a separate resource which was commissioned and produced by SCLD in May 2011. It focuses on a number of service users at home and what they eat there. Thus, enabling carers to watch/have both DVDs would have most effect. The Food For Thought DVD has a number of key messages and questions inside the cover, making a good starting point for reflection and discussion. Both DVDs are excellent resources for carers as well as service users.

6.3.8. Pilot sites were encouraged to send home photo-minutes of each session with participants as the photos would help to relay the activities along with captions for the key activities. The main reason photo-minutes were taken was to provide an accessible prompt to service users each week to recap on the topic currently being covered. Sometimes, service users' memory and recall is affected by underlying

conditions. Sending minutes home needs more promotion, in spite of the cost colour copies being much more effective than black and white. Staff at one pilot site commented that the photo minutes were also useful for service users' reviews.

6.3.9. The pack in itself has no "take home" elements and this may be an aspect worthy of development e.g. recipes, fact sheets, which could re-enforce the messages at home, aid recall of what happened in the session, and support joint healthy eating activities between service users and carers.

6.4. Build a final version of the pack ready to be reproduced and made available widely

6.4.1. Unfortunately, the project has been unable to produce a finished version which is ready for mass circulation. Weekly feedback evaluations from champions gave opportunity to comment on activities, instructions, time allocation and how sessions had gone generally. The development sessions in February and March 2011 gave detailed feedback with the benefit of hindsight and experience of delivery.

6.4.2. Observations and reflections by the food support worker were invaluable as she was closely involved in delivery across five pilot sites and could compare how messages, exercises and activities were received in different pilots as well as pacing and timing of sessions.

6.4.3. The pack is now in a complete format and it is hoped that on-going discussion with SCLD with regard to printing will result in a further production run, while keeping costs to a minimum.

6.5. Continue to involve service users in the process of developing resources adapted to their needs and evaluate changes in their knowledge as well as confidence and self esteem.

6.5.1. The project from its beginning aspired to be genuinely service user focussed, involving service users in resource development, trialling and refining these resources and involving them very much in planning developments and activities such as the open day held at Berryknowes in August 2008. It could reasonably be claimed that this objective was met as outlined in the paragraphs below.

6.5.2. The Healthy Eating Healthy Living steering group membership included service users. Service user minutes were developed from each quarterly Steering Group meeting. These minutes contain photographs of all those present at the meeting and a summary of all the key points in accessible language. Care was taken to take photographs of any visitors, new members of the group as the situation arose.

6.5.4. The list of foods and drinks (referred to in paragraph 4.5.1.) to be photographed was devised by a group of dietitians, who ran focus groups with service users to test out aspects of the photos such as best background colour, whether the photographs looked like the foods and drinks they represented etc.

6.5.4. The purchase of one day training for staff (champions, project staff and some speech and language therapists) in the evaluation technique called Talking

Mats, was to enhance communication opportunities and support robust evaluation. This training was provided in January 2010.

6.5.4.1. Talking Mats is a low-tech communication framework involving sets of pictorial symbols. Since its original conception, it is now an established communication tool, which uses a mat with clear picture symbols attached as the basis for communication. It is designed to help people with communication difficulties to think about issues discussed with them, and provide them with a way to effectively express their opinions.

6.5.4.2 Talking Mats can help people arrive at a decision by providing a structure where information is presented in small amounts, supported by symbols. It gives people time and space to think about information, work out what it means and/or choices and preferences and say what they feel and choose preferences in a visual way that can be easily recorded. Taking photographs of the mat is an ideal method of recording.

6.5.5. Two places for Training for Trainers in the Talking Mats technique were purchased with project funds for two staff (two Speech and Language Therapists) to further enhance practice and support practice on-going. They were thus skilled up and equipped to support pilot sites in developing the use of Talking Mats for the Healthy Eating Healthy Living course and worked with the food support worker to develop a mid-way reflective tool for service users.

6.6. To genuinely adapt to people's needs, the messages for each topic were kept un-complicated, although not without explanation, e.g. there was not an exploration of types of fat, the message was "say no to fat", "cut the fat" and so on. Guidance was followed on making information accessible, there was some valuable joint-working with speech and language therapists.

6.6.1 All participants completed a seven question mental health and well-being questionnaire, pre and post course. Questionnaires were designed with a consultant psychologist to be completed individually with service users pre- and post- delivery to avoid influences by others. The questions asked how service-users were feeling about themselves, attitudes to trying new things, the future, states of happiness. These indicated positive shifts overall and constitute hard evidence of the efficacy of a project such as this one and the results are one of the most significant outcomes of this project. The positive shifts reported are borne out by the observations of staff who know the service users and continue to work with them. See Table 2.

6.6.2. In North Glasgow, the mental health and wellbeing pre and post forms showed, for example, five out of six service-users scoring greater mental health and well-being in their own estimations, after completing the course, and with some reporting quite marked increases in their general willingness to try new things and how they felt about life. A couple of quieter service users surprised staff by the amount of their participation.

Changes were also noted in the case studies that pilot sites were invited to write. See Appendix 11.

7. The development of a Training Manual to support delivery of the Healthy Living Pack - four objectives:

7.1. Explore what training for carers of adults with learning disabilities was available on food, health and nutrition.

Statistics from Enable Glasgow indicate that around 60% of people with learning disabilities live with relatives. Others live alone or in supported tenancies. The role and understanding of carers in relation to food and health is therefore critical.

7.1.1. This objective was fully and quickly met in that no tailor-made courses were found in the UK. A review of training available was carried out. It revealed a lack of courses on the nutrition and health issues of adults with learning disabilities. In Scotland, the one day Food and Health Course, accredited by the Royal Environmental Health Institute of Scotland, while good, could not cover many of the health issues specific to people with learning disabilities. Thus, carers, both staff and family, are often not fully informed or aware about health and nutrition needs of adults with learning disabilities.

7.2. Specify and commission a course tailored to the needs of carers for adults with learning disabilities.

7.2.1. With the known lack of such training and some budget allocated, the impetus to commission training grew. This objective was also fully met as evidenced below.

7.2.2. The professional dietetic adviser to the project and the project lead wrote a detailed brief in April 2010, to commission the production of a specially tailored training package, based on the existing one day REHIS Food and Health course. The brief also specified that additional information be included on health issues commonly experienced by adults with learning disabilities such as osteoporosis, heart disease, gastro-oesophageal reflux disorder.

7.2.3. A freelance writer, with specialist knowledge (a state registered dietitian specialising in Learning Disabilities) and previous resource development experience, was contracted to deliver the agreed brief. A short-life working group was formed in Summer 2010 comprising: specialist dietitians; Care Scotland (as it was known then); Royal Environmental Health Institute of Scotland (REHIS); Community Food and Health Scotland (CFHS); trainers from LD service-providers; the contracted freelance writer; the professional advisor to the project; the project lead.

7.2.4. A tailored training package was produced and was accredited by REHIS, during the process and on completion as both the Director of Training and the Training Adviser were part of the working group. All members of the working group eligible for a fee declined this. REHIS agreed to fund the production of the resource materials. Part of CFHS's contribution was the financing and evaluation of pilot courses.

7.2.5. The resulting training materials comprise: powerpoint slides; trainers' notes; handouts; case-studies. The content requires a recommended delivery time of nine hours, (two days), covering the following topics:

Module 1: Introduction to food and health
Module 2: Eating for health and well-being
Module 3: Understanding energy balance
Module 4: Health issues in people with learning disabilities
Module 5: Menu-planning
Module 6: Additional resources
Module 7: Revision and knowledge check

7.2.6. The initial plan was for the draft materials to be ready by December 2010 and piloted in January 2011. This was almost on target with the draft materials being ready by January.

7.3. Pilot this course, refine and make it available

7.3.1. This objective was met and is now available through REHIS, the resource was launched on 10th June 2011.

7.3.2. This was achieved by the piloting of the final draft resource pack in February/March 2011 in four centres: Glasgow, Perth, Shetland and an Enable Scotland staff group, all in line with other aspects of the wider project.

7.3.3. Overall, trainers thought that participants received about the right amount of information in each of the modules and that participants enjoyed and found the course useful. Trainers felt confident in delivering the content and in the time suggested and all trainers would consider delivering the course as part of their regular work.

7.3.4. Participants of the training undertook a knowledge check (test) at end of two day course. From the 54 people who underwent the pilot courses, 53 passed the learning check. On-going test papers of subsequent courses are will be sent in to REHIS for accreditation and certification.

7.3.6. Only slight changes were made to the final content before the materials were printed in the REHIS house-style by their publishers. (May 2011).

7.4 Ensure that champions delivering the Healthy Eating Healthy Living Course are adequately supported with information on health and nutrition to deliver the Healthy Eating Healthy Living Course while this commissioned course is under construction.

7.4.1 The resource pack contains basic nutrition reference information at the start of each topic in the pack. Topic information sessions were delivered by the professional advisor to the project and the project lead as part of the resource pack hand-overs in May and July 2010, with topic sheets to take away. The food support worker also gave training on the practical elements of how best to deliver sections. This guidance was also emailed out.

7.4.2 Champions were also encouraged to take up places on the one day Elementary Food and Health Course accredited by REHIS, which is run nationally and many champions accessed this.

8. Additional outcomes as a result of meeting these objectives

8.1. A network has been formed among the six pilots, which can continue as they choose; they all have the pilot resources to keep and use as often as they wish.

8.2. There was improved joint-working with speech and language therapists, psychologists, day care-workers, physiotherapists, across health and social work and both the statutory and voluntary sectors. This strengthened efficient and effective team-working which was client centred.

8.3 The Healthy Eating Healthy Living course has emerged as not only an educational resource but also an activity that can happen in situ at centres, does not require transport and is fairly cheap to deliver. In most pilots, participants paid a small amount each week and this covered the costs of tasters and ingredients.

8.4 It was considered important to get an overview of how working through the pack has impacted on service users and champions. Significant impacts have been observed all round as seen in Appendix 10 which is a write up of some talking walls at the two development session.

8.5. A specialist dietitian for forensic patients at Stobhill and Leverndale came into post in the Autumn of 2010. This was a significant support to the champions. A discussion by the dietitian with an adjacent ward about the large size of many dinner plates nowadays (which encourages large portions), resulted in staff going out the next day to purchase some smaller dinner plates as a first step to moderating portion sizes. A meeting about the progress of the delivery of the course resulted in a very fruitful discussion about the challenges of psychiatric and forensic care settings, where patients had large portions historically and ate very quickly.

9. Key issues that emerged

9.1. Delivery works best if sessions happen frequently and regularly. Pilot sites found the 26 week and weekly session plan templates to be helpful tools at the beginning and throughout.

9.2. Each successful delivery of the materials requires champions, i.e. staff whose role is recognised and given sufficient time, preparation opportunity and resources by managers.

9.3. The pilot worked better in some areas than in others some pilots had unique successes in some aspects and unintentional spin offs, e.g. conversation by the forensic specialist dietitian about the course with another ward at Leverndale prompted staff to buy smaller dinner plates.

9.4 The first filming of sugar was in the North but consent was withdrawn afterwards by one carer; several staff tried to re-gain consent but this was unforthcoming. Along with some other issues, this led us to re-film sugar in Perth. This is a good example of a tension that can arise between the rights of service users and the views of carers.

9.5. As it only became available at the end of May, the Healthy Eating Healthy Living DVD is still to be measured in terms of its impact.

9.6 Many of the cost of producing the materials at the beginning were one-off, fixed costs and have been met, e.g. the commissioning of the digital photographs, the REHIS Elementary Food and Health Course for carers. Re-productions will not have those set-up costs.

9.7 The pilot at Leverndale had major challenges in on-going delivery of the pack, despite high levels of commitment from the three champions identified and trained and the wards' managers. This was partly due to the challenges of shifts that covered days and nights, 24/7. There was also the frequent need for high staff/patient ratios to fulfil legal requirements, creating some difficulties for off-site activities such as physical activities (usually walks) and shopping trips. One champion left to take up another post. The learning here is transferable for many residential setting e.g. housing providers, with 24/7 staffing rota requirements.

9.8 Obesity is a particular issue of increasing concern in the forensic setting. The two forensic wards at Leverndale have strict snack policies e.g. no "stashes" are allowed in patients' rooms and these policies help prevent weight gain. Other good practice was the monthly weighing of each patient. Extreme examples of obesity exist in forensic settings elsewhere and implementing policies to address these can prove challenging, as in the well-publicised case at State Hospital earlier in 2011. The experience of running the course in Leverndale highlighted some of the impeders such as staffing levels and the consequences of not being able to run the course from beginning to end. It would be useful for forensic settings to consider investing staff time to allow a course like this to run and see what impact it could have.

9.9 Discussions are on-going regarding whether the Healthy Eating Healthy Living pack can be modified or delivered in a shortened form. It should be noted that evaluations show that the practical and sensory elements strongly reinforce learning.

9.10 There is merit in exploring whether the resources and techniques used in the Healthy Eating Healthy Living pack and project are transferable to other lifestyle behaviours and health issues. To support smoking cessation education, for example, among many practical activities and aids, there is already a range of graphic visual models of the effects of smoking on the body, that work well with children and young people.

9.10 It would be important to explore whether the pack can be used or adapted for schools for children and young people with Additional Support Needs, further education colleges and also supported accommodation settings.

9.11 There are also valuable lessons for delivering the course to more highly functioning service users – or where there is a mix of abilities in one group - more able groups may respond to a greater focus on more cognitive exercises e.g. the health risks of too many less healthy foods or health benefits of healthier foods.

10. Recommendations:

- 10.1 In the light of the results and findings, the delivery of the materials should continue.
- 10.2 Dialogue with further education settings should take place to enable delivery on site or by outreach.
- 10.3 Supported accommodation providers should be made aware of the resources and staff trained to deliver the course.
- 10.4 The Elementary Food and Health Course for Carers of Adults with Learning Disabilities should be widely promoted and means of delivering it facilitated and resourced.
- 10.5 The dialogue among partner organisations involved so far should continue in some form to maintain the momentum gained.
- 10.6 Adaptations in pace or depth in which topics are covered may require to be altered according to the abilities of the group.
- 10.7 Carers should receive further information both through the Food and Health Course and further healthy recipes.
- 10.8 Discussion should take place with education to look at how this resource can be rolled out.

Appendix 1:

HEALTHY EATING SESSION EVALUATION



Healthy Eating Group Pilot site:

Date:.....

Topic.....

Week.....

Group Leader.....

It would be really helpful to have feedback from you on how each session goes. Could you complete the following short questionnaire immediately after the session and return to Carol Henry at Berryknowes.

1. Resources

Were all the resources you needed to run the session available i.e. Photos, Powerpoints etc? (please tick)

Yes No

- If No, what needs to be added

2. Written Information - was the written information easy to understand?

Very clear clear ok bit muddled not clear very unclear

What changes would you suggest?

3. Activities – Which activities worked well in your session?

What changes would you suggest?

Appendix 2 – Salt Quiz

Quiz Sheet

Tick the correct answer

1) What can happen if we eat too many salty foods?

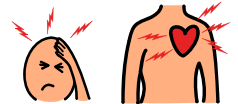
a) stroke



b) heart attack



c) both



2) Choose the?

a) Crisps with salt



b) Crisps with no salt



3) Which is healthiest for you?

a) salt



b) herbs



Table 1

Knowledge of service users pre and post

| Topic | Pre Topic Knowledge | Post Topic Knowledge |
|--------------|----------------------------|-----------------------------|
| Sugar | 40% | 76% |
| Fruit & Veg | 62% | 74% |
| Fat | 73% | 78% |
| Fibre | 51% | 80% |
| Salt | 48% | 80% |

Appendix 3

Flavour of weekly evaluations:

- **Sugar**

"the sugar sachets in cans of coke etc shocked the group and prompted lots of discussions about different drinks. Most people understood the amount of sugar due to the visualisation"

(An activity where the groups guess how many sachets of sugar are in foods and drinks)

"S has discovered a passion for dried-fruit snacks!"

What activities went well in your session?

"Games"

- **Fruit and Veg**

"All activities went well, but especially the touch, smell and taste"

What activities went well in your session? "Smelling session"

"Cutting up fruit, adding milk and yoghurt to make smoothies"

"Enjoyed preparing and cooking home-made pizza – this was definitely a hit!"

"Recapping sessions went well, especially what is a portion. Group related well to this aspect"

- **Salt**

"the group really enjoyed the salt topic and through discussion, were able to identify areas in their diet where salt could easily be reduced"

"placing (pictures of) foods on the flipchart, saying whether high or low in salt – went well"

- **Fat**

"All activities worked well—good mixture of practical and theory"

"Participants enjoyed group, our clients like information in personal files for reference"

"Mr Heart went down well. (animated powerpoint presentation).."

"Shopping session went well."

- **Fibre**

"everyone liked placing the pictures against symbols – responsibility of it"

"the taste and try session was everyone's favourite and it was really good to see people starting to talk about what they would add to their cereal to make it healthier"

"the light-bulb moment was the guys adding raisins to the Weetabix sample!! Fantastic!!"

- **Labelling**

"overall, everyone did very well. The visit to the supermarket was a success and everyone clearly identified the Green – Good, Red – Not Good and Amber as being in the middle"

"It is great to see the progress people have made and Sainsburys' own branding allowed people to put their learning into practice"

- **Healthy Bones**

"everyone was surprised about the sardines (being high in calcium) and enjoyed trying them in tomato sauce"

"This was a nice light topic to finish off with....."

....the group have thoroughly enjoyed working on the various topics....

...we hope to keep the group going until the Easter holidays"

Appendix 4: Start and end weights of clients participating:

Berryknowes/ Wedge

| Pilot Site | Client | Start weight(kg) | End weight(kg) | Gain / loss(kg) | Comment |
|------------|--------|------------------|----------------|-----------------|-------------------|
| | TC | 102.15 | 103.85 | +1.70 | |
| | AW | 104.85 | 105.95 | +1.10 | |
| | JB | 120.80 | 119.35 | - 1.45 | |
| | CP | 75.75 | 76.55 | + 0.80 | |
| | GW | 76.90 | 77.75 | + 0.85 | |
| | EW | 71.05 | 71.90 | + 0.85 | |
| | CJ | - | 74.4 | - | No initial weight |

Leverndale

| Pilot Site | Client name | Start weight(kg) | End weight(kg) | Gain / loss (kg) | Comment |
|------------|-------------|------------------|----------------|------------------|-----------------|
| | MC | 121.56 | 121.56 | 0 | |
| | DR | 83.01 | 83.01 | 0 | |
| | LM | 86.18 | 88.45 | + 2.27 | |
| | SJ | 85.28 | 94.35 | + 9.07 | |
| | NJ | 60.78 | 54.43 | - 6.35 | Had been unwell |
| | TR | 74.39 | 74.84 | + 0.45 | |
| | EJ | 81.18 | 79.83 | - 1.35 | |

Sense Scotland

| Pilot Site | Client name | Start weight(kg) | End weight(kg) | Gain / loss (kg) | Comment |
|------------|-------------|------------------|----------------|------------------|----------|
| | LY | 80kg | 87kg | +7.00 | |
| | MA | 47kg | - | - | off sick |

North Glasgow

| Pilot Site | Client name | Start weight(kg) | End weight (kg) | Gain / loss (kg) | Comment |
|---------------|-------------|------------------|-----------------|------------------|---------|
| North Glasgow | CD | 79.83 | 77.77kg | - 2.06 | |
| | CL | 79.83 | 84.37 | + 4.54 | |
| | FS | 82.1 | 83.01 | + 1.9 | |
| | AB | 56.7 | 54.89 | - 1.81 | |
| | AJ | 72.58kg | 69.6kg | - 2.98 | |
| | RR | 106.14 | 105.1 | - 1.04 | |

Thornliebank

| Pilot Site | Client name | Start weight | End weight | Gain / loss | Comment |
|------------|-------------|--------------|------------|-------------|---------|
| | WG | 57.2 | 56.6 | - 0.6 | |
| | BS | 69.0 | 67.9 | - 1.1 | |
| | DS | 61.0 | 63.7 | + 2.7 | |
| | PM | 90.5 | 90.6 | + 0.1 | |
| | SJ | 81.0 | 80.5 | - 0.5 | |
| | CS | 58.5 | 58.5 | 0 | |

Perth

| Pilot Site | Client name | Start weight | End weight | Gain / loss | Comment |
|------------|-------------|--------------|------------|-------------|---------|
| | ML | 101.6 | 107.5 | + 6.1 | |
| | RJ | 113.85 | 115.21 | + 1.36 | |
| | DK | 78.93 | 79.83kg | + 0.9 | |
| | RG | 76.2 | 73.94 | - 2.26 | |
| | MJ | 73.94 | 75.75 | + 1.81 | |
| | DC | 40.37 | 38.1 | - 2.27 | |
| | SR | 117.48 | 110.22 | - 7.26 | |

Notes

Out of 35 participants in the programme, 33 had weights recorded before and after the programme – pilot sites are to be commended.

Thirteen (39%) people lost weight, 3 people (9%) stayed the same and 17 (51%) people gained weight

Height may be difficult to record particularly in people with physical disabilities. Heights were not recorded, therefore the results do not indicate whether people were within the normal BMI range of 18.5 – 25 kg/m² or overweight or underweight at the start or end of the programme.

Appendix 5

Healthy Living Project Pre-course Focus Groups Questions

- 1. What do you think the people you are caring know about healthy eating?**
- 2. How much do you think they put into practice?**
- 3. What do you expect those you are caring for to get out of participating in the Healthy Eating / Healthy Living project. What are your expectations for them?**
- 4. What other changes / impacts do you think their participation might have?**

Thanks for your time and co-operation. I plan to re-convene and re-visit these questions after the pilot has run its course.

Appendix 6

RESOURCE CENTRE FOCUS GROUP SEPTEMBER 2010

F: What do you think the people you are caring for know already about healthy eating?

What would you say about people's knowledge already?

I think J has a reasonable idea, I don't think he could look at statistics on the back of a pack and work it out what that meant, but he knows what is good for you and what is bad for you. What would makes you fat, general things. J is quite good he won't sit and eat a whole bag of crisps. His carer is quite good - she goes and buys him fresh veg and meat. etc. In terms of J looking at a pack and looking salt levels he wouldn't know. I think that would be the difficult thing. They won't know about saturated fats. Reading a label would be difficult.

A. would never sit and eat rubbish. He may have one bag of crisps or one piece of chocolate.

N. likes his food from our habits at home, since being in his flat he did lose a bit of weight initially but I think that was down to portion sizes and the fact that he is walking to the centre every day. I don't think the temptation to go into the biscuit tin every night is the same as it was at home. I think he would know to cut the fat off meat, the difficulty would be for him to physically cut it off as his co-ordination is not great. His overall diet is reasonable, he would not know about the traffic light system or quantities.

The point for me would be how to support it. Assisting them with the difficulties i.e. analyse ingredient, cut fat off meat. Maybe include support workers at some point not to be involved *all* the time but at some point – maybe give warning if out of normal working time. The staff are good at the flats, and would be willing to come along and get involved.

The impression we have had of H, she tended to eat the same kind of things she knew what she liked. Now with the healthy eating she is experiencing new food. For someone you thought liked the same things – she was very receptive to try different things and she has been very engaged. I just want it to continue. Her review was the other day and it was mentioned then.

Will the course come with a pack they can take home?

F: There is a DVD and I will say a bit more about that at the end, week to week, there are photos taken, we could possibly send home copies of them. There are not a lot of things to take home on a weekly basis. What about things like recipes? We have set up individual folders for the people attending and we have put things like quizzes, recipes, leaflets etc in them.

I'm thinking of recipes they could take home and the carers could support them to cook them.

F: In the pack, there are five recipes people could take home. What is coming through is people are keen to get recipes to take home, some people may find themselves in a cooking role, maybe lost a partner and their son or daughter is at home.

The project has been developed so it is set out for people. We have to follow it, there is a specific outcome that you are looking for. We have come up with some suggestion that we would give feedback on. It is still a pilot, not set in tablets of stone. We ask for people's feedback every week. We want it to be as good as it can be.

The recipes are easy and simple and they are able to following. It is very hands-on.

It will be useful in terms of people's communication to see where they are at and the level the pack it pitched at. You have six different people there with different levels of understanding that will be useful feedback that will come through in the evidence. John would enjoy the challenge of telling me or his carers what was better for you, it makes him feel he is giving you information, you can tell by his emotions when he is telling you something that he is proud of his knowledge.

We have high hopes of the changes that people might see, ultimately, people's confidence and try new things not just "I did the course" and tick the boxes but internalising it and open to try new things after that.

It's not like collecting a certificate at the end of it and saying "I've done that"- it is an ongoing thing that could be life changing.

I think the certificate is good for my brother because he likes getting things like that, he feels important. He likes the appraisal.

If people didn't like it they would be voting with their feet, they have a choice to attend but when they keep coming it is a sign that they are enjoying it.

N has been doing bits and pieces of cooking since he moved into the flat so this course is helping him, he seems to enjoy it.

J likes his independence, throughout our childhood my mum always made things from scratch home cooking all the time, never any ready-made meals. John would eat everything off his plate but then go down to my gran's who had a huge biscuit tin and he would sit in front of the TV with it and she would be like "on you go, son" – she didn't know any different, she just wanted him to be happy. He would put on weight and my mum would be like, there was always this imbalance. Now he doesn't make his own food, it is mostly ready meals, although now his carer is buying things meat and pork chops and he is enjoying it and it's like when mum used to cook for us, mashed potatoes. I think something like this he will enjoy because it is food he has liked in the past, it is his opportunity to do it for himself.

I don't know if he could work with cookers? – we cover that at the beginning in our risk assessment - we make sure that knives, cookers, hot water etc. that there is good safety in place. J would always be supported to cook and it sounds that carers are taking his lead and cooking meat etc. That would be our expectation that carers

would support people to cook rather than have ready meals. The carers wouldn't let them take something hot out the oven. The care package covers that, there is always someone there at mealtimes.

Sometimes it is easier to cook for people rather than support them to cook themselves, that is why an initiative like this is good because they are able to take the lead and have some control.

My brother gets his meals made through the week, it is just the weekend. I will phone him and ask him do you want a pizza or Chinese carryout - maybe that is wrong of me for promoting bad health? I think treats are ok.

H doesn't like burgers, he likes meat, his treat would be a Chinese carry out. I make my own. I don't see anything wrong with that, everyone needs a treat.

F: What are your expectations for the people your care for?

I think that they learn the right things at the supermarket, not picking up things that are full of fat, learning how to read what is there. Becoming more forthright about what they want. Making informed choices – the right ones. Variety of food is important and understanding what is in that food. Choice - not having the same thing.

It is like pasta you I always thought it was good for you but I found it is all carbohydrates. It's not the great thing you thought. It is something you don't have every night, but in moderation it is ok.

Salt intake – you have to have it, not all but in moderation. I could not take homemade soup without salt. I do cook using salt.

All these different type of milks that are available – me and my family are on the red milk (semi-skimmed). I never thought I would do that!

A lot of us went from full fat to semi skimmed, but it is only 2% fat. The red is 1% if you are only having milk in your tea and cereal, the amount of fat you absorb is minimal.

F: Have you any other expectations?

The value of eating food, what they are going to gain from eating the right foods. Explain why it is good for them. Five fruit and veg a day what does that constitute? We have a big thing the size of a table cloth – an eat well plate, it is divided into portions according to the amount of food stuff you should eat from each food group. There is quite a lot of time spend on what is a portion.

We are inclined to eat big portions in Scotland. I put (*on the plate*) what I think is a portion.

The message is eat a colourful diet, soft fruits, like blueberries, raspberries; root veg is good for you, a variety of all within your five a day. Orange juice is not the best thing for you, squeeze your own, it (packet orange) is all sugar.

What do you think of the mixed veg juice like V8? I think it is handy to have in the cupboard.

A lot of people don't have 5 a day. I think a lot of people don't know what constitutes your five.

F: What changes do you think you might see overall as a result of there participation?

If my brother went bowling, the eating facilities they have is a burger, hot dogs, chips, he would be inclined to eat that, even if he came through your programme and knew what was what he would still have it. I think they would learn from what they are being told that it is just a treat. As long as they are not eating fat foods all the time.

V would like his fish and chips.

We are trying to discourage that here, there are a lot of packed lunches now. There is also the cost issue around the affordability of fast food - it is cheaper than other food. We are trying to promote healthy eating as much as possible hopefully people will take something from it.

F: I think you are doing a lot, what happens for lunchtime?

You tend to eat what is available, I am guilty of that. If the food here is healthier then that is good for me.

We are trying the packed lunch approach, when we are going to venues we arrange rooms to eat in and the food is being cooked here.

When N was at college they took a packed lunch.

I don't think you can stick to a strict food regime all the time.

F: Anything else about what changes you think you will see?

Within themselves I don't think there will be a great change, I think you will see a difference in their attitude towards what you are giving them. I would hope they have learned something about food. I think they will have confidence to say what they want. Participation levels and co-operation might be better.

It is typical that they are likely to listen to someone else other than their mother or father.

It is interesting when the shoe is on the other foot and you are the parent.

Anything else?

A positive lasting impact I think, I would hope so.

Knowledge and attitude.

It is crucial that carers are involved. If you could give me something to give to him.

We will pass things onto them.

Staff: We want it to be a useful exercise as I would like it to be something we carry on with. For participation level and focus it is not the tokenistic group where people make food and eat it all, it is all broken down, there is real purpose, the structure is there and we can use that foundation as a springboard to continue it. The demand seems to be there. People usually need to be given the message over again to remind them.

Staff: A few people have been asking can we do it again. But we have been saying well other people need to have a chance to do it.

We have the materials now - we could do a refresher course.

The tools have been given to us but I think it works better with yourselves being involved it gives it more credibility and allows us to link in with dieticians. It is good to have deadlines to work towards. Accountability.

We will use it for our inspection as evidence of things we are doing.

F: The funding we have to run is from Scottish Government until March we have to report back to them and explain how we have used the money, how it has worked and what we have achieved. We want to use what we have achieved that there is a need for more money to take it further and work with people like Cosgrove.

I think carers need to know this sort of thing as well.

The contrast with my Dad he has dementia, and has a carer - all they do is take a ready meal from the freezer, heat it and leave it, don't wait and see if he has eaten it. Quite often I go in and he hasn't eaten it and it has gone cold.

You should maybe speak to your Doctor about meals on wheels about. Maybe twice a week.

I made him homemade soup one day and he gave it to the dog.

A pity you couldn't take your Dad round to your brother's for dinner.

F: Thank you very much for all that.

Appendix 7

Healthy Living Project Post Pack Focus Groups Questions

1. What do you think the people you are caring for know NOW about healthy eating?

Sugar?

Fat?

Fruit and Veg?

Fibre?

Salt?

Healthy Bones?

Food Labelling?

2. How much do you think the service-users are putting their learning into practice?
3. Is it rubbing off at home?? What has changed?
4. What do you expect those you are caring have got out of participating in the Healthy Eating / Healthy Living project?
5. If you cast your mind back to last summer, would you say that their experience has matched your expectations for them?
6. What other changes / impacts do you think their participation has had?

Thanks for your time, thoughts and reflections!

Appendix 8

Post-course Focus Group

March 2011

F: Good afternoon! We're back again to talk about people's experience of the course.
N has a big operation on tummy
D has lost a stone.

F: What do you think people learned about Sugar?

Group member: You can take too much sugar.

Carer: N doesn't take it.

I'm not too convinced that E has taken it too heart.

E. now does a lot of baking this involves a lot of sugar. Enjoys baking – thinks you need sugar.

Baking is a new thing since starting the course. Could healthy baking recipes be developed at the Centre?

It was good when E learned about different flavourings instead of sugar.

M took on board lots of theory, the practice was quite good already.

M put in a lot of work. He didn't gain weight. I have acquired a taste for no sugar.

Fat

Carer: I use flora. No fried eggs, chips, no sausages.

We use sunflower cooking oil.

E: I like an omelette – Low-fat cheese.

N – traffic light system – we eat a lot of green now. Less red.

Watercress soup, poached pear.

Home-made bread.

E and her Dad made bread – it was tough! (Cheese Loaf)

Worked well when we used the right flour.

Different kinds of baking.

Fruity bacon grills a big hit. E made the macaroni and tomato sauce.
Staff – Fruity bacon grills works perfectly. We cut the fat off the bacon – it weighed 100g out of 400g.

Y – cooks the chicken without fat, just water.

Made a fruity bacon grill, cut the fat off. After cooking an egg, places it on a piece of kitchen towel.

M microwaves his eggs.

There is a surface that you can fry an egg with no fat. It worked ok.

Good habits have been re-enforced.

Fruit & Veg

People liked putting your hand in the shredded paper, guessed by the feel – juicy/smooth

Broccoli was a strange one.

Kiwi

Pineapple – jaggy

Did quick pizza

We looked up the top ten exotic fruits – including dragon-fruit, like kiwi in appearance. Bright pink flesh – absolutely beautiful, but tasted slimy!

Smoothies were a big hit.

It was good for staff too, to look for something different.

F: Has anyone been buying more fruit and veg?

Carers: We now get kiwi, water-melon that we didn't used to buy.

Carer: N loves when he's made something himself. Eats lots of new things. N has tried lots new things too since the course started would now opt for a fruit dessert rather than say crumble or custard.

"M eats more fruit at home – bananas.... T like lychees... N eventually tried them and liked them!"

Y likes them too.

"We got thru more bananas than they do in Edinburgh Zoo!"

"Liked how we could add in more fruit and veg. to diet e.g. banana on cereal, glass of orange."

I'd like more about cooking pears – they're often under-ripe. Tried a poached pear recipe, with a raspberry coulis.

M and N liked the cottage cheese.

F: What do people say about Fibre?

"We get it from skins of Fruit and Veg. More fibre in brown rolls, brown rice, wholemeal pasta".

"Didn't now that skin of baked potato had fibre so now I eat the skin. Diet high in fibre fills you up".

Cereals – Weetabix

Others have Weetabix

Wholewheat cous cous

Salt

Carer: Our family have a history of high blood pressure.

Staff: What alternatives to salt did we use?

Group: Pepper, basil, corriander, herbs, onions garlic. Didn't use spices a lot paprika could be used.

Staff – I don't add it now to veg or potatoes. I just add pepper. Just add pepper to my poached egg.

Healthy Bones

Vitamin C, Vitamin D – helps absorption of calcium.

Milk is good for healthy bones. Sardines, Mackerel dip – mixed in soft cheese, some lemon juice.

Need healthy bones to sit up straight.

Staff: Could you keep up walking if you broke a leg – no.

Group: You'd get a broken leg put in a plaster or a sling.

Food labelling

Staff: This is confusing for all of us.

Carer: I looked at a ready meal from Asda.

Carer: These percentages didn't add up.

F: These were percentages of your RDAs?

Calories, fat, Sugar, Salt are all different M&S, Asda, Sainsburys, Co-op use traffic light system.

E is looking at labels more, her Dad agreed.

M and his mum look at the labels. T – still got caught eating a bacon roll!

Staff: I now use less salt it to get the other flavours. I've learned a lot myself going through it. I'm surprised how much I've got out of it.

Let's have more recipes – give it marks out of 10 or stars.

One community facilitator does fitness fives.

I didn't like the filming in the morning.

F: What was your favourite bit about the course?

Y: "I liked all the course" "My favourite was the poached eggs!"

N- "Very best bit was making macaroni cheese".

E: "The course has helped me make choose good options. I love the cooking". E

N's favourite bit was the cooking.

M's favourite bit was the eating.

T's favourite bit was the eating.

E is a lot more confident in cooking, wants to try more, but an over-reliance on sugar in backing. She makes sponge cakes.

Staff: Everyone's participated today in the group. This makes things real and memorable for people – they'd be keen to be in this group again.

F: What would you say to other service users?

"Try it out - you'd enjoy it!"

That was unanimous.

Appendix 9

Healthy Living Project – Questionnaire for Carers

Now that the Healthy Eating Healthy Living course has ended, officially anyway, I am very keen to get your views on the effects you think it is having and continuing to have on the person you care for.

- 1. What do you think the people you are caring for know about healthy eating now that they have completed the course?**

E.g., what do they know or tell you about the following and what has changed, regarding what they like to eat, drink at home and out and about:

Sugar

Fat

Fruit and Veg

Fibre

Salt

Healthy Bones

Food Labelling

- 2. How much do you think the service-users are putting their learning into practice?**

- 3. Is it rubbing off at home? What has changed at home?**

4. **What do you think those you are caring have got out of participating in the Healthy Eating / Healthy Living project?**

5. **If you cast your mind back to last summer, when the Project started, would you say that their experience has matched your expectations for them?**

6. **What other changes / impacts do you think their participation has had?**

7. **Has it caused you to think about food choices at home and how these could be healthier?**

8. **What changes if any, have you made?**

9. **What further help do you think you need to make the changes you would like to eat more healthily?**

A DVD about Fat, Sugar and Fruit and Vegetables is being made across the six pilot sites that have take part in this project and you will receive a copy of it to keep, in due course. I hope that you will like it!

Thank you very much for your time, thoughts and reflections!

Please return this form to Summerston Resource Centre, Glenbervie Place, Summerston.

**Dorothy Morrison
Health Living Project Lead**

Appendix 10 Observations you have of the impact on service users

- Loved the group, very positive about it, character building showed more confidence, encouraged initiating conversation, genuine interest in activities.
- Some service users have made big changes to their eating habits and commitment to exercise.
- Out of the group of guys in our pilot there are a couple that have a definite higher level of awareness about what they are eating and drinking and have incorporated it into their lives.
- Increased awareness of their own health and choices they can make themselves.
- Enjoyed learning and letting others know what they had learned.
- Able to share what they had learned with family and staff.
- Our service users are more aware of their health and choosing the healthier option at lunchtime.
- At times you hear the service users advising their friends at the centre at lunchtime i.e. too much salt is bad for you.
- More aware of the "traffic light" system.
- Alternatives to sugar, (good understanding).
- Alternatives to salt.
- How to include more fruit and veg into their daily diet.
- Loss of weight.
- I have witnessed service users having greater confidence to explore and question their diet choices and to be empowered to challenge their service providers/carers/parents on how they are involved or not in how they control their diets.
- Service users seem to enjoy the groups.
- All group members are happy to continue with the format into the next year. This will give us the opportunity to adapt certain areas. Service users have been very positive about their experience. Confident and forthcoming with ideas.

Anything else you would like to say?

- We feel that having a food support worker on hand to advise and support us throughout the course has been very beneficial.
- Look at the people who can read – this will incorporate many different client groups. Visual communication is the way forward - link to Big Plus?
- Fantastic piece of work after first thinking it was a huge input i.e. the 28 weeks – feel that the repetition is important and works.
- Think this has been a great learning curve. The DVD was very successful at our recent Open Day/Coffee morning. All staff have worked well together to make the pilot scheme work. Will take the momentum from this and maintain in the area and hopefully in others.

Managers' observations of the Champions

- Staff are keen to make a difference and really want service users to achieve their individual goals.
- I feel that the champions have shown high levels of motivation and commitment to the pilot scheme. During the winter period we experienced some difficulties and challenges that we managed to overcome.
- Champions benefit from focus of group. Having structure gives them the opportunity to look at their practice, reflect and adapt.
- Staff are more knowledgeable in all aspects of Healthy Eating.
- Staff are more confident in their role.
- I have noticed that staff are really organised and working well as a team.
- Enthusiastic
- Increased own knowledge
- Took ownership and responsibility
- Enjoyed chance to develop service users.
- Staff are motivated and very keen to continue this project and are looking at ways to incorporate this into their group.
- Champions have increased in confidence as the weeks progressed and take it all seriously.

Champions' observations in their own practice

- I have learnt a lot from this project about what goes into food that never even entered into my thinking before. I now find myself looking at labels almost absent mindedly and being very aware of what I am eating.
- I now use alternative flavourings rather than salt.
- More aware of the "traffic light" system.
- I am more aware of my own cooking practice, grilling rather than frying, poaching etc.
- Different ways of educating service users.
- To keep aware of changes in the food industry
- To encourage more discussion about health issues with service users.
- To challenge in supportive manner service users level of responsibility over their own diets.
- Gained confidence for delivering the pack in the future.
- Really enjoyed project. Surprised at the level of understanding the group members developed. Adaptability and looking forward to each section/day.

ALL

Plans/ideas/next steps in own pilots

- We plan to continue with the pack and run it for another 28 weeks. During this time we will look at modifying if required in certain areas.
- To feed the topics into independent living skills group and health groups.
- Increase family/carer participation especially for service users with complex needs.
- To hopefully roll this project out to another group of service users within Kinnoull Day opportunities.
- More visual aids like sugar sachets, salt sachets, fat to allow people to relate to amounts.
- Develop personalised communication to enable more people to take part.
- Looking forward to going through the pack again with a different group of service users and especially having done it one, it won't have the same extra pressures of the pilot.
- At Summerston we have finished the pack and are currently keeping the group together and we are using the time each week to recap over what we have already done. We have also included a practical cooking session. In which we discuss a menu plan for a 3 course meal to coincide with the main objectives from the pack.
- To focus on delivering the pack to more services users with different needs and abilities. Adapting the content appropriately.
- To encourage more discussion on food labelling/labelling styles in order to promote more active thinking in decision making when food buying.

Appendix 11 Healthy Eating Healthy Living Case Studies.

11.1 Healthy Eating Healthy Living

Case study framework

Please cover the following details:

- 1. Gender, age and ability of person you have chosen to feature as a case study – please say something about their particular needs and issues, while maintaining confidentiality obviously**
- 2. Does he / she live independently or with carers / family or some other arrangement?**
- 3. Why was he / she selected / invited to be part of the pilot group in your area?**
- 4. What are your observations of what he/she has got out of being a participant in the pilot around:**
 - a) Knowledge about food and drink choices**
 - b) Attitudes towards food and drink choices, including trying out new foods and drinks**
 - c) Actual foods and drinks chosen**
- 5. Please say something about the other impacts attending the course and working through it have had on the person**

This might include aspects like more:

- confidence
 - willingness to try other new activities
 - more keen to do more exercise
 - actually doing more exercise – what types
 - changes in mood well-being
- 6. Please describe any other points of note that you feel could be attributed to the project**

11.2. Case Study 1

For the purpose of this case study the service user who is involved would like to be called Bet Lynch.

Bet Lynch is a 53-year-old woman who has a mild learning disability who lives at home with her mum. Due to her mum's deteriorating health and Bet's desire to be as independent as possible, she receives 20 hours of support per week from a support agency.

Bet attends a day centre 4 days per week, where she is involved in various activities including accessing a Further Educational college course. Outwith the centre Bet has 2 part time voluntary jobs, both within her local area.

As stated previously Bet wants to lead as independent a life as possible and makes full use of the supports around her to do so. Within day services, Bet appears keen to make her own choices although sometimes she will seek support and re-assurance from her key worker or her peers.

Her body language is very positive which usually leads others to assume that she understands what is being discussed; those that know Bet believe this is not always the case and that she will often just agree with what is being said. However when Bet is questioned she is unable to provide much detail about the conversation.

Bet leads an active lifestyle out with the centre as she now receives evening and weekend support; she attends a ladies evening at her local sports centre and enjoys using all the facilities including swimming, sauna and working out at the gym. Within the day centre Bet participates well in various group activities which involve a level of fitness such as soft games, belly dancing, Wii Fit, badminton and walking groups.

Bet has been actively trying to lose weight for many years and in the past she often spoke about her mum constantly telling her to go on a diet. Bet would often tell her peers that she was " on a diet " but would actually opt for an unhealthy lunch or snack rather than a healthier option and would often ignore advice regarding this.

After a discussion, Bet was invited to join the HLP, as it was felt it would be beneficial for her to have an opportunity to learn about healthy living. Bet has been assessed as finding it hard to retain new or complex information, understanding basic, simple step instructions, which is routinely repeated to her, this is the way the pack would be delivered.

Members of staff, and her family have commented that Bet's general mood appears has become more positive since starting the HLP and she has become more confident within herself.

When asked Bet states that the knowledge and practical skills that she had learned from the group have benefited her in the day centre and at home. The pack has also helped her to look at healthier choices when out for meals and when purchasing provisions for the house:

2 evenings a week she leaves from the centre and goes shopping to purchase her evening meal and prepare it when she goes home, the knowledge she has learned

from the HLP has helped her to be aware of which is the healthier options and now buys more fruit and vegetables and now is looking at labelling with support.

While in the centre Bet has stopped all fizzy drinks and only drinks water, she chooses the healthier option at lunch time as well as being very vocal in advising other service users of what they should be eating and what food contains, e.g high in sugar or salt.

Overall it appears that the HLP has been a great opportunity for Bet and has come at a good time in her life as she is preparing for the future in the event of her living independently.

11.3. Case study 2

Mr X is a 38-year-old man with an intellectual disability. Mr X lives within a secure environment as he exhibits behaviours deemed a risk to the public. Mr X requires constant assistance and support from nursing staff on a day-to-day basis, as he often has difficulties with carrying out simple tasks and informed decision-making. Mr X has reasonable general health, although he is clinically obese and this causes him some difficulties with completing day-to-day activities. Mr X also lacks insight/knowledge into the health issues/risks surrounding obesity. Therefore, these are the reasons why we invited Mr X to be part of the pilot group.

Through my own observation (staff nurse), Mr X thoroughly enjoyed the healthy living groups. He has shown an increased knowledge of 5-a-day and has tried to incorporate more fruit and vegetables within his diet. Mr X acknowledges his need to improve his diet and to lose weight and is trying to limit his intake of unhealthy foods, however he continues to struggle with this at times and he does continue to overeat. Mr X has shown other signs of trying to improve his diet by swapping high sugar snacks for low-sugar snacks.

Mr X's has become more confident in trying healthier foods. He is also keen to exercise by walking and playing the Nintendo WI, which is often positive in relation to his mood and behaviour.

11.4. Case Study 3

G. is a 57 year old man with a moderate learning disability, a fairly reserved demeanour and a keen sense of humour which is sometimes more apparent at home than at the centre. His blood pressure is monitored regularly as it has been high in the past and this is part of the reason he initially joined the Healthy Living Pilot Project. Aside from this, his family have always been very keen to encourage G. to follow a healthy eating regime.

G. has lived in supported accommodation for several years but still has regular contact with his family, most significantly his mother and brother who keep in regular contact with staff at home, particularly in relation to diet. G. always brings a packed

lunch so there are few opportunities at the centre to see what sorts of foods G. would choose although residential staff have stated that he usually asks for fruit to be included.

One chance that day centre staff do have to observe G.'s food choices is when he goes on an all day outing. On the whole, when in a restaurant, he will choose something healthy such as a Caesar salad. There are rare occasions when the group have stopped off for fish and chips and this has caused confusion. G. does not always relay accurately to his family what he has eaten, sometimes causing them to think his diet is worse than it is, i.e. he tells them he's had fish and chips when, in fact, it's been something quite healthy.

Further to G.'s eating and shopping choices at home, it has been noted that G. has often chosen a healthy option even when other residents around him are having a high fat meal. Staff have also commented that when on supermarket trips G. will often point to items and say, "That's healthy". These would include foods such as fruit and chicken so this proves that G. is clearly focussing on dietary issues.

Since the conclusion of the Healthy Living Group sessions a small number of participants have continued to take part in healthy cookery sessions. During these sessions there are regular references to some of the main messages from the course and it is positive that with a little prompting, G can respond appropriately. Questions might include "Can you point to the foods on the table which would count towards our 5 a day?" or "Which bread is better for us, brown or white?"

As far as exercise is concerned, G. has always been quite willing to take part in certain types of moderate exercise, for example hill walking, line dancing etc. and this has remained true.

As with exercise, the promotion of healthy eating has been an issue for such a long time that it is unfortunately quite difficult to discern which habits have come about as a result of the project and which have been instilled over past years although recollection of specific messages is likely to have been learned from the course work. Overall, the course has been very appropriate to G.'s needs and abilities.

11.5 Case Study 4

D is a 45 year single man who has mild learning disabilities. He currently lives independently in his own flat within Perth. D has two sisters who pop into see him weekly.

D receives no additional support from social services. However it has been identified that additional support is required to maintain his home to a safe and hygienic standard.

D suffers from an on going ankle injury in his left ankle and carrying excess weight exacerbates to this. D possess basic/reading/writing skills, so would benefit from learning about label recognition within the traffic light system to enable him to distinguish healthy foods from foods which are high in fat, salt, sugar etc.

Having observed D's diet while he has been accessing Kinnoull Day Opportunities, it mainly consists of pies, pastries, pot noodles etc and very little fresh fruit and vegetables. His sisters highlighted that they were concerned about the food he was cooking e.g. the mince was still pink when he was about to serve it. D is receptive to support and guidance within this area.

D was initially selected for this pilot as he sadly recently just lost his mother with whom he lived. D was responsible for cooking meals and keeping the house at an acceptable level of cleanliness. Initial assessment performed by the social work assistant indicated that D would benefit from attending any appropriate training programmes relating to living skills and healthy eating. It also indicated that D possessed basic meal preparation skills and would benefit from support and assistance to develop these, the evaluation went on to detail that D plans his own menus but tends to eat "fatty" foods and would benefit from advice and education following a healthy diet and the positive effects it would offer him.

Through my observation of D participating in the pilot project he is receptive to support and guidance while attending Kinnoull Day Opportunities but may suffer difficulty implementing this practice whilst at home and in the community. D retains information well and works competently while part of the group. While in the local supermarket he distinguishes healthy foods from unhealthy foods. It is evident from the lunches that D brings into the centre that they are not always nutritious; convenience foods feature e.g. bought sandwiches, pastries, pot noodles, fizzy juice etc.

D possesses a reasonable knowledge with regards to food and drink choices and with further support, I am sure this would improve. He is always willing to try new foods and is particularly receptive to fruit and vegetables and homemade meals e.g. soup, smoothies etc. As previously mentioned, D distinguishes healthy foods from non healthy foods.

With regards to other impacts this pilot has had on D's life I would like to think the he has become more confident within himself and is more willing to try different foods and ask advice on foods. He walks everywhere so he is always keen to exercise.

D is a kind and usually happy guy, so I think it would be difficult to say whether participating in the pilot has changed his moods, however I believe that by participating and working through each module within the pilot and as D has gained confidence and developed his knowledge and skills, this has led to an improvement in his all round well being.

To conclude I would like to say that D has recently benefitted from being part of this group, from the social aspect and also from the educational viewpoint. I think this is evident from the weight charts that were filled in on a weekly basis that he put some of the education he learned into practice!! D lost 7.26kg (1 stone) So, well done!

11.6. Case Study 5

D.S. is a 59 yr old woman with Cerebral Palsy & a learning disability. She has good mobility when supported to use her walking frame & self-propels her wheelchair in all other instances. She has some communication difficulties but is able to articulate her needs well. She lives with one another woman in an accessible home in the outskirts of Glasgow. Her home support is delivered by a local care provider. D. was considered to be a candidate for the project due to a number of factors:

1. Her ability to absorb the course material.
2. She has a reluctance to broaden her diet; often eating the same meals day after day.
3. That participation in the project may improve her confidence to try new things such as speaking out in group settings, changing her dietary habits & give her the knowledge to be empowered to take more control of how her diet is managed.

D was observed throughout the project's duration to have an already good understanding of dietary health matters but we found that by exploring the individual topics, her overall understanding improved. Her reluctance to try new foods during the food taster sessions persisted at first, but with some gentle encouragement from staff & the other participants; she did try things that she'd have never eaten before. D does not like milk. She is very clear about this. She did however, try a fruit smoothie & found it to taste 'ok'. She also found dates and a few other dried fruits to be tasty despite her initial hesitance to try them. Cottage cheese, rice cakes & a whole host of fresh fruit were also sampled by her & given the nod of approval.

We enjoyed working with D as she seemed to enjoy being a part of the project & as her confidence grew, her level of participation increased. She also brought a lot of humour to the sessions which was good to see as historically, she'd prefer not to interact in group settings. Following the accompanying exercise DVD was a good tool for her to get involved & we shared a few laughs doing so!

Table 2 : Mental Health and Well-being - Pre- and Post-project

| Pre | Th bank | | | Perth | | | North | | | Sense | | | Levdale | | | Bknowes/wedge | | |
|---|---------|-----------|-------|-------|-----------|-------|-------|-----------|-------|-------|-----------|-------|---------|-----------|-------|---------------|-----------|-------|
| | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot |
| 1. I've been feeling relaxed | | | 6 | | | 6 | | 2 | 4 | | | 2 | | 3 | 4 | | 2 | 5 |
| 2. I enjoy my meals | | | 6 | | | 6 | 1 | 4 | 1 | | | 2 | | 1 | 6 | | | 7 |
| 3. I've been feeling fit and healthy | | | 6 | | 3 | 3 | 1 | 1 | 3 | | | 2 | | 3 | 4 | | 3 | 4 |
| 4. I like to exercise such as going out for a walk, going to the leisure centre | | | 6 | | 3 | 3 | 1 | 2 | 3 | | 1 | 1 | | 1 | 6 | | 5 | 2 |
| 5. I've been feeling confident about trying new things | | 1 | 5 | | 3 | 3 | 1 | 4 | 1 | | 1 | 1 | | 2 | 5 | 2 | 1 | 4 |
| 6. I've been making choices about what I eat | | 1 | 5 | | 2 | 4 | | 3 | 3 | | | 2 | | 5 | 2 | 1 | 5 | 1 |
| 7. I've been feeling happy | | | 6 | | 1 | 5 | 1 | 2 | 3 | | | 2 | | 1 | 6 | | 2 | 5 |
| Total | 0 | 2 | 40 | 0 | 12 | 30 | 5 | 18 | 18 | 0 | 2 | 12 | 0 | 16 | 33 | 3 | 18 | 28 |

| Post | Th bank | | | Perth | | | North | | | Sense | | | Levdale | | | Bknowes/Wedge | | |
|---|---------|-----------|-------|-------|-----------|-------|-------|-----------|-------|-------|-----------|-------|---------|-----------|-------|---------------|-----------|-------|
| | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot | No | A wee bit | A lot |
| 1. I've been feeling relaxed | | | 6 | | 1 | 3 | | 1 | 5 | | | | | 4 | 3 | | | 7 |
| 2. I enjoy my meals | | | 6 | | | 4 | | | 6 | | | | | 4 | 3 | | 1 | 6 |
| 4. I've been feeling fit and healthy | | | 6 | 1 | 1 | 2 | | 1 | 5 | | | | | 5 | 2 | | 1 | 6 |
| 4. I like to exercise such as going out for a walk, going to the leisure centre | | | 6 | | | 4 | | 2 | 4 | | | | | 1 | 6 | | 3 | 4 |
| 5. I've been feeling confident about trying new things | | 1 | 5 | | 1 | 3 | | 3 | 3 | | | | 1 | 2 | 4 | | 5 | 2 |
| 6. I've been making choices about what I eat | | 1 | 5 | | 1 | 3 | | 3 | 3 | | | | | 3 | 4 | 1 | 4 | 2 |
| 7. I've been feeling happy | | | 6 | | | 4 | | 1 | 5 | | | | | 3 | 4 | | 1 | 6 |
| Total | 0 | 2 | 40 | 1 | 4 | 23 | 0 | 11 | 31 | - | - | - | 1 | 22 | 26 | 1 | 15 | 33 |

NB Information for four service users is incomplete.