UNDERSTANDING THE BARRIERS TO, AND IMPACT OF, MEN'S ENGAGEMENT IN PHYSICAL ACTIVITY AND HEALTH RELATED BEHAVIOURS: AN EXAMINATION OF AN ENGLISH PREMIER LEAGUE FOOTBALL IN THE COMMUNITY MEN'S HEALTH PROGRAMME

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"Sport has the power to change the world. It has the power to inspire. It has the power to unite people, in a way that little else does."

(Nelson Mandela, 2000)

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Declaration

I declare that the work contained in this thesis is entirely my own. Some of the work has been submitted to academic journals and presented at regional, National, European and International conferences and are listed below:

Curran, K. (2013) Corporate Social Responsibility in Professional Football Clubs: A case study of Everton Football Club. Sport and Social Responsibility conference, Portadown, Northern Ireland. 6th September 2013. ORAL.

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Abstract

This thesis outlines research undertaken by formal collaboration between Everton Football Club's Football in the Community (FitC) scheme; Everton in the Community (EitC) and Liverpool John Moores University, School of Sport and Exercise Sciences.

In recent years, there has been recognition of the influence that English Premier League (EPL) football clubs can have in attracting men to physical activity and health engagement programmes. Despite attempts to align FitC programmes with suitable evaluation procedures, there still remains limited evaluative empirical evidence.

Study 1 adopted ethnographic principles to explore the effectiveness of, and identify the barriers to, promoting positive health behaviours and messages to male football fans at an EPL football stadium on match days. Results showed that in general, men did not wish to engage in health related behaviours on match days however approaches that did not impose on, nor contaminate, the men's match day experience were more successful.

Study 2 adopted a multi-method approach to explore the distinct barriers that hard-to-reach (HTR) male populations encounter when attempting to commit to regular participation in physical activity and health behaviours and to examine the impact of engaging in a 12 week FitC intervention. Economic, environmental and social barriers to engagement in regular physical activity and positive health behaviours are highlighted and specific biopsychosocial effects of engaging in the FitC programme are identified.

Study 3 utilised informal semi structured interviews with programme participants to explore the contextual, environmental and psychosocial barriers experienced by men from HTR populations. Psychosocial motivations for programme uptake and the impact of regular engagement in the FitC men's health programme are discussed.

It is recommended that commissioning agencies should endorse and fund men's health initiatives delivered in and by professional sports clubs. To maintain participant engagement and maximise improvements to men's health and wellbeing, alterations to current practice and research are discussed.

Acknowledgements

A former student once wrote "completing a PhD is like running a marathon", and I have to say, I rather agree. Thankfully, there was a lot less physical pain (and vomiting!!) during the completion of this marathon than during my actual marathon effort, but there have been many similarities. During both 'marathons' I experienced the feeling of flying, the feeling of plodding and the feeling of being well and truly stuck to the spot. So too did I experience the emotion of excitement followed by exhaustion and the feeling of utter relief and personal satisfaction when the finishing line was eventually crossed. Another similarity lies in the number of people I came to lean on, and in some cases, *depend* on, for support during the journey. There are a number of people whom I wish to sincerely thank, as without them, I would not have been successful in finishing this marathon.

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"Paradigms? Oh yeah! I used to eat those for breakfast when I was a kid."

(Mark Curran, 2010)

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Chapter One:

Introduction

"He who enjoys good health is rich, though he knows it not."

(Italian Proverb)

1.1 Chapter Overview

This chapter provides a basis for the research aim and objectives. The chapter opens by clarifying the definitions, and outlining the current trends, of physical activity for health amongst UK adult populations. The review then examines the current status of men's health in the UK, followed by an exploration into the barriers associated with men's engagement in physical activity and positive health related behaviours. Explicit evidence concerning hard-to-reach groups is presented. Next the review examines the role of sport as a vehicle for addressing social issues. The review then presents the position of 'Football in the Community' schemes and the paralleled health agenda, within English Premier League football clubs. An examination of the evidence related to the effectiveness of community football schemes is then presented. Chapter one then closes with a description of the research project, a health profile of the target area and an overview of the author's operational role within a Football in the Community scheme during this research period, before concluding with the aims, objectives and structure of the research.

1.2 Physical Activity and Health

Physical activity has been defined as, *"...any bodily movement produced by skeletal muscles which results in energy expenditure above resting level"* (Caspersen et al., 1985, p126) and includes *"...the full range of human movement, from competitive sport and exercise to active hobbies, walking and cycling or activities of daily living"* (Department of Health (DH), 2004, p81). Engagement in regular physical activity has a positive influence on a person's health (DH, 2011). Health has been defined as "a

state of complete physical, mental and social wellbeing and not merely in the absence of disease or infirmity" (World Health Organization (WHO), 1948, p100).

Non-communicable diseases (NCDs) and physical inactivity are leading causes of premature death across the world (WHO, 2004). Non-communicable diseases (also known as chronic diseases) refer to diseases that are not passed from person to person; they are of long duration and generally slow and progressive. The four main types of non-communicable diseases are cardiovascular diseases, cancers, chronic respiratory diseases and diabetes (WHO, 2011). Non-communicable diseases can often be avoided by modifying certain behavioural risk factors. Tobacco use, unhealthy diets, the harmful use of alcohol and physical inactivity are all examples of lifestyle related behaviours which increase the risk of, or cause, most NCDs (WHO, 2011). According to the World Health Organization (2011), tobacco use accounts for almost six million deaths in the world every year, approximately 1.7 million deaths are attributable to low fruit and vegetable consumption and half of all annual deaths from harmful drinking are caused by NCDs. Furthermore, approximately 3.2 million deaths annually can be attributed to insufficient engagement in physical activity (WHO, 2011).

Engaging in regular physical activity can reduce premature death, decrease the risk of non-communicable disease and improve psychological wellbeing[1] (DH, 2004; Chief Medical Officer (CMO), 2011). In 2011, Professor Dame Sally Davies (CMO for England) co-authored the *Start Active, Stay Active* report (CMO, 2011) which

1 Psychological wellbeing refers to 'positive psychological functioning' (Ryff, 1989)

outlined the updated physical activity guidelines for children, young people and adults. The new recommendations outlined the amount, and type, of physical activity which should be undertaken across the life-course, while also highlighting the health risks associated with sedentary lifestyles. The *Start Active, Stay Active* report (CMO, 2011) recommends that adults undertake at least 150 minutes of moderate intensity physical activity (accumulated in bouts of at least 10 minutes or more) or 75 minutes of vigorous intensity[2] physical activity across a week, with exercises to improve muscle strength on at least two days a week.

Townsend et al. (2012) reported that 61% of adult men and 71% of adult women in the UK are not meeting the CMO's recommendations for physical activity. Physical inactivity is now regarded as the fourth leading risk factor for global mortality and is commonly associated with an increased risk of obesity, coronary heart disease, hypertension, musculoskeletal conditions, cancer, depression and anxiety (CMO, 2011). Physical inactivity, along with an unhealthy diet, has contributed to rapid increases in non-communicable disease in England and the UK (DH, 2004). Within the UK alone, physical inactivity costs the National Health Service (NHS) up to £1.06 billion per year (CMO, 2011).

The physiological benefits of being physically active have long been documented, however, there is now increasing evidence that supports the notion that physical

2 Moderate intensity physical activity refers to a level of exertion during exercise that raises a person's heart rate to a point where they sweat and feel that they are working, yet are still able to carry on a conversation. In comparison people engaging in vigorous intensity physical activity will breathe more rapidly (further increased heart rate), are likely to break into a sweat and will only be able to speak in short phrases.

activity can contribute to psychosocial wellbeing and improve self-esteem[3], self-confidence[4], and develop social capital[5] (Fox, 1999; Spaaij, 2009). Consequently, physical inactivity has been linked to poor psychological health (Fontaine, 2000). However, the rapid rise in non-communicable disease and poor psychological health suggests that despite the known health benefits of physical activity, the majority of the UK population fail to meet the CMO's recommendations. Therefore, increasing engagement in physical activity and positive health related behaviours remains a major public health concern.

1.3 Men's physical activity and health behaviours in the UK

In the UK, there is a particular concern regarding the physical activity and health behaviours of men. National statistics indicate that the health of men in the UK is poor. A recent and comprehensive report by White et al. (2011a) entitled *The State of Men's Health in Europe* highlighted that more than 100,000 men in the UK die prematurely (i.e., under the age of 75 years) each year and many of these deaths are a result of non-communicable lifestyle diseases such as fat related cancers, diabetes and cardiovascular disease. Compared to women, men have a lower life expectancy (i.e., 77.4 years for men compared to 81.6 years for women), are three times more likely to become dependent on alcohol, more likely to commit suicide and twice as likely to die from a circulatory disease (White et al., 2011a).

3 Self-esteem refers to 'an awareness of good possessed by self' (Campbell, 1984).

4 Self-confidence refers to 'an individual's belief that he or she is able to control his or her environment and self' (Woodman and Hardy, 2001).

5 Social Capital refers to the 'sum of the resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition' (Bordieu and Wacquent, 1992: 119).

Lifestyle behaviours play a critical role in influencing health, illness and mortality (White et al., 2011a). Harmful lifestyle behaviours such as smoking, drinking alcohol, drug use, diet and lack of physical activity contribute to the prevalence of many preventable health problems and premature mortality. Recent statistics indicate that 21% of the UK male population regularly smoke cigarettes, 39% of men consume alcohol at harmful levels (Office for National Statistics, 2011), and the UK has one of the highest mortality rates for drug related deaths amongst men in Europe (White et al., 2011a). According to White et al. (2011a) unhealthy diets and physical inactivity are among the leading causes of the major non-communicable diseases that contribute substantially to the burden of disease, death and disability. Unfortunately, men's diets in the UK are generally less healthy and less nutritiously balanced than women's diets and men generally have a higher fat intake (Office for National Statistics, 2011).

Engagement in regular physical activity has important health benefits for men (DH, 2004; WHO, 2004; Men's Health Forum (MHF), 2010). White et al. (2011a) reported that 65% of men in the UK are currently classified as overweight or obese (BMI <25), yet Townsend et al. (2012) reported that only 39% of the male population are currently meeting the Chief Medical Officers recommendations for physical activity. Therefore, increasing the proportion of men engaging in regular physical activity and health behaviours continues to be a major public health concern.

Thus far, the review has discussed men as a homogeneous group. However, the poor health status of specific male populations from 'hard-to-reach' groups is also

of particular concern to health professionals in the UK. Hard-to-reach (HTR) populations are defined as *"those who are difficult to access due to a specific factor that characterises its members* (Faugier and Sargeant, 1997, p792). Such factors may include (but are not limited to) language, age, gender, geographic location, income, ethnicity, education, religion, health and accommodation (Moffett, 2010).

Although often debated, the term 'hard-to-reach' is used within the health sector with reference to individuals who prove difficult to engage in physical activity and other health behaviours or who do not access the services that are available to them (Sinclair and Alexander, 2012). Examples of these populations include ethnic minorities, those of lower-socio economic status, homeless people and drug users (Sinclair and Alexander, 2012). White et al. (2011a) reported that men who live in poorer material and social conditions are likely to eat less healthily, engage in less exercise, be overweight/obese, consume more alcohol, be more likely to smoke, engage in substance misuse and have more risky sexual behaviours. Taking a homeless man as an example, the health implications of this lifestyle are profound; there is increased risk of premature death and serious illness including an increased risk of pneumonia, sexually transmitted infections, drug and alcohol misuse and mental health problems (European Men's Health Forum (EMHF), 2011).

The poor state of men's health in the UK is further exacerbated by the apparent continued reluctance of men (particularly those from HTR groups) to engage with traditional health services. The Men's Health Forum (2010) suggest that if men could be encouraged to achieve the recommended levels of moderate intensity

physical activity (CMO, 2011), engage in other health related activities and access health services then male premature morbidity in the UK could be significantly reduced. Specifically, the MHF (2010) stated that addressing the poor health behaviours of men in the UK could result in approximately 36,000 more men per year living longer and healthier lives.

1.4 Men's barriers to engagement in physical activity and health related behaviours

Whilst it is recognised that genetics play a part in determining human lifespan and health (WHO, 2004), Macdonald (2006) and White et al. (2011a) argued that the status of men's health is more than simply a consequence of biological, physiological or genetic factors. Instead, health it is affected by much broader economic, social, cultural and environmental elements which typically heighten the existing barriers to engagement in positive health related behaviours.

White et al. (2011b) recently reported that men in the UK visit their GP less frequently than women and are also much less likely to use other health services. There is a large body of empirical research to support the concept that men are reluctant to seek help from health professionals (Addis and Mahalik, 2003). The reasons cited for this poor level of engagement include the limited opening hours of health services, excessive delays for appointments and/or a lack of vocabulary required to discuss sensitive issues (White et al., 2011a). Social constructions of masculinity have been implicated as explanations for men's poor uptake of health services. The writings of Harrison (1978), Courtney (2000), Robertson (2007) and

Gough and Robertson (2010) for example, highlighted the negative impact that masculinity and male role socialisation can have on influencing men's health behaviours and thus, men's health status. For example, Gough (2013) highlighted that concealing vulnerability is often associated with male role socialisation with men not wishing to appear weak by seeking help and engaging with health services (also see Courtenay, 2000 and Lee and Owens, 2002). Furthermore, Gough (2013) highlighted how traditional health care and health advice is typically dominated by women friendly practice and therefore men can be regarded, and often regard themselves, as intruders in a female land.

Barriers attributed to men's engagement in physical activity in the UK have also been documented (i.e., Salmon et al., 2003; National Obesity Forum, 2006; National Obesity Observatory; 2011). The Health Survey for England (2007) for example, reported the following as the greatest barriers for men engaging in physical activity; work commitments, lack of time, caring for children or older people, lack of money, lack of motivation, poor health, injury and physical limitations. According to the World Health Organization (2003a), the ten main social determinants of health in society today are; social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. These determinants are believed to have enormous interplay between each other (e.g., low socio-economic status means lack of money, which contributes to stress and in turn is often linked as a cause to such things as limited job opportunities, social exclusion and alcohol misuse) (Macdonald, 2006). This interplay is particularly prevalent amongst hard-to-reach groups such as the homeless. Therefore, it can be argued

that academics and practitioners must seek to understand these generic determinants within various contextual settings.

Health promotion literature offers many theories and models of behaviour change. Each behavioural change theory or model focuses on different psychosocial factors in an attempt to achieve and explain behaviour change. Evidence suggests that people from disadvantaged and hard-to-reach populations are less successful in achieving positive behaviour change (Kidd and Altman, 2000). These populations include those who experience poverty and/or barriers to self-sufficiency, those with low educational attainment and those who experience a lack of psychosocial wellbeing (Mayer, 2003). Community based programmes promoting physical activity and health behaviour change for example, have more difficulty in recruiting participants from low socioeconomic groups and also find higher attrition rates among low income participants (Yancey et al., 2006). Michie et al. (2009) suggested that the physical and social environments of disadvantaged populations can undermine attempts to positively change behaviour. Social and economic conditions can prevent people from changing their behaviour to improve their health, and can also reinforce behaviours that damage it. Furthermore, the psychological characteristics (i.e., attitudes, beliefs, personality traits) of disadvantaged populations can act as barriers to engagement in positive behaviour change (National Institute for Health and Care Excellence (NICE), 2007).

In a review investigating the models of health-behaviour change used in physical activity and health interventions targeting socially disadvantaged groups, Michie et

al. (2009) reported that the following theories, concepts and accounts have been used as a basis for behaviour change; transtheoretical model, social cognitive theory, theory of reasoned action, precaution adoption model and the precede-proceed model. These models are briefly outlined below:

The transtheoretical model (also referred to as the Stages of Change model) (Prochaska, 1979; Prochaska and DiClemente, 1983; Prochaska et al., 1992) is a widely applied cognitive model which sub-divides individuals between five categories that represent different milestones, or 'levels of motivational readiness' along a continuum of behaviour change. These stages are (i) precontemplation, (ii) contemplation, (iii) preparation, (iv) action, and (v) maintenance. The rationale behind this staged model is that individuals at the same stage should face similar problems and barriers, and thus can be helped by the same type of intervention (Nisbet and Gick 2008). Movement or transition between stages is driven by two key factors (i) self-efficacy and (ii) decisional balance (that is, the outcome of individual assessment of the pros and cons of a behaviour) (Heimlich and Ardoin 2008; Armitage et al., 2004). Relapse and moving backwards through the stages however, is common.

Social cognitive theory (SCT) (Bandura, 1962) is a concept of behaviour change which suggests that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment and behaviour. Social cognitive theory considers the unique way in which individuals acquire and maintain behaviour, while also considering the social environment in which individuals

perform the behaviour. The theory takes into account a person's past experiences, which factor into whether behavioural action will occur. These past experiences influences reinforcements, expectations, and expectancies, all of which shape whether a person will engage in a specific behaviour and the reasons why a person engages in that behaviour (Glanz et al., 2002).

The theory of reasoned action (TRA) (Ajzen and Fishbein, 1980) suggests that a person's behaviour is determined by his/her intention to perform the behaviour and that this intention is, in turn, a function of his/her attitude toward the behaviour and his/her subjective norm. According to TRA, the best predictor of behaviour is intention. Intention is the cognitive representation of a person's readiness to perform a given behaviour, and it is considered to be the immediate antecedent of behaviour. This intention is determined by three things: attitude toward the specific behaviour, subjective norms and perceived behavioural control (Glanz et al., 2002).

The precaution adoption model (PAPM) of behaviour change (Weinstein and Sandman, 1992) aims to explain how a person comes to the decision to take action, and how he and she translates that decision into action. The PAPM suggests that the adoption of a new precaution or cessation of a risky behaviour requires deliberate steps that are unlikely to occur outside of conscious awareness. Therefore PAPM focuses on the psychological processes within individuals prior to action being taken rather than in terms of factors external to the person (Glanz et al., 2002).

Finally, the precede-proceed model (Green and Kreuter, 1999) rests on a fundamental principle of practice, the principle of participation, which states that success in achieving change is enhanced by the active participation of the intended audience in defining their own high-priority problems and goals and in developing and implementing solutions (Glanz et al., 2002). This model is used to explain health-related behaviours but is also commonly used to design, implement and evaluate community health programmes and interventions. The purpose and guiding principle of the Precede-Proceed model is to direct initial attention to outcomes, rather than inputs. This model therefore guides planners through a process that starts with desired outcomes and then works backwards in the causal chain to identify a mix of strategies for achieving those objectives (Glanz et al., 2002).

The research literature evaluating the relevance and use of these theories and models of behaviour change amongst disadvantaged populations however, is inconsistent. For example, NICE (2007) argue that behaviour change studies/interventions with hard-to-reach and disadvantaged populations include multiple adaptations of particular models, poor study designs and studies that fail to take account of all the confounding factors associated with the complex lives of these populations (i.e., Sykes and Marks, 2001; Lowther et al., 2002; Hahn et al., 2004; Emmons et al., 2005; Andrews et al., 2007). In their report examining the use of behaviour change models with disadvantaged populations, NICE (2007) concluded that the evidence did not support the use of any particular model. Consequently, NICE advocated that it is important that the social, environmental,

economic and legislative factors that affect the ability of people from disadvantaged populations to change their behaviour are addressed, rather than focusing on the use of specific models.

Harkins et al. (2010) asserted that the elements of health promotion strategies that are most effective for recruiting and engaging participants are not well understood and, in particular, there is a lack of good quality research examining the most effective strategies to engage men from hard-to-reach populations in health. It appears that very few initiatives are directly focused on the needs of men (i.e., either in a form that men would use or in places that men would more easily access). The concept of male specific health promotion initiatives was argued by Wilkins and Baker (2003, p6) who stated:

> *"A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and necessitates male-specific actions to achieve improvements in health or wellbeing at either individual or population level."*

Therefore, it would appear necessary to develop male-specific health initiatives that operate based on the needs of men. However, according to White et al. (2011b) men have seldom been the focus of specific or targeted health education or health promotion initiatives.

1.5 Sport and Health

According to Pringle et al. (2011), men's uptake of traditional health services in the UK has been highlighted as an area of concern for health professionals. The combination of barriers which have been outlined, alongside the evident unhealthy state of the UK male population has started to encourage practitioners to find new

and innovative ways to engage men with health issues. White and Witty (2009a) proposed that the setting in which male targeted interventions are delivered is an important factor in engaging men in health related behaviours and services. The UK Government's White Paper *Healthy People, Healthy Lives* (DH, 2010) identified the *community* as an appropriate setting to make contact with populations who are not engaging with health services in traditional settings. Wilkins and Baker (2003) suggest that the most appropriate community settings to deliver health messages are in places that men already go and where they are more likely to feel comfortable. Examples of such places include community groups or forums and groups associated with sport, sports events and/or sports stadia.

Sport is said to be one of the great modern experiences with an appeal that spans the globe (Brown et al., 2009). In recent years, there has been recognition of the influence that professional sports clubs can have in engaging fans to wellbeing related activities (National Health Service (NHS) Confederation, 2013). Although much of this engagement relates to increasing participation in sport, there is a major focus on promoting health and wellbeing messages with specific programmes on healthy eating, being more active, self-esteem and mental wellbeing. In many cases, these initiatives target those who may be disengaged from mainstream health promotion activities, but who are attracted to initiatives because they are being run by their local sports club (NHS Confederation, 2013).

Using sport as a vehicle for targeting men's health in leisure time has recently been achieved through a number of innovative projects in the UK. The 'Boundaries for

Life' project, for example, successfully engaged male fans over the age of 35 years who attended international England cricket matches. Men were eligible to participate in a free 20 minute health screening process that measured blood pressure, body mass index and cholesterol levels. Participants were also provided with the opportunity to see a dentist who performed a basic mouth screen to identify signs of mouth damage associated with potentially cancerous conditions and provided with simple healthy lifestyle advice, and where necessary, an additional referral letter to their doctor or dentist for follow up (England and Wales Cricket Board, 2011).

The 'Tackling Men's Health' (Witty and White, 2010) intervention provides a further example of a health promoting intervention targeting men at large UK sports stadia. The intervention targeted men attending popular Rugby League matches, with the aim of promoting men's engagement with health services and thus, promoting improved health and wellbeing. The intervention saw nurses undertaking health checks in bars, cafes and entrance areas before the matches started. The intervention achieved good levels of engagement with the target group (202 participants were recruited for study; 89 participants provided both baseline and follow up data) and received positive responses from attendees of the rugby stadium (Witty and White, 2010). Furthermore, the club also ran a successful weight loss group for men, where retention levels and overall weight loss were higher than the standard programmes. According to Witty and White (2010) many of the participants reported that they had only joined because of the connection with the club.

1.6 Football as a vehicle for health promotion

In the UK, football is the highest profile and most popular sport (Jenkins and James, 2012). With this in mind, recent community based men's health initiatives have taken place in and around football stadia. It has been argued that football offers a unique opportunity to reach the most marginalised communities and has been utilised frequently to attend to government and/or political policy agendas and causes (Richardson et al., 2011). In 2005, the 'Football for Health' manifesto was released highlighting the importance of building partnerships between local health institutions and football organisations in the United Kingdom to promote health and activity (DH, 2005). The then Public Health Minister, Caroline Flint stated:

> *"Football is an important part of many people's lives and with its family friendly policies including smoke free grounds, family enclosures and football in the community work carried out by club players it provides great opportunities to get across key messages about living healthy, active lives"(Kick Start to Health, 2005, p1).*

Moreover, the emphasis on the potential impact football can have across the globe is clearly highlighted in a report on 'Football for Health' (FIFA, 2008). FIFA stated that not only can playing football help tackle obesity, diabetes and hypertension but stated:

> *"... why not tap the full potential of this unique tool [football] to spread simple but effective messages on how to protect oneself from the most devastating infectious diseases such as HIV, tuberculosis and malaria? Because these 'big three' are responsible for about three million deaths in Africa every year, the FIFA World Cup 2010 South Africa will be an invaluable opportunity to reach those most heavily threatened by them" (p146).*

These statements highlight the potential for football to act as a vehicle for delivering crucial health messages and creating positive health changes to the most 'at risk' and marginalised people both nationally and internationally.

In the UK, several community health programmes operate from, and in partnership with, professional football clubs. Jenkins and James (2012) suggest that health service providers choose to work in partnership with football clubs because they are a powerful tool for engagement and have good access to a variety of groups of people. For example, the 'It's a Goal' initiative is a community mental health project based within football stadia which provides men with mental health promotion and mental health awareness training. This project has been successful in helping young men to address issues such as depression, self-esteem, inclusion and suicide (Pringle and Sayers, 2004). In 2010, the 'Football Fans in Training' (FFIT) programme was launched in a number of Scottish Premier League football clubs. FFIT is a successful 12 week physical activity, weight loss and healthy living intervention delivered to men aged 18-35 years (Gray et al., 2011). Similarly, in England, men's health has recently been addressed by an innovative project called 'Premier League Health' based in a number of English Premier League[6] football clubs.

1.7 Premier League Health

The Premier League Health (PLH) programme was a unique £1.63m three year men's health programme commissioned by the Premier League, funded by the UK

6 'Premier League' refers to a professional football league consisting of the top teams in England and Wales (Collins Dictionary).

Football Pools and delivered by sixteen English Premier League Football Clubs through their Football in the Community (FitC) schemes. PLH was the first national men's health promotion initiative delivered by Premier League football clubs targeted at male football supporters between the ages of 18-35 years. The Premier League Health programme used the unique opportunity that football offers to reach some of the most marginalised individuals in the community. Throughout all sixteen clubs, PLH activities typically included health checks and awareness raising activities combined with a programme of regular weekly exercise classes designed to improve health and wellbeing (White et al., 2012). Awareness and engagement in health behaviours was achieved through a variety of approaches and engagement tools based on the theory that men will respond to health messages offered in places that they feel comfortable (see Pringle et al., 2011).

The programme was successful at raising awareness and engaging men in health related behaviours at the football club on non-match days, and in some cases, on match days (White et al., 2012; Pringle et al., 2013). According to White et al. (2012), three quarters of men who engaged in the programme (across the sixteen clubs) made positive health changes. Furthermore, a quarter of men reduced harmful lifestyle risk factors, over 40 per cent improved their level of physical activity, a third moved to a healthier weight categories and 30 per cent reduced harmful levels of alcohol consumption. With this project in mind, the review will now move to focus on the role of English Premier League football clubs and the rapidly growing investment in Football in the Community schemes for delivering on local, regional and national agendas.

1.8 Football in the Community schemes

In England, Football in the Community (FitC) schemes were established in 1986 by the Footballers' Further Education and Vocational Training Society (FFEVTS). At this time, English football was suffering from serious economic problems and FitC schemes were established to 'do good' in the community, in part as a way of reconnecting professional clubs with their local communities (Brown et al., 2009, p17). In essence, football clubs, like other corporations, were increasingly expected to indicate their commitment to civil society and social justice by engaging in 'socially responsible' activities (Brown et al., 2009, p18).

Football in the Community schemes (typically registered charities and the community arm of football clubs) are now found in the majority of professional football clubs in England and Wales (Mcguire and Fenoglio, 2008). FitC schemes often use the 'brand' of the football club as a powerful tool for engagement (Richardson et al., 2011) however they are a separate entity to the football club, have their own staff and are independently funded (although often receive some in-kind support from the club) (Jenkins and James, 2012). Initially, FitC schemes concentrated on the provision of grassroots football coaching with children, however, in 1997 the New Labour government identified football as a potential key deliverer of a range of policy objectives in areas as diverse as health, education, community cohesion, regeneration and crime reduction (Brown et al., 2009, p17). In recent years, football's potential 'power' has been increasingly utilised by the UK coalition government to assist in attending to these social agendas resulting in an increasing amount of community work being undertaken by FitC schemes. As a

result, FitC schemes have evolved from traditional participation based football 'coaching' in local communities, to now being at the forefront of major agendas, addressing and tackling significant community issues. This evolution has led to the term 'Football in the Community' being dropped by many in the field in favour of such terms as 'Club Community Organisation', 'Community Foundation' or 'Community Trust'. However, for the purpose of this thesis, the author will continue to refer to the term 'Football in the Community'.

In order to assist with the increasing responsibility and demands of FitC schemes, the Premier League took responsibility for community programmes in 2007 and have significantly increased investment into this area since. Nearly 4% of Premier League revenue is now committed into good cause activity delivered by Football in the Community schemes in the Premier League, Football League and Football Conference (Premier League, 2012). This activity is rounded up under the 'Creating Chances' umbrella brand which uses the power of football to positively change lives. The Premier League operates central community programmes with national partners but also funds clubs to deliver local projects with local partners. Governance and quality assurance is provided by the newly formed 'Premier League Charitable Fund' (PLCF). The PLCF is a registered charity which donates funding to club community organisations to help them engage with their local community. The new charity aims to add strength to the Premier League's existing Creating Chances programme by positively changing lives in communities throughout England (Premier League, 2012).

In recent years, the popularity of professional football clubs' community engagement (i.e., Football in the Community) programmes have been championed as a vehicle to reach and connect with men, especially those from HTR populations (see Pringle et al., 2011; White et al., 2012; Pringle et al., 2013). However, despite the increasing responsibility aligned with FitC schemes, there still remains limited research which has evaluated the effectiveness of their programmes.

1.9 The effectiveness of Football in the Community schemes

Football's potential 'power' for positive change has resulted in an increasing amount of enthusiasm and financial support being provided to FitC schemes in recent times. Despite this investment however, FitC interventions and approaches appear to lack rigorous monitoring and/or evaluation into effectiveness and an understanding of 'what works?' (Jenkins and James, 2012).

There is an increasing demand for work funded by public agencies to become more focused in demonstrating effectiveness through evaluation. As early as the year 2000, Watson criticised the lack of robust evaluation procedures encountered on FitC schemes. Watson stressed the need to assess what is actually happening 'on the ground' in order to increase the prospect of projects making a 'real' difference to the lives of local people. However, in a systematic review of academic literature, Jackson et al. (2005) identified a lack of studies which demonstrated the effects of any sport-based policy interventions on promoting healthy behaviour. Two years later, Tacon (2007) reinforced these mounting frustrations and called for more rigorous evaluation of FitC schemes.

A close examination of the current literature suggests that, in the last five years, there have been noticeable attempts to address these issues and to align FitC programmes with suitable evaluation procedures. For example, Parnell et al. (2012) studied the effects of a FitC programme on promoting positive behaviour change in children. Pringle et al. (2011), White et al. (2012), Pringle et al. (2013) and Zwolinsky et al. (2013) have published findings from their examination into the effects of a men's health initiative delivered in Premier League football clubs by their FitC schemes (discussed later). Furthermore, in order to improve their funded programmes and demonstrate impact and value, the Premier League have recently partnered with social research cooperative 'Substance'. Substance work with clients to conduct on the ground research and provide them with user-centred tools and approaches to help them to demonstrate impact and value, influence policy and effect positive social change.

Despite this apparent increase in the adoption of monitoring and evaluation techniques, there still remains limited empirical evidence which assesses the approach and effectiveness of Football in the Community interventions. Jenkins and James (2012) argued that whilst FitC schemes undertake a certain amount of measurement, more needs to be done to get a true picture of the impact of community work and better capture the benefits both to the club and the community. Health professionals usually work in a climate where they are expected to implement their role (practice) based on knowledge of 'what works' (evidence based practice) (Marks, 2002). However, this is not possible if the evidence base is poor. The developmental processes which help the professional/practitioner to

understand what is working are essential (Dugdill et al., 2009). Therefore, despite 'Football for Health' being heralded as successful partnerships (FIFA, 2008), the 'real' effect of such partnership and their projects appears difficult to gauge. Specifically, more rigorous research is required in order to establish the effectiveness and impact of these football-oriented health interventions so that useful feedback can be provided to enhance and develop practice, future policy, and strategies.

1.10 Setting the scene

At this point it appears relevant to identity to the reader that throughout the duration of this research, the author was employed as a full time member of staff by Liverpool John Moores University, School of Sport and Exercise Sciences (LJMU SPS) and was based at the Everton Active Family Centre (EAFC) within Goodison Park, home of Everton Football Club (EFC). It was here that the author worked full-time with/for 'Everton in the Community' (EitC) as their 'Premier League Men's Health Co-ordinator'. An overview of Everton in the Community, the collaboration between EitC and LJMU SPS, the Everton Active Family Centre, Everton in the Community's Premier League Health programme and the role of a Premier League Men's Health Co-ordinator will now be outlined. It is hoped that by setting the scene and clarifying this position at this point, the reader can travel through this thesis with the knowledge of the author's set up and additional operational role during this time.

1.10.1 Everton in the Community

Everton in the Community is a financially independent charity that uses the influential brand of an English Premier League football club (Everton Football Club) to motivate, educate and inspire diverse communities in the North West of England and North Wales. EitC, who are based within the grounds of Everton Football Club, has undertaken community work since 1988. This community work has specifically responded to the high prevalence of socio-economic deprivation in Liverpool's inner-city areas during that time, and the recognised potential that football offered as a vehicle for positive social change. Everton in the Community was formalised as a registered charity in 2004 (no.1099366) and has since become one of the most successful sporting charities in the world. The charity currently employs a specialist team of 32 full-time members of staff, 45 casual staff and more than 175 volunteers, with an annual turnover of approximately £1.6m.

Everton in the Community work alongside a network of local, national and international multi-sector partners to deliver targeted projects focusing on a range of social issues such as health, education, employment, disability, social inclusion and community cohesion. Everton in the Community's mission is as follows:

> *"Through the positive promotion of sport, physical activity and the brand of Everton Football Club, we are committed to provide high quality, accessible participation and development opportunities that positively change lives and bring enjoyment to our communities."*

1.10.2 Liverpool health profile

Almost two thirds of professional football stadia are located within deprived areas of the UK (Men's Health Forum and Federation of Stadium Communities, 2009).

Everton Football Club is no exception and is based within a deprived ward in the city of Liverpool, UK. The City of Liverpool is the eighth largest city in the UK and is situated in the North West of England, with a population of 434,900 (Liverpool City Council, 2010). Liverpool is one of the most socially deprived areas within England (Liverpool City Council, 2010), with more than half of Liverpool residents residing within the 10% most deprived areas in the country (Noble et al., 2008). Liverpool suffers with substantial health inequalities in comparison to the rest of the nation, with life expectancy approximately three years below the national average and recorded mortality rates significantly higher than the national average (Liverpool Public Health Intelligence Team, 2009). Furthermore, Liverpool also has significantly higher rates for prevalence of cancer, coronary heart disease and stroke. Equally, Liverpool has a high smoking prevalence and is amongst the one of worst areas in England for alcohol related health disorders (Liverpool City Council, 2010). Moreover Liverpool residents have the lowest overall mental wellbeing score in the North West of England (Deacon et al., 2010).

1.10.3 The ward of Everton

Everton in the Community is based in the ward of Everton which is located within the City & North Neighbourhood Management Area (NMA) in Liverpool, a region which falls within the most deprived 10% in the country (Liverpool City Council, 2012). Long-term unemployment in this area is high (Liverpool Primary Care Trust, 2010). Communities with high levels of deprivation are often characterised by very complex social and health problems (Dugdill et al., 2009). Therefore, health issues within the ward of Everton are of particular concern. In 2010, Liverpool City Council

reported that life expectancy in Everton is amongst the lowest in Liverpool (70.2 years for men). Furthermore, over 50% of the adult population are classified as overweight/obese and smoking prevalence and hospital admissions for alcohol-related conditions are amongst the highest in the city (Liverpool City Council, 2012). Despite a growing number of health initiatives based within in this ward, there is still apparently poor physical health and little evaluation or dissemination of health related barriers.

1.10.4 Collaboration

A formal collaboration between Liverpool John Moores University, School of Sport and Exercise Sciences and Everton in the Community was established in June 2007. The partnership's philosophy was as follows:

> *"to deliver quality programmes that aim to promote 'real' positive behaviour and lifestyle change improving the quality of life and the wellbeing of people within our community across a range of social agendas via a plethora of projects, programmes, initiatives and campaigns."*

Furthermore, the research conducted through the collaboration endeavoured to establish whether or not the programmes delivered by Everton in the Community '*make a difference*' and subsequently improve the quality of life of those within the local community (i.e., Parnell et al., 2012). Undeniably, it was this collaboration that acted as a catalyst for the research presented in this thesis.

1.10.5 Everton Active Family Centre

Through the collaboration between LJMU SPS and EitC, the 'Everton Active Family Centre' (EAFC) was developed, established and operated from June 2008 to August 2012. EAFC was a bespoke LJMU SPS satellite centre within the grounds of

Goodison Park and acted as hub for LJMU SPS staff and students to conduct immersed community based health research in the heart of a Premier League Football Club based within a deprived community. The centre was equipped with gym and fitness equipment, bathroom and showering facilities and a furnished common room/office. EAFC was the base of both the author and Everton in the Community's Premier League Health programme between August 2009 and August 2012.

1.10.6 Everton in the Community's Premier League Health programme

The aim of Everton in the Community's Premier League Health programme was to use the powerful brand of Everton Football Club as a vehicle to motivate and inspire hard-to-reach males in Liverpool, to make positive, healthy lifestyle choices. The programme was based within the grounds of Goodison Park and operated from the Everton Active Family Centre.

The programme aimed to deliver the following outputs:

- Weekly exercise activities engaging men from the local community
- Specific physical activity and health intervention with targeted HTR groups
- A series of health themed match day events
- Health drop in services operating from the football stadium
- Guided research to assess the effectiveness of the project

Everton in the Community's Premier League Health programme tackled six pertinent regional health themes, these were; alcohol and substance misuse, cancer, mental health, obesity and cardiovascular disease, sexual health and smoking cessation. The programme was directed at men 18-35 years of age, although adult men beyond 35 years were eligible to enrol. Enrolment on the programme was voluntary and participants either self-referred or were referred by one of the programmes many project partners (i.e., drug, alcohol and smoking cessation service staff). EitC's Premier League Health programme offered participants the following engagement opportunities:

- A range of weekly physical activity sessions within or surrounding the grounds of Everton Football Club
- Regular health checks
- Mentoring support
- Expert support and advice with any existing health issues from partner agencies
- Pathways to education, training and employment

The programme's physical activity engagement with participants consisted of a series of intermittent twelve week interventions with targeted hard-to-reach groups alongside the delivery of on-going weekly activities with, what the project team called, the 'continuous group'.

A typical twelve week intervention consisted of a football specific physical activity and health intervention targeted at a specific hard-to-reach group (namely homeless men and men recovering from drug and alcohol misuse), and was conducted intermittently during the project's lifetime. Participants were typically referred to the interventions by local health service providers or had come into direct contact with the project co-ordinator (the author) during a talk delivered at one of the project partner venues (i.e., homeless shelter, drug service) and had expressed that they were interested in joining the programme. The twelve week interventions consisted of two 2 hour sessions per week with a maximum of thirty five participants able to enrol per intervention (with the aim of approximately twenty attending any given session). In total, three twelve week interventions were conducted during the three year project period.

The 'continuous group' however, consisted of participants who had typically self-referred themselves onto the programme alongside those who had 'exited' from one of the three twelve week interventions. Participants engaged in a range of weekly physical activity sessions; football, circuit training and boxing (developed in conjunction with the project participants) which took place in the evening time between 18:00-20:00hrs. Typically, between ten and twenty five participants attended each physical activity session per week, with football being the most popular activity and circuit training the least popular.

Both the continuous and intermittent groups were exposed to regular health checks and topical health talks from local health service providers (alcohol and substance

misuse, cancer, mental health, obesity and cardiovascular disease, sexual health and smoking cessation) which all aimed to promote engagement in positive healthful behaviours and highlight the negative effects of unhealthy behaviours.

1.10.7 Playing two roles: a practitioner-researcher

A practitioner-researcher is someone who holds down a job in some capacity and is, at the same time, involved in carrying out systematic enquiry which is of relevance to the job (Robson, 1993). In 1998, Jarvis (p10) wrote *"...as far as I know, there are few, if any, full time appointments designated as practitioner-researcher positions...it is high time that such a position be considered."* By 2009 however, such a position was created, advertised and the author was appointed to this post. The role 'Premier League Men's Health Co-ordinator' was a joint appointment between Liverpool John Moores University and Everton in the Community and required the author to adopt a practitioner-cum-researcher approach. As Jarvis (1998, p180) stated *"creating the possibility of joint appointments between the universities and colleges and fields of practice can narrow the gap between theory and practice."*

Carmichael and Miller (2006) suggested that the use of practitioner-researchers is an appropriate and powerful method of plunging deep into the culture and environment of the research setting in ways that would be very difficult to achieve otherwise. This is supported by Gray (2004) who argued that practitioner-researchers are vital for understanding culture, strengths, weaknesses and developing needs within an organisation. Carmichael and Miller (2006) continued, *"practitioner research is one way to provide the cultural immersion required by*

ethnographic research however the price tag that comes with that strength is one of time. The research process itself is inevitably slower and more complex. A simpler and more direct research methodology would be quicker and easier to direct, but would also be lacking in richness, in the 'thick description' that this method is aimed at developing" (p2).

The author's role as a practitioner-researcher involved the day-to-day management and continuous development of the Premier League Health programme within Everton in the Community. Furthermore, due to the collaboration with Liverpool John Moores University, this role encouraged the author to examine the current men's health and Football in the Community based literature to identify the gaps in knowledge before constructing the research question and aims and objectives of this research.

1.10.8 Premier League Health evaluation

Everton in the Community were the only Football in the Community scheme to have partnered with an academic institution to produce independent research outputs from their Premier League Health project. However, it should be noted that researchers at Leeds Metropolitan University were commissioned by the Premier League to undertake an independent evaluation of the Premier League Health initiative across the 16 professional football clubs (Pringle et al., 2011; White et al., 2012, Pringle et al., 2013; Zwolinsky et al., 2013). From a stakeholder perspective, both the research presented in this thesis and the research conducted by the team at Leeds Metropolitan University provide a unique opportunity to explore how the

power of sport and professional football clubs can influence the health of men and if and/or how the investment made by the Football Pools has impacted the lives of those who engaged.

1.11 Framing the research questions of the thesis

Recent health statistics indicate that men are a cause for concern in the UK. Significant health inequalities exist within Liverpool and, more specifically, in the ward of Everton. Meryn and Young (2010) argued that behind statistics such as these, there are a set of experiences and realities that explain behaviour. Smith and Robertson (2008) stated that although the field of men's health had grown markedly over the past few decades, practitioners and academics argue that more needs to be done to explore and understand these realities within a range of contexts. Smith and Robertson (2008) go on to argue that there remains a lack of accessible, research-based evidence, not so much about the causes of male ill health, but what lies behind male health-related behaviours or practices, and more specifically about the effectiveness (or not) of different types of innovative approaches to health promotion among men. This thesis therefore aims to further understand where, when and how men choose to engage with health promoting activities, services and messages within a community setting. It is hoped that generating evidence from local practice will provide valuable insights into 'overall best practice' and thus improve delivery of similar programmes.

In recent years, there has been recognition of the influence that professional sports clubs have in attracting fans to wellbeing related activities, particularly with hard-

to-reach groups (NHS Confederation, 2013). English Premier League Football in the Community (FitC) schemes have been enthusiastically funded by local, regional and national health agencies to use the 'power' of the football club brand to engage hard-to-reach populations and create positive behaviour change. Despite this influx of financial support and the recent examples of good practice in this field (i.e., White et al., 2012, Pringle et al., 2013; Zwolinsky et al., 2013), there still remains limited empirical evidence which describes the effectiveness of, and biopsychosocial impact of, engagement in Football in the Community programmes. This leaves us to speculate as to whether Football in the Community programmes are indeed effective in achieving what they set out to do.

Given the apparent lack of research based evidence examining the impact of Football in the Community programmes within the literature and the increasing demand for FitC schemes to demonstrate effectiveness, it appears essential that effective evaluations of community football oriented health interventions take place in order to better understand where 'real' positive behavioural change can occur. Given the status of men's health in the UK, it would also appear to necessary evaluate what aspects of a Football in the Community health promotion programme work specifically for men and why, and conversely which do not work and why. Carmichael and Miller (2006) suggested that evaluation such as this can be successfully achieved through practitioner-research. Thick, descriptive knowledge gained from this type of approach can assist those on the ground (i.e., Football in the Community health practitioners) in tailoring their approach to their health behaviour programmes. Subsequently, such knowledge can assist

practitioners to reduce the challenges to engagement, ensure regular and sustained engagement and thus ensure successful implementation of health promotion programmes. This research is important for building an evidence base, and advancing the literature, in both men's health promotion and Football in the Community health programmes.

1.12 Thesis aims

The principle aim of thesis is;

To understand the barriers to, and impact of, men's engagement in physical activity and health related behaviours through an examination of a Football in the Community men's health programme at an English Premier League football club.

1.13 Summary of Objectives

The above aims were achieved through three research studies with the following objectives:

Study 1:

- Examine the effectiveness of, and barriers to, promoting and engaging male football fans in positive health related behaviours and messages at an English Premier League football stadium on match days.

Study 2:

- Examine the barriers that men from hard-to-reach populations encounter when attempting to commit to regular physical activity and health related behaviours.

- Examine the biological, psychological and social impact of engaging in a Football in the Community men's health programme.

Study 3:

- Critically analyse the contextual barriers that men from hard-to-reach populations encounter when attempting to engage in regular physical activity and positive health related behaviours.
- Examine the psychosocial impact of engagement in a FitC men's health programme.

Chapter Two:

Philosophical Positioning

&

Adopted Methodologies

"All the world is a laboratory to the inquiring mind."

(Fischer, 1942, p42)

2.1 Philosophical Positioning

It has been argued that a researcher's interpretation of knowledge is often driven by their philosophical positioning. Morrow (2005) suggested that researchers should make their philosophical position (i.e., worldviews, assumptions and biases) explicit within their work in order to aid the reader in understanding the researcher's approach to the identified issue and the criteria against which the research should be interpreted and judged. Schurink (2010, p422) explains that a researcher's beliefs are more than just tools enabling them to collect particular types of data and answer a particular research question(s), *"...taking a specific research stance means that the researcher is making certain assumptions about the nature of truth, human behaviour and representation of the 'other'."* Eriksson and Kovalainen (2008, p12) stated that, *"...too often researchers do not consider the philosophical underpinnings of their research which can lead the reader to think that the researcher either finds philosophical questions as non-relevant in their research settings or they take their own philosophical positioning as evident and self-known."* This chapter briefly outlines the factors that inform research methodologies (in line with Crotty, 1998), and offers the reader an understanding of the methodological approach to this research by providing an overview of the researcher's philosophical underpinning including the adopted theoretical perspective, ontology and epistemology of each study.

Clough and Nutbrown (2002) emphasised the importance of adopting a research stance that is appropriate to the topic being studied. For example, a quantitative research approach typically seeks to prove or disprove a hypothesis or look for

causal relationships, rather than to seek to explore a particular issue or phenomenon. "*Qualitative research is a field of inquiry which aims to provide an in-depth understanding of people's experiences, perspectives and histories in the context of their personal circumstances and/or settings*" (Spencer and Britain, 2003, p3). The qualitative research community consists of groups of globally dispersed persons who are attempting to explore and understand everyday life in order to answer research questions such as "How?" or "What?" as opposed to quantitative researchers who (typically) aim to understand "Why?" (Denzin and Lincoln, 2011).

Academic research is associated with a complex, interconnected family of terms, concepts and assumptions such as 'research paradigms' (i.e., the viewpoint of complexity of the real world that guides the researcher), 'ontology' ('what is' the nature of existence) and 'epistemology' (the relationship between the knower and the known; how we know what we know). Research paradigms, ontology and epistemology all relate to a researcher's 'theoretical perspective' (i.e., the philosophical stance that lies behind methodologies) and informs the methods that a researcher will use (Denzin and Lincoln, 2005). For example, two academics that hold different beliefs of ontology and epistemology may be interested in examining the same phenomenon, but their beliefs will lead them to use different methods due to their differing views of evidence, analysis and purpose of research (Potter, 1996). This argument is supported by Crotty (1998) who developed the diagram below to highlight how choices of methods are influenced by a researcher's philosophical positioning;

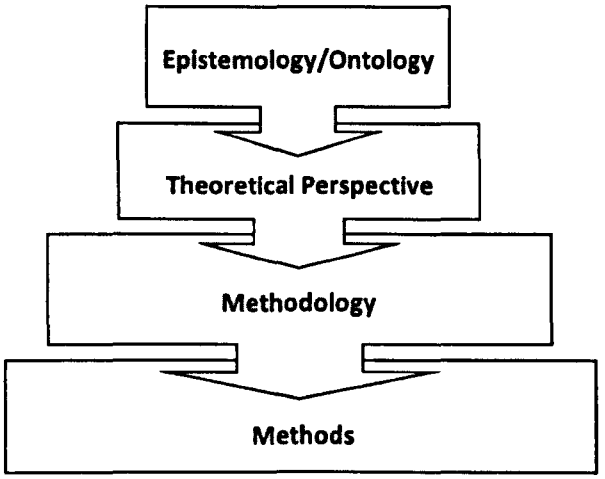


Figure 2.1. Four elements of research that inform one another (Crotty, 1998, p4)

2.2 Epistemological position

"Epistemology deals with the nature of knowledge, its possibility, scope and general bias" (Hamlyn, 1995, p242). Epistemology is concerned with providing a theoretical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate (Maynard, 1994). As Carter and Little (2007) assert, *"...epistemology modifies methodology and justifies the knowledge produced."* Hence researchers need to justify the epistemological stance that they adopt (Crotty, 1998). According to Crotty (1998) there are a range of epistemological positions; *objectivism* (value free), *constructivism and constructionism* (value based) and *subjectivism* (value laden). Objectivist epistemology holds that meaning (and therefore meaningful reality) exists as such apart from the operation of any consciousness, it is value free. *According to Crotty (1998, p97) constructivism describes "the individual human subject engaging with objects in the world and making sense of them". Constructionism, to the contrary, denies that this is what actually happens, at least in the first instance. Instead, each of us is introduced directly to a whole world of meaning. The cultures and sub-*

cultures into which we are born provide us with meanings, they establish a tight grip upon us and, by and large, shape our thinking and behaviour throughout our lives. Subjectivism however, holds that meaning does not emerge from an inter-play between subject and object but is imposed on the object by the subject, therefore, it is value laden (Crotty, 1998).

2.3 Ontological position

Ontological and epistemological issues tend to emerge together within the literature. However, Eriksson and Kovalainen (2008, p13) argue that researchers must understand themselves in terms of ontology, which they describe as *"...the way you believe deep down how social reality should be viewed."* Ontology concerns ideas about the existence of and relationship between people, society, and the world in general (Eriksson and Kovalainen, 2008). As Bryman and Bell (2003, p19) highlight, *"ontology is a question of whether social entities can and should be considered objective entities that have a reality external to social actors, or whether they can and should be considered social constructions built up from the perceptions and actions of social actors."* Similarly, Kvale (1996, p41) describes ontology as, *"...the conception of knowledge as a 'mirror of reality' or the conception of knowledge as the 'social construction of reality' where the focus is on the interpretation and negotiation of the meaning of the social world."* According to Crotty (1998) there are a range of ontological perspectives; *realist* (i.e., a belief that reality is something 'out there', it is a law of nature just waiting to be found), *critical realist* (i.e., a belief that things exist 'out there' but as human beings our own presence as researchers influences what we are trying to measure) or *relativist* (i.e.,

a belief that knowledge is a social reality, value-laden and it only comes to light through individual interpretation).

2.4 Research Paradigms

Research paradigms refer to *"...a basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways"* (Guba and Lincoln, 1994, p105). In other words, a research paradigm is inseparable from the researcher's ontological, epistemological and methodological positioning (Denzin and Lincoln, 2005). Morrow (2007) suggests that each and every individual who engages in research will make sense of the world through a particular set of *paradigmatic lenses* and it is likely that the researcher's particular paradigm (and thus, 'lens') will colour what you read. Guba and Lincoln (1994), and Crotty (1998) provide categorisations and descriptions of the various research paradigms; positivism, post-positivism, interpretivism, constructivism, post modernism and critical inquiry.

Although a researcher may have particular biases and thus preferred methodologies, it can be argued that an academic researcher should not be hostage to one research paradigm or another and therefore should link their choice of methods directly to the purpose and nature of the research question(s) posed (Crotty, 1998). Quite simply, researchers should choose the most appropriate method for answering the research question. This 'what works' tactic will allow the researcher to address the research question through an informed decision making process (Tashakkori and Teddlie, 1998; Armitage, 2007).

2.5 Thesis Structure, philosophical positioning and adopted methodologies

The contents of chapters 3 to 5 represent each phase of the research relating to the aims of the thesis. Each phase seeks to contextualise meaning to the understanding of the barriers to men's engagement in physical activity and health related behaviours and furthermore, to understand the impact of engagement in a Football in the Community men's health programme. The theoretical perspectives and methodologies I have adopted for this research were based on an informed decision making approach and represent what I (the researcher) believe to be the most appropriate tools to answer the particular aims of each study within the thesis.

Study 1 presents the reconnaissance phase investigating the effectiveness of, and barriers to, promoting positive health behaviours to men attending an English Premier League football stadium on match days through a range of relaxed and informal reflective methodologies. This phase adopts a predominately inductive lens and an author involved form of creative writing in which I am aligned to the constructivist paradigm, subjective epistemology and relativist ontology.

Study 2, investigates the challenges that hard-to-reach male populations encounter when attempting to commit to regular and sustained participation in physical activity and health behaviours. This investigation adopts ethnographic and observational methodologies with both an inductive and deductive approach to the analysis. Furthermore, Study 2 aims to understand the biological, psychological and social impact of engagement in a 12 week Football in the Community intervention

through a 'mixed method' approach (i.e., with the adoption of both qualitative and quantitative research methods). During Study 2 I consequently shift between paradigmatic lenses. The ethnographic element of this study is arguably aligned with the interpretivist paradigm in which I hold a value based epistemology and relativist ontology whereas the experimental nature of assessing the physiological impact of the FitC programme is aligned with the post positivist paradigm in which I hold an objective epistemology and critical realist ontology.

Study 3 examines men's 'real life' experiences of physical activity and other health related behaviours and aims to identify common barriers to engagement. This study also aims to examine the impact of sustained engagement in a Football in the Community men's health programme. This study utilises semi structured interviews in order to 'get closer' to the research participants and understand their 'real world'. Analysis of research data occurs through inductive as well as deductive interpretation. Thus, this study becomes an extension of my previous interpretivist work.

For the duration of the research (studies 1, 2 and 3) I adopted a practitioner-cum-researcher role (Robson, 1993; Jarvis, 1998; Gray, 2004) and utilised a range of informal, open and relaxed approaches (e.g., observation, conversations) to data collection. Such an approach enabled me to explore issues as they evolved 'on the ground' and to develop closeness, trust and familiarisation with the programme participants. Engagement and immersion within all research settings therefore allowed me to develop contextual knowledge, gained 'in action' (Schon, 1983).

Throughout this research, personal reflections, observations and quotes from programme participants were recorded through informal field notes and reflective diaries (Atkinson and Hammersley, 1994) in an attempt to capture the context and culture of the research environment (McFee, 1992; Krane and Baird, 2005) and to understand 'what is going on'. In general, the setting for this research required a flexible method of data collection. Therefore, when it was assumed that note taking may jeopardise the quality of conversation or observation, mental notes were made (Lofland, 1995). These mental notes were typically key words and quotes and were jotted on a note pad and developed at the end of the day in to more detailed personal reflections (Sanjek, 1990; Lofland, 1995). Personal reflections were then continually developed throughout the research period through a process of staged reflection (Knowles et al., 2007). In this regard, data was captured and immediately recorded, followed by a delayed method which involved revisiting and developing the data at temporal intervals throughout the research process.

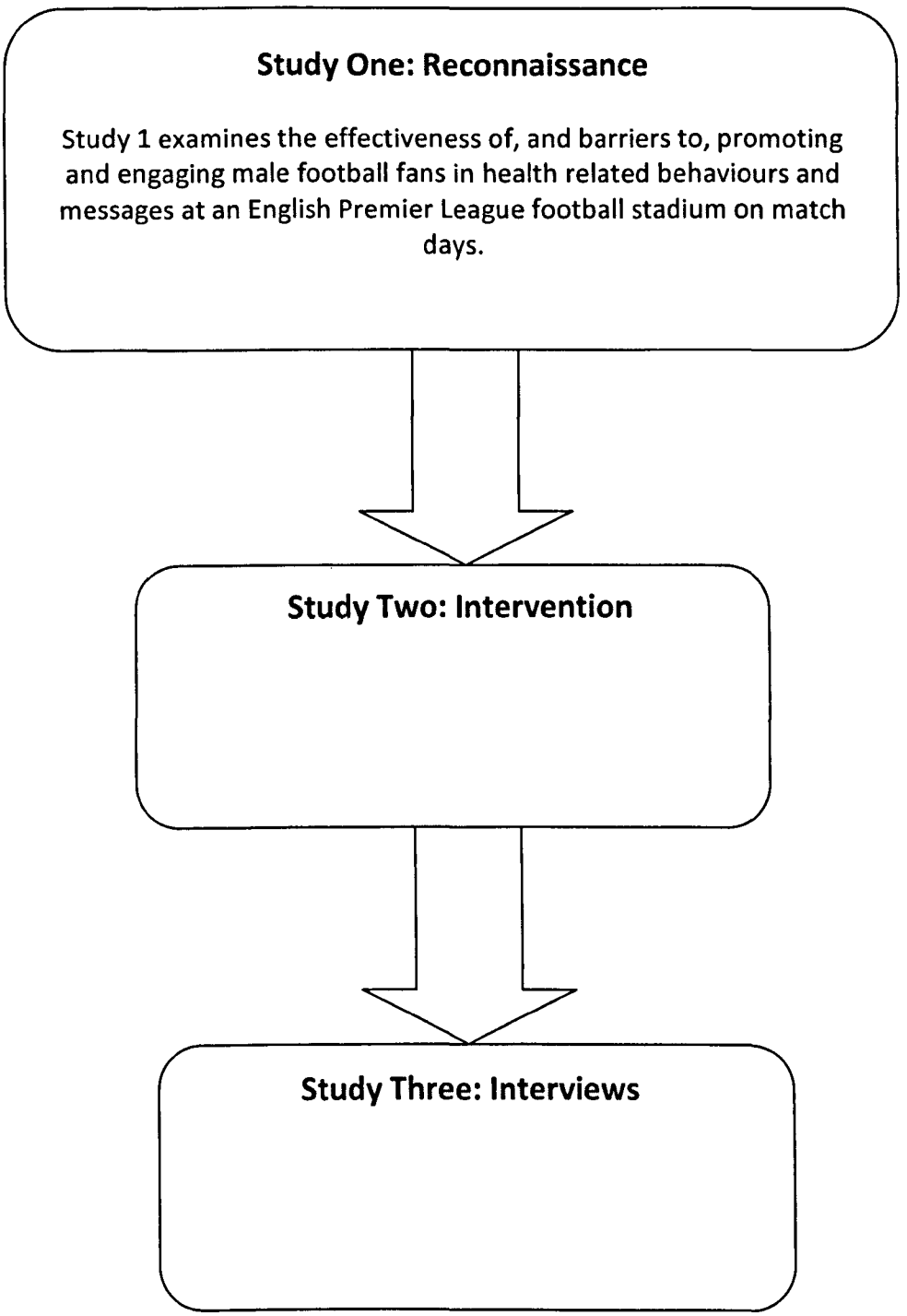
The ability to adopt a range of appropriate methodologies that align with the needs of the research aims highlights my ability as a researcher to address the purpose and nature of the research question posed, and thus, adapt my research design and philosophical positioning accordingly. Whilst a range of methodologies have been adopted across this research, the aim to understand the barriers to, and impact of, men's engagement in physical activity and health related behaviours is echoed throughout.

Chapter Three:

Study 1

"The role of sport demands the attention of the academic."

(Mangan et al., 2009, xii-xiii)


Study One: Reconnaissance
Study 1 examines the effectiveness of, and barriers to, promoting and engaging male football fans in health related behaviours and messages at an English Premier League football stadium on match days.
Study Two: Intervention
Study Three: Interviews

3.1 Introduction

Over the last 20 years, there has been an increased awareness of the influence that professional sports clubs can have on supporters' behaviours, particularly in relation to health. A recent report by the NHS Confederation (2013, p2) highlighted that *"sports clubs often have attractive, iconic premises which fans feel comfortable accessing, and which can provide an ideal location for delivering health services."* In recent years, there has been a major focus on promoting health behaviours, services and messages within professional sports stadiums to under-engaged groups (i.e., those disengaged from mainstream health promotion activities) (see Witty and White 2010; Gray et al., 2011; White et al., 2012; Pringle et al., 2013).

The English Premier League reports an annual match day attendance of over 13 million, with the majority of attendees being male (Premier League, 2012). It has been suggested therefore, that the English Premier League has a significant role in transmitting health messages and delivering health services to men (particularly those who are disengaged from traditional health services) on match days (NHS Confederation, 2013). White and Witty (2009a) asserted that whilst this may not be healthcare as we currently know it, some radical thinking is needed in the way we deliver health services in order to influence the UK population's poor state of men's health.

In 2009, the Men's Health Forum and the Federation of Stadium Communities (FSC) argued that whilst some stadium based men's health activity is occurring, the initiatives are few in number, and mostly small scale. Furthermore, most of the

existing projects are not working together to share information and ideas or to build a case for additional activity and investment in this field. Therefore, more evidence regarding the impact of sport and sports stadia on men's health engagement is needed (MHF and FSC, 2009).

Chapter one highlighted a number of recent male specific interventions based in sports stadia which have provided evidence of men's engagement with wellbeing related activities and positive health messages on match days such as the 'Tackling Men's Health' intervention (Witty and White, 2010) and 'Boundaries for Life' project (England and Wales Cricket Board, 2011). Whilst this evidence is useful for building an evidence-base in, and advancing, men's health initiatives, it can be argued that more needs to be done. It has been suggested that men will only achieve the highest level of wellbeing when health promotion programmes are built on an understanding of the social factors underpinning men's health related decision making practices (Robinson et al., 2010). It would appear necessary therefore, to undertake further evaluation of what aspects of a community health promotion activity work for men and why, and conversely identify activities that do not work and why.

This study focuses on the accounts and personal reflections of the researcher (practitioner-researcher) during the development and delivery of a series of health themed match day events through Everton in the Community's Premier League Health programme. Each match day event aimed to engage male football fans in health related information and behaviours in a community setting, during their

leisure time. This study aims to examine the effectiveness of, and barriers to, promoting and engaging male football fans in positive health related behaviours and messages at an English Premier League football stadium (i.e., a community setting) on match days. Moreover, this study aims to provide valuable insights into the best ways to communicate health messages to men and offer suggestions for effective strategies that will better engage men in health information and behaviours.

3.2 Method

During this study, six health promoting match day events were organised by the researcher over a period of eight months. The match day events took place both in and around Everton Football Club (an English Premier League football club) as part of Everton in the Community's (Everton Football Club's Football in the Community scheme) Premier League Health programme. The match day events all aimed to create awareness of a particular health theme and motivate men to consider adopting and/or engaging in recommended health behaviours. Health themes were dictated by the programme funding body and included physical activity, cancer, sexual health, mental health, alcohol awareness and smoking cessation. Where possible, match day health themes were chosen to align with regional and national health awareness days, for example, national alcohol awareness week, national no smoking day and World cancer day. During each event, the researcher worked alongside community health service providers and key organisations working in relevant fields in order to promote appropriate local health services.

In order to increase the awareness of a particular health message, a range of marketing techniques were adopted within a targeted space and time. According to (Walsh et al., 1993) marketing has been advocated as a powerful tool for segmenting, profiling, and targeting specific populations in public health messages. Information on the health themed match day event were uploaded onto the official football club website, independent fan websites and a variety of social networking websites, approximately one week prior to the event. Simultaneously, an e-mail was distributed to season ticket holders and a targeted press release was produced for the local media by the football club communications department. It was envisaged that by increasing the awareness of the event and the aligned health message, that acceptance and engagement in health behaviours and messages on the match day would be amplified.

On the day of each of the match day events, dissemination of the health messages occurred both in and around the stadium through a range of promotional materials such as the distribution of leaflets and health themed car air fresheners, a series of health themed awareness bathroom stickers installed into the male toilets throughout the stadium and a page of health literature was contained in the official match day programme. Additionally, specific health information were transmitted pre, post and during the match day in a series of multifaceted multimedia outputs including Bluetooth messages to mobile phones, large visual screen images and verbal health information relayed by the announcer both pre match and during the half time interval. Such techniques were based on the premise that men will engage in health behaviours in places that they already go and feel comfortable (Wilkins

and Baker, 2003). As a direct result of the marketing and promotion of the event, and the gender sensitive approach adopted, it was expected that men would wish to engage with health information on match days. In anticipation of the demand for health services, health experts from relevant national and local organisations were available on the day for male fans to engage with. These health partners were based at a *health station* inside the grounds of the stadium at each match day event.

3.2.1 Research Design

Throughout the study the researcher adopted a practitioner-researcher role (Robson, 1993; Jarvis, 1998; Gray, 2004). The researcher was responsible for the planning and delivery of all health themed match day events and for the collection of data. Carmichael and Miller (2006) suggested that the use of practitioner-researchers is an appropriate and powerful method of plunging deep into the culture and environment of the research setting in ways that would be very difficult to achieve otherwise.

Prior to data collection ethical consent was sought and granted by Liverpool John Moores University ethics board. During each match day event the researcher adopted principles of ethnography and observational research (Tedlock, 2000). Specifically, data was collected through observations and reflections logged via autobiographical field notes (Atkinson and Hammersley, 1994; Clandinin and Connelly, 2000). Typically, field notes were made in the researchers' office after the events of the day had ceased. These initial field notes were then used to form the

framework of further reflective accounts. Data was also collected via e-mails received from match day attendees and health service staff. This relaxed and informal reflective methodology allowed for *sense making* and encouraged the researcher to learn from the knowledge gained *in action*. In essence, the researcher was able to comprehend a greater understanding of the situation, and place specific encounters and events into fuller and more meaningful contexts that were useful for explaining human behaviour (Polkinghorne, 1988; Tedlock, 2000; Knowles et al., 2007).

In this study, knowledge was predominately gained from the first hand experiences of the researcher. The researcher learnt from and reflected upon these experiences through the construction of autobiographical field notes using principles of autoethnography (Heider, 1975). In line with a constructivist approach (Crotty, 1998), I (the researcher) endeavour to show you (the reader) what I know, what I saw and how I saw it (Mitchell and Charmaz, 1996).

3.2.2 Data Analysis and Representation

The researcher engaged in a period of close reading in order to become immersed in the data (Sparkes, 2005). At this stage initial ideas and thoughts were recorded. Following this, principles of content analysis were adopted by the researcher in order to identify and categorise themes arising from the data (Elo and Kyngäs, 2008). Data was analysed through deductive and inductive reasoning. Deductive analysis (based on presented evidence) followed by inductive analysis ensured that relevant theoretical and contextual themes and categories emerged from the data.

The data and themes were then presented by the researcher to a senior colleague by means of co-operative triangulation (Shenton, 2004). The colleague critically questioned the analysis and cross-examined the data and themes. This process allowed for alternative interpretations of the data to be offered. The researcher and colleague discussed the data and emergent themes until an acceptable consensus had been reached. This process allowed the researcher to refine the specifics of each theme and generate clear definitions and names for each theme.

Data is represented through a series of themed narrative accounts in order to capture 'moments' from applied observations and reflections to give the reader a greater understanding of the lived experiences of the researcher. The researchers field note extracts and personal reflections are presented as *italics* within the text. Furthermore, the voice of the football fan and health practitioner are also captured and utilised in this study to illustrate the personal experiences of others. This data is represented through verbatim citations and identified as single spaced lines and a smaller font (i.e., font 10) within the text. Pseudonyms are used throughout the results phase. Finally, a number of images are presented in order to help bring-to-life aspects of the data and supplement the text. The following results and discussion sections outlines what the researcher perceives to be the relevant issues emerging from the expansive data collected.

3.3 Results

Not now, no thanks

In contrast to existing research (i.e., Witty and White, 2010), only a small number of men engaged with health services at the stadium on match days. In order to increase men's awareness of, and engagement in, health messages, a range of services were deliberately placed in areas where men frequently attend and feel comfortable (i.e., an English Premier League football match). However, whilst, information on the health themed match day event was advertised through a range of different mediums in the lead up to the event, it appeared that this had little or no effect on the 'engagement behaviour' of the male football supporters. To put this into context, approximately 32,000 male fans attended each football match, therefore, a total of roughly 192,000 male bodies were present over the six health themed match day events. Whilst this figure includes the possible repeat attendances of the 26,048 male season ticket holders it is still a vast number of men that were potentially exposed to the match day health themes. However, the health experts present on each of the match days only engaged with a total of 14 men.

Practitioner Reflection 16/02/2010, 14:05:

The health stations at the match day events just don't seem to be working. It seemed like such a good idea; men aren't going out of their way to access health services so we'll put health experts in a place where they are already going! Thousands of men are passing by our health stations in the hours leading up to kick off and it's [the health station] right there under their noses and yet they just don't

want to know. When I watch them [the male football fans], they mostly seem to be in a rush. It's like they know where they are heading to and they don't want anything, or anyone, to interrupt them. It was the same a couple of hours before the match kicked off, when it's less busy and more chilled out. But they (the men we are trying to engage with) would rather go and watch the players park their cars than stop and talk to us about their health. It's hard to put into words just how frustrated and disappointed I am with this outcome. It took a lot of hard work to get these health stations accepted by the Club and I think I've even put a strain on some professional relationships whilst arguing the case for them.

Figure 3.1. (below) epitomises the men's behaviour on a typical match day. Specifically, the scene captures the researcher's frustrations as we see hoards of men preferring to loiter around the area where the first team players park their cars (depicted by the arrows) rather than stop and talk to health professionals about their health in the hours leading up to kick-off.

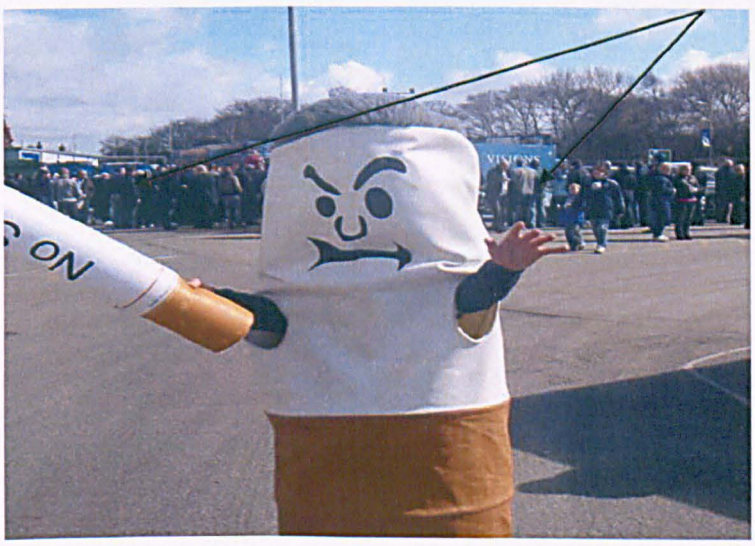


Figure 3.1. Smoking cessation match day awareness event

The dissemination of health messages through the distribution of leaflets also had little impact on the men's engagement with health messages and health services. Leaflets were generally disregarded and when approached, many men verbalised such comments as, *"Not now love/girl"* and *"No thanks, I just want to watch the match."*

Branded freebies and subliminal messages; a step in the right direction?

Football club branded health themed car air fresheners, however, had a greater acceptance than health themed leaflets and information stations. Car air fresheners were designed in the profile of a football shirt, printed in the corresponding colour of the home team and displayed printed signs and symptoms of bowel cancer (see figure 3.2. below). Over 5,000 air fresheners were distributed to male fans during one match day event in various locations in and around the stadium grounds, with men appearing content to receive them.

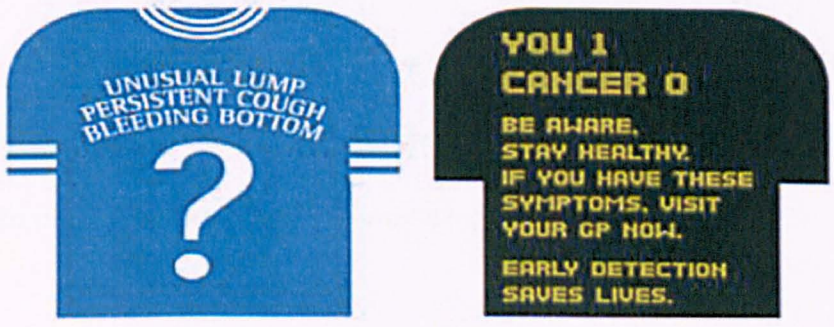


Figure 3.2. Car air fresheners displaying printed signs and symptoms of bowel cancer

Practitioner Reflection 05/12/2009, 16:30:

Today was interesting! A couple of weeks ago we handed out health information leaflets and not many men took them. Those that did take a leaflet tended to stuff

them in their pockets very quickly or threw them on the floor. Today we handed out health information again, but this time it was printed on car air fresheners. I was amazed by the difference in response! Not only did everyone want one, but men even came up asking if they could have another couple for their mates. I know it's not because of the health messages that people want them, but that doesn't matter, as soon as they are dangling in front of them in the car, they won't be able to escape the health messages printed on them. It's only one small step for health promotion but perhaps one giant leap for health promotion with men?

This finding highlights the power of the football club brand (Richardson and O'Dwyer, 2003) and suggests that health practitioners are able to disseminate health information material to men on match days. However, in order to create interest and acceptance the health messages/material need to be in a form that is tangible, it must be complimentary and it is advisable that it reflects the brand of the football club (i.e., colours and logo) without infringing upon it. It is also important that the health messages do not drown the merchandise. Instead, subtle subliminal messages seemed more appropriate for these products so that they are still deemed *masculine* and therefore appealing to the target audience.

Get me now I'm in

Specific health information transmitted both pre match and during the half time interval via a series of multifaceted multimedia outputs (including bluetooth messages to mobile phones, large visual screen images, verbal health information relayed by the stadium announcer and health literature in the official match day

programme) were generally considered welcome by the target population in comparison to invasive engagement approaches (i.e., stopping men to talk and handing them health information leaflets). These methods of engagement also appeared not to impose on, nor contaminate, the men's match day experience. Furthermore, these methods of engagement occurred within the confines of the football stadium. It could be argued that, when the men were inside the stadium, they became a more captive audience. Once inside, the stadium the men appeared more settled and were (generally) more likely to connect with health information than when they were outside the stadium. Typically, the experience outside of the stadium before the match involved the intricate navigation through large crowds in order to get inside the ground, get to your seat and get settled before kick-off. It appears that such a hectic environment is not conducive to the promotion and/or receipt of health related information.

Another example of the non-invasive and more subliminal approach to engaging the men inside the ground was the use of the cancer awareness vinyl bathroom stickers (see figure 3.3). These health awareness raising stickers were provided by the local cancer network service (stickers were produced for a larger social marketing campaign) and were installed into the male toilets throughout the stadium by the first author prior to a cancer awareness health themed match day event. The stickers aimed to raise awareness of the signs and symptoms of prostate and bowel cancer in an informal male dominated setting.

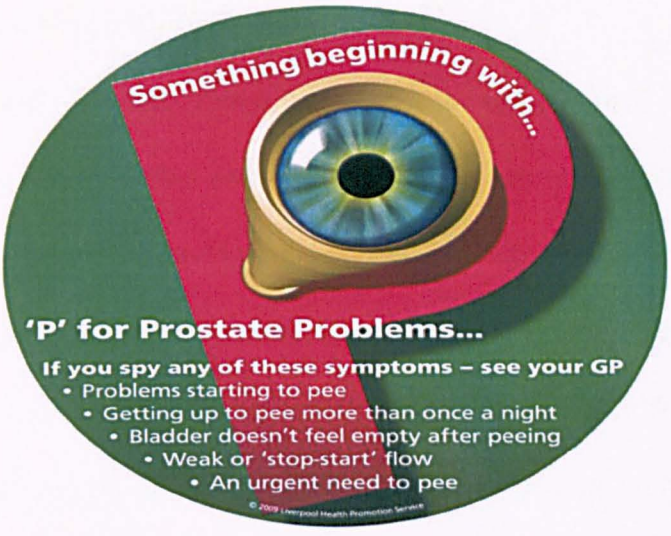


Figure 3.3. Cancer awareness bathroom stickers

In the subsequent months, the researcher received the following feedback via e-mail.

E-mail received 01/02/2010, 09:17:

> "Dear Kathryn, After going to the bathroom in the Park End of the Goodison Stadium my awareness was raised by the large sticker in relation to prostate and bowel cancer. I already had a slight problem with my prostate, but after reading the symptoms in relation to the bowel problems, I realised that I had some of the symptoms. I have since been to the doctors, had a CAT scan, been diagnosed with bowel cancer and had an operation to remove the problem. I feel that most males of my age and generation are not aware of the risks in relation to both bowel and prostrate problems and, like myself, would probably not go to seek advice from there General Practitioner, I feel that the Premier League Health bathroom sticker campaign alerts people and makes them far more aware of the potential risks to them."
>
> Peter, Male, 51, Liverpool.

The following reflection captures the thoughts and feelings of the researcher upon receiving this information;

Practitioner Reflection 25/01/2010, 10.00:

This week I received an e-mail from a man who had realised that he had significant cancer symptoms after reading one of our cancer awareness bathroom stickers. I was quite emotional after receiving this information. The day I put the stickers up in the male toilets throughout the stadium, was a freezing cold December day and nobody wanted to help me with it (I don't blame them!). I was freezing cold, my fingers were red raw, the toilets were pretty unpleasant and I felt really lonely. I have always recalled this day as one of the only days that I haven't enjoyed since starting this project. Yet now I know that my actions on this day may have contributed to saving this man's life. This just shows that we can make a difference and men are actually taking notice of some of the things we have been doing. I have a very different feeling about that cold lonely day in December now.

This data reinforces the concept that health promotion within an English Premier League Football Club is possible and that it can be both efficient and effective if the correct methods are adopted for capturing the attention of your target audience.

A take-home message

Following each match day awareness event, an e-mail was sent by the researcher to health service staff that had been involved in the match day event. The purpose of the e-mail was to determine the usefulness and impact of the event to their organisation. An unanticipated finding emerged that the majority of organisations reported significantly higher traffic on their website and/or phone line in the one to two weeks following the match day event.

E-mail received 20/02/2010, 13:45:

"Hi Kathryn, We had a great time on Wednesday, especially as the Blues won too!!! The following day we received 16 requests for postal chlamydia kits via our website or text system which is a significant increase on the average daily number of testing requests. If anyone else mentions that they heard about us via the match day awareness event we will be sure to let you know. Regards, Rachel."

As the organisation's website and phone number were predominantly advertised through a series of branded multifaceted multimedia outputs, this finding again supports the concept that non-invasive health promotion messages that are branded with the football club logo were better received, and thus, more successful. This finding also supports the theory that men live in the *now* (Deutsch, 2010) and so when we market health information to men we should take into account that men will typically concentrate on what is currently happening (in this regard, a football match) and are more likely to take on board information targeted at them in their down-time.

3.4 Discussion

In 2009, White and Witty (2009b) asserted that more evidence of the impact of sport and sports stadia on men's health engagement was needed. This study aimed to contribute to this call for research by understanding the effectiveness of, and barriers associated with, promoting, and engaging male football fans in, health related behaviours and messages at an English Premier League football stadium on match days.

Through the use of reflective methodologies, this study has provided contextual real-life information which offers valuable insights into men's engagement with

health messages and behaviours on a match day at an English Premier League football club. The findings also formulate a number of important messages and future directions for men's health practitioners/researchers to take into consideration.

White and Witty (2009a) proposed that the setting where male targeted interventions are delivered is an important factor in men's engagement with health. Moreover, Wilkins and Baker (2003) suggested that men will respond to health messages offered in places that they already go and feel comfortable such as sports stadia. This finding was supported by the Tackling Men's Health intervention which concluded that the delivery of a men's health intervention at large UK Rugby stadia was feasible and achieved good levels of engagement. In contrast, the Premier League Health health themed match day awareness events at this large UK football club did not appear to achieve such levels of engagement with men in and around the stadium. Therefore, a clear differentiation in engagement between two popular male dominated spectator sports in the UK has been identified. It would appear that whilst there is an appeal to use sport, and sports stadia in particular, for engaging men in health messages, *one size may not fit all*. Specifically, we cannot assume that male supporters will absorb health messages in and around all sport stadia.

Importantly, this study revealed that whilst one approach may not be successful in all stadia settings there is a case for engaging men in health issues in the community setting, during their leisure time and more specifically at an English

Premier League football club and on a match day. In this instance, health related awareness and engagement methods that encroached on men's match day experiences were not successful as the majority of male football fans appeared to have a *match day ritual* (i.e., catch a glimpse of the players as they park their cars, meet with friends, navigate their way inside the stadium and get to their seats) during which, they did not like to be disturbed. Having said this, it would appear that practitioners can be successful in communicating with and engaging men in health information in this, or similar settings. In order to successfully promote health behaviors and messages to male football fans on an English Premier League match day, practitioners should aim to adopt a range of subtle, non-invasive approaches that may include multimedia messages or the development of tangible, masculine, club branded promotional materials that allude to published health messages.

3.5 Conclusion and future research

This study has identified what aspects of a football based health promotion activity worked for men on a match day, and conversely what did not work, and why. Furthermore this study has offered suggestions for effective strategies that will better engage men in health information and behaviours in similar settings. By doing so, this study contributes to an underserved area within health promotion and men's health literature and offers a potential solution to the concerns raised regarding men's under use of health services (Gough, 2013). However, there still remains a lack of accessible, research-based evidence examining the effectiveness of different types of innovative approaches to health promotion among men

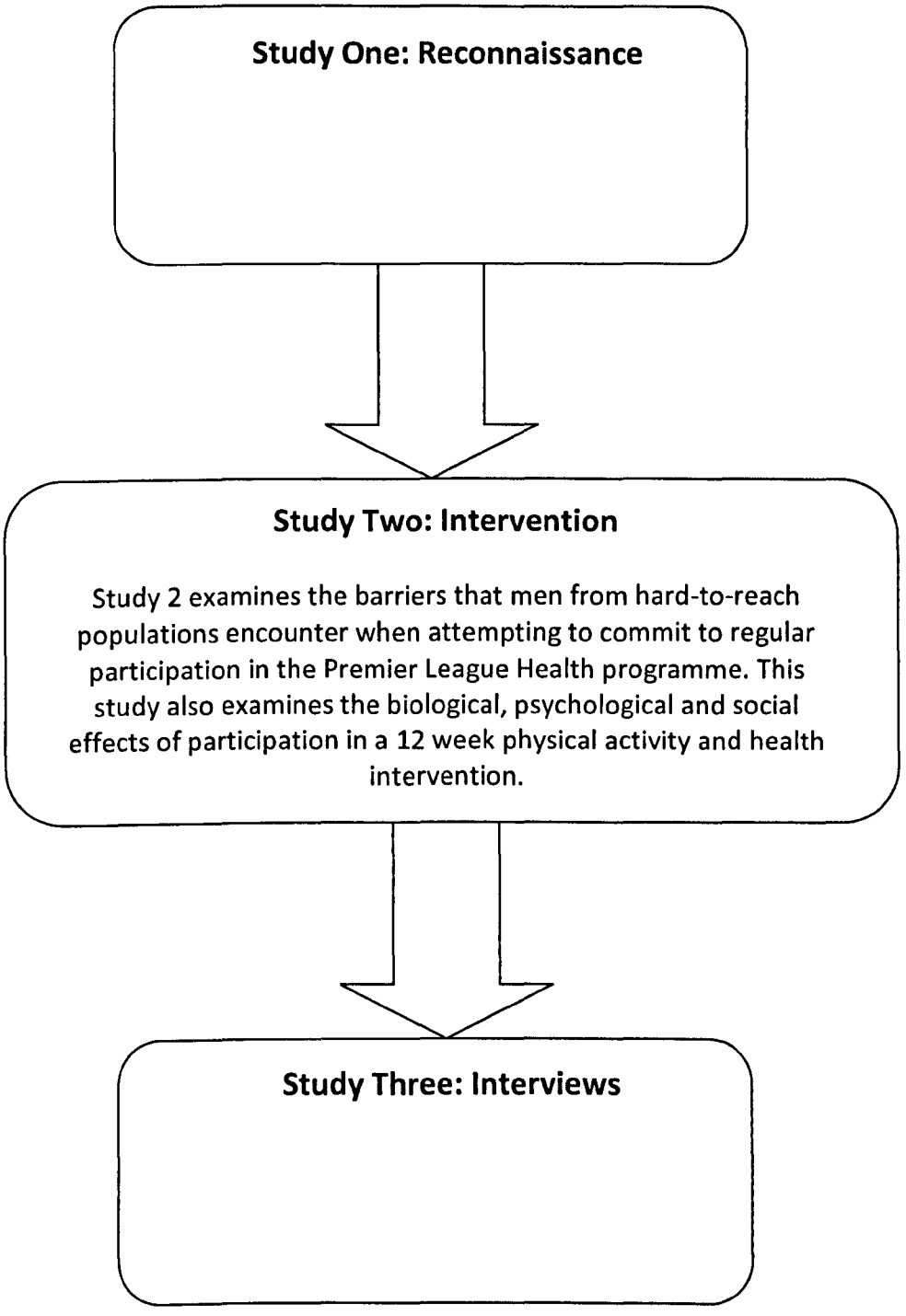
(Robinson et al., 2010). Therefore, it can be argued that more contextual evidence is required in order to build a more informed understanding of men's engagement with health services in community settings and subsequently assist in the advancement, and creation of, future men's health promotion initiatives and interventions.

Chapter Four:

Study 2

"Individuals do not live in a vacuum; rather efforts to modify behaviour are often constrained (or facilitated) by a range of social, economic and environmental forces..."

(Ball, 2006, p367)


Study One: Reconnaissance
Study Two: Intervention
Study 2 examines the barriers that men from hard-to-reach populations encounter when attempting to commit to regular participation in the Premier League Health programme. This study also examines the biological, psychological and social effects of participation in a 12 week physical activity and health intervention.
Study Three: Interviews

4.1 Introduction

Hard-to-reach male populations frequently report poor health statistics and have, therefore, been highlighted as a particular area of concern for men's health practitioners/professionals (NHS, 2012). The definition of hard-to-reach (HTR) populations (see chapter one) describes populations who are difficult to access and/or engage due to specific factors such as accommodation, age, ethnicity, gender, income, language, location and religion. Although the term 'hard-to-reach' has been the subject of much debate (see Brackertz, 2007), it is deemed an appropriate term for use in this study and will be applied consistently throughout.

It has been argued that participation in regular physical activity can significantly improve the overall health and wellbeing of HTR populations (WHO, 2003b; Sport England, 2008). However, people from HTR groups often experience difficulty engaging in physical activity for a sustained period of time (WHO, 2003b; Frisby and Millar, 2007; Sport England, 2008). At present there remains a lack of contextual evidence which provides insight into the difficulties (i.e., barriers) experienced by men from HTR groups when attempting to engage in physical activity and health behaviours for a sustained period of time (Roby et al., 2008). In order to extend our understanding of *why* men from HTR groups experience difficulty engaging in physical activity and health behaviours for a sustained period of time, it is critical to understand the contextual barriers and challenges that such populations encounter (Sherry et al., 2012).

For many years, health promotion efforts, targeting a range of health behaviours, have tended to focus primarily on individual lifestyle and behaviour change. Specifically, the accepted approach was to place the onus on the individual to take responsibility for managing or improving their own health (Stokols, 1996). According to Ball (2006, p367) however, this approach was problematic as *"individuals do not live in a vacuum, rather efforts to modify behaviour are constrained (or facilitated) by a range of social, economic and environmental forces."* There is now a wealth of evidence to support the notion that physical health, mental health and social wellbeing are deeply influenced by the social, economic and environmental contexts of people's lives (see Stokols, 1996; WHO, 2003a; Ball, 2006; Macdonald, 2006; Sallis et al., 2008).

Collins and Kay (2003) undertook a review of the literature on sport and social exclusion amongst hard-to-reach groups and found social, economic and contextual constraints (namely; a lack of structure, income, skills and social capital and a sense of powerlessness) as the major barriers to engagement. These barriers resonate with the World Health Organization's (2003a) 'Social Determinants of Health' (see chapter one). Although social, economic and environmental influences/barriers have been identified and recognised amongst hard-to-reach groups, there remains a lack of contextual research evidence which gives voice to hard-to-reach populations and allows HTR populations to express their needs and challenges when engaging in sport, exercise, physical activity and health behaviours (Frisby, 2005).

Sport England (2008) argued that it is important to identify what specific health, wellbeing and social benefits HTR populations can accumulate from regular engagement in physical activity and positive health behaviours and programmes. Recent research by Sherry and Strybosch (2012) analysed the longitudinal outcomes of engagement in Australia's Community Street Soccer Programme (CSSP) for HTR populations. The CSSP programme engaged hard-to-reach male participants in weekly soccer (football) specific training sessions and aimed to promote independence, self-reliance and build social capital. The majority of the participants in this study derived from low socio-economic situations, had past or current experience of homelessness and associated social disadvantages including drug and alcohol dependency and long term unemployment. Participants of the scheme were interviewed to investigate the intrinsic benefits and the social outcomes of participation in the programme. The study found that engagement in the programme improved health, developed social capital, built self-esteem, created structure and routine, and created a positive self-identity. However, this study acknowledged that the HTR participants had a range of complex issues which they brought with them and thus, hindered retention and successful implementation of the programme.

The findings of these studies are useful for building an understanding of the barriers to, and impact of, engagement in a football specific programme for hard-to-reach male populations. However as Frisby (2005) suggested, we need to dig deeper in order to develop rich contextual evidence which examines what 'lies behind' health-related behaviours amongst hard-to-reach populations, and more

specifically about the long term effectiveness (or not) of health promotion interventions with these populations.

As highlighted in previous chapters, an emerging area of men's health in the UK is the provision of health and wellbeing programmes and activities delivered in and by sporting organisations. Due to the popularity of the English Premier League (EPL), Football in the Community programmes have been championed as a vehicle to reach and connect with HTR populations (Pringle et al., 2011). Such programmes provide a platform for gathering contextual data which aims to offer a 'real life' appreciation of HTR men's barriers to engagement in regular and sustained physical activity and health behaviours.

The aim of this study is to examine the distinct challenges that hard-to-reach populations encounter when attempting to commit to regular participation in Everton in the Community's Premier League Health programme and explore the biological, psychological and social effects of participation in a 12 week physical activity and health intervention. Through these aims, this study endeavours to provide men's health practitioners with knowledge and guidance for tailoring their approach to physical activity and health behaviour programmes with HTR populations in order to; reduce the alleged challenges to engagement, ensure more sustained participation, maximise health and wellbeing benefits and subsequently ensure successful implementation and maintenance of men's health programmes.

4.2 Method

After obtaining ethical approval, HTR populations were recruited for participation in a 12 week football-specific physical activity intervention which formed part of Everton in the Community's Premier League Health programme. Initially, two HTR populations were identified; homeless men and men recovering from drug addiction[7]. Two services hosting these particular HTR populations were then contacted. These services included a men's homeless shelter and a drug addiction service within the City of Liverpool, UK, who were already working in partnership with EitC's PLH programme. Participants were recruited over a period of three months using a variety of mechanisms including face-to-face engagement, phone calls, referrals from service staff and word of mouth. The intervention was directed at men 18-35 years of age, although adult men beyond 35 years were eligible to enrol. Enrolment on the programme was voluntary and participants were free to withdraw at any point.

Following the recruitment drive, 34 men (aged 18-45 years) who were from populations defined as hard-to-reach enrolled on the football-specific physical activity intervention. The majority of the subjects were smokers, were living in homeless shelters and/or had a history of drug-use (i.e., all participants were described as 'recovering' and had not taken drugs for at least 6 months) and did not regularly participate in any form of structured physical exercise. The football-specific physical activity intervention consisted of two 2-hour football sessions each week alongside the dissemination of healthy living messages. Football sessions

7 It was acknowledged that these populations may not be mutually exclusive categories and that some participants may fall into both groups.

were conducted by a qualified FitC coach. Typically, each session involved a short informal 'talk' from a health service provider followed by a standardised warm-up, fitness activities, skills practice and concluded with a small sided game.

4.2.1 Research Design

Frisby (2005) suggested that novel qualitative methodologies (i.e., those that allow for the voices, experiences and insights of HTR populations to be heard) offer a greater understanding of HTR populations. Throughout the study the researcher adopted a practitioner-cum-researcher role (Robson, 1993; Jarvis, 1998; Gray, 2004). The researcher adopted the principles of ethnography and observational research (Tedlock, 2000) in order to gain a deeper understanding of the day-to-day realities and challenges of the participants. Tierney (2002) suggested that qualitative researchers broaden the narrative strategies used in research and open up a space in social science texts for a more protean and engaged portrayal of the lives we observe and live. The ethnographic process is summarised by Tedlock (2000):

> *"...by entering into close and relatively prolonged interaction with people... in their everyday lives, ethnographers can better understand the beliefs, motivations and behaviours of their subjects than they can by using any other approach..." (p456).*

The researcher was immersed in the planning and delivery of the programme from the outset and subsequently engaged in a 4 week period of regular casual conversation and active participation with programme participants in order to develop relationships, trust and rapport. Throughout the following 8 weeks, psychosocial issues were discussed with all programme participants through

informal client-researcher interactions. Data was collated through logged researcher observations and field notes (Atkinson and Hammersley, 1994). Records of attendance were also logged and participants who failed to attend a session were contacted via telephone. The participants' reason(s) for non-attendance were recorded. Text messages sent by the participants to the researcher in relation to the intervention were also logged. Such an approach encouraged a more meaningful contextual understanding of the participants' real life experiences and barriers to engagement (Polkinghorne, 1988; Tedlock, 2000).

In order to 'bring to life' the reality that I (the researcher) faced during the ethnographic phase of this work it seems appropriate to share my personal concerns and experiences of being a practitioner-cum-researcher with you (the reader). By doing so, it is hoped that you can begin to understand the complex world within which this research took place. The following vignette documents my personal reflections upon 'entering the field' (i.e., emergence of the researcher into the culture and environment of Study 2) however several other reflective' stop offs' occur throughout this study in order to contextualise the position of the author, the participants and the environment at that point in time. All vignettes embrace the genre of 'author involved text' (Gilbourne and Richardson, 2006), in which the researcher is presented as the narrator using a first person writing style (Jones, 2002):

Reflective stop off

Concerns upon 'entering the field'

Within the field of ethnography 'entering the field' is a complicated process where ethnographers must learn to juggle a number of different aspects at the same time (Barley, 2011). Schensl et al. (1999) highlighted that ethnographers need to become familiar with the norms, beliefs, rules, rituals and language of the field, learn how to locate and build relationships and learn how to unobtrusively collect and record data. This following offers a brief reflection of my personal experiences upon entering the field.

My aim, methods and research design for Study 2 had been outlined and approved, my plan was clear and I knew what I had to do. The next step was to recruit participants. This was going to involve visiting several homeless shelters and addiction services, where staff had informed the service users that I would be coming in to talk to them about 'a football course with Everton'. I was nervous. I was venturing into unfamiliar territory and I knew that I would be faced with talking to groups of men who were likely to be very different to the men in my day-to-day life. My main worry was about how to present myself. The following highlights some of my concerns:

What should I wear?
There was a lot to learn about the culture of Everton Football Club and Everton in the Community. However, one of the most obvious cultural conducts was the clothing that staff wore. In general, the management/professional staff wore smart office clothes whereas the delivery staff (who were typically young, male football coaches) wore Everton Football Club tracksuits. Typically, I am a quite a 'girly girl' who likes to wear smart clothes, my hair down, make-up and nail varnish. Furthermore, I like to be perceived as professional. Therefore, I tended to wear smart office clothes to work. However, I was aware that initial contact with the programme participants was going to be vital; it would be where I made my first impression. I decided that my usual image wasn't going to work, and so I decided to wear my Everton Football Club tracksuit for all interaction with the participants. I removed my expensive diamond engagement ring, wore less make up, removed my nail varnish and tied my hair up. I didn't look like my normal self and I worried that I looked unprofessional to others but I knew this attire was more appropriate for engaging with the participants in order to break down some barriers, and that is what mattered the most.

How should I talk?
After initial contact, I worried about my language and the tone of my accent. Having grown up in South Liverpool and having spent four years at university in the East Midlands surrounded by 'southerners', my regional accent was not anywhere near as pronounced as the accents of the participants. Furthermore, I'd never even heard of some of the slang words they used. I needed to be as accepted as possible, however, I knew this was going to be difficult. After all, I

could change what I wore very easily, but I couldn't 'put on' a thick North Liverpool accent.

How should I act?

When the intervention was about to commence I also worried about how I should act. Should I just be myself or should I behave in some different way? Do I join in with the activities or do I stand and watch? If I join in with the activities what would the participants think? After all, I wasn't going to help myself to build relationships with them if they lost the game or activity because I am a rubbish football player! But if I just stand and watch, will I ever get to know them?

In essence, I had to decide how I wanted others to perceive me and therefore 'who I should be'. Upon reflection I realised that this was all a learning process and arguably, it was a matter of identity (Le Compte and Preissle 1993; Coffey; 1999). Coffey (1999) suggested that clothing, speech and behaviour are all important aspects in the construction of identity in fieldwork. This is supported by Hammersley and Atkinson (1994) who argued that ethnographic researchers must judge what sort of impression they want to create and manage appearances accordingly.

In order to assess the health benefits of engagement in the intervention, a series of physiological tests were conducted throughout the study. Physiological testing was completed at 3 time points (Weeks -1, -6 and -12). Participants were assessed for; body composition, blood pressure, resting heart rate and blood lipid profile. All testing sessions were carried out at similar times to control for circadian variations. In accordance with Liverpool John Moores University ethical procedures, participants were given a verbal briefing about the study and a participant information sheet (Appendix A), familiarised with the intervention's physical activity 'training' programme and testing procedures and all participants gave their written, informed consent to participate in the study (Appendix B). Participant's body composition was assessed via Dual-energy X-ray Absorptiometry (DXA) (Hologic QDR Series Discovery A, Bedfored, MA). Height and mass measurements were taken according to the anthropometric procedures recommended by the

International Society for the advancement of Kinantropometry (ISAK) (Marfell-Jones et al., 2006) using a Stadiometer (Seca, Germany) and electronic weighing scales (Seca, Hamburg, Germany). Resting blood pressure and heart rate were measured using an automatic upper arm blood pressure monitor (Dynamap, Critikon, UK) following a 5 minute period of seated rest. Three measurements of each variable were obtained from each individual during all data collection points, the mean values were determined and used for analysis. Blood samples were obtained from the antecubital vein and collected in 2mL syringes without heparin. Plasma from centrifuged samples was collected and stored at -20°C until subsequent analysis. High density lipoprotein (HDL), low density lipoprotein (LDL), triglycerides and total cholesterol were determined flourometrically on an automatic analyser (Cobas Fara, Roche, France) using enzymatic kits (Roche Diagnostics, Mannheim, Germany).

The intensity of all physical activity training sessions was recorded throughout the study. Heart rate was continuously monitored throughout football sessions and was recorded every 5 seconds using heart rate monitors (Polar Team System, Polar, Kempele, Finland). The mean heart rates of each individual was determined and used for analysis. Perceived exertion was determined following each session using Borg's CR10-scale (modified by Foster et al., 1995). Training load (RPE_{load}) was determined by multiplying the training duration (minutes) by the session RPE, as described by Foster et al. (1995). This RPE-based method of training load quantification has been shown to be a good indicator of internal training load in football (Imellizzeri et al., 2004).

This study therefore required a mixed method approach. Consequently, the researcher shifted between paradigmatic lenses. The ethnographic element of this study was arguably aligned with the interpretivist paradigm in which the researcher held a value based epistemology and relativist ontology whereas the experimental nature of assessing the physiological impact of the intervention was aligned with the post positivist paradigm in which the researcher held an objective epistemology and critical realist ontology.

4.2.2. Data Analysis and Representation

Following the intervention, the researcher engaged in a period of close reading in order to become immersed in the qualitative data (Sparkes, 2005). Initial ideas and thoughts were recorded. Following this, qualitative data (including all field notes and informal dialogue and/or interaction with participants) was analysed through deductive and inductive reasoning in order to extrapolate a meaningful understanding of the participants' behaviour and voices (Polkinghorne, 1988). Deductive analysis followed by inductive analysis ensured that relevant theoretical and contextual themes and categories emerged from the data. There is a wealth of evidence to support the notion that health is deeply influenced by social, economic and environmental influences and barriers (i.e., Stokols, 1996; WHO, 2003a; Ball, 2006; Macdonald, 2006; Sallis et al., 2008). Furthermore, research evidence highlighting the biopsychosocial impact of engagement in football specific physical activity interventions for hard-to-reach populations has been highlighted (see Gray et al., 2011; Sherry and Strybosch., 2012; White et al., 2012; Pringle et al., 2013). The findings of previous research therefore, provided a basis for the theoretical and

contextual themes used for analysis in this study. Data is represented through a series of themed verbatim extracts that capture the voice and experiences of the participants. The voice of the participants are represented in this study through a series of direct quotations and evidenced as *italics* within the text. Pseudonyms are used for all participants.

Physiological data was analysed to examine differences at each time point during the intervention. All physiological variables were assessed for the assumption of normality using the Shapiro-Wilks test for normality of distribution. Mauchly's test of sphericity was performed on all data to assess for the assumption of sphericity. Within-group data for all variables for pre-, mid- and post-testing (Weeks -1, -6, and -12) were evaluated by one-way analysis of variance on repeated measures (ANOVA). When a significant interaction was detected, data was subsequently analysed using Bonferonni correlated pair-wise comparison post-hoc test. The level of statistical significance was set at $P< 0.05$. All statistical analyses were carried out using SPSS Statistical Analysis Software (SPSS® Version 15.0.01 for Windows®, Chicago, Illinois, USA).

Before presenting and evaluating the results of the study it seems appropriate to share with you (the reader) the experiences and difficulties experienced by the researcher in achieving the research aims through the methods adopted. In the vignette to follow I recount my experiences of building and maintaining relationships with several programme participants and highlight what I learnt from such experiences:

Reflective stop off

Building Relationships

I arrived as an outsider. I was someone who the participants didn't know and didn't trust. I was not part of their social environment and I had limited knowledge of their lives and their normal patterns of everyday conduct. I also had no experience of the climate and culture of the venue/environment where Study 2 took place. The programme participants had very different norms and behaviours to me and I knew that if I got something wrong, or if I acted or presented myself in a way that was not fitting with them, it may affect my relationships with the participant's long term and thus, my research (see Coffey, 1999). I needed to build relationships and I needed to do this quickly...

I often recall my first day engaging with the participants within the research setting. I was too shy to join in with the activities so I was stood on the side lines watching. After a while, I walked over to talk with a programme participant, Andrew, who was also sitting on the side lines and not joining in with the activities. I asked if he was OK. He told me he was fine but he was too 'stoned' to join in. This was a significant moment for me. I realised that perhaps this study was going to be much more complicated than I had anticipated. I recognised that not only was I naïve to not have noticed the state he was in, but also naïve because this barrier for participation in physical activity is not one that would have ever crossed my mind.

Given that Andrew was the only participant not joining in with the activities that day I thought it would be a good idea to try and build a relationship with him. I decided to sit on the floor with him and have a chat. First, I checked that this was ok. Although sitting and chatting is a natural act (especially for me, someone who loves to talk), I remember feeling really awkward. Although I initially struck up a light-hearted conversation, during the next 40 minutes Andrew told me a lot about life. He told me about losing his parents at a young age and how this had fuelled his drug use. He shared with me his story of why he decided enough-was-enough with Class A drugs after he went to a 'crack den' and spent the afternoon in a house full of people inserting heroin into their groins. Andrew also told me that he hears voices in his head. I found it difficult to know how to respond so I just listened.

Although superficial in comparison to the other stories that Andrew told, I remember being shocked when he told me that he takes his PlayStation to Cash Converters every week to get some money to buy cannabis and how he buys his PlayStation back (at a higher price) when his dole money came through. To me, this didn't make any sense and it was also a situation that I had never been in, nor could I relate to. Again, I struggled to know what to say.

The conversation I had with Andrew on 'day one' both surprised and shocked me, however in the following weeks there were many unexpected conversations, experiences and situations that I found myself in which would highlight the difficulty I had in building and maintaining researcher-participant relationships. The following provides just two of these examples;

Throughout Study 2 I always tried to arrive early to the sessions. By doing so, I hoped that I would get to speak with one or two of the participants before the activity began, and thus, build relationships whilst trying to dig a little deeper into my research question. I parked my car, removed the kit and equipment needed for the session from my car boot and slammed it shut. However, it was then I realised that I had shut the boot (which was on auto lock) with my car keys inside. A few minutes later Peter (participant) arrived. I didn't know Peter very well. Despite my efforts, he never seemed to want to talk and he didn't give much away. I called Peter over thinking to myself that this will be a good chance to build a relationship with him. After all, locking my keys in my car was a daft thing to do so I thought to myself, "we can have a laugh about it that should break the ice." "I'm so stupid, I've just locked my car keys in my car" I said and began to laugh hoping Peter would join in the laughter with me. I was not at all expecting what came next, "Not a problem," he said, "I can get into that [break into my car] in 30 seconds. It will leave a big dent like, but do'ya want me to?" I tried my best not to look horrified as I thanked him for offering and explained that help was on its way. "Ok" he said as he walked off. I remembering thinking, "Well that didn't work! I'm not sure I will ever get to know him."

I recall another occasion when I was stood on the side lines of the pitch with Brian (participant) while the majority of the participants took part in a small sided game of football. Brian was suffering from an injury and so we sat down on the floor together and began to engage in light-hearted conversation. Before I knew it, Brian was telling me about his life in prison. Brian described how he used to be 'addicted' to armed robbery and how it was like a 'game' to him. Brian told me that he turned into an 'animal' in prison and because of his behaviour, the prison staff wouldn't let him out for his mother's funeral. He told me that this had resulted in a lot of hate and anger now he is out of prison and his mum is no longer there. Brian described some of the things he had done to steal money and cars in the past. It was unthinkable. Later in the conversation Brian told me that I was one of the nicest people he had ever met but he didn't trust me. He said that he didn't trust anyone and never would.

A few weeks later Brian arrived at my office door at EAFC. He was dropping off some paperwork given to him by Drew (Premier League Health Coach). At the same time that Brian arrived I was walking out of the door with my coat on and bag in hand, on my way to the venue for the session. This was where Brian was on his way to also. He asked me for a lift. I was thrown off guard and couldn't think of an excuse quick enough...

I had been told by EitC management; "don't allow programme participants in your car." Furthermore, due to the nature of Brian's personality and given the conversation Brian and I had a few weeks earlier I wasn't altogether comfortable in his company, especially alone. I was put in a compromising position. What was I supposed to do? Jump in my car, tell him I will see him there and let him walk for fifteen minutes when I was travelling to the same place? Try to explain that I am not 'allowed' to have participants in my car? I knew this would not be easy to say to someone who doesn't generally follow rules. I had spent a long time building a relationship with Brian, yet I knew it could all be ruined in one moment, one decision. Furthermore, I knew he would be sure to tell the other participants that I let him walk when I was driving there at the same time. What would they think? I had no colleagues around to ask for support and so, in that moment I decided the only thing I could really do was to give him a lift. I said "Yeah of course", trying my best to sound relaxed. I drove the whole way to the venue praying that Brian wouldn't pull a gun out on me. Perhaps this was the wrong decision to make, I know it certainly would be in the eyes of the management at Everton in the Community, the University ethics committee and also in the eyes of my husband and parents (sorry mum!), but it was also a decision that could have ruined the relationships I spent so long building, and thus, my research.

By this point I realised that the topic I had sketched out in my research plan seemed very simple in comparison to the complex reality that I was now faced with. Very soon I realised that in order to achieve my research aims I was going to have to wade through, and deal with difficult, challenging and chaotic situations and conversations.

4.3 Results

The results of this study are separated in this section into three distinct categories;

1) Challenges to engagement in the 12 week Premier League Health intervention

2) Psychosocial impact of engagement in the 12 week Premier League Health intervention

3) Physiological impact of engagement in the 12 week Premier League Health intervention

4.3.1 Challenges to engagement in the 12 week Premier League Health intervention

Despite the apparent ambition of the HTR participants to regularly participate in the Football in the Community programme, regular adherence to the programme was poor. Through the adoption of ethnographic methods in this research, a period of 'down time' was established within the physical activity programme (generally prior to activity commencing and between activities). This time period became particularly useful for building practitioner-participant relationships and consequently for identifying a number of challenges experienced by the HTR participants.

All of the participants reported that regular engagement and adherence posed a real challenge for them. Three dominant themes emerged which captured the context of this irregular and/or non-attendance namely; 'economic', 'environmental' and 'social' challenges (see Macdonald, 2006; Sallis et al., 2008).

Economic Challenges: Budgetary restraints are a significant barrier for participating in sports activities for people of low income (Steenhuis et al., 2009). Similarly, it became increasingly evident that financial constraints were a significant challenge for the HTR participants, who were generally not in employment, when attempting to engage in the PLH programme. Although there was no direct cost for participation in the PLH programme, the indirect cost of transport to and from the sporting venue arose as a significant challenge for the majority of participants throughout the programme. This finding was epitomised by Gary, 31, a recovering

drug user, when he exclaimed:

> *"I can't afford the bus fare. I want to come like, but just can't always get up there." (Gary)*

Similarly, Ben, 24, an enthusiastic participant who was living in a homeless shelter, stated:

> *"Sorry that I didn't turn up Kath. I've got no money to get there. Sorry." (Ben)*

This financial challenge was also evidenced by Dave, 31 who said:

> *"I'm not going to be able to make it today Kath, sorry. I'm still waiting for some money."(Dave)*

Environmental Challenges: The influence of the environment on sports participation has been described as *"any aspect of the physical (natural) environment or the urban or constructed (built) environment that subconsciously or consciously relates to an individual and their sport and physical activity behaviour"* (National Institute for Health and Clinical Excellence (NICE), 2008, p2). The location of the recreational facilities (built environment) which were used for the intervention emerged as a dominant theme preventing the HTR participants from sustained participation in the programme. This finding is illustrated by James, a 26 year old participant who was living in a homeless shelter who exclaimed:

> *"It's [the venue] just too far away from where I live. It takes me ages to get up there." (James)*

Another participant, Andrew, 25, also stated:

> *"I will struggle to make it every week Kath coz it [the venue] isn't on a bus route from me house." (Andrew)*

Similarly, during an informal researcher-participant telephone conversation Ben, 24, said:

> *"It's too far to walk there [venue] from the shelter and I can't afford the bus fare at the moment."(Ben)*

Social Challenges: The influence of social factors as a determinant of physical activity engagement is widely recognised (McNeill et al., 2006). Social challenges to participation which emerged from the data in this study were largely related to the participants' primary priorities (i.e., for survival in their day-to-day existence). For example, the HTR participants in this study were living in homeless shelters and/or recovering from drug misuse and were commonly assigned to 'community support workers' who were helping them to rebuild their lives. As a result of this however, attendance was often prohibited due to participants having obligatory meetings with their community support workers. Rob, 23, stated:

> *"I've messed up again. Now I have to see my officer [support worker] every Tuesday." (Rob)*

Similarly, Andrew, 25, said:

> *"I've gotta meet me support worker today so can't make it." (Andrew)*

Furthermore, participants commonly stated that they had other situational obligations to attend to during the time that they hoped to attend the Premier League Health programme, for example, Dan, a 34 year old unemployed, homeless participant explained:

> *"I've got to sign-on [job seekers allowance] on Tuesday afternoons Kath so I won't be able to make it here half the time." (Dan)*

Similarly, Tom, 27, unemployed said:

> *"I will struggle to make it [to session] as I need to be at the dole office at 2pm and it will be too much messing around." (Tom)*

The participants' apparent chaotic lifestyle also influenced engagement in the intervention, with a range of apologies being reported on a regular basis which recounted issues of lateness, organisational chaos, legal issues and unlawful behaviours (i.e., those that found them or vice versa), for example Adam 38 said:

> *"Sorry I've not been there [at session] lately. I have been up the wall" (Adam)*

Similarly, Andrew 25, unemployed explained:

> *"Kath I'm dead [really] sorry I didn't come, I've been in court all day." (Andrew)*

Another participant Ben, 24, also stated:

> *"Kath I'm sorry I've not been coming, I got jumped [attacked] and I can't' see coz my face is a fuckin' mess." (Ben)*

4.3.2 Psychosocial impact of engagement in the 12 week Premier League Health intervention

Despite the economic, environmental and social barriers to engagement in the Premier League Health intervention for the majority of participants, when engagement in the programme did occur it appeared to result in positive psychosocial developments. Three dominant themes emerged from the data which highlighted the psychosocial impact of engagement in the intervention for its hard-to-reach participants. These three themes are as follows; structure, social interaction and social capital.

Structure: The term 'structure' refers to regular patterns of lifestyle activity that help us to get things done. Men living in homeless shelters and/or men who have recently been involved in drug misuse often lack structure in their day-to-day lives and frequently experience somewhat 'chaotic' unstructured lifestyles (Moore, 2007; Hoare and Moon, 2010). During the 12 week intervention, many of the participants expressed that engagement provided (some) structure to their lifestyle. For example, Harry, a 30 year old participant explained:

> *"It [the PLH programme] gets me out of bed this! I know it's 1 o'clock like but I don't go to bed until like 4 or 5 [am] most days. Dunno why." (Harry)*

Similarly, Adam a 38 year old unemployed participant stated:

> *"I'd only sit around or get myself into trouble again if I wasn't coming here." (Adam)*

These comments typify the stories of other participants such as Stephen, 42, Tom, 27, and Andrew, 25, who also made reference to structure which had developed in their day-to-day lives as a result of engagement in the PLH programme.

Social Interaction: 'Social interaction' refers to a relationship between two or more individuals and is a vital component of both mental and physical health (Holt-Lunstad et al., 2010). During the course of the study, it emerged that many participants had been lonely or socially isolated prior to commencing the programme. Cloke et al. (2000, p730) explained how the homeless experience can result in a lack of belonging and thus leave a person feeling "*out of place*." Adam, a 38 year old participant who was living in a homeless shelter, stated:

> *"Before this [the PLH programme] I didn't go anywhere, didn't see anyone or do anything." (Adam)*

Similarly, Dan, 34, who was also living in a homeless shelter, said:

"I didn't really talk to anyone before starting on this [programme]." (Dan)

Klee (1995) argued that drug misuse can lead to social isolation and often to feelings of suicide. In a quieter moment, Stephen, 42, a close friend of a participant who was recovering from drug misuse confided:

"This programme hasn't half helped Daniel ya know. He was in a dark, dark place. We almost lost him." (Stephen)

Social Capital: Bourdieu and Wacquant (1992, p119) defined the term 'social capital' as *"the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition."* Similarly, Putnam (1993, p67) described social capital as *"properties of social life such as trust, norms and networks which promote cooperation and make it possible to achieve certain goals, which would not have been achievable in its absence."* Positive developments in social capital were evidenced within the programme as the participants appeared to develop friendships, trust, support networks and aspects of social bonding both within and outside of the group. Adam, a 38 year old participant expressed this finding when he said:

"I've made some good mates, before this I just fuckin' sat in every day...all day. It was depressin' but now I've got something to look forward to and I'm loads fitter." (Adam)

Similarly, Stephen, 42, said:

"Kath, thanks for everything because if I didn't get put forward [signed up to the programme] with the heart and dedication and drive that is you, I wouldn't have met so many sound [nice] people. I've made some good mates ya know." (Stephen)

Furthermore, throughout the 12 week intervention Rob, James, Tom and Harry also made reference to the friendships that they had gained as a result of engaging in the programme.

4.3.3 Physiological impact of engagement in the 12 week Premier League Health intervention

A series of physiological testing conducted throughout the study aimed to assess and understand the health benefits of participation in the intervention. Due to inconsistences in adherence to the programme, full data sets were only available for 20 male participants (mean ± SD: Age: 34±10 years, Mass: 75±14 kg, Height: 1.75±0.8m and Body Fat: 19±6%). These complete data sets were used for analysis.

Due to the relaxed, social and developmental nature of the Premier League Health programme, the physical activity training intervention that was administered had no systematic approach to physiological loading. This approach resulted in an uncontrolled (football based) recreational physical activity intervention to be administered. As a result, it appears that the physiological loading was not of a sufficient intensity, for a sufficient duration, during training sessions in order to result in significant changes to the following physiological health markers; body composition, blood pressure and blood lipid markers. Resting heart rate however, changed significantly from pre to post programme. The following results highlight this finding;

Average heart rate during sessions (throughout the 12 weeks) was 138 ± 7 bpm, corresponding to 75±4 $\%HR_{max}$. Average time spent >90% HR_{max} (calculated as 220-age) for each session was 13 ± 7 min (Table 1), corresponding to 15% of training time. Mean RPE over the 12 weeks was 6 ± 1 (VAS 1-10), corresponding to an RPE_{load} of 475 ± 71 (Table 4.1).

Table 4.1. Mean ± SD Heart rate training data for 12-weeks of football training.

Week	Overall Mean Heart Rate (bpm)	%HRmax	Time >90% HRmax (min)
Week 1	136±24	75±3	10±06
Week 2	135±16	74±3	02±02
Week 3	145±20	79±3	21±18
Week 4	132±18	72±3	10±15
Week 5	136±23	74±3	15±15
Week 6	133±24	73±3	08±11
Week 7	148±22	81±3	21±18
Week 8	141±21	77±3	17±15
Week 9	132±19	72±3	14±12
Week 10	140±25	76±3	14±15
Week 11	143±19	78±3	12±15
Week 12	132±24	72±3	07±07
Overall Mean ± SD	**138±7**	**75±3**	**13±7**

Body Composition

No significant changes (P>0.05) occurred over 12-weeks of training for total mass, fat and lean mass, bone mineral density (BMD) and % body fat (Table 4.2).

Blood Pressure and Resting Heart Rate

No significant differences (P>0.05) were observed for RHR between weeks-1 and -6. Resting heart rate did, however, change significantly (P<0.05) from 87 ± 22 bpm at week-6, to 72 ± 17 bpm at week-12 (Table 2). However, no significant changes were

observed in resting systolic or diastolic blood pressure following 12-weeks of training (Table 4.2).

Table 4.2. Mean ± SD Group body composition, blood pressure and resting heart rate for Weeks 1, 6 and 12.

	Week 1	Week 6	Week 12
Body Composition			
Mass (kg)	75.4 ± 13.7	74.7 ± 13.7	74.0 ± 14.7
BMD (g·cm2)	1.240 ± 0.135	1.247 ± 0.124	1.194 ± 0.093
Fat Mass (kg)*	13.9 ± 6.4	14.7 ± 7.3	13.8 ± 6.3
Lean Mass (kg)*	54.0 ± 8.9	53.6 ± 8.3	55.0 ± 9.7
Total Fat (%)*	19.2 ± 5.8	20.2 ± 6.4	18.9 ± 5.6
Blood Pressure			
Systolic BP (mmHg)	134 ± 14	134 ± 12	131 ± 11
Diastolic BP (mmHg)	76 ± 13	78 ± 9	79 ± 9
RHR (bpm)	88 ± 20	87 ± 22	72 ± 17# **

* Indicates subtotal value (i.e. excluding head)
# Significant difference from Week 1
**Indicates significant difference from Week 6

Blood Analysis

Similarly, no significant changes (P>0.05) were observed over 12-weeks of training for blood lipid markers, including HDL, LDL, triglycerides and total cholesterol (Table 4.3).

Table 4.3. Mean ± SD blood lipid values for Weeks 1, 6 and 12.

	Week 1	Week 6	Week 12
Cholesterol	5.28 ± 0.83	5.28 ± 0.49	5.31 ± 0.79
Triglycerides	1.85 ± 0.42	2.04 ± 0.43	1.83 ± 0.40
HDL	1.10 ± 0.15	1.13 ± 0.22	1.12 ± 0.20
LDL	3.53 ± 0.95	3.50 ± 0.81	3.46 ± 0.92

4.4 Discussion

In line with Sherry (2010) who reported that the complex lives of the participant's hindered retention in the Homeless World Cup, this study also found that the complexities associated with the lives of HTR participants resulted in barriers to engagement in the Premier League Health 12 week intervention. This study has identified three dominant challenges that HTR populations encounter when attempting to commit to regular participation in physical activity and health behaviours; economic, environmental and social barriers. Whilst these findings resonate with themes described in previous literature with generic populations, the specific findings that have emerged in this study under these three universal themes allude to somewhat more 'severe' challenges that are on a more pronounced level to those faced by generic populations. It is likely that these differences are due to the often complex, chaotic and unstructured lives and extenuating circumstances of the HTR participants. For example, HTR participants in this study experienced severe economic difficulties. Unlike more generic populations who perhaps cannot afford to pay for a monthly gym membership, many of the participants in this study simply could not afford the bus fare to attend the (free of charge) Premier League Health sessions. It can be argued that in order to facilitate sustained engagement, an empathic level of understanding and more informed practice is required by men's health practitioners/professionals who engage and/or are considering engaging HTR populations prior to the conception and development of such community health programmes.

Specifically, it would appear that in order to achieve regular and sustained engagement, practitioners engaging HTR participants should immerse themselves in a period of direct contact and focused interaction with their participants prior to the programme design in order to gain a greater understanding of the day-to-day existence of their participants and recognise the economic, environmental and social challenges associated with the population with whom they are engaging. During this period of reconnaissance or due diligence, health practitioners/professionals should also seek to understand pragmatic yet critical, logistical organisational factors such as location, cost and timing of the events, activities or programme. Wherever possible, direct contact should also be made with the participants' community support workers in order to minimise the chance of obligatory meetings being scheduled during the same time as the programme. Therefore, in order to reach 'hard to reach', practitioners need to fully understand their situational context and then design a programme that is more feasible, accessible and attainable. This 'bottom up' programme design and management strategy is therefore likely to reduce the challenges facing HTR participants when attempting to engage in physical activity and health programmes and result in greater adherence and thus, positive outcomes.

This study has identified specific psychosocial effects of engaging in a Football in the Community programme, most notably, the development of structure, social interaction and social capital amongst the participants. These outcomes support the findings of Sherry and Strybosch (2012) who reported positive changes in social capital, structure and routine amongst HTR participants following engagement in a

football specific programme. Furthermore, these findings highlight the benefits of engaging in physical activity and Football in the Community programmes for improvements in mental health and social wellbeing.

Community-based football programmes endorsed by professional football clubs appear well positioned to connect and attract hard-to-reach populations. The evidence suggests that such programmes can improve psychosocial health amongst these populations. However, the current study suggests that exercise administered during these programmes may not be efficient in promoting positive and significant physiological health changes (with the exception of resting heart rate). It is important for long-term success that the education of participants and 'healthy lifestyle' messages endorsed by such programmes are supported by measurable positive health adaptations. Therefore, careful consideration needs to be taken when planning the training load of a Football in the Community physical activity and health intervention so that an intervention which is likely to positively impact the physiological health status of the participants is designed and administered.

4.5 Conclusion and future research

It can be argued that the findings and recommendations of this study puts men's health practitioners in a better position to tailor their programmes so that they work for those who are classified as HTR and thus *keep* hard-to-reach men engaged in health promoting activities whilst maximising positive psychosocial outcomes. However, there are limitations that should be addressed in future research. Mainly, this work has solely concentrated on men who are classified as homeless and/or

recovering from drug misuse. Therefore, it would seem appropriate to explore the experiences of other groups classified as HTR (e.g., older age groups and/or ethnic minorities) in order to deepen the understanding of the issues encountered amongst hard-to-reach populations.

Further contextual and immersed research with HTR populations is needed to 'dig deeper' in order to enhance understanding of the constraints that hard-to-reach men encounter when attempting to engage in regular physical activity and health promoting activities (Frisby and Millar, 2007). Furthermore, further research is required which examines the impact of engagement in Football in the Community physical activity and health programmes in order to contribute to understanding within underserved area of research (Tacon, 2007). It can be argued that this work is important for building an evidence base in, and advancing, men's health promotion work at a range of levels.

In closing, the following vignette shares with the reader the personal reflections of the researcher in relation to researcher development and the development and maintenance of researcher-participant relationships achieved during Study 2:

Reflective stop off

Researcher development and building/maintaining relationships

Throughout Study 2 I had developed as a researcher. I had become familiar with the language and behaviours of the participants and had adapted my own behaviours to fit the situation. I was now more relaxed and enjoyed interaction with the participants. In general, we had a laugh together. There were many times that they forgot they were in female company and jokingly apologised to me after having said something rude. I didn't mind though, in fact, I saw this as a success. On the surface, building and maintaining relationships with the participants required humour, wit and banter. However, in quiet spaces it also involved listening, empathising and offering advice.

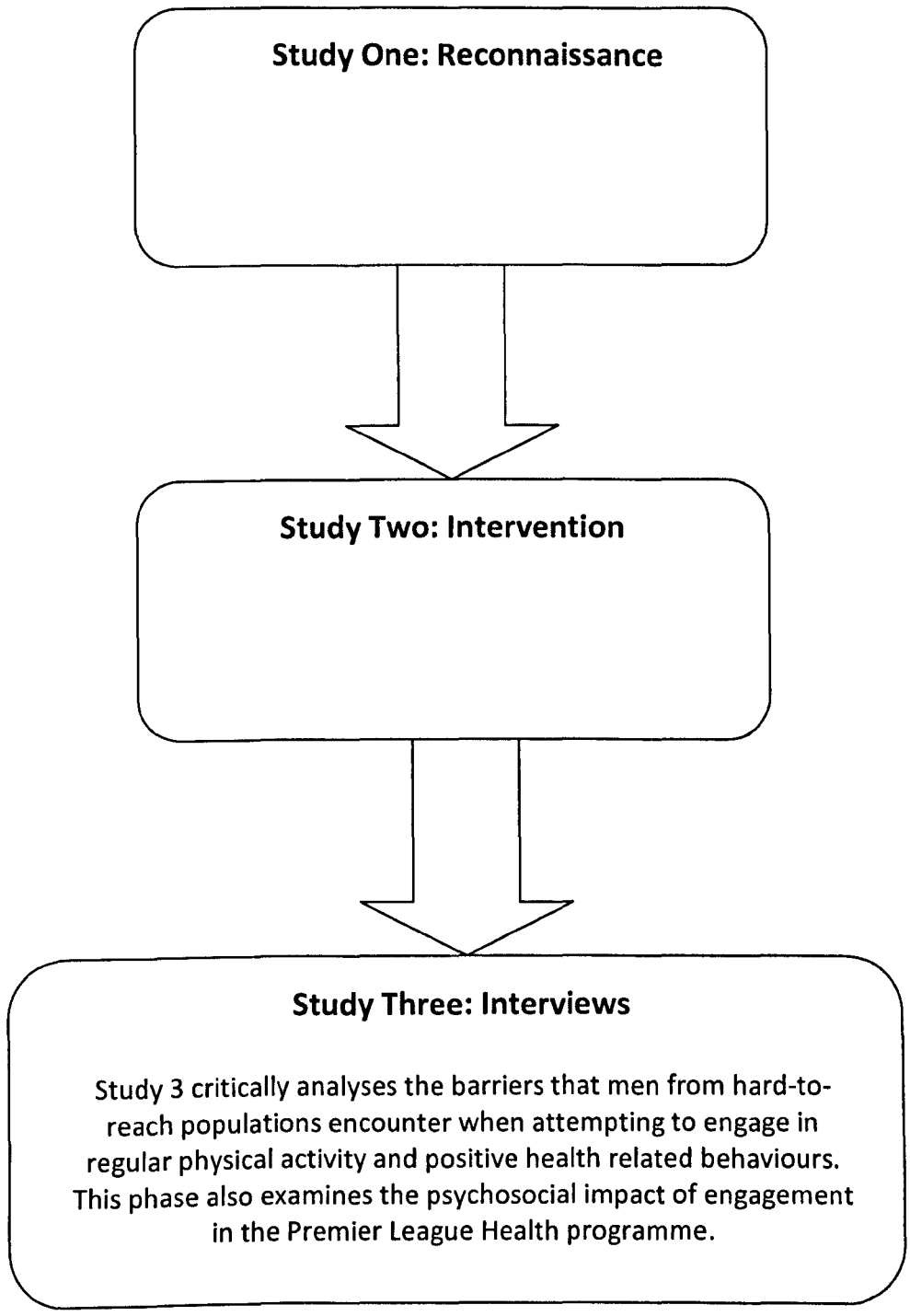
Due to the nature, the norms and the behaviours of the participants I was working with, achieving my research aims for this study had been not an easy task. It was a task that involved a lot of emotion, motivation, dedication and time. Furthermore, due to the central role I played in the project and in the lives of the participants it became an all-consuming and mentally tiring experience. It was a role that I lived and breathed and one that I really struggled to switch off from.

Chapter Five:

Study 3

"We need to provide an arena where hard-to-reach groups can voice their needs and concerns."

(Doherty et al., 2004, p6)


Study One: Reconnaissance
Study Two: Intervention
Study Three: Interviews
Study 3 critically analyses the barriers that men from hard-to-reach populations encounter when attempting to engage in regular physical activity and positive health related behaviours. This phase also examines the psychosocial impact of engagement in the Premier League Health programme.

5.1 Introduction

Men from disadvantaged hard-to-reach (HTR) populations often display a complex array of health issues (Sherry and Strybosh, 2012). Harmful lifestyle behaviours and poor socio-economic circumstances contribute to the prevalence of many preventable health problems (Zwolinsky et al., 2013). Understanding the wider determinants that prohibit engagement in health related behaviours is therefore important for the development of health promotion strategies with men (Macdonald, 2006). Whilst existing research provides information on how men engage in sport, exercise and physical activity and their motives for doing so, there is a dearth of sufficient contextual evidence from local practice which describes the barriers experienced by men, especially those from HTR groups. Moffet et al. (2010) described hard-to-reach men as those that were difficult to access due to a range of compounding factors such as age, geographic location, income, education, and accommodation. Moreover, engaging and encouraging HTR male populations in health related behaviour is an extremely challenging endeavour (Kovandžić, et al., 2011).

Kovandžić et al. (2011) argued that the experiences of men from hard-to-reach groups can offer important insights into barriers to engagement in health behaviours and thus, influence government policy and practice. The majority of work examining HTR populations within health literature has relied heavily on practitioners' perspectives rather than the perspectives of hard-to-reach populations themselves (Sinclair and Alexander, 2012). Typically, research in this area tends to focus *on,* rather than *with,* hard-to-reach populations. Such an

approach has tended to exclude the perspectives of hard-to-reach populations and has silenced the subjective voice of their personal experiences (Carless and Sparkes, 2007). Atkinson and Flint (2001) argued that members of HTR populations may be involved in, or exposed to, activities that are considered deviant, or 'outside' societal norms (e.g., drug taking, alcohol abuse) making them reluctant to take part in formalised studies using traditional research methods. Emmel et al. (2007) also reported a distrust of research, and researchers in general, amongst the participants in their study of HTR socially excluded people. Certainly, through my own experiences of working with such populations (i.e., Study 2 and through daily management of the Premier League Health programme) I (the researcher) have seen suspicion of research, a lack of trust in others and a reluctance to engage in conversations that discuss personal matters. I find it unsurprising therefore, that there is little research evidence that examines the subjective voice of hard-to-reach populations. In order to 'get closer' to HTR populations a significant amount of time is required in order to build up relationships, trust and rapport with participants before authentic research evidence can be obtained.

It has been argued that qualitative research is well suited for understanding phenomena within their context, uncovering links amongst concepts and behaviours and for generating and refining theory (Quinn, 2005), and, as such, has become increasingly popular in health service research (Bradley et al., 2005). Through the use of qualitative research, the previous findings of this thesis have contributed to the growing body of knowledge in understanding the barriers of engagement in health behaviours for hard-to-reach men and an appreciation of the

impact that engagement in a Football in the Community programme can have on the lives of those that regularly engage. The primary aim of Study 3 is to build on this understanding by articulating the subjective experiences of the Premier League Health participants, who typically came from populations defined as HTR. This study aims to better understand the barriers that men from hard-to-reach populations encounter when attempting to commit to regular and sustained participation in physical activity and health behaviours. Moreover, this study aims to examine the psychological and social impact of engaging in the Premier League Health programme. Given the strength and bond of the researcher-participant relationship at this point in time, the researcher believed that richer, more authentic and meaningful data could now be successfully collected.

Understanding the influences on, and barriers to, engagement in physical activity and health behaviours is important for the development of effective physical activity interventions and health services. Through the use of relaxed and informal methodologies, Study 2 reaffirmed social, economic and environmental barriers as the major influences to engagement in regular physical activity and health related behaviours for populations defined as hard-to-reach (i.e., men who were living in homeless shelters and/or recovering from drug misuse). Although a relaxed, informal, casual and humanistic approach to data collection was appropriate for Study 2, the researcher believed that the now established relational bond allowed for a more formal, semi-structured approach to the research method in this study.

Whilst Study 2 confirmed that the HTR participants were challenged by social, economic and environmental factors that impinged on their lives, it did not appear to fully capture the complexity of the participant's day-to-day existence that I witnessed. Wicker (1979, p4) suggested that *"people are but one component of a larger behaviour-setting system which restricts the range of their behaviour by promoting and sometimes demanding certain actions and by discouraging or prohibiting others."* Similarly, the social ecological model (SEM) proposed by McLeory et al. (1988) acknowledges this behaviour-setting system and recognises that an interwoven relationship exists between an individual and their social and physical environment. Specifically, SEM offers a framework for understanding how this behaviour-setting system subsequently influences individual physical activity and health related behaviours.

The core concept of the social ecological model is that behaviour has multiple levels of influence; intrapersonal, interpersonal, community and policy (Gregson et al., 2001). According to McLeory et al. (1988) *intrapersonal* influences refer to individual characteristics that influence behaviour such as knowledge, attitudes, beliefs, and personality traits. *Interpersonal* influences recognise an individual's immediate situation and involve other people who they interact with in a face-to-face context. This includes relationships with family members, friends, neighbours and acquaintances that provide social identity, social support and role definition (Gregson et al., 2001; McLaren and Hawe, 2005). *Community* influences refer to social networks, norms and standards within defined boundaries (i.e., the behaviours that are typical and accepted in the community that a person lives),

whereas *policy* influences refer to local, regional and national policies and laws that regulate or support physical activity and health related behaviours (McLaren and Hawe, 2005). The social ecological model has commonly used a layered or 'onion' structure to represent these multiple levels of influence on behaviour, as presented below:

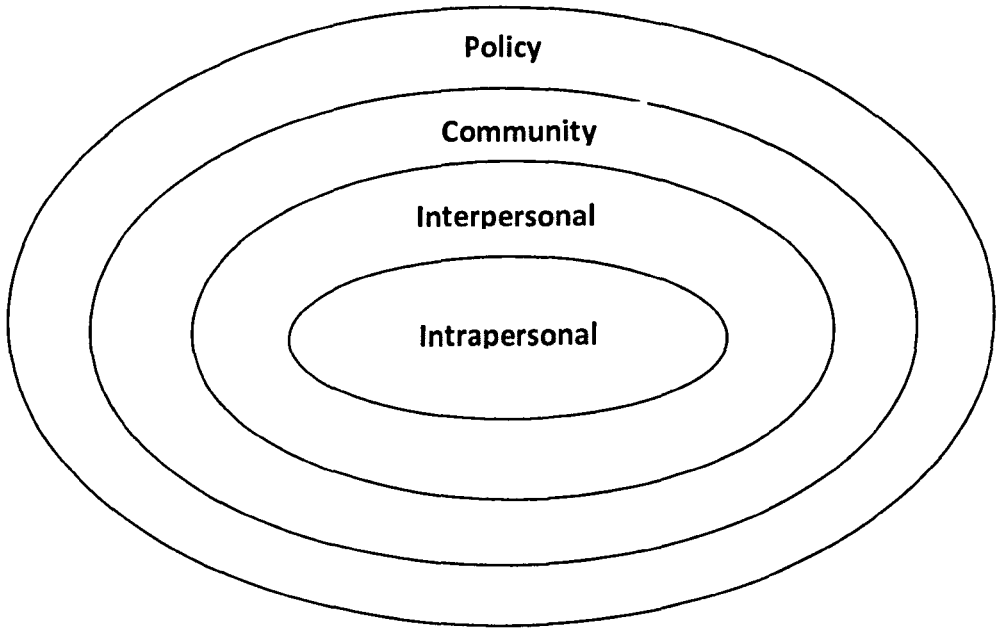


Figure 5.1. Social ecological model (adapted from McLeory et al., 1988).

Whist there is little or no evidence of the use of the social ecological model in qualitative physical activity and health research with men from hard-to-reach populations, its inclusion in Study 3, alongside the awareness of social, economic and environmental barriers, provides an opportunity to extend our contextual understanding of the wider, multi-layered influences that prohibit and motivate engagement in physical activity and health behaviours amongst HTR populations.

5.2 Method

A series of in-depth one-to-one semi-structured interviews were employed for this study. DiCicco-Bloom and Crabtree (2006, p315) stated that *"the aim of the research interview is to gain an insight into an individual's perspective and experiences of a particular issue."* According to Fontana and Frey (1994), interviewing is one of the most powerful ways that researchers can try to understand fellow human beings. Interviews can enhance our understanding of health related topics (Pickler, 2007) and have been demonstrated as an excellent research tool for obtaining rich and meaningful data that can aid our understanding of complex health behaviours (DiCicco-Bloom and Crabtree, 2006; Reeves et al., 2006).

In order to gather rich, meaningful, contextual data, it has been argued that the researcher should first build a relationship of trust and confidence with research participants (Fontana and Frey, 1994). According to Fontana and Frey (1994, p367) *"close trust and rapport with research respondents open doors to more informed research data."* Prior to this study, I was immersed in a period of 12 weeks-24 months of regular, relaxed, and informal contact with the programme participants and during this time I established close, trustful practitioner-participant relationships with a number of the Premier League Health programme participants. This prolonged and regular engagement with such challenging populations alongside the development of a genuine and caring practitioner-participant relationship has ultimately allowed for Study 3 to adopt a more formal, semi-structured, qualitative approach. However, Fontana and Frey (1994, p367)

highlighted that even though trust can be gained, it can be very fragile; stating that, *"any faux pas by the researcher may destroy days, weeks or even months of painstakingly gained trust."* Furthermore, Fontana and Frey (1994) argued that the decision of how to present oneself during an interview is very important because after ones presentational self is 'cast' it leaves a profound impression on the respondents and great influence on the success (or failure) of the study. Given the typically distrustful and fragile nature of the research population in this study and the already relaxed and informal relationship between the researcher and the participants, the researcher adopted a relaxed and authentic approach toward the interviews (DiCicco-Bloom and Crabtree, 2006). Typically, this involved the researcher making cups of tea for both the researcher and the participant to drink throughout the discussion, wearing 'the usual' Everton Football Club tracksuit and often removing trainers and curling up on the coach opposite the participant, as if amongst friends. Moreover, the researcher only shared a snapshot of the academic background of the study and reason for interview as it has been suggested that researchers must be able to put themselves in the role of the respondents and attempt to see the situation from their perspective rather than impose the world of academia and preconceptions on them (Fontana and Frey, 1994). It was also felt that this approach would best capture and construct the participants' lived experiences.

5.2.1 Research Design

Prior to data collection ethical approval was sought and granted by Liverpool John Moores University ethics board. Six participants defined as 'hard-to-reach' (i.e., participants who had recently been released from prison, recovering from substance misuse and/or had lived in a homeless shelter) were recruited for participation in semi-structured interviews. The aim and purpose of the study, together with pre-existing knowledge of the subject matter influenced the sampling method adopted. In order to gain rich information and avoid superficial data, participants who had the 'closest' practitioner-participant relationships with the researcher were approached and asked to part take in the interviews. Vaughn et al. (1996) suggested the main aim of this type of sampling is not generalisability of the findings, but rather the provision of sufficient understanding of a topic. Whilst random sampling may have avoided bias, it was important to gain in-depth information which can be greater achieved through close researcher-participant relationships (Millward, 2006). Recruitment was conducted via face-to-face conversation with participants.

Participants were male and aged between 31-43 years. The demographic profile of the sample is representative of the programme participants. Participants were given a verbal briefing about the study and a participant information sheet (Appendix C). A follow-up conversation occurred during the following week in order to answer any questions about the study that had arisen from the participant information sheet, and to arrange a suitable time for the interview. Interviews were conducted in the Everton Active Family Centre (a place that the participants were

already familiar with) in order to enable the participants to share their experiences and personal outcomes of the programme with the researcher in a comfortable, non-threatening and suitable environment. This environment also ensured the health and safety of the researcher and the participants. The researcher identified the dangers that might have existed in the setting before conducting research (Paterson et al., 1999) and put measures in place to prevent them. Paterson et al. (1999) argued that although qualitative researchers may face safety issues at any research interview, they are particularly vulnerable when studying certain types of participants (i.e., those with a violent or aggressive nature). In this study, participants included those with a known history of aggression and persons who are/have been involved in drug use and gun crime. Therefore, ensuring my own safety was an important factor. Once the participant and researcher were settled in the research setting, the researcher explained the purpose of the study and then obtained formal signed consent (Appendix D) for participation in the research. The researcher emphasised that the participant did not have to answer any questions that they did not wish to, that they had to the right to withdraw at any point and could ask for certain data to be withdrawn or not feature in the output of the research.

It is been argued that interviews are a form of autobiographical story telling that give shape to life experiences (Gaydos, 2005). On this basis, a semi-structured interview schedule (Appendix E) was developed, which acted as an aide to the researcher and utilised various topic areas to guide the discussion. The interview guide was developed alongside literature and conceptual themes and constructed

utilising guidelines set out by Foddy (1993) in order to promote a clear sequence of questions. However, in order to encourage dialogue, the structure also permitted the researcher to adopt a flexible approach where appropriate. For example, participants may refer to, and answer, later elements of the discussion outlined in the research schedule prior to the information being requested.

Interview questions were designed to explore all of the study aims by engaging participants in a discussion about their experiences of, and barriers to, engagement in physical activity and health related behaviours, their motivations for joining the Premier League Health programme and the psychosocial impact of engagement in the programme. The interview questions were underpinned by current literature surrounding men's barriers to engagement in physical activity and health related behaviours, the use of professional sports clubs for engagement in health and the impact of engagement in a male specific health programme (as detailed in chapter one).

Semi-structured interviews allow for a detailed exploration of a topic (Britten, 1995). Britten (1995) suggested that the qualitative interview should start with questions which can be answered easily before probing for the more difficult and sensitive topics. In this study, phase one (Introduction) of the interview schedule aimed to establish comfort and rapport with the participant. During this phase the researcher explained the research protocol and allowed the participant to absorb the information and ask any related questions. Although each participant was previously made aware of the background of the research and their role within it,

this information was reiterated during the introduction. Phase 2 (Participants Background) was selected as a relatively 'safe' starting point that would allow the participant to talk freely about their own life and help build rapport while minimising any possible or perceived threats by raising sensitive issues.

The interview then moved on to discuss topics directly relating to the aim and objectives of the study whilst examining sentiments of the SEM. Phase 3 was designed to develop an understanding of the participants' barriers to engagement in physical activity and health behaviours prior to engagement in the Premier League Health programme. Phase 4 specifically explored the participants' motivations for joining the Premier League Health programme, which typically flowed directly into phase 5 which investigated the role of Everton Football Club in the life of the participant. Phase 6 was designed to allow the participant to express the impact of engagement in the Premier League Health programme and discuss their experiences of engagement in the programme. Phase 7 allowed the participant to verbalise the barriers that they had experienced with engaging in physical activity and positive health related behaviours when participating in the Premier League Health programme. Phase 8 allowed the participant to discuss their health related goals and aspirations for the future. Phase 9 offered an opportunity for further clarification and/or dialogue, and finally phase 10 expressed an appreciation of the participants' time and articulation of their experiences.

Weiss (1994) argued that in order to determine the feasibility of a research study, a pilot should be conducted to determine if the method chosen is appropriate.

According to Breakwell (2006), piloting interview questions is a critical part of the process in order to get the wording, structure and links between questions correct and to put the researcher at ease. As advocated by Weiss (1994), pilot interviews were carried out with programme participants (i.e., those not selected for the main sample) prior to the study (n=3). The experiences and comments from the pilot interviews resulted in minor changes to the interview schedule but generally confirmed the content and nature of delivery of the interview itself. As a result of the nature of qualitative research, the researcher's knowledge of the area also developed as preliminary data analysis happens concurrently with data collection (DiCicco-Bloom and Crabtree, 2006). The final interview schedule was developed by the researcher and checked by the research team for accuracy and appropriate content. Table 5.1 outlines the ten phases of the interview schedule.

Table 5.1. Summary of the interview schedule

Phase 1 – Introduction Aim: Outline the structure of the interview (expected duration, interview schedule and aims) and to reinforce confidentiality for the participant (Britten, 1995).
Phase 2 –Participants background Aim: To explore the participant's background and day-to-day life.
Phase 3 –Pre Programme Barriers Aim: To examine the participant's barriers to engagement in physical activity and health related behaviours (Wicker, 1979; McLeory et al., 1988; Macdonald, 2006; Kovandžić, et al., 2011).
Phase 4 – Motivators Aim: To explore what motivated the participant to join the Premier League Health programme (Biddle and Mutrie, 2008).

Phase 5 – The role of the Football Club
Aim: To examine the role of Everton Football Club in the life of the participant (Witty and White, 2010; Gray et al., 2011; Pringle et al., 2011).

Phase 6 – Impact of engagement in programme
Aim: To examine the biopsychosocial impact that engagement in the Premier League Health programme has had on the life of the participant (Tacon, 2007; Sherry, 2010; Gray et al., 2011; Pringle et al., 2013).

Phase 7 –Challenges of engagement in programme
Aim: To examine the barriers to engagement in physical activity and positive health related behaviours when engaged in the Premier League Health programme (Wicker, 1979; McLeory et al., 1988; Macdonald, 2006; Kovandžić, et al., 2011).

Phase 8–Future
Aim: To allow the participant to discuss their health related goals and aspirations for the future

Phase 9- Other
Aim: To offer an opportunity for further clarification and/or dialogue

Phase 10- End
Aim: To express an appreciation of the participant's time and articulation of their experiences

During the interview, probes were used to ask participants for more details, resolve any ambiguities in the narrative and reassure participants that the interviewer was paying attention to what was being said (Rubin and Rubin, 1995). Participants were given the freedom to explain and expand on their views and experiences beyond the realm of the questions outlined.

Interviews took place between April and July 2012. Interviews were recorded digitally which allowed the researcher to capture data more faithfully (Patton, 1990), and allowed the researcher to concentrate on the interview rather than

hurriedly making written notes (Hoepfl, 1997). Each interview lasted for approximately one hour.

5.2.2 Data Analysis and Representation

Semi-structured interviews were listened to and transcribed verbatim by the researcher, producing a total number of 137 single-spaced pages of data. The researcher then engaged in a period of close reading in order to become immersed in the data (Sparkes, 2005). At this stage, initial ideas and thoughts were recorded. Following this, principles of content analysis were adopted by the researcher in order to identify and code themes arising from the data (Elo and Kyngas, 2008).

A narrative thematic analysis (Burnard, 1991) was undertaken using the qualitative data analysis software NVivo 10 (QSR International, Doncaster, Victoria, Australia). NVivo was used to code, store and analyse all transcribed qualitative interviews and interview audio files. This software allowed the researcher to organise and code the data (interview transcripts) into clusters/themes in order to build an understanding of the expansive data collected. Codes are described as 'tags' or 'labels' which are assigned to paragraphs, sentences or words (Miles and Huberman, 1994). Analysis proceeded using the following steps:

1. Organising the data: Interview transcriptions were entered into the software package, NVivo 10.
2. Generating categories, themes and patterns: Coding was undertaken by the researcher using NVivo 10 software to identify the topics that had been raised by the participants. Coding assisted in condensing themes, making

connections between the links and unifying constructs within and between themes. Coding according to common ideas and experiences was conducted using sentences. An open coding approach was then undertaken to discover new ideas and common themes. The 'making meaning' step was completed manually through immersion in the data contained in the main categories and sub categories, allowing for a powerful synthesis of the data.

Malterud (2001) argued that qualitative data has previously been questioned due to its lack of scientific rigour and therefore researchers should adopt a more systematic process to the analysis of qualitative data. Throughout this thesis inductive and deductive content analysis has been used (Elo and Kyngas, 2008). Analysis in this study began deductively through an examination of the themes that emerged from Study 2; social, economic and environmental correlates (Green et al., 1995; Macdonald, 2006; Sallis et al., 2008) and existing literature. Furthermore, the integration of the social ecological model (McLeroy et al., 1988) offered an additional framework for clustering the data. Analysis was then followed by a more inductive approach to code additional contextual themes that emerged from the data (Elo and Kyngas, 2008).

The resulting analysis was read and re-read by the author. It has been argued that a single researcher conducting all the coding is both sufficient and preferred, especially in studies embedded in on-going relationships with research participants (Janesick, 2003). Such an analysis may not be possible to be repeated by others who have differing paradigms. It seems important that I disclose my biases and

philosophical position at this point in order to assist you (the reader) in understanding and interpreting my results. The aim of Study 3 was to develop an understanding from openness and dialogue which is aligned with the interpretivist paradigm. The interpretivist paradigm gave me the opportunity to seek understanding and make sense of others' perspectives which are shaped by the philosophy of social constructions (Taylor 2008). Through this paradigm, I was able to gain a fuller understanding of meanings, reasons, and insight into human action (i.e., the participants' actions) (Bryman, 2001).

The verbatim quotations were presented by the author to two senior colleagues by means of co-operative triangulation (Shenton, 2004). The colleagues critically questioned the analysis and cross-examined the data and themes. This process allowed for alternative interpretations of the data to be offered. The researcher and colleagues discussed the data and emergent themes until an acceptable consensus had been reached. This process allowed the researcher to refine the specifics of each theme and generate clear definitions and names for each theme. According to Priest et al. (2002) verbatim transcription of data and triangular consensus procedures afforded credibility and transferability.

In order to fully capture the contextual voice and reality of the participants' existence the data is presented as a series of themed narrative accounts which draw on the participants' own words, experiences and realities (Polkinghorne, 1988). Participant quotations have been used directly from interview transcripts and included in the results/discussion section in order to offer an illustration of key

themes to the reader. The voices of the participants are presented as *italics* within the text. Pseudonyms are used for all participants throughout.

In order to enable the reader to become familiar with the research participants, the next section briefly introduces each participant and their background. The participant profiles are then followed by the results/discussion section which outlines what the researcher perceives to be the pertinent issues emerging from the expansive data collected.

5.2.3 Participant Profiles

John

'John' is a 41 year old White British male participant from North Liverpool. John, a divorcee, is an avid Everton Football Club fan who lives with his three teenage children. He works full time (often night shifts) and has an average of 4 hours sleep per night. John is a regular car user and has engaged in very little exercise for the past 20 years. He describes himself as a former heavy smoker (smoking on average 40 cigarettes per day from the age of 16 years) but gave up when he was aged 31 resulting in significant weight gain. John has experienced substance misuse and admits to concealing the truth from his children as to how much alcohol he has consumed. John engaged in regular 5-a-side football until he got married (aged 21 years) and admits to struggling to find the time or motivation to engage in physical activity since. John has been involved in the Premier League Health programme (intervention) for 12 weeks after hearing about it on a popular social networking internet site. He states that he joined the scheme having realised that he needed to make a change to his life. John claimed that the prospect of being further involved with the football club also appealed to him.

Brian

'Brian' is a 43 year old unemployed, Black British male participant from South Liverpool who has recently been released from prison where he served a five year sentence for armed robbery. Brian now lives alone in a one bedroom flat provided by a local probation programme. Brian has very little body fat and has always been physically active, especially during his time in prison where he used exercise as a means to stay out of trouble and release his feelings of frustration and anger. Brian is a non-drinker but a heavy smoker (smoking on average 40 cigarettes per day), who attributes the increased amount of tobacco he has smoked in recent months to the stresses of everyday life outside of prison. Brian became aware of the PLH programme through his 'community support worker' and was interested in the programme as he wished to engage in something positive. Brian stated that he is unreliable and hopes that the programme will help him to implement structure into his otherwise chaotic lifestyle. Brian has been involved in the PLH programme for approximately 9 months having initially engaged in a 12 week intervention.

Simon

'Simon' is a 43 year old unemployed White British male from North Liverpool who has been involved in the PLH programme for two and a half years. Simon first heard about the programme through a friend who he had known for over 30 years. Simon has a history of alcohol and drug misuse and has spent a period of his life in prison for theft. In the year leading up to joining the programme, Simon had made a decision to turn his life around in order to become a better role model for his four children who he lived with at the time. Simon has always enjoyed playing football but had not been regularly physically active in approximately 10 years as he suffered from poor health due to his lifestyle. Simon is a heavy smoker (30 cigarettes per day) and describes his former self as a 'hard core raver'. At the time of joining, Simon described his life as being surrounded by undesirable people and believed he lacked motivation, structure and direction. Simon is a huge Everton [football club] fan.

Gary

'Gary' is a 42 year old, unemployed, White British male participant from North Liverpool who lives alone and has a long history of drug and alcohol misuse which began when he was just 13 years old. Gary is a heavy smoker of both tobacco and cannabis (smoking on average 30 cigarettes per day). Gary asserts that he grew up on a poor diet and whilst he enjoyed engaging in physical activity (predominately football), lack of motivation and a negative mental attitude resulted in sedentary behaviours. Gary has recently been released from prison where he served two years for a drug related offence. Whilst in prison, Gary curbed his drug and alcohol dependency and undertook physical activity on a daily basis (sometimes twice or three times a day). However, when Gary was released from prison he admitted that he 'slipped back into his old ways'. Shortly after his release from prison, Gary's mother passed away, and he believes that this traumatic life event 'kick started' a radical change in his life. Gary heard about the Premier League Health programme through a local drug rehabilitation service and was keen to get involved to make a change in his life with 'his' football club. Initially, Gary engaged in a 12 week intervention but was signposted into the 'continuous group', and has now been engaged in the programme for two and a half years.

Tom

'Tom' is a 31 year old unemployed White British male from North Liverpool. Until the age of 21, Tom was physically active, had a reasonable diet and engaged in regular 5-a-side football with his brother and his friends. However, the arrival of his first baby (who was 3 months premature and severely unwell) resulted in a radical lifestyle change for Tom and his health began to suffer. Tom is now widowed and lives with his two young, disabled children who require his full time care. Tom attributes lack of time (due to caring for his children) to his sedentary behaviours and poor diet. Tom is a particularly heavy drinker (often drinking more than the government's recommended weekly allowance in one day) and describes himself as 'weekend smoker'. Tom is a lifelong Everton fan and asserts

that, "the Club is his life." Tom heard about the Premier League Health programme through a 'dad and lads club' at a local community centre and has now been regularly engaged in the programme (continuous group) for 18 months.

Colin

'Colin' is a 41 year old, unemployed White British male from North Liverpool. Colin joined the British Army aged 18 where he kept physically active most days, had a reasonable diet and enjoyed playing golf and football in his leisure time. Colin left the army aged 22 following a particularly traumatic event and suffered from severe mental health issues for the following two years. At 24 years of age he came into contact with a friend's dad who encouraged him to get back into football. This resulted in Colin becoming regularly engaged in physical activity alongside his job as a joiner until he was 30 years old. However, when Colin was aged 30, he lost his regular employment and attributes the following decline in positive health and physical activity behaviours to a sudden lack of money and motivation. Colin remained physically inactive and had a poor diet throughout his 30's. During the 6 months prior to joining the PLH programme Colin became homeless and spent a short period of time in a homeless shelter which he described as being "mentally stressful and mentally tiring." However, it was here that Colin first heard about the programme and signed up. He stated that he wanted to improve his lifestyle, put his energy into something positive and be further involved with Everton Football Club. Shortly after, Colin left the hostel and moved in to live with his new partner and her two children. Colin became regularly engaged in the PLH programme (continuous group) for a period of 9 months but then became unengaged in the programme for the following 9 months due to suffering from Barrett's oesophagus (i.e., cancer of the lower gullet). Following several operations and a recovery period, Colin re-joined the programme and has now been fully engaged in the programme for a further 18 months.

5.3 Results/Discussion

The participants were enthusiastic about partaking in the interviews and appeared to want to have their voices 'listened to'. The findings of the study are structured and aligned to the key research questions outlined in the interview schedule; 'barriers to engagement in physical activity and health behaviours prior to engagement in the Premier League Health programme', 'motivations for joining the Premier League Health programme', 'impact of engagement in the Premier League Health programme' and 'barriers to engagement in physical activity and health behaviours when engaged in the Premier League Health programme' are outlined. Under each section, the pertinent issues that emerged from the data analysis are presented.

5.3.1 Barriers to engagement in physical activity and health behaviours prior to engagement in the Premier League Health programme

5.3.1.1 Environmental Barriers: *'there was dickheads all around me'*

The term 'environment' within ecological models of behaviour refers to *the space outside of the person* (Sallis and Owen, 2002). Within the social ecological model, environmental barriers are captured under 'community' influences (i.e., relating to the social networks, norms and standards within the community that a person lives) (McLeory et al., 1988). According to Biddle and Mutrie (2008) there has been less research on environmental/community influences than there has been on interpersonal or intrapersonal barriers to physical activity and health.

In line with Study 2 and previous literature (i.e., Sallis et al., 1988; Giles-Corti and Donovan, 2002) the participants' environment was highlighted as a barrier to engagement in physical activity and positive health related behaviours. This finding is epitomised by Colin who described the social environmental challenges he faced when attempting to engage in physical activity whilst he was living in a homeless shelter:

> *"...I was finding meself getting dragged into like bad atmospheres and because what was goin' on in there [the homeless shelter]...out of about 40 residents you'd be looking at 38 would have drug or alcohol issues...I had me own set of weights, a small set of weights, and I found if I had me door open, coz it was only a small room and it was hot, and if I had a bit of music playin' and I was doing weights, some of the staff would be comin' up to me sayin' 'you can't have the music on because of people with other issues'. I was like 'well what issues are that?' Oh 'they've got drug issues or alcohol issues so they might wanna have a lie down an' a nap.' So I was a bit perplexed by that because I was like well of a night time, like 2 or 3 o'clock in the morning, when they're runnin' round kickin' each other's doors in I said 'an they're keeping me awake' and I complain, I have to accept that they've got issues. My issue is I'm tryin' to keep fit and lead as normal life as possible while I'm in here and youse are telling me I can't coz I've got to be aware of other people." (Colin)*

Specifically, the environmental barrier experienced by Colin relates to the sociocultural norms and 'accepted' behaviours of the shelter that he was living in. Sociocultural norms emerged as a particular environmental barrier to engagement in physical activity and positive health behaviours amongst other participants interviewed in this study. According to Turner et al. (1994) social norms are created through social processes and interaction with others and can have a significant effect on an individual, both restricting and enabling behaviours. The influence of sociocultural norms on engagement in negative health behaviours was exemplified

by Gary who described how his drug use was exacerbated during time spent with his friends who lived in his community:

> *"It just progresses doesn't it, it's mostly to do with the people you hang round with as well, you know what I mean, coz like where I live up the road there, all me mates, we all smoked, we all smoked weed [cannabis], because we all grew up together we all just progressed into the exact same things at the same time, you know what I mean? So we was goin' from one drug to drink to a stronger drug then a stronger drug and then once we got into our late teens, early 20's then no-one can say nothin' to you really can they, you know, even your parents can't say 'don't be doin' that' coz you'd just take no notice anyway." (Gary)*

Gary later highlighted that this negative health behaviour continued into his adult and working life:

> *"I used to smoke weed [cannabis] in work, use to fuckin' do everything like I'd wake up, go to work, go out of a night and I wouldn't even go to sleep, know what I mean, I'd just stay up all night and then go straight into work the next day either rotten stinkin' drunk or fuckin' stoned or whatever you know what I mean. There was times when I'd go for days on end...most of those jobs I'd do with me mates as well so we've always been together, and we always did the same things...it was good [laughs]." (Gary)*

During a discussion of personal barriers to engagement in physical activity and health related behaviours, Simon also made reference to the influence of the community in which he lived, and in particular, the negative influence of those who he was surrounded by:

> *"...me lifestyle was surrounded by dickheads all around me, so I was in that circle. I didn't wanna be there." (Simon)*

In Study 2 the physical environment emerged as a barrier to engagement in the Premier League Health programme. The findings of this study therefore extend our

understanding of environmental influences by highlighting the effect of the participant's social environment as a barrier to engagement in physical activity and positive health related behaviours prior to engagement in the Premier League Health programme. The impact of sociocultural norms within the place or community that the participants lived, and in particular, the negative influence of friends and acquaintances emerged as a barrier to engagement in positive behaviours for men who are from populations defined as hard-to-reach.

5.3.1.2 Psychological Barriers: *'me head used to go west'*

Within the physical activity and health promotion literature psychological barriers have been well documented (see Giles-Corti and Donovan, 2002; Biddle and Mutrie, 2008; Townsend et al; 2012). Within the social ecological model, psychological barriers to health are captured under intrapersonal influences (i.e., knowledge, attitudes, beliefs, and personality traits that influence an individual's behaviour) (McLeory et al., 1988). For our participants, psychological issues emerged as a major barrier to engagement in physical activity and positive health related behaviours prior to engagement in the Premier League Health programme. In particular, the stresses and pressure associated with everyday life appeared to have a negative effect on the psychological health and health behaviours of participants, as captured in the following words from Tom and John:

> *"I went on a little bit of a downward spiral. I was drinkin' vodka. Started on the vodka, the lagers, Vodka, JD [Jack Daniels] and I was just I went a little bit nuts. Just, things like you know when your head just goes west, me head just used to go west and I used to just...I can't explain it but, I dunno I just used to go 'where's that bottle?' and just down it...*just all things isn't it...goin' the hospital all the time [with his son] an things like that, it used to just play on me mind." *(Tom)*

"I started drinkin'. I was havin' a few problems in me family life and drink, it seemed to be the answer at the time." (John)

The pressure and stresses of everyday life also appeared to have a negative effect on the health behaviours of participants who had previously spent a period of time within an institution (i.e., in prison or in the British Army). This was captured by Brian and Colin's experiences:

"...in prison I could make half an ounce of tobacco last me a week, you know what I mean? Out here I smoke a lot...I think it's more what to do with the pressure of, you know, everyday life; bills an managin' money an things you know, things that come with the stresses, of not havin' a job an stuff, know what I mean, worryin' about finding work and what's gonna happen when me licence [prison] has finished an stuff like that." (Brian)

"...when I got out [Army] I had like mental health issues, so as a result I took like two years just trying to get meself together and that, and I didn't really do much [physical activity]." (Colin)

These findings highlight the prevalence of psychological barriers to engagement in physical activity and health related behaviours amongst hard-to-reach populations. Although psychological barriers are well documented within the physical activity and health promotion literature it can be argued that these psychological barriers are more distinct and arguably more 'extreme' than those that are typically documented (i.e., attitude and beliefs) and are inextricability linked to the participants chaotic lifestyles and social circumstances.

A closer examination of the data highlighted *how* the participants typically coped with the stresses and pressure that they were experiencing. In most cases, it

appeared that participants engaged, excessively, in, what they described as, pleasurable (but potentially destructive and negative) activities. After delving into the literature to attempt to understand *why* participants engaged in such behaviours, the presence of addictive personality traits emerged as a rational explanation. The existence of an addictive personality has been extensively debated (Berglund et al., 2011). According to Lang (1983) an addictive personality refers to a particular set of personality traits that make an individual predisposed to addictions. People with addictive personalities tend to indulge in excessive use of pleasurable activities to cope with unmanageable internal conflict, pressure and stress (Hatterer, 1982). Below John describes how he indulged in excessive use of alcohol to cope with the stress of his divorce and separation from his children:

> *"...I can go days without alcohol and it wouldn't bother me in the slightest and then like some days I'll think, oh yeah, I'll have a drink an then I just can't stop. I'll drink a bottle, bottle an' a half, two bottles of Vodka in the night an everything... when I got divorced I really hit the bottle bad coz she stopped me from seeing the kids. I was really down. I know it's quite sad but I was just on the internet playing poker...it was worse because when I was sober I was losin' coz I was thinkin' too much about oh well they could have that card, it could be possible that I'm working out percentages, whereas if I'd had a couple of drinks, was more aggressive an like used to put the anti-up on people, like try an bully them to fall out, to fold their cards, so I would win on poor hands. So I got into a mind set to think if I'm drunk I'm goin' to win more, and it is the wrong message but I did, I won six and a half grand [laughs]." (John)*

John later described how his drinking behaviour developed into a 'game' in which he would conceal the true extent of his alcohol consumption from his children:

> *"...they [his children] knew about the drinkin' coz obviously after a couple of months she [ex wife] used to let me see them so it was a Sunday so they used to come to me and like, you know the recycling thing, all they'd see was empty bottles of Vodka [laughs] all the time so they used to moan and what they used to do, they used to try and help me by puttin' markers on the bottles, you*

know so they knew how much I was havin' an things like that. But I ended up being like a little kid, I would pour the Vodka into a jug and then fill the bottle of Vodka with water, so it was back up to the same mark so it looked like I haven't had a drink, things like that. I was just like, trickin' meself an trickin' the kids, and I used to then like just drink the Vodka and then take the bottle with me when I was goin' shoppin' and put in the recycling things." (John)

In accordance with the theme and quotes above Simon and Gary also discussed how despite wanting and needing to make a change to their behaviours they continued with, or slipped back into, their negative drug-taking habits:

"I was a party animal an it was like every party, I was there you know...you know, drugs and drink I was such a hard core raver at one time girl...I used to take ecstasy but once they started getting mixed with all shite I stopped...had a little dabble with this that and the other, nottin' heavy, nottin' you know it was all like, what do you call it...you know just goin' out drugs, that kind of thing, and a little bit of pot [cannabis] here and there." (Simon)

"I was playin' [football] for a fair few teams like, but I stopped then coz I started doing other 'activities'. I should say...everything else apart from physical activity [laughs] drinkin', takin' drugs, whatever, everythin', know what I mean...I was messed up a touch! [laughs]...before I went to jail, I was fucked. Before I went to jail the only thing that would have stopped me from doin' what I was doin', was going to jail, you know what I mean, so I just thought in a way it's doin' me a favour...I wanted it, I expected it, I knew it [jail] was comin' sooner or later. At first, when I first got out [of prison] I just fell back into me old ways a little bit, you know what I mean, started doin' the things that I was doin' before I went to jail [drugs]. I started doin' the same things as I used to. So I just got back and then had to pull meself back from that then, but it was, it was getting...it was progressively sliding down the hill like." (Gary)

These findings highlight the prevalence of psychological barriers to engagement in physical activity and positive health related behaviours prior to engagement in the Premier League Health programme and extend our understanding of the participants lived realities. Furthermore, these findings suggest that even if the *'desire, want* and *need'* to change has been recognised by an individual, behaviour

change can prove difficult to achieve and sustain. Such characteristics appear to pervade those from hard-to-reach populations (i.e., men recovering from substance misuse) and those who possess addictive personality traits.

This study has highlighted community (environmental) and intrapersonal (psychological) influences as the major barriers to engagement in physical activity and health related behaviours amongst hard-to-reach populations prior to engagement in the Premier League Health programme. These findings offer important insights into the day-to-day lives and realities of the programme participants and develop our understanding of their struggle to engage in positive healthful behaviours. These observations support the World Health Organization's 'Social Determinants of Health' (2003a) (i.e., stress and addiction) however these findings challenge generic physical activity and health promotion literature such as the recent publication by Townsend et al. (2012) who reported work commitments, lack of time and caring for others as the major barriers to engagement in physical activity and health behaviours amongst men in England. The findings of this study are unique to challenging or HTR populations. The barriers to engagement that have been identified would appear to be a direct consequence of their chaotic lifestyles and social circumstances.

5.3.2 Motivations for joining the Premier League Health programme

5.3.2.1 The Football Club Brand: *'I was interested as soon as they mentioned Everton'*

The 'Tackling Men's Health' intervention reported that many participants had joined the programme due to the connection with the rugby club (Witty and White, 2010). Similarly, Pringle et al. (2011) and White et al. (2012) highlighted the importance of club-related branding and activities for the recruitment of men into the Premier League Health programme across sixteen English Premier League football clubs. In line with these findings, the association with Everton Football Club emerged as the primary attraction for initial interest and engagement in Everton in the Community's Premier League Health programme. This finding was emphasised by Colin, an avid and lifelong Everton Football Club supporter:

> *"That was big [finding out the programme was delivered by Everton Football Club], that was a big, big, big thing that, that was just like winnin' the world cup, the champions league an everything all in one, it really was." (Colin)*

Similarly, Gary and Simon indicated the importance of the football club brand as a 'hook' for gaining their interest in the programme:

> *"I was interested as soon as they mentioned Everton [laughs]." (Gary)*
>
> *"...when they mentioned it [the programme] and it was to do with Everton, I was like yeah it's to do with Everton being an Everton fan...anything to do with Everton I was interested, you know what I mean." (Simon)*

Furthermore, Tom and John (two lifelong Everton Football Club supporters) both described how the 'hook' of Everton Football Club not only made them take notice of the programme but it also made them take notice of the aligned health messages:

> *"...Oh it's [Everton Football Club] everythin' you know what I mean, you have to be an Everton supporter, you don't choose, you get chosen...it [Everton Football Club] just means everythin', since I was a little kid as far as I can remember all I wanted to do was watch Everton, support Everton, play for Everton an everythin', just everythin'... I used to go and sit in the main stand, you know with them silly little cushions [laughs], propping you up and havin' your hot Bovril at half time an everythin' [laughs]. You probably wouldn't get involved if it was something else, you'd probably think look at it and go yeah I might do and not do anything about it, whereas like you see like Everton and your thinking, you sort of take more note type of thing." (Tom)*

> *"...I mean like where you get a flyer off your Doctor or, you know, through the post or you see the NHS adverts and you think, no that won't happen to me type of thing. Whereas, if you have something that you associate your life with; Everton Football Club saying look this is it, this is what's gonna happen, you take more note than what you would do you know from the NHS or somethin' like that you take more note coz you think of Everton as part of your family sort of thing, so you take more note. I know it sounds stupid and everythin'... you take more note, an like it sinks in more than what it would you know like if you saw an NHS advert..." (John)*

John's opinion (above) supports the findings of the 'Football Fan's in Training' programme (Gray et al., 2011, see chapter one) where men reported that they would not have participated in a similar programme if it was delivered by the National Health Service. It can be argued therefore, that this finding demonstrates the importance of gendered approaches to health care (Gough, 2013) and places professional football clubs at the centre stage for men's engagement in health behaviours and with health services.

5.3.2.2 Psychosocial motivators: *'I just thought this has all got to change'*

As depicted in the participant profiles at the beginning of this section, many of the participants in this study were recovering from substance misuse. Sociological accounts of the process of recovery from substance misuse have emphasised the importance of the individual constructing a new positive self-image (McIntosh and McKeganey, 2000). According to Best and Lubman (2012) recovery from drug and alcohol dependency often involves an individual experimenting and trying new activities which become part of their new self-image. The construction of a new positive self-image, or identity, was an apparent motivator for engagement in the Premier League Health programme for our participants. The following quote typifies this finding:

> *"I've got 4 kids an I wanted to like be a good role model for them you know, rather than them seeing me drinkin', partyin', partyin', partyin'." (Simon)*

Simon's ambition to create a new, positive identity and to become a better role model for his children also resonates with Erikson's (1980) 'Life Stages Theory'. According to Erikson, all human beings pass through eight stages of psychological development in their lifetime, during which, individuals confront and master new challenges. According to Erikson, if a stage is not successfully completed it may reappear in the future. It could be argued therefore, that Simon (above) and Gary and Brian (below) are revisiting the 'identity' stage (typically completed in adolescence) of their psychological development in order to reconstruct, and improve, their personal perception of 'who am I?' and 'who can I be?' This finding is highlighted by Gary who said:

"I just wanted to better me life Kath, that's what I was tryin' to do. I mean, I don't know what was I doin' before." (Gary)

"...I got out of jail in 2005, the end of 2005, and then in the beginning of 2007 me Ma [mother] died, so that was another shock. But in the meantime like I'd been doin' bits of what I was doin' before like before I went to jail, and I was just fallin' backwards into the same old thing...then me Ma died and I just thought this has all got to change, you know what I mean." (Gary)

Similarly, Brian described how, at the time of joining the Premier League Health programme, he wanted to make a positive change his life. Furthermore, Brain also alluded to wanting to create a positive self-image as he has spent the majority of his life engaging in negative activities and behaviours:

"It [the programme] couldn't have come at a better time for me to be honest coz it was, you know, it was something I needed to do and that sort of give me a kick start to get up and change me life around." (Brian)

"...I excelled at most things [sports], but instead of puttin' me energy an stuff into positive things I started veering off into negative stuff, you know what I mean. I wasted a lot of time and now I'm, you know, late on, like 43, I'm tryin' to catch up now. I'm tryin' to make amends for some of the negative stuff I've done." (Brian)

Simon, Gary and Brian's perspectives raise the issue that, for some, engagement in community physical activity and health programmes is driven by more than a desire to improve physical health. In this instance, engagement was driven by a desire to modify and improve self-image in a safe and supportive yet masculine (football based) environment.

Prior to engagement in the Premier League Health 12 week interventions, Drew [PLH coach] and I invited all of the participants to a short informational meeting in one of the suites at Everton Football Club. At this meeting Drew and I would speak

to the participants about the programme and allow time for them to interact with each other. The below quotes highlight Colin and Gary's thoughts after this initial meeting:

> *"...they all seemed good lads and none of them had any like, drug or alcohol issues or stuff like that which basically I thought, well that helps me out as well. I'm mixing in a better environment." (Colin)*

> *"...the majority of them I never knew in the past anyway, you know what I mean? I was taken out of me old surroundings sort of thing so I had no bad influences around me." (Gary)*

In the previous section the influence of the social environment was highlighted as a debilitative barrier to participation in physical activity and health related behaviours. Here, Colin and Gary demonstrate the importance of a new positive social environment that can be more facilitative to their needs. In particular, the quotes above highlight the importance of the nature of fellow participants for engagement in the programme. Indeed, through the words of Colin and Gary, and via my own observations, it became apparent that the participants were seeking to construct their new positive self-image with like-minded people in a welcoming environment without the presence of any 'dickheads' (as described by Simon) who could potentially contaminate or obstruct their new pathway. It can be argued therefore, that in order to facilitate positive behaviour change and continued engagement in the programme amongst (HTR) populations who are attempting to make positive changes to their social wellbeing; a collective positive social determination to move forward is required amongst participants within the group. This argument is supported by Sherry and Strybosh (2012) who reported that many participants of the Homeless World Cup highlighted that a welcoming atmosphere from, and

positive perception of, fellow participants was integral to engagement in the programme. Furthermore, it appeared that the importance of the social environment for engagement in the Premier League Health programme was not only related to the nature of fellow participants, but also to the nature of the programme delivery staff. In the final report of the Premier League Health evaluation, White et al. (2012) asserted that the project staff and their ability to interact with the participants on a personal and social level was as key factor in facilitating participant adoption to the Premier League Health programme. Consistent with these findings, the following quote captures Gary's view on the nature of the programme staff as facilitators for programme adoption and maintenance:

> *"Even though it's not that good round here like but [laughs] I couldn't see meself living anywhere else, but.... like youse, youse [practitioners] have all been alright with us an that, you know what I mean. That makes it easier as well, it's like, well say youse are teachers like aren't youse really, you know what I mean, tutors sort of thing, so like if they're alright then that's even half the battle. Coz if you get a little shit or something, they can put people off from goin' as well, an people just won't enjoy it, people won't go." (Gary)*

This finding was supported by Brian and Colin who also made reference to the welcoming and supportive nature of the programme staff as a motivator for engagement:

> *"I'd say you and Drew, as a team, you were very welcomin', there was no individuals, everyone was treated the same, so it was good, it was good and professional the way youse are all, the welcome side of it...but then it was always maintained as well, very well throughout. If there was any problems youse were always there, Drew always helped ya, yourself always helped us, youse were there to help throughout the entire course and that was what I really liked about it, it was like, it wasn't, as I said it was ran professionally, it*

wasn't arsed about, youse were there, and because youse where there, we said we would be there, so we had to be there." (Brian)

"At first when I first was goin' in with the operation I was petrified, but with you and Drew sayin', you know, I've got that support and then, you know but that was a big weight off me shoulders, you know what I mean... being able to come and talk about like anything, you know what I mean is was good like." (Colin)

Social support also emerged as a key motivator for engagement in the Premier League Health programme amongst our hard-to-reach participants. Biddle and Mutrie (2008) argued that social support is associated with the physical activity behaviours of adults. Sheridan and Radmacher (1992, p156) defined social support as *"the resources provided to us through our interactions with other people."* According to Taylor et al. (1994) social support refers to emotional, informational and material support. This is consistent with interpersonal influences captured within the social ecological model (McLeory et al., 1988). The following quote provides evidence of informational social support provided by others which aided Brain's entry into the PLH programme:

"...in Resettle [support programme for those recently released from prison] there's staff, like you've got Probation Officers and you've got Key Workers...Peter [key worker] will go and do as much homework as he can an find as many courses an as many, you know, opportunities for what you said you wanted to do an he'll call you like once a week. You have a sit down meetin' with him, an he'll suggest, like with this [the programme], he went out an done all the leg work for this an then come to me and said "Everton in the Community have this course, 12 week course, an would you be interested in doin' it?", an because it was football an it was sport orientated , I agreed to it, an that's how I ended up doin' this course." (Brian)

Similarly, Tom and Gary (who were also engaged in external support programmes/groups) highlighted the impact of social support from the staff of their support programmes for entry into the PLH programme:

> *"...after Karen [his wife] passed away, there was this thing called a Dad's Club so then I started goin' there of a late Friday with Dan and George [children] and I remember sayin' to Sarah [staff], I went 'is there any chance I can start doin' some trainin or something to just get meself sorted out' and she said 'yeah, leave it with me.' So it took a few months and then I think she'd phoned up here [EAFC] for me." (Tom)*

> *"Erm, [I heard about the programme] through some other place I used to go called Genie in the Gutter [addiction support programme]...but, you go in there and people are fuckin' rotten stinkin' drunk, stoned, smacked up to the eyeballs, do everythin' and so I walked out and they were getting cobs on [annoyed] with me so they said to me 'what do you want to do?', and I said "'don't know, but I'm not doin' no more of them meetings'. I said 'what have you got for me?' and they told me about this Everton programme." (Gary)*

Simon also highlighted the influence of friends and word of mouth for engagement in the programme as he first heard about the programme through Gary (whom he had known for over 30 years):

> *"Gary rang me up and said 'there's a programme goin' on so I went down, an that's when I met yourself and Drew [Premier League Health coach]." (Simon)*

These findings demonstrate the importance of others for encouragement and motivation to engage in physical activity and health behaviours amongst hard-to-reach populations. These findings resonate with Pringle et al. (2011) who reported that friends, word of mouth and referrals from partner services were all important for participant engagement in the Premier League Health programme (across 16 EPL football clubs).

In summary, improved self-image, improved social environment, the caring, approachable and skilled nature of practitioners (programme staff), social support and encouragement from others emerged as the key psychosocial motivators for participant adoption and engagement in the Premier League Health programme. These findings both support and extend the work of White et al. (2012) who reported participant motivations for adoption of the Premier League Health programme. Interestingly, participants in this study did not highlight improvement in health and fitness as a key motivator for engagement in the Premier League Health programme which raises the issue that, for our hard-to-reach participants, the programme acted as a vehicle for social change (i.e., to improve and change their lives and to construct a new self-image), but not as the programme initially intended to do (i.e., to improve health and fitness).

5.3.3 Impact of the programme

Coalter (2007) argued that the inherent and obvious benefit of participation in physical activity programmes is the tangible effects of improved physical health, however for the more marginalised HTR populations within this study, it appears that the development of social benefits were significant to their initial, and sustained, involvement. This argument is strengthened by recent findings from Sherry (2010). Through an evaluation of the Homeless World Cup, Sherry (2010) found that the programme attracted vulnerable marginalised individuals into a football programme and impacted the physical health improvement of participants. However, according to Sherry, the programme also guided access to other support and health services and improved the mental health of participants through raising

their self-respect, self-esteem, self-confidence and creating a sense of belonging and identity. In an evaluation of engagement in a Football in the Community programme delivered by Scottish Premier League football clubs, Gray et al. (2011) also found that positive physiological, psychosocial and lifestyle changes (such as diet) were achieved through participation in the programme. Similarly, through an evaluation of the Premier League Health programme across sixteen English Premier League football clubs, White et al. (2012) and Pringle et al. (2013) found that regular participation in the programme was associated with beneficial changes in health status and health-promoting behaviours.

5.3.3.1 Physical Health: *'I could see like the difference it made in me health'*

Consistent with previous literature, positive changes in physical health were perceived by participants of the programme who had been engaged for a significant amount of time (i.e., 12-36 months). Colin, for example, highlighted the difference he felt in his fitness following regular (i.e., 2-3 sessions per week over an 18 month period) engagement in the programme:

> *"I could see like the difference it made in me health as well...I could see a difference in how long I could run for, you know what I mean, and then getting me football skills back, so I was made up and I was keeping up with the younger lads and I was like, oh this is great, so it was an ego boost in mid-life crisis." (Colin)*

John and Simon also made reference to the evident decrease in their waist size as a result of engaging in the programme:

"It's bettered me life, bettered me life in many ways. It's took me beer belly away [laughs]. I do watch what I eat an all. I went from a 36 [inch waist] to a 32!" (Simon)

"I've lost weight and everythin'. I've lost about half a stone, but like me pants are swimming on me, where I was a 38 waist, now I'm a 36 and these are a bit loose now an everythin'." (John)

Furthermore, positive improvements in diet were evidenced in the data as illustrated by Gary and Simon:

"...now like when I'm in [the house], which is most of the time anyway, I will cook a proper meal, you know what I mean, I try and get me 5 fruit and vegetables a day down me. I'm not a great lover of water but I drink like loads of juice and milk and that or I know tea and coffee aren't good for you like, but it's some sort of fluid innit...But it has, it's changed a lot, like a big deal. I try and be like what is it, cut out a lot of salt and that, sugar and just try and get as much vitamins and that, whatever inside ya and don't fuckin' fry nottin'. I mean if I do fry things it'll be dry fried, you know what I mean, I don't cook nottin' in fat or nothing like that, so it's a big change like." (Gary)

"I find meself when I'm goin' the supermarket, I'm reading what's on the back [of packaging] and I've never ever done that before an I'm looking what per cent of meat's in the sausages and how many calories are in that and you know...if you looked in my fridge now it's all green, yellow and orange, it's all lovely colours, it used to be just a big dull brown but now everything's healthy looking." (Simon)

The data highlights that although participants did not advocate improvements in their health and fitness as a key motivator for engagement in the programme, the experiences cited above indicate that improvements in physical health, fitness and diet were made as a result of engagement in the programme. Furthermore, whilst Study 2 demonstrated that engagement in a 12 week football specific intervention did not result in significant changes to physiological health, participants such as Simon and Colin who had been regularly engaged in the programme for over two years indicated explicit (e.g., waist size) and perceived (i.e., feeling fitter) changes to

their health and fitness which suggests that continued maintenance of regular engagement in the programme (i.e., more than and/or post 12 weeks) will more likely result in significant changes to physical health and fitness.

5.3.3.2 Access to health services: *'It wouldn't have been something I would have been comfortable approachin' unless it was put to me first'*

In line with findings from Sherry (2010), the Premier League Health programme appeared to break down barriers to accessing external health services. Colin's comments below illuminate that accessing external health services is something that he wouldn't have done without the support of the programme:

> "...because I have high cholesterol, I wanna get more into speakin' to them [British Heart Foundation]. So I know there's the link there then, you know it wouldn't have been something I would have been comfortable approachin' unless it was put to me first." *(Colin)*

> "...if it hadn't been for this programme, *if I was just going to a Lifestyles [council] gym, they wouldn't have brought that service in [Cancer Research UK], you know what I mean. If it's just been a leaflet or a card, which you may look at, read and put away, you know, we had somebody physically comin' and sayin' and then offering us a visit to their Centre...It was me going there and then them actually getting on to it [a health problem]...where I wouldn't have found out if I was anywhere else, going to work or going the dole or you know goin' to like a sports centre, playin' squash or going to like a Lifestyles gym, there wouldn't have been...I wouldn't have come across that person, you know what I mean? So, it does open a lot of doors, especially health wise." (Colin)*

Colin's comments typify the stories of other men in this study and therefore demonstrate the power of the Premier League Health programme for men's engagement in external health services. Specifically, men in this study would

engage with traditional health services if engagement occurred through the programme and health services/staff were brought to them.

5.3.3.3 Mental Health: *'I'm stronger in me mind than what I ever have been'*

The psychological impact of engagement in sport, physical activity and health related behaviours has been at the forefront of much academic attention. There is now a worldwide acceptance that engagement in physical activity and positive health related behaviours has a positive effect on mental health (Biddle et al., 2002). According to Taylor et al. (1985) engagement in regular physical activity improves self-esteem, self-confidence and cognitive functioning. Furthermore, Best and Lubman (2012) highlighted the importance of engagement in community sport and physical activity programmes for recovery from drug and alcohol dependency. Sherry (2010) reported positive changes in self-esteem and self-confidence amongst participants who took part in the Homeless World Cup. This study highlighted positive psychological changes in participant's mental health as a result of engagement in the programme. This finding is reflected in Colin and Gary's quotes below:

> *"...it's made me a happier person, you know what I mean." (Colin)*
>
> *"Every time I wake up in the morning, just feel as if nottin' worryin' me whatsoever, know what I mean, you haven't gotta go out an do whatever to get drugs. I think if I feel healthy in my body then my head's alright." (Gary)*

Furthermore, Brian and Tom described the positive influence that participating in the Premier League Health programme had on their self-confidence and self-esteem:

"It's given me a bit more confidence, as to you know, relating to people I think." (Brian)

"...meetin' all people like yourself, Drew and that, all good lads. It gives you a boost, you get a good boost out of it, you feel it is right, it makes you feel better you know what I mean, you feel well better and you've done somethin' coz that's what it's for isn't it Yeah physically better, mentally better, just given me a real boost type of thing coz there's been times where I could, not withdraw but I dunno, you don't seem to, you don't realise, I just went into one, I could just sit there and just go into one, I don't know it's mad but doin' this thing, it has made me better." (Tom)

Below, Simon also discusses the positive impact that engagement in the programme had on his mental health and wellbeing and describes how participating in the programme has been especially helpful to him during a time of personal and emotional upheaval:

"I'm just getting over you know, I'm still a little bit shocked about splittin' up with her [his wife] so this [Premier League Health programme], it takes me mind off it you know. Otherwise if I was sittin' in the house now, I'd just be looking at four walls, looking through the telly you know, when I don't think about it. It doesn't bother me at all, so I keep active and keep doin' shit (stuff)." (Simon)

"...you know people try and rope [persuade] me into little things here and there, people are thinkin' I'm vulnerable coz I've split with me girlfriend. But I'm not as vulnerable as they think, I'm stronger in me mind than what I ever, ever have been. I mean it so true what they say isn't it, healthy in the body, healthy in the mind." (Simon)

Data also highlighted that engagement in the programme developed both empowerment and a sense of belonging amongst participants. According to McIntosh and McKeganey (2000) empowerment and a sense of belonging is important for the creation of a new identity which is instrumental in the recovery of addiction. Furthermore Grigsby et al. (1990) argued that a sense of belonging is

important for those who have experienced homelessness or unemployment. The following comments convey the sense of empowerment and belonging that Colin, who had spent a period of time living in a homeless shelter, had mental health issues and is long term unemployed, attributed to his engagement in the Premier League Health programme:

> *"...they [participants] were askin' me about what it was like when I was first went on it [the programme] and what do you gain from it and then speaking to them about it, and it just gave me a bit of a buzz that I was able to like sort of take a mentoring role...you don't get that at home watching Jeremy Kyle do you [laughs]." (Colin)*

> *"...it [the programme] gives me an outlet because, because of the health issues I have I can't go back into doing me normal work...it's also given me an outlook on sort of becoming a volunteer, do you know what I mean...me main focus is on like, the programme and stepping up from being a service user and stepping up and being like a mentor-cum-volunteer. But the programme, it's sort of become somethin' I'm engrossed in...my mind is constantly thinking Everton in the Community Men's Health, you know what I mean. It's constantly on the go an what can I give back basically and help out and get on board. Coz it has been a totally breath of fresh air and probably somethin' I wished that there was like in me younger years... every session with Everton in the Community I always look forward to, think 'oh I can't wait, I wanna go, I can't wait to go', you know what I mean, like it has made a big change in my life for the better, but I don't want it to stop there, I wanna be able to progress and then be able to progress an be in a position to give somethin' back." (Colin)*

Similarly, Simon described the attachment he felt to the Everton Active Family Centre (the base of the Premier League Health programme and location of the circuit training and boxing sessions). It can be argued that attachment of this depth is undeniably linked to feelings of empowerment and belonging:

> *"I mean, as I say Kath, the likes of this place it's like a second home to me now it's only round the corner and I'm part of the furniture." (Simon)*

5.3.3.4 Social Wellbeing: 'I've made a hell of a lot of friends'

Another key outcome that emerged from the data analysis was the development of social wellbeing and in particular, social capital. Social capital is defined by Putman (1995, p66) as *"features of social organisation such as networks, norms and trust that facilitate coordination and cooperation for mutual benefit."* According to Jackson (1993) participation in community physical activity programmes provide an opportunity to develop and foster social capital. This argument is strengthened by Sherry (2010) who found that participation in the Homeless World Cup allowed friendships to develop and camaraderie and togetherness to form between participants. Similarly, Ottesen et al. (2010) reported the development in social capital amongst participants who engaged in a 16-week football specific physical activity programme. Furthermore, White et al. (2012) reported a statistically significant improvement in social support networks among participants who regularly engaged in the Premier League Health programme (across 16 EPL football clubs).

The value of sport interventions for fostering social capital amongst participants has long been discussed (Sherry 2010). According to (Sherry, 2010) the social capital built within sport and physical activity programmes is greater than the sum of its parts. The following quote from Simon exemplifies the social capital gained through his engagement in the PLH programme:

"I've made a hell of a lot of friends from doin' this course." (Simon)

According to Carron et al. (2003, p4) "*the need for interpersonal attachment is a fundamental human motive and has important implications for adherence in physical activity.*" In this study, the data provided evidence of the friendships made through engagement in the programme and alluded to the fact that regular engagement in the programme was fostered through these friendships and bonds. This finding was captured by Colin:

> *"They're, how can I put it? They're me circle of friends... I don't associate really with anybody else, you know what I mean." (Colin)*

> *"...I used to hate going to Lifestyles [council gym] and think 'oh I can't be bothered', but I'd go just to get me out of there [hostel], whereas on this programme I look forward to every session, do you know what I mean...and to participate and speak to lads and bond, because I haven't really bonded with the number of people that I have done on this programme since me Army days. Even when I was playin' football like with the other teams, when I was younger, I didn't bond with them, you know what I mean. I just distanced meself but here I've just found it easier to bond with the lads you know and I see them frequently an it's basically I see them frequently to do the programme. So it's sort of took over our lives but in a healthy way, you know what I mean, not like somethin' takes over your life in like an unhealthy way or forced upon ya. It's just taken over...you wake up of a mornin' and it's like, am I with Everton today?" (Colin)*

Furthermore, the following comment from Tom describes the close bond he felt between himself, the participants and the project staff:

> *"...we're like a little clique, like a little team now you know what I mean...I've met some crackin' lads. I've met yourself, I've met like I say Drew, Matt, you know, honest a God, great, great bunch an yeah like a little family type of thing isn't it." (Tom)*

The previous section highlighted improvements to social environment as a key motivator for participant engagement in the programme and data suggested that participants wanted to interact with others than those ('dickheads/deadheads')

who they were currently surrounded by. Simon's quotes below allude to the fact that engagement in the programme had helped him to achieve this:

> *"It's a lovely thing, it's lovely to meet people like yourself and Drew and youse are all nice people an it's really good to see you know people like yourselves, it's like I wish I was around more, you know, more people like yourselves." (Simon)*

> *"...you get the odd dickhead anywhere like, but, when I was doin' like a different course, it was all lads out of hostels, you know, this is goin' back 6 years ago, my probationer, she got me on this course and from there I tried to turn me life around but I was still with a few deadheads. Now I'm on this programme I've got rid of all the deadheads out me life, all negativity's gone." (Simon)*

> *"...it's made me change me life around...here I come across nice people like yourself, Drew. You know I live in a shit hole, an you know, I've lived there all me life, you know, born and bred up there, people are scared to walk through that estate." (Simon)*

Simon's comments (above) demonstrate the wider impact of engagement in the Premier League Health programme on the lives of participants. Simon's comments also highlight the importance of the nature of fellow participants in order for him to achieve and maintain improvements to his day-to-day existence. From my own observations, I saw how the occasional 'deviant' participant (i.e., participant who was still involved in negative and destructive activities and involved others in their behaviours) who entered the programme was not wanted or welcome. Typically, the deviant wouldn't stay engaged in the programme for long as the regular and long-term participants such as Simon and Colin would not welcome their presence in the group.

In line with the findings of Study 2 and previous literature (Sherry, 2010), social interaction again emerged as a major outcome of engagement in the Premier League Health programme. Below Colin describes how this interaction improved his life:

> *"...it was takin' me mind off the operation and because it caused a lot of discomfort it took me mind off that and I felt like at least I'm maintaining somethin', you know, coz it was like just comin' and talkin' with different people as well you know, rather than being sat in that house going "oh oh oh I've had an operation, can't do nothing", it was good just to come up and even chat to people, you know what I mean." (Colin)*
>
> *"It's had a big impact on my life because I, I'm not one who socialises with big groups but this gives me the chance to socialise in like with big groups type of thing." (Colin)*

Rookwood and Palmer (2011) questioned whether football programmes with development objectives that engage marginalised 'hard-to-reach' populations are just opportunities for participants to put their life troubles on hold rather than fostering significant change. The findings of this study challenge this argument by highlighting a number of psychosocial benefits and changes for participants who have been engaged in the programme for a sustained period of time.

5.3.4 Barriers to engagement in physical activity and health behaviours when participating in the Premier League Health programme

5.3.4.1 Psychosocial influences: *'smoking is the only thing that I've got left'*

In contrast to Study 2, economic and environmental challenges did not emerge as significant barriers to participation in the Premier League Health programme or in other physical activity and positive health related behaviours during participation in

the programme. It can be argued that this is because those who were interviewed had been engaged in the Premier League Health programme for a significant amount of time and therefore did not experience, or had overcome, economic and environmental barriers to participation. Psychosocial influences however emerged as a barrier to engagement in positive health related behaviours. In particular, the prevalence of addictive personality traits and apparent life pressure/stresses continued to influence participant's behaviour. Gary's comment below illustrates this finding:

> *"I went to the Fagends' [smoking cessation service] talk, but like I said I still smoke so it never done anything, it never worked, you know what I mean [laughs]. But I will, I'll try and pack it in sooner or later, I just never give it a proper go coz it's the only thing that I've got left really I think, you know what I mean. I think it's tryin' to cling on to something [laughs]. I gave up everything else...it's the only thing left but the worst out of all of them an I wouldn't mind but me Ma died of cancer and me Da's died of cancer, so it's like, if that's not a hint to pack in smoking." (Gary)*

Gary makes reference to smoking being the *'only thing he has left' and 'something to cling on to'*. In this regard, it can be argued that Gary felt that he had already made significant changes to his lifestyle by ceasing his excessive use of drugs and alcohol and removing himself from the negative social circles he engaged in, and so he was not yet ready or willing to change his smoking behaviours as well. In other words, changing his smoking behaviours in addition to the lifestyle and behaviour changes he had already made would have been a step too far for Gary. Furthermore, despite making radical changes to their lifestyle and health related

behaviours (as evidenced in previous section: impact), Simon and John described the negative influence that continued life stressors [8] had on their health behaviours:

> *"I still smoke. When Drew got the FagEnds [smoking cessation service] in we had a little go an at the time I was goin' through a little crisis in the family, me girlfriend she was wantin' to party still an I was wantin' to go on health side of it an we ended up just goin down separate pathways you know. 27 years I've give the girl an the more I was in the gym the worse it was getting' for her. She didn't like to see me gettin' fit for some reason an before I knew it she was off with some 59 year old fella....so every now and then I'll still go out to town or whatever and then when I go out like I'll neck a few tablets or something or have a few halfs or something, know what I mean." (Simon)*
>
> *"I had a few stresses at Christmas. I ended up starting [smoking] again, I stopped for two months on FagEnds and then started again. (John)*
>
> *"Like I did a full month without drink and everythin' and targeted meself and had the bottle of Vodka right in the middle of the kitchen, by the kettle, so I could see it every single day and everyone was like 'oh, I'd love to drink that' an it just give me the incentive not to, just looking at it. But like I did the worst thing, when the month finished, I finished work at half 1 on the Friday night, went home and celebrated that I did it for a full month by drinkin' the bottle of Vodka [laughs]." (John)*

This finding highlights that whilst community health projects such as the Premier League Health programme aim to improve many aspects of participant's health and health behaviours (i.e., mental health, sexual health, physical activity, smoking) practitioners should be aware that for hard-to-reach populations such as those engaged in this study, a 'one-step-at-a-time' approach may be necessary and more appropriate due to the wider issues associated with the participants challenging backgrounds. Further implications of this finding to practitioner approaches are discussed below (5.4).

8 'Sources of stress and anxiety in our everyday life' (Biddle et al., 2002, pg.9).

5.3.4.2 Limited activities and sessions: *'I'd like to see like daytime activities'*

In order to engage in further physical activity behaviours, participants vocalised that they would like a wider range of activities to be offered as part of the Premier League Health programme. In particular, participants said they would like a wider variety of activities to be offered during the daytime. This finding was captured in the following quotes:

> *"I'd like to see like daytime activities you know, some stuff more in the daytime, an possibly a little bit more variety." (Colin)*
>
> *"If youse had more stuff I'd do a lot more with youse." (Gary)*
>
> *"I'd like to see like daytimes you know, some stuff more in the daytime." (Brian)*
>
> *"I'd like to do badminton, badminton, erm, again maybe a run every week, somethin' like that." (Simon)*

These findings highlight that despite engaging in physical activity and health related behaviours through the Premier League Health programme, participants still struggled to overcome some psychosocial barriers and continued to deal with life stress and pressures through excessive use of unhealthy behaviours such as binge drinking and smoking. Furthermore, participants suggested that in order to further engage in physical activity the Premier League Health programme should consider the introduction of additional and varied sessions.

5.4 Implications for practice

The knowledge gained from this study puts us in a better position to comprehend the complexities associated with men from populations defined as HTR and to understand the motivations driving behaviour change and participant engagement

in programmes such as Premier League Health. Furthermore, this study provides an understanding of 'what works' for engaging men from challenging backgrounds in regular physical activity and health related behaviours and provides important insights into the impact that programmes such as Premier League Health can have on the lives of HTR men. This knowledge therefore, can be used to improve the design and delivery of this, and similar programmes engaging men from HTR populations in physical activity and health related behaviours and to strengthen delivery efforts (evidence based practice). While it is recognised that the majority of Football in the Community physical activity and health programme funders, programme managers and practitioners are unlikely to be involved in research, they are likely to be involved in planning and implementing physical activity programmes or initiatives with men. Therefore, the issues discussed in this study are considered to be relevant and to have implications for the design and delivery of physical activity and health programmes with HTR male populations. Furthermore, as there is increasing pressure from funding agencies and commissioning bodies to design programmes and interventions founded on evidence-based practice, the following text aims to provide an overview of findings and the implications that they have for practice:

Social cultural norms within the community and/or environment that the participant lived were identified as a major barrier to engagement in physical activity and positive health related behaviours prior to engagement in the Premier League Health programme for HTR populations. Furthermore, the pressures and stresses associated with the everyday life of HTR participants were identified as

psychological barriers to engagement in positive lifestyle choices. It should be noted at this point that although the themes in this study were represented in the narrative as distinct, they are undeniably interlinked. For example, the social environment (environmental barriers) in which a participant lived resulted in feelings of pressure and stress (psychological barriers) which, in turn, led to engagement in negative health behaviours such as excessive alcohol consumption. Clearly the results of this study are context and population specific, however, the results suggest that project funders, programme managers and practitioners of Football in the Community physical activity, health and behaviour change programmes need to understand the 'bigger picture' (i.e., the wider contextual and socio-ecological issues associated with the populations with whom they are attempting to engage). Prior to programme design and delivery, practitioners should assess the potential barriers to engagement in the programme and barriers to positive behaviour change and implement strategies to address and/or remove these issues. Multi-level programmes which focus on the needs of the target population (i.e., focus on the environment as well as the individual) should then be designed and developed in collaboration with individuals and groups from the target populations. Where appropriate, practitioners should also consider employing interventions which target multiple health behaviours (e.g., physical activity alongside stress management) as physical activity alone is unlikely to meet the wider needs of men from HTR populations such as those in this study (see NICE, 2007).

The brand of Everton Football Club was identified as a key motivator for participant engagement in the Premier League Health programme and for engagement in health literature and messages. Therefore, a marketing and promotion strategy for the Premier League Health programme (and similar programmes) should be built around the brand of the football club. Furthermore, key health messages and health literature should be aligned with football club brand as much as possible.

Psychosocial motivations (i.e., improvements in self-image and improvements to social environment) for engagement in the Premier League Health programme were also identified. Interestingly, this finding has highlighted that even though the Premier League Health programme was marketed and promoted as a physical activity and health engagement programme, health behaviour change was not necessarily the major motivator behind engagement in the programme amongst participants in this study (i.e., those from populations defined as HTR). Instead, broader psychosocial issues influenced engagement in the programme. This finding highlights that Football in the Community practitioners need to be trained beyond 'the typical' Football Association Level 2 or UEFA B qualification and should develop skills such as counselling and behaviour change management in order to deal with, successfully manage and support individuals at this critical stage in their social and identity redevelopment. Furthermore, whilst community projects such as Everton in the Community's Premier League Health programme often have a remit to be inclusive and open to all, practitioners should be aware of 'deviant' participants (i.e., those who are still engaged in negative social circles, deviant activities, are not

ready for change and could potentially upset the progress and dynamic of the group) and have strategies to deal with them so damage is mitigated.

Parnell et al. (2012) highlighted how Football in the Community schemes need to make sure that the right people with the right skills are employed in order for FitC schemes to tackle major social issues and effectively manage the apparent complex issues associated with the lives of their programme participants. The findings of this study support this argument by highlighting that engagement in the PLH programme was influenced by positive perceptions and opinions of the programme practitioner/s. In order to successfully engage with men from HTR populations such as those in this study, practitioners should be personable and respectful of the backgrounds of the HTR participants. Furthermore, practitioners should consistently seek to develop trustful and meaningful practitioner-participant relationships. This requires a practitioner who talks with the participants and gets to know them as individuals; a practitioner who makes time for them and who genuinely wants to see the participant's better themselves and/or achieve their personal goals (see Gilbert, 2001; Radger, 2005; Coy, 2006). From my own experiences of working with HTR populations (throughout the duration of the Premier League Health programme) I strongly believe that empathy, respect, humour and a sense of genuine care help to achieve this.

Positive improvements to participant's physical health, mental health and social wellbeing were evidenced as the major outcomes from regular and sustained engagement in the Premier League Health programme. However, participants also

highlighted that through engagement in the programme they accessed external health services and alluded to the fact that they wouldn't have done so otherwise (i.e., due to logistical barriers, anxieties surrounding masculinity and the mere fact that they didn't know the services existed). These findings highlight that whilst men are reluctant to seek help from traditional health services (Addis and Mahalik, 2003) they will do so through programmes such as Premier League Health (see White et al, 2012). Therefore, it can be argued that the programme itself acts as a barrier removal. It is recommended therefore, that programme managers should continue to develop links with external health services and practitioners should seek to educate participants in the knowledge of local health services and furthermore bring local health service staff into PLH sessions. Here, it is recommended that health service staff should raise awareness of their health services and deliver key health messages through short (5-10 minutes maximum), informal talks with the group (see White et al., 2012) and offer additional 'take home' information. Furthermore, it is recommended that non-obligatory, non-invasive and non-threatening opportunities to connect with health services are made available as and when the participants are ready to engage.

Continued psychosocial influences (i.e., addictive personality traits and life stresses) emerged as barriers to successful attainment of, or further engagement in, physical activity and positive health related behaviours when the participant was engaged in the PLH programme. The research findings evidenced that engagement in positive health related behaviours involved a continual struggle against their chaotic and stressful lifestyles and addictions. This finding again points to a set of skills required

by practitioners for the successful delivery of health behaviour change programmes engaging challenging HTR populations such as Premier League Health. Specifically, practitioners should be empathetic, supportive, and adopt a 'one-step-at-a-time' approach. For example, even if an individual appears 'ready for change', practitioners shouldn't expect multiple behaviour change to occur at once as participants may be making, or adjusting to, changes to their wider lives (i.e., removing themselves from long standing social circles). Practitioners should therefore aim to meet the needs of the participant and make themselves available to talk to whilst also providing time and space for the participant to adapt any other lifestyle/behavioural changes being made (see NICE, 2007).

Participants in this study highlighted that they would like to engage in further physical activity sessions through the Premier League Health programme. Specifically, participants alluded to a need for a greater variety, and number of, physical activity sessions offered by the programme. The obvious implication of this finding for practice is to recommend the introduction of additional Premier League Health sessions which are based on participant feedback and demand. However, several logistical factors must be taken into consideration at this juncture, as the introduction of additional sessions would require flexibility within programme and further financial demand for staffing and potential equipment/venue hire. Therefore, the introduction of additional sessions may be unobtainable within the project budget and structure. If so, then it is recommended that programme managers should develop links with external sport and physical activity organisations and community programmes so that practitioners can offer referrals

(signposting) and support onto other programmes which provide daytime and additional physical activity sessions. It is also recommended that programme managers ensure all future funding applications allow for the provision of programme development and growth. Furthermore, practitioners should seek to manage participant expectations so that participants understand the constraints associated with the expansion of such programmes.

5.5 Conclusion

Harkins et al. (2010) asserted that effective health promotion strategies for recruiting and engaging men are not well understood and, in particular, there is a lack of good quality research examining the most effective strategies to engage men from hard-to-reach populations. According to Sinclair and Alexander (2012), the majority of work examining HTR populations within health promotion literature has relied on practitioners' perspectives rather than the perspectives of hard-to-reach populations themselves and has therefore silenced their subjective voice and personal experiences (Carless and Sparkes, 2007). This study therefore attends to the gap in this area of research by offering a contextual understanding of the experiences and realities of men from HTR populations. By sharing the perspectives of male participants from populations defined as hard-to-reach, this study has provided valuable insights into the psychosocial motivations behind men's engagement in the PLH programme and has subsequently offered suggestions for effective recruitment and engagement strategies for future physical activity and health promotion programmes with similar populations.

The methods adopted in this study alongside trustful, comfortable researcher-participant relationships allowed for the collection of rich, detailed data that highlighted the key intrapersonal, interpersonal and community influences which resulted in barriers for men's engagement in physical activity and health related behaviours (both pre and during engagement in the PLH programme) and the impact that regular engagement in the PLH programme had on the lives of participants. Consistent with the findings of Study 2 and the social ecological model (McLeory et al., 1988), environmental (community) and social (interpersonal) challenges were identified as barriers for men's engagement in health, furthermore psychological (intrapersonal) barriers emerged from the data. Furthermore, Study 2 reported the development of structure, social capital and social interaction as the major outcomes of engagement in the PLH programme for participants. The findings of Study 3 support the outcomes identified in Study 2 however, our understanding of the impact of engagement in the PLH programme is extended by the emergence of the deeper more meaningful biopsychosocial effects.

This study has extended, supported and challenged the findings of previous literature and has been crucial for developing and extending the knowledge gained in Study 2. Although the findings of this study may not be generalizable to the wider population (i.e., the barriers, motivations and project impact are likely to be specific to HTR populations due to their chaotic lifestyles and social circumstances) or other contexts, the findings of this study have led to the development of important implications and recommendations for the enhancement of practice in this and future physical activity and health programmes engaging HTR male populations.

Chapter Six:

Synthesis

"Public health workers deserve to get somewhere by design, not just by perseverance."

(McKinlay and Marceau, 2000, p25)

6.1 Chapter Overview

This chapter will reflect on the original aims of the research and discuss the overarching findings that emerged from the three research studies conducted and presented in this thesis. The practical implications that the research findings have for policy and practice will then be discussed alongside recommendations for the design and delivery of this, and similar men's health and physical activity initiatives. Furthermore, I (the researcher) will reflect on the philosophical positioning adopted throughout the research in order to highlight the researcher's experiences of adopting a mixed method approach. The strengths and limitations of the research are then considered and recommendations for future research are presented.

6.2 Achievement of research aims

The principle aim of the research contained in this thesis was to:

> ***Understand the barriers to, and impact of, men's engagement in physical activity and health related behaviours through an examination of a Football in the Community men's health programme at an English Premier League football club.***

This aim has been achieved through the strategic positioning of the researcher within the fabric of Everton in the Community's Premier League Health programme (a men's health and physical activity programme delivered by a Football in the Community scheme based in an English Premier League football club (see chapter one)) for a three year period. Furthermore, this aim has been achieved through the

successful completion of three research studies (Studies 1, 2 and 3) within this setting, throughout which, the researcher adopted a practitioner-cum-researcher role (Robson, 2002).

Chapter three outlined the first research study (i.e., Study 1). Study 1 aimed to provide valuable insights into the best ways to communicate health messages to men in a community setting and offer suggestions for effective strategies that will better engage men in health information and behaviours. An eight month period of reconnaissance was conducted during which the researcher investigated the effectiveness of, and barriers associated with, promoting and engaging male football fans in positive health behaviours and messages at an English Premier League football stadium on Premier League match days. During this study the researcher was responsible for the planning and delivery of six health themed match day events which all aimed to engage male football fans in health related information and behaviours in a community setting during their leisure time (i.e., a non-traditional health care setting). The researcher was immersed in the setting utilising the principles of ethnography and data was predominately collated through observations and personal reflections logged via autobiographical field notes. Data was analysed through deductive and inductive reasoning (Polkinghorne, 1988).

Chapter four described the second research study (i.e., Study 2). Study 2 aimed to provide men's health practitioners with practical knowledge and guidance for tailoring approaches to physical activity and health behaviour change programmes

with men from hard-to-reach populations in order to reduce the barriers to engagement, ensure sustained participation and subsequently design and implement successful men's health programmes and initiatives. This study examined the distinct challenges that men from specific hard-to-reach populations (i.e., homeless men and men recovering from drug misuse) encountered when attempting to engage in a 12 week football specific physical activity and health intervention. The research was conducted during an incessant 12 week period of immersed practitioner-research. The secondary aim of this study was to determine the biological, psychological and social impact of engaging in the physical activity and health intervention (Premier League Health programme). Data was predominately collated through observations and personal reflections logged via field notes and analysed using deductive and inductive reasoning (Polkinghorne, 1988). Biological markers (body composition, blood pressure, resting heart rate, LDL and HDL cholesterol) were measured pre, mid and post intervention through a series of physiological assessments and evaluated by one-way analysis of variance on repeated measures (ANOVA).

Given that understanding the barriers to, and impact of, men's engagement in physical activity and health related behaviours was the focus of this thesis, it was deemed important to obtain the real life experiences and perspectives of the men who regularly engaged in the Premier League Health programme. Therefore, when trust and rapport was established within the practitioner-participant relationships, semi structured interviews were conducted with programme participants who regularly engaged in the Premier League Health programme (i.e., participants

whom had been regularly engaged for a period of 12 weeks-36 months). Chapter five described the third research study (i.e., Study 3). By articulating the subjective experiences of men who came from populations defined as HTR, this study aimed to develop a deeper understanding of the contextual barriers experienced by men from HTR groups when attempting to engage in physical activity and positive health related behaviours. Furthermore, through the use of relaxed and informal semi-structured interviews, this study aimed to uncover the psychosocial motivations driving participant engagement in the programme and the psychosocial impact of regular engagement in a Football in the Community men's health programme. An interview schedule was developed alongside conceptual themes and data was collected by a digital recorder and transcribed and analysed by the researcher using principles of content analysis (Elo and Kyngas, 2008).

6.3 Summary of findings

The following offers a summary of findings from the three research studies described above. For clarity, these findings will be presented in bullet point format;

6.3.1 Study 1

- Only 14 men out of a potential 192,000 engaged with health services at the Premier League football stadium across six match days.
- The dissemination of health messages through the distribution of leaflets had little impact on men's engagement with health messages and/or health services.

- Football club branded health themed merchandise had a greater acceptance by men than health themed leaflets and information stations.
- Male football fans appeared to have a *match day ritual* during which they did not like to be disturbed.
- Methods of engagement in health information that occurred within the confines of the football stadium rather than outside the grounds were more accepted.
- Subliminal methods were successful at raising awareness of health messages (e.g., cancer awareness vinyl bathroom stickers).
- Higher traffic was reported on health service website and/or phone line in the one to two weeks following the health themed match day event.
- Subtle and subliminal methods of engagement in health information that did not impose on, nor contaminate, the men's match day experience were generally more accepted.

6.3.2 Study 2

- Regular adherence to the programme was poor.
- Regular engagement in the programme posed a real challenge for participants.
- Financial constraints (i.e., the cost of transport to and from the sporting venue) were a significant challenge for the participants when attempting to engage in the programme.

- The location of the recreational facilities which were used for the intervention prevented sustained participation in the programme.
- Attendance at the programme was often prohibited due to participants having obligatory meetings with their community support workers or having other situational obligations to attend to during the time that they hoped to attend the Premier League Health programme.
- Engagement in the programme resulted in positive psychosocial developments; the development of structure, social interaction and social capital.
- No significant changes ($P>0.05$) were observed in body composition, blood pressure and blood lipid markers over 12-weeks of training.
- Resting heart rate changed significantly ($P<0.05$) from pre to post programme.
- The exercise administered during the programme was not efficient in promoting positive and significant physiological health changes, with the exception of resting heart rate.

6.3.3 Study 3

- Social cultural norms within the community and/or environment that the participant lived were major barriers to engagement in physical activity and positive health related behaviours prior to engagement in the programme.
- The pressures and stresses associated with the everyday life acted as psychological barriers to engagement in positive lifestyle choices.

- Participants appeared to possess addictive personality traits which prohibited positive health behaviour change.
- The brand of Everton Football Club was a major motivator for participant engagement in the programme and for engagement in health literature and messages.
- Psychosocial motivations such as improvements in self-image and improvements to social environment drove engagement in the programme.
- Health behaviour change was not the major motivator behind participant engagement in the programme. Instead, broader psychosocial issues and support from referral services influenced engagement in the programme.
- Regular and sustained engagement in the programme resulted in perceived positive improvements in physical health (i.e., fitness, waist size) and diet.
- Regular and sustained engagement in the programme resulted in positive improvements to mental health (i.e., the development of self-confidence, self-esteem, empowerment and a sense of belonging).
- Regular and sustained engagement in the programme resulted in positive improvements in social wellbeing (i.e., the development of social capital and removal from negative social circles).
- Participants accessed external health services through the programme and alluded to the fact that they wouldn't have done so otherwise.
- Continued psychosocial influences (i.e., addictive personality traits and life stresses) acted as barriers to successful attainment of, or further engagement in, physical activity and positive health related behaviours.

6.4 Practical implications

Health professionals typically work in a climate where they are expected to implement their role and practice based on knowledge of 'what works' (evidence based practice) (Marks, 2002). However, this is not possible if the evidence base is poor (Dugdill et al., 2009). Given the apparent lack of research based evidence examining the effectiveness and impact of Football in the Community programmes (Tacon, 2007), the use of sports stadia for men's health promotion (MHF, 2010), and barriers to engagement in physical activity and health behaviours amongst HTR populations (Roby et al., 2008), the findings of this research unravel important implications for programme design, delivery, policy and practice. Following the results presented in each study (i.e., Studies 1, 2 and 3) contained in this thesis, the implications of the findings for future practice have been discussed. However, when synthesised, the findings of the three studies highlight a number of dominant themes which provide guidance for good practice. They are presented below;

6.4.1 Commission men's health initiatives delivered in and by professional sports clubs

The overall findings of this research strongly support the recommendation that commissioning agencies should endorse and fund men's health initiatives delivered in and by professional sports clubs (see White et al., 2012). This research has highlighted the role that a professional football club can have in providing community services and attending to government health agendas. The research demonstrated that the brand of a professional football club can act as a catalyst for HTR men's engagement in physical activity and positive health related behaviours.

Specifically, participants in this research acknowledged that they would not have engaged in the Premier League Health programme if it was delivered by the NHS, and thus, illustrated the 'power' and 'pull' of the football club brand. Although health themed match day events were unable to attract a significant number of men to engage face-to-face with health service staff, the research demonstrated the ability of an English Premier League football club for disseminating and engaging men in health messages and information through subtle, subliminal and non-invasive approaches on match days and non-match days. Commissioning agencies should therefore seek to develop the number, and quality, of men's physical activity and health engagement programmes and initiatives delivered in and by professional sports clubs.

6.4.2 Implement a marketing and promotion strategy based on the brand of the professional sports club

This research has highlighted the 'power' and 'pull' of a professional football club brand for attracting men (particularly those from populations defined as HTR) to a physical activity and health engagement programme and in health information and messages. Therefore, it is recommended that stadia based men's health programme managers implement a marketing strategy that utilises the club badge for the promotion of the programme and for the dissemination of aligned health information and messages.

6.4.3 Implement a bottom-up programme design

This research confirmed the imperative need for men's physical activity and health programme managers and practitioners to understand the service user's barriers, needs, and desired outcomes prior to designing and implementing programmes and initiatives. It is recommended that programme managers tailor men's health initiatives to the needs of the service users in order to result in more feasible, accessible and attainable programmes for men. The findings of this research illuminated the hidden sociocultural barriers that prevented initial and subsequent long term engagement in the Premier League Health programme for HTR participants. Practitioners should therefore seek to understand the sociocultural context of the community in which participants live, and address their situational barriers to engagement in physical activity and health behaviours within the context of the programme. Furthermore, the research alluded to the fact that physical activity alone is unlikely to meet the wider psychosocial needs of men from HTR populations, therefore it is recommended that multi-level, multi-behavioural programmes that address the wider issues impacting upon men's health practices should be considered.

6.4.4 Employ practitioners with an appropriate skill base

The findings of this research suggest that Football in the Community practitioners need to be trained beyond 'the typical' Football Association Level 2 or UEFA B qualification in order to deal with the increasing demands of FitC schemes for addressing government agendas and social ills (see Parnell et al., 2012). The outcomes of this research lead to the recommendation that FitC men's health

practitioners should be qualified or trained in additional skills such as counselling and behaviour change management (see White et al., 2012) in order to deal with, successfully manage and support the increasing needs of the 'new age' of FitC programme participants. Furthermore, the findings of this research highlighted that participant engagement in the Premier League Health programme was influenced by positive perceptions and opinions of the programme practitioner/s. In order to successfully engage with men from HTR populations therefore, it is recommended that personable, respectful, empathetic, supportive and caring practitioners (see Gilbert, 2001; Radger, 2005; Coy, 2006) are employed into such positions of responsibility.

6.4.5 Encourage the use of reflective practice amongst programme managers and practitioners

This research has relied heavily on the personal reflections of the practitioner-researcher for learning 'on the job', for understanding the contextual barriers experienced by the participants and for the subsequent development of the Premier League Health programme based on an understanding of 'what works'. Reflective practice plays a vital role in enabling professionals to learn and understand the impact of their actions (Dugdill et al., 2009). Therefore, it is recommended that men's health programme managers and practitioners should continually seek to reflect on practice in order to learn from their applied work in the field and develop men's health programmes and initiatives accordingly.

6.4.6 Enforce and reinforce expected behaviour and boundaries amongst programme participants

The findings of this research highlighted that even though Everton in the Community's Premier League Health programme was marketed and promoted as a physical activity and health engagement programme, health behaviour change was not necessarily the major motivator behind engagement in the programme amongst HTR participants. Broader psychosocial issues such as the participants desire to create a positive self-image and remove themselves from negative people and negative environments influenced engagement in the programme. It is therefore recommended that programme managers and practitioners should enforce and reinforce expected behaviour and boundaries amongst programme participants and have strategies for dealing with participants who do not comply. It is also recommended that practitioners should seek to assess the 'readiness to change' of potential participants so that 'deviant' participants (i.e., those who are still engaged in negative social circles, deviant activities, are not ready for change and could potentially upset the progress and dynamic of the group) do not enter the programme and upset the sociometry and/or psychosocial development of the group.

6.4.7 Implement and execute a training load that is sufficient to significantly influence physiological health

The findings of this research highlight that the training load delivered in community based physical activity and health programmes needs careful consideration if the programme is going to significantly influence participant's physiological health

markers and thus reduce non-communicable disease risk factors. It is important that healthy lifestyle messages and wider changes to participant's psychosocial health are supported by measurable positive health adaptations. Therefore, a training programme of sufficient intensity and duration to positively affect participant's physiological health and fitness should be designed and implemented.

6.4.8 Design and deliver programmes that work in partnership with external health and physical activity organisations

The findings of this research suggest that men's health programmes and initiatives delivered in and by professional sports clubs should operate in partnership with local health and physical activity organisations. The research illustrated that through the Premier League Health programme, men engaged with external health services and alluded to the fact that they wouldn't have done so otherwise. Through my own practitioner-researcher observations I witnessed how short, informal talks from health service providers within the programme setting appeared to be the most successful strategy for engaging and retaining the interest of the participants. Therefore, it is recommended that programme managers should develop links with external health and physical activity services, invite them in to the programme sessions to deliver short (5-10 minute), informal talks and offer further 'take home' information. Furthermore, it is recommended that non-obligatory, non-invasive and non-threatening opportunities to connect with these services are made available as and when the participants are ready to engage.

The recommendations presented above aim to provide guidance for the design, delivery and commissioning of more coherent physical activity and health initiatives for men, especially those from HTR populations. It should be noted however, that some of the recommendations have resource implications. Availability of resources therefore, should be considered prior to adoption. The practical implications and recommendations drawn from the findings of the research conducted and presented in this thesis strongly support the recommendations of White et al. (2012) and therefore, put policy makers and practitioners in a better position to commission and deliver programmes that engage and retain men in physical activity and positive health related behaviours.

6.5 Reflection on philosophical positioning and application of mixed methods

Although I have particular biases and preferred methodologies for conducting research, the research contained in this thesis required a mixed method approach to achieve its aims. Subsequently, I had to adapt the research design and my philosophical position accordingly. The following section outlines my predominant thoughts following the adoption of such an approach:

Through the adoption of a practitioner-cum-researcher role and aligned qualitative methodologies in Study 1, I was able to collect a vast amount of data from 'the field'. Via methods of reflection I was then able to make sense of my experiences through the constructivist paradigm. This approach and paradigm was particularly useful for reporting pertinent 'moments' from the field and for sharing with the reader what I saw, how I saw it and what implications this had for practice. The

experimental design employed in Study 2 (to assess the physiological adaptations to training) required the adoption of a post positivist paradigm. Through this paradigm I was able to collect and analyse statistical data objectively. However, through the incorporation and alignment of qualitative methods and field based data collection I was able to interpret and place the physiological data into a more meaningful context. In essence, through the interpretivist paradigm I was able to understand the person and the situation behind the statistics. This was particularly useful for understanding the wider influences that impacted on the participant's engagement in physical activity and health behaviours and thus, their physiological adaptations (or not) to engaging in a 12 week football specific intervention. The use of semi-structured interviews in Study 3 provided the opportunity to gather and examine detailed narrative accounts of programme participants from populations defined as hard-to-reach. Through the interpretivist paradigm and the presentation of excerpts from interviews with programme participants, this study has provided rich insights into the experiences and perceptions of men from HTR populations; a population who have (generally) remained silent. This approach was particularly useful for crafting recommendations based on a critical appreciation of the context, environment and barriers associated with men from HTR populations rather than based on the perceptions of the practitioner, which has typically been the case in previous work concerning HTR groups (Carless and Sparkes, 2007).

The findings of this research support the current thinking related to behaviour change theory with disadvantaged populations (see 1.4). Study 2 highlighted social, economic and environmental barriers that prevented participants from

engagement in the programme and positive behaviour change. These findings led to the utilization of the social ecological model (McLeory et al, 1988) in Study 3 in order to extend our contextual understanding of the wider influences on physical activity and health behaviour change amongst programme participants. Specifically, Study 3 highlighted the prevalence of psychological barriers associated with behaviour change (i.e, addictive personality traits, stress and pressure of everyday life) amongst programme participants. In accordance with NICE (2007), the research findings suggest that the use of any one model of behaviour change would have failed to capture and address the complexities associated with the lives of our hard-to-reach, disadvantaged participants. Therefore, interventions or programmes targeting disadvantaged or hard-to-reach populations should identify and attempt to remove social, economic, environmental and psychological barriers that prevent people from making positive changes in their lives rather than seek to adopt a potentially unhelpful, overly simplistic and/or ineffective model of behaviour change.

6.6 Strengths and limitations of the research

The research contained in this thesis has a number of strengths and limitations. As the previous section (6.5) suggests, the main strengths of this research lie in the research methodology that was adopted. Furthermore, a major strength of this research is the richness and quality of the data collected. According to Lee (1993) negotiating access to research participants and the subsequent collection of good quality data depends on the quality of interpersonal relationships between researchers and participants. Wilson and Neville (2009) argued that research

projects working with populations who are marginalised or hard-to-reach should involve the participants from the outset so that the power dynamic between researcher and researched is shared or flattened. However, other academics (i.e., Ensign, 2003; Liamputtong, 2007) argue that the researcher needs to first spend a period of immersion in the field to gain trust, rapport and familiarity with potential research participants owing to their vulnerability and suspicion of outsiders. Gaining access to the research participants in studies 2 and 3 of this thesis was achieved via the latter approach due to the imbedded nature of my role within the Premier League Health programme. Being 'there' and being 'seen' (Sixsmith et al., 2003) was particularly important in this research to get as close as possible to the participants, to build relationships, trust and rapport and subsequently to understand the participants day-to-day lives, norms and behaviours. The quality and richness of the data collected in studies 2 and 3 therefore, is a direct reflection of the qualitative methods adopted and the strength of the participant-researcher relationships.

However, these methods also have their limitations. The data collected and presented in studies 2 and 3 stem from interaction with participants who had (generally) adhered to the programme or who were at least contactable (via text message or phone call). In this sense, the participant experiences and perspectives that have been reported in this research are of participants who were mostly able to negotiate and overcome their barriers to engagement in the programme. Therefore, the voices of the participants who did not manage to overcome their personal and situational barriers and sustain long term engagement in the PLH

programme are not reported. However, due to the complex and chaotic nature of the lives of the majority of the Premier League Health participants who came from populations defined as HTR, gaining access and attaining data of this nature would have been extremely difficult if not impossible to achieve. As previously stated, trust and rapport was essential for the collection of data in this research, therefore without a relationship with research participants, data may have been superficial. Certainly, I was constantly aware that trust and rapport remained fragile throughout my research, and at times maintaining researcher-participant relationships felt like a 'tightrope walking act' (see Sixsmith et al., 2003). Furthermore, it should be noted that a huge investment in time and emotional energy was required on the part of the researcher in order to achieve the aims of this research through the qualitative methods employed.

Throughout this research I have adopted, maintained and attempted to balance the responsibilities associated with a practitioner-cum-researcher role (Robson, 2002). However, it should be brought to the attention of the reader that whilst this was a particularly useful approach for the researcher in this context and for the collection of rich data 'in the field', there were many occasions where this dual role became difficult to balance. For example, the design and delivery of six health themed match day events at a Premier League football club on a match day (Study 1) was a particularly demanding and time consuming task. Consequently, throughout Study 1 I struggled to equally balance my practitioner-researcher role and I was often forced to surrender to the demands of the practitioner duties. It could be argued therefore, that this pressure and 'time out' from research may have had

consequences for the amount and quality of the data collected in the field during Study 1. However, I strongly believe that without adopting this duel role, a true picture of the intricacies associated with promoting and engaging male football fans in health messages and behaviours on Premier League match days could not have been captured.

Due to the social, economic and environmental barriers highlighted in Study 2, the social ecological model (McLeory et al., 1988) was adopted and integrated in Study 3 to assist with the clustering of qualitative data. I believe that the social ecological model provided an interesting, meaningful and useful way to analyse data. However, I also believe that there are practical and philosophical issues associated with its application. Certainly, my own experience of using the social ecological model in practice (Study 3) raised some philosophical issues. For example, as a qualitative researcher I strongly believe that data should not be 'forced' into conceptual categories. Whilst the SEM was useful for conceptualising an understanding of the wider, multi-layered influences that determine engagement physical activity and health behaviours, in this study the SEM seemed unable capture the 'full picture' of the complexities associated with the HTR participants within the defined categories.

6.7 Recommendations for future research

The findings from this thesis highlight a number of areas that require further investigation. Further research is needed to examine the use of sports stadia for transmitting health messages, delivering health services and engaging men in

health behaviours on match days and non-match days. The findings of the current research also highlight that there is a need to place emphasis on and investigate, the intensity of the training load required in community based physical activity interventions in order to achieve significant physiological adaptations within a specific period of time (Haskell et al., 2007). This research has given a voice to men from specific populations defined as hard-to-reach who participated in Everton in the Community's Premier League Health programme, however gathering the perspectives of those who did not adhere to the programme and the experiences of other groups classified as hard-to-reach would provide further and essential knowledge that would be useful for crafting and defining appropriate recommendations and implications for policy and practice. Furthermore, there is also need to develop and conduct longitudinal research which assesses the long term impact of engagement in programmes such as Premier League Health on participants' biopsychosocial health and health behaviours. Further investigation into all the above mentioned could provide beneficial insights for policy makers, programme funders, managers and practitioners.

6.8 Conclusion

This research ultimately set out to obtain a greater understanding of men's barriers to engagement in physical activity and health related behaviours and to comprehend the biopsychosocial impact of engagement in a Football in the Community men's health programme delivered by a Premier League football club. Through the use of qualitative methodologies, the research observed the complexities associated with the lived realities of men from HTR populations (i.e.,

men who had recently been released from prison, recovering from substance misuse and/or had lived in a homeless shelter) and highlighted how, and why, their economic, environmental, social and psychological barriers influenced engagement in physical activity and positive health related behaviours. Although the common determinants associated with HTR men's engagement in physical activity and health behaviours resonated with many of the predominant issues reported in generic health promotion and physical activity literature, the intensity and severity of the barriers observed and reported by men from HTR populations in this research illustrated the need for gender and population specific approaches to health promotion and delivery. It is imperative therefore, that men's barriers to physical activity and health engagement are understood from the service user's perspective in order to design and develop interventions and programmes which reflect their needs, overcome or reduce the barriers and thus, are more likely to be successful in engaging and sustaining men in positive health behaviours.

The strategic use of an English Premier League football club as a vehicle for the delivery of health messages and a men's health intervention was also investigated in this thesis. The findings of this research uncovered important insights into HTR men's psychosocial motivations for engagement in a physical activity and health behaviour change programme, highlighted the importance of the football club brand and provided an understanding of the approaches to health promotion that appear to connect with, and are deemed 'acceptable' by men on Premier League match days. Furthermore, the research contained in this thesis investigated the physiological adaptations and psychosocial impact of engagement in a Football in

the Community men's health programme for men from HTR populations. The evidence of this research revealed that FitC programmes can significantly improve participant's psychosocial health however the exercise administered during these programmes may not always be efficient in promoting significant physiological health changes.

In this thesis I have explored the multifaceted, contextual and complex barriers experienced by men from HTR populations. The contribution of the participants of the Premier League Health programme, coupled with my own ethnographic engagement and observations, has enabled recommendations for policy and practice to be crafted. Key implications for managers and practitioners of men's health promotion and physical activity initiatives have also been proposed. Whilst the findings of this research do not pretend to be generalizable on a global scale, this research is unique in both method and focus and the results make an important contribution to the understanding of men's health behaviours and the use of Football in the Community schemes as a vehicle for addressing government health agendas. The research contained in this thesis both supports and extends the work of authors such as Pringle et al. (2011), White et al. (2012) Pringle et al. (2013) and Zwolinsky et al. (2013) (see Chapter One; 1.10.8), by providing a contextual, in-depth biopsychosocial examination of the Premier League Health programme that was only attainable through prolonged engagement in the research setting and through the mixed methods adopted. In particular, this research extends the work of the authors listed above by providing specific empirical information concerning the physiological impact of engagement in the Premier League Health programme.

Furthermore, this research offers an honest and comprehensive understanding of the social and psychological constraints associated with behaviour change amongst the Premier League Health participants (i.e., hard-to reach populations) which were unachievable through the methods adopted by previous research.

The findings of this research clearly emphasise the need for additional research into the use of professional football clubs and sports stadia as a vehicle for delivering men's health initiatives. Furthermore, the findings of this research highlight that if the correct approaches are used, we can connect with, and begin to understand the needs of HTR men. Therefore, it is hoped that the nature and role of this qualitative work will act as a catalyst to assist in the understanding of health behaviours of HTR men worldwide.

Chapter Seven:

Researcher Reflection...

'Exiting the Field'

"When spending any prolonged period of time in a research environment we need to be aware that it is likely to have some effect on our own lives."

(Hallowell et al., 2005, p19)

7.1 Reflection upon exiting the research setting

Within ethnographic literature, access to research populations has received understandable attention, as ethnographic research could not be conducted without researchers 'getting in' (Iversen, 2009). However, little attention has been paid to the challenges faced by researchers when 'exiting the field' (disengagement from the research setting and participants) (Gobo, 2008). Literature surrounding disengagement from the ethnographic process has generally centred on the impact for research participants, with a particular focus on implications for ethical practice (Taylor, 1991). However, Stebbins (1991) argued that there are often complexities associated with disengagement from the field and lasting emotional consequences of ethnographic research for the researcher. However, according to Hallowell et al. (2005) the lived experiences of conducting ethnographic research from the researcher's point of view have rarely been reported. The following vignette therefore offers the reader an insight into the thoughts and feelings of the researcher following withdrawal from the research setting. By reflecting upon and outlining my experiences, I (the researcher) aim to provide you (the reader) with an understanding of the challenges and dilemmas I encountered when 'exiting the field' and how conducting the research contained in this thesis impacted on my life:

Reflective stop off

'Exiting the field'

At the time of writing, it has been exactly eight months since I said goodbye to my colleagues at Everton in the Community and made the move to LJMU to write up my research findings. Eight months is a significant amount of time. So much has happened in my life since then, yet barely a day has gone by that I haven't thought about the Club, those I worked with, and most of all, the participants the of the Premier League Health programme.

This led me to question <u>why</u>?

My initial thoughts were quite simple; "I have been writing up my research findings for the past eight months and so it's only natural to be thinking about my experiences at Everton" I told myself. This provided me with a rationale for a short while. However, I knew deep down that it was more than that.

When I was appointed to this post, I was a 23 year old 'girl' who was only one year out of University. I had spent my childhood wrapped up in cotton wool (although I didn't know it at the time) and showered with love by my parents and grandparents. I grew up in an affluent area in the suburbs of South Liverpool in a well-kept semi-detached house. When I 'flew the nest' at 18 [years old] and went to University, I spent the next four years in what can best described as the Loughborough 'bubble'. Loughborough was another affluent area populated by well educated, middle class people. For me, life had been filled with love and positive experiences from time spent with family and friends and in education and sport. In hindsight, I was not all prepared for what was about to come...

My tenure at Everton in the Community was a stressful and emotionally draining experience. Over a three year period I encountered new challenges on a daily basis, interacted with people who came from very different backgrounds to myself, saw and heard things that I didn't know how to deal with and had conversations that I never would have imagined that I'd have. I frequently laughed but I also cried, both alone and in the company of close colleagues.

On reflection, I realise that conducting this research has taught me a great deal, not only about the day-to-day realities of the participants and their challenges to engaging in physical activity and health, but about myself. The person writing this now is not the same person who was sat in the interview room back in July 2009, nervously spouting out facts that I knew about men's health which I had accumulated from a brief 'Google' search. Looking back, I realise that I am different because of this experience.

The other thing that plays most on my mind is leaving the programme and saying goodbye to the participants. Did I get this right?

Disengagement from the field was difficult. I decided to leave it until as late as possible to announce to the participants that I was leaving. I felt as if I was letting them down. I worried that they would think I was better than them or that they were no longer important to me. I was worried that they would feel abandoned and the trust and rapport (and in some cases, friendships) that I spent so long building, would be damaged.

On the day I left, the participants wrote a card and bought me some flowers and gifts. Some messages were that of simple goodbye and good luck, others were more heartfelt and sincere, thanking me for helping them to change

their lives. They were lovely messages but difficult to read at the time.

After leaving Everton in the Community I had to return my work mobile phone to the University. To an outsider this may seem like a simple task, but to me it was much more difficult. I was faced with the reality of exiting the field. What was I supposed to do? Give my personal mobile phone number to the participants or cut them out? My heart won the battle as I knew that I couldn't cut contact with the people who I'd spent three years in daily contact with and who I cared about. However, I knew that providing them with my personal mobile phone number was not ideal and perhaps unethical. I decided the best approach was to go and buy a cheap pay-as-you-go mobile phone so that I could pass on my number to them. I don't use this phone for anything else; it is purely for contact with programme and research participants.

At first, many of the participants kept in touch with me, and I with them. After a few months this number had reduced to just a handful. Now, eight months on, I only have regular contact with one- Simon (Study 3). This left me thinking, why him?

I believe that answer to that question lies in my relationship and the respect I have for Simon. It was a relationship of genuine care. Out of all of the participants I would argue that Simon made the biggest change to his life as a result of engaging in the programme. In my eyes, he was a 'good egg' but had lived his life in a way that I couldn't even imagine. Simon was always open and honest with me, he is one of the few that always thanked me for what I did and I felt that he would always look out for me. In a way, I knew Simon would protect me from any of the 'bad eggs' that occasionally came into the programme. I had come a long way from the naïve girl back in 2009, there were a lot of situations and people I could now handle that I couldn't have before, but not always. Simon was the hardest person to say goodbye to.

It's difficult to say what I would do differently given the chance to 'exit' the field again. I'm honestly not sure that there is much else I could have done. Yet I still feel that I have let many of the participants down in some way. There are certain characters that I will not miss and even some who I hope I never bump into again, but there are others that I miss and think about regularly. I must live with the fact that I am no longer privy to the lives and activities of those I interacted with, helped and studied for so long. Their lives will go on without me knowing the rest of their story. I guess this is the reality of working and researching a community project.

On University Open Days I find myself talking to potential students and parents about the work and research I did at Everton in the Community. I often think that if this had been someone telling <u>me</u> and <u>my</u> parents that by doing an undergraduate degree I could become a researcher working at a football club, with men, many of whom were or had been, involved in serious crime and substance misuse, we would have ran a mile. Yet I feel privileged that I got the chance to do so.

I once read "not all research involves deep emotion. However when spending any prolonged period of time in a research environment we need to be aware that it is likely to have some effect on our own lives" (Hallowell et al., 2005, p19). This was certainly the case for me. The participants and my experiences at Everton in the Community will remain with me always.

References

Addis, M. and Mahalik, J. (2003) Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58 (1), 5-14.

Ajzen, I. and Fishbein, M. (1980) *Understanding attitudes and predicting social behaviour*. Englewood Cliffs: Prentice-Hall.

Andrews, J., Bentley, D., Crawford, C., Pretlow, L. and Tingen, M. (2007) Using community-based participatory research to develop a culturally sensitive smoking cessation intervention with public housing neighbours. *Ethnicity and Disease*, 17, 331-337.

Armitage, A. (2007) A pragmatic business education: The return of common sense. *International Journal of Applied Institutional Governance*, 1 (2), 1-11.

Armitage, C., Sheeran, P., Conner, M. and Arden, M. (2004) Stages of change or changes of stage? Predicting transitions in transtheoretical model stages in relation to healthy food choice. *Journal of Consulting and Clinical Psychology*, 72, 491-499.

Atkinson, P. and Hammersley, M. (1994) Ethnography and participant observation. In: Denzin, N. and Lincoln, Y. (eds.) *Strategies of Qualitative Inquiry*. London: Sage.

Atkinson, R. and Flint, J. (2001) *Accessing hidden and hard-to-reach populations: Snowball research strategies*. Social Research Update, 33.

Ball, K. (2006) People, places...and other people? Integrating understanding of intrapersonal, social and environmental determinants of physical activity. *Journal of Science and Medicine in Sport*, 9 (5), 367-370.

Bandura, A. (1962) Social learning through imitation. In Jones, M. (Ed.), *Nebraska Symposium on Motivation*. Lincoln: University of Nebraska Press.

Barley, R. (2011) Why Familiarise? *Social Research Update*, 62, 1-4.

Berglund, K., Roman, E., Balldin, J., Berggren, U., Eriksson, M., Gustavsson, P. and Fahlke, C. (2011) Do men with excessive alcohol consumption and social stability have an addictive personality? *Scandinavian Journal of Psychology*, 52, 257-260.

Best, D. and Lubman, D. (2012) The emergence of a recovery movement for alcohol and drug dependence. *Australian and New Zealand Journal of Psychiatry*, 46, 586.

Biddle, S., Fox, K. and Boutcher, S. (2002) *Physical activity and psychological wellbeing*. London: Routledge.

Biddle, S. and Mutrie. N. (2008) *Psychology of physical activity. Determinants, wellbeing and interventions*. 2nd ed. London: Routledge.

Bourdieu, P. and Wacquant, L. (1992) *An Invitation to Reflexive Sociology*. Chicago: University of Chicago Press.

Brackertz, N. (2007) *Who is hard to reach and why? ISR Working Paper*. Available at: www.sisr.net/publications/0701brackertz.pdf [Accessed 5th March 2012].

Bradley, E., Carlson, M., Gallo, W., Scinto, J., Campbell, M. and Krumholz, H. (2005) From adversary to partner: Have quality improvement organizations made the transition? *Health Services Research,* 40 (2), 459-476.

Breakwell, G. (2006) Interviewing methods. In: Breakwell, G., Hammond, S., Fife-Shaw, C. and Smith, J. (eds.) *Research methods in psychology*. 3rd ed. London: Sage.

Britten, N. (1995) Qualitative research: qualitative interviews in medical research. *British Medical Journal,* 311, 251-253.

Brown, A., Crabbe, T., and Mellor, G. (2009) *Football and community in the global context. Studies in theory and practice.* Oxon: Routledge.

Bryman, A. *(2001) Social Research Methods.* Oxford: Oxford University Press.

Bryman, A. and Bell, E. (2003) *Business research methods*. Oxford: Oxford University Press.

Burnard, P. (1991) A method of analysing interview transcripts in qualitative research. *Nurse Education Today,* 11, 461-466.

Campbell, R. (1984) *The new science: Self-esteem psychology*. Lanham: University Press of America.

Carless, D. and Sparkes, A. (2007) The physical activity experiences of men with serious mental illness: Three short stories. *Psychology of Sport and Exercise*, 9 (2), 191-210.

Carmichael, J. and Miller, K. (2006) The challenges of practitioner research: Some insights into collaboration between Higher and Further Education in the LfLFE project. In: J. Caldwell et al. (eds) *What a difference a pedagogy makes: researching lifelong learning and teaching. Proceedings of 3rd International CRLL Conference* (2005), Glasgow: Centre for Research in Lifelong Learning, 700-702.

Carron, A., Hausenblas, H. and Estabrooks, P. (2003) *The psychology of physical activity*. New York: McGraw-Hill.

Carter, S. and Little, M. (2007) Justifying knowledge, justifying method, taking action: Epistemologies, methodologies and methods in qualitative research. *Qualitative Health Research,* 17 (10), 1316-1328.

Casperson, C., Powell, K. and Christenson, G. (1985) Physical activity, exercise and physical fitness: definitions and distinctions for health-related research. *Public Health Report*, 100, 126-130.

Chief Medical Officer (2011) *Start Active Stay Active: A report on physical activity for health from four home countries*. Department of Health: London.

Clandinin, D. and Connelly, F. (2000) *Narrative inquiry: experience and story in qualitative research.* San Francisco: Jossey-Bass.

Cloke, P., Milbourne, P. and Widdowfield, R. (2000) Homelessness and rurality: 'out of place' in purified space? *Society and Space*, 18 (6), 715-736.

Clough, P. and Nutbrown, C. (2012) *A student's guide to methodology*. London: Sage.

Coalter, F. (2007) *A wider role for sport. Who's keeping the score?* London: Routledge.

Coffey, A. (1999) *The ethnographic self: fieldwork and the representation of identity*. London: Sage.

Collins, M. and Kay, T. (2003) *Sport and Social Exclusion*. London: Routledge.

Courtenay, W. (2000) Constructions of masculinity and their influence on men's wellbeing: A theory of gender and health. *Social Science and Medicine*, 50, 1385-1401.

Coy, M. (2006) This morning I'm a researcher, this afternoon I'm an outreach worker: Ethical dilemmas in practitioner research. *International Journal of Social Research Methodology*, 9 (5), 419-431.

Crotty, M. (1998) *The foundations of social research: Meaning and perspective in the research process.* London: Sage.

Deacon, L., Carlin, H., Spadling, J., Giles, S., Stanfield, J., Hughes, S., Parkins, C. and Bellis, M. (2010) *North West Mental Wellbeing Survey 2009*. Liverpool: North West Public Health Observatory, Liverpool John Moores University.

Denzin, N. and Lincoln, Y. (2005) *The Sage handbook of qualitative research*. 3rd ed. London: Sage.

Denzin, N. and Lincoln, Y. (2011) *The Sage handbook of qualitative research*. 4th ed. Thousand Oaks: Sage.

Department of Health (2004) *At least five a week- evidence on the impact of physical activity and its relationship to health- a report from the Chief Medical Officer.* London: Department of Health.

Department of Health (2005) *Kick Start to Health*. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4112043 [Accessed 21st March 2012].

Department of Health (2010) *Healthy people, healthy lives: our strategy for public health in England.* London: Department of Health.

Department of Health (2011) *Healthy lives, healthy people: a call to action on obesity in England.* London: Department of Health.

Deutsch, R. (2010) Presentation: *Gender Differences in Cognition*. Ad Club of New York, 29/10/09.

DiCicco-Bloom, B. and Crabtree, B. (2006) The qualitative research interview. *Medical Education*, 40, 314-321.

Doherty, P., Stott, A., and Kinder, K. (2004) *Delivering services to hard to reach families in 'On Track' areas: Definition, consultation and needs assessment.* Home Office Development and Practice Report No. 15. London: Home Office.

Dugdill, L., Coffey, M., Coufopoulos, A., Byrne, K. and Porcellato, L. (2009) Developing new community health roles: can reflective learning drive professional practice? *Reflective Practice: International and Multidisciplinary Perspectives*, 10 (1), 121-130.

Elo, S. and Kyngäs, H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing*, 62 (1), 107-115.

Emmel, N., Hughes, K., Greenhalgh, J. and Sales, A. (2007) Accessing socially excluded people- trust and the gatekeeper in the researcher-participant relationship. *Sociological Research Online*, 12 (2). Available at: http://www.socresonline.org.uk/12/2/emmel.html [Accessed 5th March 2012].

Emmons K., Stoddard, A., Fletcher, R., Gutheil, C., Suarez, E., Lobb, R., Weeks, J. and Bigby, J. (2005) Cancer prevention among working class, multiethnic adults: Results of the healthy directions-health centers study. *American Journal of Public Health*, 95, 1200–1255.

England and Wales Cricket Board (2011) *Boundaries for Life target cricket fans*. Available at: http://www.ecb.co.uk/news/england/natwest-series/health-checks,314732,EN.html [Accessed 21st March 2012].

Ensign, J. (2003) Ethical issues in qualitative health research with homeless youths. *Journal of Advanced Nursing*, 43, 43-50.

Erikson, E. (1980) *Identity and the Life Cycle.* New York: Norton.

Eriksson, P. and Kovalainen, A. (2008) *Qualitative methods in business research.* London: Sage.

European Men's Health Forum (2011) *Response to the EC report on the state of men's health in Europe*. London: European Men's Health Forum.

Faugier, J. and Sargeant, M. (1997) Sampling hard to reach populations. *Journal of Advanced Nursing*, 26 (4), 790-797.

FIFA (2008) *Football for Health*. Available at: http://www.fifa.com/mm/document/footballdevelopment/medical/01/48/54/48/e_11forhealth_innen_20110427mini.pdf [Accessed 21st March 2012].

Foddy, W. (1993) *Constructing questions for interviews and questionnaires*. Cambridge: Cambridge University Press.

Fontaine, K. (2000) Physical activity improves mental health. *The Physician and Sports Medicine*, 28 (10), 83-84.

Fontana, A. and Frey, J. (1994) The Art of Science. In: In: Denzin, N. and Lincoln, Y. (eds.) *The Handbook of Qualitative Research*. Thousand Oaks: Sage.

Foster, C., Hector, L., Welsh, R., Schrager, M., Green, M., and Snyder, A. (1995). Effects of specific versus cross-training on running performance. *European Journal of Applied Physiology and Occupational Physiology*, 70 (4), 367-372.

Fox, K. (1999) The influence of physical activity on mental wellbeing. *Public Health Nutrition*, 2, 411-418.

Frisby, W. (2005) The good, the bad and the ugly: Critical sport management research. *Journal of Sport Management*, 19 (1), 1-12.

Frisby, W. and Millar, S. (2007) The actualities of doing community development to promote the inclusion of low income populations in local sport and recreation. *European Sport Management Quarterly*, 2 (3), 209-233.

Gaydos, H. (2005) Understanding personal narratives: an approach to practice. *Journal of Advanced Nursing*, 49 (3), 254-259.

Gilbert, K. (2001) Introduction: Why are we interested in emotions? In: Gilbert, K. (ed.), *The emotional nature of qualitative research.* Florida: CRC Press LCD.

Gilbourne, D. and Richardson, D. (2006) Tales from the field: Personal reflections on the provision of psychological support in professional soccer. *Psychology of Sport and Exercise*, 7 (3), 325-337.

Giles-Corti, B. and Donovan, R. (2002) The relative influence of individual, social and physical environmental determinants of physical activity. *Social Science and Medicine*, 54, 1793-1812.

Glanz, K., Rimer, B. and Lewis, F. (2002) *Health Behaviour and Health Education. Theory, Research and Practice.* San Fransisco: Wiley & Sons.

Gobo, G. (2008) *Doing Ethnography.* Los Angeles: Sage.

Gough, B. (2013) The Psychology of Men's Health: Maximising Masculine Capital. *Health Psychology*, 32 (1), 1-4.

Gough, B. and Robertson, S. (2010) *Men, masculinities and health: Critical perspectives.* Hampshire: Palgrave Macmillan.

Green, L. and Kreuter, M. (1999) *The precede–proceed model. Health promotion planning: an educational approach.* 3rd ed. Mountain View (CA): Mayfield Publishing Company.

Gray, C., Hunt, K., Mutrie, N., Anderson, A., Treweek, S. and Wyke, S. (2011) Can the draw of professional football clubs help promote weight loss in overweight and obese men? A feasibility study of the Football Fans in Training programme delivered through the Scottish Premier League. *Epidemiology and Community Health*, 65 (2), A37-A38.

Gray, D. (2004) *Doing research in the real world.* London: Sage.

Green, L., Richard, L. and Potvin, L. (1995) Ecological Foundations of Health Promotion. *American Journal of Health Promotion,* 10, 270-281.

Gregson, J., Foerster, S., Orr, R., Jones, L., Benedict, J., Clarke, B., Hersey, J., Lewis, J. and Zotz, K. (2001) System, environmental and policy changes: Using the social-ecological model as a framework for evaluating nutrition education and social marketing programs with low income audiences. *Journal of Nutrition Education and Behaviour*, 33, S4-S15.

Grigsby, C., Baumann, D., Gregorich, S. and Roberts-Grey, C. (1990) Disaffiliation to entrenchment: A model for understanding homelessness. *Journal of Social Issues*, 46 (4), 141-56.

Guba, E. and Lincoln, Y. (1994) Competing paradigms in qualitative research. In: Denzin, K. and Lincoln, Y. (eds.) *Handbook of qualitative research*. London: Sage.

Hahn, E., Rayens, M., Chirila, C., Riker, C., Paul, T. and Warnick, T. (2004) Effectiveness of a quit and win contest with a low-income population. *Preventive Medicine*, 39, 543-550.

Hallowell, N., Lawton, J. and Gregory, S. (2005) *Reflections on research. The realities of doing research in the social sciences.* Maidenhead: Open University Press.

Hamlyn, D. (1995) Idealism, philosophical. In: Honderich, T. (ed.) *The Oxford companion to philosophy*. Oxford: Oxford University Press.

Harkins, C., Shaw, R., Gillies, M., Sloan, H., MacIntyre, K., Scoular, A. Morrison, C., MacKay, F., Cunningham, H., Docherty, P., MacIntyre, P. and Findlay, I. (2010) Overcoming barriers to engaging socio-economically disadvantaged populations in CHD primary prevention: a qualitative study. *BMC Public Health*, 10, 391.

Harrison, J. (1978) Warning: The male sex role may be damaging to your health. *Journal of Social Issues,* 34, 65-86.

Haskell, W., Lee, I., Pate, R., Powell, K., Blair, S., Franklin, B., Macera, C., Heath, G., Thompson, P. and Bauman, A. (2007) Physical activity and public health: updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. *Medicine & Science in Sports and Exercise*, 39 (8), 1423-1434.

Hatterer, L. (1982) The addictive process. *Psychiatric Quarterly,* 54 (3), 149-156.

Health Survey for England (2007) *Healthy lifestyles: knowledge, attitudes and behaviour.* Available at: http://www.hscic.gov.uk/pubs/hse07healthylifestyles [Accessed on 25th January 2013].

Heider, K. (1975) What do people do? Dani auto-ethnography. *Journal of Anthropological Research,* 31 (1), 3-17.

Heimlich, J. and Ardoin, N. (2008) Understanding Behaviour to Understand Behaviour Change: A literature review. *Environmental Education Research*, 14 (3), 215-237.

Hoare, J. and Moon, D. (2010) *Drug misuse declared: Findings from the 2009/10 British Crime Survey: England and Wales.* London: Home Office.

Hoepfl, M. (1997) Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education*, 9(1), 47-63.

Holt-Lunstad, J., Smith, T., and Layton, J. (2010) Social relationships and mortality risk: a meta-analytic review. *PLoS Medicine*, 7(7). Available at: e1000316. doi:10.1371/journal.pmed.1000316 [Assessed on 22nd November 2012].

Impellizzeri, F., Rampinini, E., Coutts, A., Sassi, A. and Marcora, S. (2004) Use of RPE-based training load in soccer. *Medicine and Science in Sports and Exercise*, 36 (6), 1042-1047.

Iversen, R. (2009) 'Getting Out' in Ethnography. A seldom-told story. *Qualitative Social Work,* 8 (1), 9-26.

Jackson, E. (1993) Recognizing patterns of leisure constraints: results from alternative analyses. *Journal of Leisure Research*, 25 (2), 129-149.

Jackson, N., Howes, F., Gupta, S., Doyle, J. and Waters, E. (2005). Policy interventions implemented through sporting organizations for promoting healthy behaviour change. *The Cochrane Database of Systematic Reviews*, 2. Available at: DOI:10.1002/14651858.CD004812.pub2. [Accessed on 1st April 2012].

Janesick, V. (2003) The choreography of qualitative research: Minuets, improvisations, and crystallization. In: Denzin, N. and Lincoln, Y. (eds.) *Strategies of Qualitative Inquiry*. Thousand Oaks: Sage.

Jarvis, P. (1998) The practitioner–researcher in nursing. *Nurse Education Today*, 20 (1), 30-35.

Jenkins, H. and James, L. (2012) *It's not just a game: community work in the UK football industry and approaches to corporate social responsibility*. Available at: http://davidcoethica.files.wordpress.com/2012/09/its-not-just-a-game1.pdf [Accessed on 1st April 2012].

Jones, G. (2002) Performance excellence: A personal perspective on the link between sport and business. *Journal of Applied Sport Psychology*, 14, 268–281.

Kidd, K. and Altman, D. (2000) Adherence in social context. *Controlled Clinical Trials*. 21, 694-696.

Klee, H. (1995) Drug misuse and suicide: Assessing the impact of HIV. *Aids Care*, 7 (1), 145-156.

Knowles, Z., Gilbourne, D., and Tomlinson, V. (2007) Reflections on the application of reflective practice for supervision in applied sport psychology. *Sport Psychologist*, 21 (1), 109-122.

Kovandžić, M., Chew-Graham, C., Reeve, J., Edwards, S., Peters, S., Edge, D., Assem, S., Gask, L. and Dowrick, C. (2011) Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. *Social Science and Medicine*, 72 (5), 763-772.

Krane, V. and Baird, S. (2005) Using ethnography in applied sport psychology. *Journal of applied sport psychology, 17*(2), 87-107.

Kvale, S. *(1996) Interviews. An introduction to qualitative research interviewing.* Thousand Oaks: Sage.

Lang, A. (1983) Addictive personality: A viable construct? In: Levison, P., Gerstein, D. and. Maloff, D. (eds.) *Commonalities in substance abuse and habitual behaviour.* Massachusetts: Lexington Books.

Le Compte, M. and Preissle, J. (1993) *Ethnography and qualitative design in educational research.* London: Academic Press Inc.

Lee, R. (1993) *Doing research on sensitive topics*. Newbury Park, CA: Sage.

Lee, C. and Owens, R. (2002) *The psychology of men's health*. Buckingham: Open University Press.

Liamputtong, P. (2007) *Researching the vulnerable: A guide to sensitive research methods.* Thousand Oaks, CA: Sage.

Liverpool City Council (2010) *Key Statistics and Data*. Available at: http://liverpool.gov.uk/council/key-statistics-and-data/data/ [Accessed on 17th March 2011].

Liverpool City Council (2012) *Ward Profile of Everton*. Available at: http://liverpool.gov.uk/council/key-statistics-and-data/ward-profiles/ward-map/ [Accessed on 20/05/12].

Liverpool Primary Care Trust (2010) *Public Health Annual Report 2009-2010*. Liverpool: Liverpool Primary Care Trust.

Liverpool Public Health Intelligence Team (2009) *Key Demographics and Health Statistics by Neighbourhood Management Areas*. Liverpool: Liverpool Primary Care Trust.

Lofland, J. (1995). Analytic Ethnography. Features, Failings, and Futures. *Journal of Contemporary Ethnography, 24*(1), 30-67.

Lowther, M., Mutrie, N. and Scott, E. (2002) Promoting physical activity in a socially and economically deprived community: A 12 month randomized *control trial of* fitness assessment and exercise consultation. *Journal of Sports Sciences*, 20 (7), 577–588.

Macdonald, J. (2006) Shifting paradigms: a social-determinants approach to solving problems in men's health policy and practice. *Medical Journal of Australia*; 185 (8), 456-458.

Malterud, K. (2001) Qualitative research: standards, challenges and guidelines. *The Lancet*, 358, 358-399.

Mangan, J., Majumdar, B. and Dyreson, M. (2009) Series Editor's Foreword. In: Brown, A., Crabbe, T., Mellor, G. (eds.) *Football and Community in the Global Context*. Studies in theory and practice. Routledge: Oxon.

Marfell-Jones, M., Olds, T., Stewart, A., and Carter, J. (2006) *International standards for anthropometric assessment*. London: International Society for the Advancement of Kinanthropometry.

Marks, D. (2002) *Perspectives on evidence-based practice*. Available at: http://www.nice.org.uk/niceMedia/pdf/persp_evid_dmarks.pdf [Accessed on 20th April 2012].

Mayer, J., Jermanovich, A., Wright, B., Elder, J., Drew, J. and Williams, S. (1994) Changes in the health behaviours of older adults: The San Diego Medicare Preventive Health Project. *Preventive Medicine*, 23, 127–133.

Maynard, M. (1994) *Methods, practice and epistemology: the debate about feminism and research*. London: Taylor and Francis.

McFee, G. (1992) Triangulation in research: two confusions. *Educational Research*, *34*(3), 215- 219.

McGuire, B. and Fenogilo, R. (2008) Football in the Community: Still 'the game's best kept secret'? *Soccer and Society*, 9 (4), 439-455.

McIntosh, J. and McKeganey, N. *(2000)* Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science and Medicine,* **50,** 1501-*1510.*

McKinlay, J. and Marceau, L. (2000) To boldly go... *American Journal of Public Health,* 90 (1), 25-33.

McLaren, L. and Hawe, P. (2005) Ecological perspectives in health research. *Journal of Epidemiology Community Health*, 59, 6-14.

McLeory, K., Bibeau, D., Steckler, A. and Glanz, K. (1988) An ecological perspective on health promotion programs. *Health Education*, 15, 351-377.

McNeill, L., Kreuter, M. and Subramanian, S. (2006) Social environment and physical activity: a review of concepts and evidence. *Social Science Medicine*, 63 (4), 1011-1022.

Men's Health Forum (2010) *Up and Running: Improving the health of men and boys through physical activity and sport*. London: Men's Health Forum.

Men's Health Forum and Federation of Stadium Communities (2009) *A game of two halves': a policy symposium on the role of sport and sports stadia in improving men's health*. Available at: www.nwhpaf.org.uk [Accessed 20th April 2010].

Meryn, S. and Young, A. (2010) Making the global case for men's health. *Journal of Men's Health*, 7 (1), 2-4.

Michie, S., Jochelson, K., Markham, W., and Bridle, C. (2009) Low-income groups and behaviour change interventions: a review of intervention content, effectiveness and theoretical frameworks. *Journal of epidemiology and community health*, *63*(8), 610-622.

Miles, M. and Huberman, A. (1994) *Qualitative data analysis: An expanded sourcebook*. London: Sage.

Millward, L. (2006) Focus groups. In: Breakwell, G., Hammond, S., Fife-Haw, C. and Smith, J. (eds) *Research Methods in Psychology*. 3rd ed. London: Sage.

Mitchell, R. and Charmaz, K. (1996) Telling tales and writing stories- postmodern visions and realist images in ethnographic writing. In: Grills, S. (ed.) *Doing Ethnographic Research- Fieldwork Settings*. London: Sage.

Moffett, L. (2010) *Community engagement and visible manifestations of conflict programme. Extending our reach*. Available at http://northeastpeace.com/wp-content/uploads/2009/08/Programme-6a-Report-Extending-Our-Reach-February-2010.doc [Accessed on 21st May 2012].

Moore, J. (2007) Polarity or integration? Towards a fuller understanding of home and homelessness. *Journal of Architectural and Planning Research*, 24 (2), 143-159.

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, 52 (2), 250-260.

Morrow, S. (2007) Qualitative research in counselling psychology conceptual foundations. *The Counselling Psychologist*, 35 (2), 209-235.

National Health Service Confederation (2012) *Mental health and homelessness.* Available at: http://www.nhsconfed.org/Publications/Documents/mental_health_homelessness.pdf [Accessed on 10th January 2013].

National Health Service Confederation (2013) *NHS Sport and Health: Sport and Health a winning team.* Available at: http://www.nhsconfed.org/Publications/briefings/Pages/sport-and-health.aspx [Accessed on 18th March 2013].

National Institute for Health and Clinical Excellence (2007) *Behaviour change.* London: NICE.

National Institute for Health and Clinical Excellence (2007). *Behaviour Change at Population, Community and Individual Levels.* NICE public health guidance 6. London: NICE.

National Institute for Health and Clinical Excellence (2008) *Promoting and creating built or natural environments that encourage and support physical activity.* London: NICE.

National Obesity Forum (2006) *Barriers to Physical Activity*. Available at: http://www.nationalobesityforum.org.uk/index.php/healthcare-professionals/treatment-mainmenu-169/191-barriers-to-physical-activity.html [Accessed on 25th January 2013].

National Obesity Observatory (2011) *Knowledge and attitudes towards healthy eating and physical activity: what the data tell us*. Available at: www.noo.org.uk/uploads/doc/vid_11171_Attitudes [Accessed on 26th January 2013].

Nisbet, E. and Gick, M. (2008) Can health psychology help the planet? Applying theory and models of health behaviour to environmental actions. *Canadian Psychology*, 49, 296-303.

Noble, M., McLennan, D., Wilkinson, K., Whitworth, A. and Barnes, H. (2008*) The English indices of deprivation 2007*. London: Communities and Local Government.

Office for National Statistics (2011) *General Lifestyle Survey*. Available at: http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/index.html [Accessed on 25th January 2013].

Ottesen, L., Jeppesen, R. and Krustrup, B. (2010) The development of social capital through football and running: studying an intervention program for inactive women. *Scandinavian Journal of Medicine and Science in Sports*, 20 (1), 118-131.

Parnell, D., Stratton, G., Drust, B. and Richardson, D. (2012) Football in the Community schemes: exploring the effectiveness of an intervention in promoting positive healthful behaviour change. *Soccer and Society*, 14 (1), 35-51.

Paterson, B., Gregory, D. and Thorne, S. (1999) A protocol for researcher safety. *Qualitative Health Research*, 9, 259-269.

Patton, M. (1990) *Qualitative evaluation and research methods*. California: Sage.

Pickler, R. (2007) Evaluating qualitative research studies. *Journal of pediatric health care*, 21, 195-197.

Polkinghorne, D. (1988) *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Potter, J. (1996) Discourse analysis and constructionist approaches: Theoretical background. In: Richardson, J. (ed) *Handbook of Qualitative Research Methods for Psychology and the Social Sciences.* Leicester: British Psychological Society.

Premier League (2012) *Creating Chances 2012 Report. Using the power of football to positively change lives*. Available at: http://www.premierleague.com/en-gb/creating-chances/2012-13/download-copy-of-creating-chances-2012-report.html [Accessed on 25th January 2013].

Priest H., Roberts P. and Woods L. (2002) An overview of three different approaches to the interpretation of qualitative data. Part 1: theoretical issues. *Nurse Researcher*, 10 (1) 30-42.

Pringle, A. and Sayers, P. (2004) 'It's a Goal!' Basing a community psychiatric nursing service in a local football stadium. *Journal of the Royal Society for the Promotion of Health*, 124 (4), 234-238.

Pringle, A., Zwolinsky, S., McKenna, J., Smith, A., Robertson, S. and White, A. (2013) Effect of a national programme of men's health delivered in English Premier League Football Clubs. *Public Health*, 127, 18-26.

Pringle, A., Zwolinsky, S., Smith, A., Robertson, S., McKenna, J. and White, A. (2011) The pre-adoption demographic and health profiles of men participating in a programme of men's health delivered in English Premier League football clubs. *Public Health*, 125 (7), 411-416.

Prochaska, J. (1979) *Systems of Psychotherapy: A Transtheoretical Analysis.* Homewood: Dorsey Press.

Prochaska, J. and DiClemente, C. (1984) The Transtheoretical Approach: Towards a Systematic Eclectic Framework. Homewood: Dow Jones Irwin.

Prochaska, J., DiClemente, C. and Norcross, J. (1992) In search of how people change. Applications to addictive behaviours. *American Psychologist,* 47 (9), 1102-1114.

Putnam, R. (1995) Bowling alone: America's declining social capital. *Journal of Democracy*, 6 (1), 65-78.

Putnam, R., Leonardi, R. and Nanetti, R. (1993) *Making democracy work: civic traditions in modern Italy.* Princeton: Princeton University Press.

Quinn, N. (2005) *Finding Culture in Talk*. New York: Palgrave MacMillan.

Radger, K. (2005) Compassion stress and the qualitative researcher. *Qualitative Health Research,* 15, 423.

Reeves, S., Lewin, S. and Zwarenstein, M. (2006) Using qualitative interviews within medical education research: why we must raise the 'quality bar'. *Medical Education*, 40, 291-292.

Richardson, B. and O'Dwyer, E. (2003) Football supporters and football team brands: A study in consumer brand loyalty. *Irish Marketing Review*, 16 (1), 43-51.

Richardson, D., Burgess, T., Newland, A., Watson, L., Bingham, D. and Parnell, D. (2011) *Football as an Agent for Social Change*. European College of Sport Science 16th Annual Conference, Liverpool (UK), 9th July, 2011.

Robertson, S. (2007) *Understanding men and health. Masculinities, identity and wellbeing*. Berkshire: Open University Press.

Robinson, M., Robertson, S., McCullagh, J. and Hacking, S. (2010). Working towards men's health: Findings from the Sefton men's health project. *Health Education Journal*, 69 (2), 139-149.

Robson, C. (1993) *Real world research: a resource for social scientists and practitioner researchers*. Oxford: Blackwell.

Roby, D., Kominski, G. and Pourat, N. (2008) Assessing the barriers to engaging challenging populations in disease management programs. The Medicaid experience. *Disease Management and Health Outcomes*, 16 (6), 421-428.

Rookwood, J. and Palmer, C. (2011) Invasion games in war-torn nations. Can football help to build peace? *Soccer and Society*, 12 (2), 184-200.

Rubin, H. and Rubin, I. (1995) *Qualitative Interviewing: The art of hearing data*. Thousand Oaks: Sage.

Ryff, C. (1989) Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of personality and social psychology, 57* (6), 1069.

Sallis, J., Bauman, A. and Pratt, M. (1998) Environmental and policy interventions to promote physical activity. *American Journal of Preventive Medicine*, 15 (4), 379-397.

Sallis, J. and Owen, N. (2002) Ecological models of health behaviour. In: Glanz, K., Lewis, F. and Rimer, B. (eds.) *Health behaviour and health education: Theory, research, and practice*. 3rd ed. San Francisco: Jossey-Bass.

Sallis, J., Owen, N. and Fisher, E. (2008) Ecological models of health behavior. In: Glanz, K., Lewis, F. and Rimer, B. and Viswanath, K. (eds.) *Health behaviour and health education: Theory, research, and practice*. 4th ed. San Francisco: Jossey-Bass.

Salmon, J., Owen, N., Crawford, D., Bauman, A. and Sallis, J. (2003) Physical activity and sedentary behaviour: A population-based study of barriers, enjoyment and preference. *Health Psychology,* 22, 178-188.

Sanjek, R. (1990). *Fieldnotes: The makings of anthropology*. Cornell University Press.

Schensul, S., Schensul, J. and Le Compte, M. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires*. London: Altamira Press.

Schon, D. (1983) *The Reflective Practitioner: How professionals think in action.* New York: Basic Books.

Schurink, W. (2010) The importance of theorising in proposal writing. *Journal of Public Administration*, 44 (3), 420-434.

Shenton, K. (2004) Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.

Sheridan, C. and Radmacher, S. (1992) *Health psychology: Challenging the biomedical model.* Wiley: New York.

Sherry, E. (2010) (Re)engaging marginalized groups through sport: The Homeless World Cup. *International Review for the Sociology of Sport*, 45, 59-71.

Sherry, E. and Strybosch, V. (2012) A kick in the right direction: longitudinal outcomes of the Australian Community Street Soccer Program. *Soccer and Society*, 13, (4), 495-509.

Sinclair, A. and Alexander, H. (2012) Using outreach to involve the hard-to-reach in a health check: What difference does it make? *Public Health*, 126 (2), 87-95.

Sixsmith, J., Boneham, M. and Goldring, J. (2003) 'Accessing the community: gaining insider perspectives from the outside'. *Qualitative Health Research*, 13, 4578-4589.

Smith, J. and Robertson, S. (2008) Men's health promotion: a new frontier in Australia and the UK? *Health Promotion International*, 23 (3), 283-289.

Spaaij, R. (2009) Sport as a vehicle for social mobility and regulation of disadvantaged urban youth: Lessons from Rotterdam. *International Review for the Sociology of Sport*, 44 (2), 247-264.

Sparkes, A. (2005) Narrative analysis: Exploring the whats and hows of personal stories. In: Holloway, I. (ed) *Qualitative Research in Health Care*. Maidenhead: Open University Press.

Spencer, L. and Britain, G. (2003) *Quality in qualitative evaluation: A framework for assessing research evidence*. Government Chief Social Researcher's Office, London: Cabinet Office.

Sport England (2008) *Engaging hard to reach groups. Lessons from the Active England programme*. London: Sport England.

Stebbins, R. (1991) Do we ever leave the field? Notes on secondary fieldwork involvements. In: Shaffir, W. and Stebbins, R. (eds.) *Experiencing fieldwork: an inside view of qualitative research*. California: Sage.

Steenhuis, I., Nooy, S., Moes, M. and Schuit, A. (2009) Financial barriers and pricing strategies related to participation in sports activities: The perceptions of people of low income. *Journal of Physical Activity and Health*, 6 (6), 716-721.

Stokols, D. (1996) Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 10 (4), 282-298.

Sykes, C. and Marks, D. (2001) Effectiveness of a cognitive behaviour therapy self-*help programme for smokers* in London, UK. *Health Promotion International*, 16, 255-60.

Tacon, R. (2007) Football and social inclusion: evaluating social policy. *Managing Leisure,* 12 (1), 1-23.

Tashakkori, A. and Teddlie, C. (1998) *Mixed methodology: Combining qualitative and quantitative approaches*. London: Sage.

Taylor, P. (2008) Multi-paradigmatic research design spaces for cultural studies researchers embodying postcolonial theorising. *Cultural Studies in Science Education*, 4 (3), 881-889.

Taylor, S. (1991) Leaving the field: research, relationships and responsibilities. In: Shaffir, W. and Stebbins, R. (eds.) *Experiencing fieldwork: an inside view of qualitative research*. California: Sage.

Taylor, C., Sallis, J. and Needle, R. (1985) The relation of physical activity and exercise to mental health. *Public Health Report*, 100, 195-202.

Taylor, W., Baranowski, T. and Sallis, J. (1994) Family determinants of childhood physical activity: A social-cognitive model. In: Dishman, R. (ed.) *Advances in Exercise Adherence*. Champaign, IL: Human Kinetics.

Tedlock, B. (2000) Ethnography and Ethnographic Representation. In: Denzin, N. and Lincoln, Y. (eds.) *The handbook of qualitative research*. 2nd ed. Thousand Oaks: Sage.

Tierney, W. (2002) Get real: Representing reality. *International Journal of Qualitative Studies in Education*, 15 (4), 385-398.

Townsend, N., Bhatnagar, P., Wickramasinghe, K., Scarborough, P., Foster, C. and Rayner, M. (2012) *Physical activity statistics 2012*. London: British Heart Foundation.

Turner, J., Oakes, P., Haslam, S. and McGarty, C. (1994) Self and collective: Cognition and social context. *Personality and social psychology bulletin,* 20, 454-454.

Vaughn, S., Schumm, J. and Sinaqub, J. (1996) *Focus group interviews in education and psychology*. London, Sage.

Walsh, D., Rudd, R., Moeykens, B. and Moloney, T. (1993) Social marketing for public health. *Health Affairs*, 12, 104-119.

Watson, N. (2000) Football in the Community: what's the score? *Soccer and Society*, 1, 114-125.

Weinstein, N. and Sandman, P. (1992) A model of the precaution adoption process: evidence from home radon testing. *Health psychology*, *11*(3), 170-180.

Weiss, R. (1994) *Learning from strangers: the art and method of qualitative interview studies.* New York: The Free Press.

White, A., De Sousa, B., De Visser, R., Hogston, R., Madsen, S., Makara, P., Richardson, N. and Zatonski, W. (2011a) The State of men's health in Europe. Luxembourg: European Commission.

White, A., De Sousa, B., De Visser, R., Hogston, R., Madsen, S., Makara, P., McKee, M., Raine, G., Richardson, N., Clarke, N. and Zatonski, W. (2011b) Men's health in Europe. *Journal of Men's Health*, 8 (3), 192-201.

White, A. and Witty, K. (2009a) Men's under use of health services- finding alternative approaches. *Journal of Men's Health*, 6 (2), 95-97.

White, A. and Witty, K. (2009b) Men's Health and Sporting Venues. *Journal of Men's Health*, 6 (3), 273.

White, A., Zwolinsky, S., Pringle, A., McKenna, J., Daly-Smith, A., Robertson, S. and Berry, R. (2012) *Premier League Health: A national programme of men's health promotion delivered in/by professional football clubs. Final Report 2012.* Leeds: Centre for Men's Health and Centre for Active Lifestyles, Leeds Metropolitan University.

Wicker, A. (1979) *An introduction to ecological psychology*. Cambridge: Cambridge University Press.

Wilkins, D. and Baker, P. (2003) *Getting It Sorted: a policy programme for men's health*. London: Men's Health Forum.

Wilson, D. and Neville, S. (2009) Culturally safe research with vulnerable populations. *Contemporary Nurse,* 33 (1), 69-79.

Witty, K. and White, A. (2010) *The Tackling Men's Health evaluation study*. Leeds: Centre for Men's Health, Leeds Metropolitan University.

Woodman, T. and Hardy, L. (2001) Stress and anxiety. In Singer, R., Hausenblas, H. and Janelle, C. (Eds.), *Handbook of research on sport psychology*. New York: Wiley.

World Health Organization (1948) Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 states *(Official records of the World Health Organization, No. 2)* and entered into force on 7 April 1948. Geneva: World Health Organization.

World Health Organization (2003a) *Social Determinants of Health*. Available at: http://www.who.int/social_determinants/publications/en/ [Accessed on 21st May 2012].

World Health Organization (2003b) *Health and Development through Physical Activity and Sport.* Available at: http://whqlibdoc.who.int/hq/2003/WHO_NMH_NPH_PAH_03.2.pdf [Accessed on 21/05/2012].

World Health Organization (2004) *Global Strategy on Diet, Physical Activity and Health*. Available at: http://www.who.int/dietphysicalactivity/strategy/eb11344/en/index.html [Accessed on 25th January 2013].

World Health Organization (2011) *Global Status Report on Non-communicable Diseases 2010*. Geneva: World Health Organization.

Yancey, A., Ortega A. and Kumanyika, S. (2006) Effective recruitment and retention of minority research participants. *Annual Review of Public Health*. 27 (9), 1-28.

Zwolinsky, S., McKenna, J., Pringle, A., Daly-Smith, A., Robertson, S. and White, A. (2013) Optimizing lifestyles for men regarded as 'hard-to-reach' through top-flight football/soccer clubs. *Health Education Research*, 28 (3), 405-13.

Appendix

Appendix A

LIVERPOOL JOHN MOORES UNIVERSITY PARTICIPANT INFORMATION SHEET

The impact of a football in the community health programme on the health status and fitness of men aged 18-35 years.

Dr Barry Drust, Research Institute for Sport and Exercise Sciences
Kathryn Dunn, Research Institute for Sport and Exercise Sciences

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important that you understand why the research is being done and what is involves. Please take time to read the following information and take time to decide if you want to take part or not. Please ask if there is anything that is not clear or if you would like more information.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine the physiological adaptations to participation in a 12 week physical activity football in the community programme. The results of this investigation will be used to design and implement more effective community-based football interventions.

DO I HAVE TO TAKE PART?

No. It is up to you to decide whether or not to take part. Your participation in the study is completely voluntary and you may choose to stop participating at any time without giving a reason. Your decision not to volunteer will not influence the nature of your relationship with any person at Liverpool John Moores University either now, or in the future.

WHAT WILL HAPPEN TO ME IF I TAKE PART?

You will be asked to participate in a 12 week physical activity programme consisting of two 60 minute football training sessions per week. All training sessions will take place at a local football facility. During the training sessions we will be conducting the procedures below, in which you will be asked to part-take:

- **Heart Rate**: The intensity of all training sessions will be recorded throughout the study using a heart rate monitor. You will be asked to wear a loose fitting belt placed around your chest for the duration of each training session
- **Perceived Exertion:** Following each training session you will be asked to determine the intensity/exertion level to which you perceive you have worked by choosing a number on Borg's CR10-scale which will be presented to you by the researcher.

Appendix A

You will also be asked to visit the laboratory in Liverpool John Moores University, School of Sport and Exercise Sciences on three separate occasions for the procedures listed below. The testing sessions will be carried out during a period of 12 continuous weeks and each visit will take approximately 1 hour to complete. You will be asked to visit the labs prior to commencing in the activity programme, at weeks 1, 6 and 12 of the programme:

- **Dual Energy X-ray Absorpiometry** (DXA): Your body composition will be assessed using a body scan taken using DEXA. You will lie down fully clothed for apporxiamtely 10 minutes while a scanner projects an accurate image of your percentage bone, muscle and body fat
- **Body Mass Index:** This will be calculated by measuring your current height and weight
- **Blood Pressure:** This will be measured using an upper arm blood pressure monitor
- **Resting Heart Rate:** This will be measured using an upper arm blood pressure monitor
- **Venous Blood Samples:** Blood samples will be collected to assess High Density Lipoprotein cholesterol, Low Density Lipoprotein cholesterol and Triglycerides

ARE THERE ANY RISKS/BENEFITS INVOLVED?

POTENTIAL RISKS

The exercise sessions in this study have the potential to cause some risks or discomfort to you. There can be a potential risk of injuring yourself through exercise. You have the discretion to terminate the exercise completed in any organised session at any point if you feel stressed, injured or unwell. There are some hazards associated with the completion of the pre and post exercise interventions used in the investigation. There are risks of contamination by infectious disease from blood. Precautions for collecting venous blood, handling body fluids and the subsequent disposal will be made in agreement with the LJMU Health and Safety Policy on Body Fluids (H.S.C.P. 5.18.1), Guidance Notes G26 (Syringes/Needle sticks) and COSHH. The SHARPS policy will be strictly followed. Blood contaminated material will be disposed of in the method specified in Health and Safety guidelines. The researcher taking and handling blood samples will be appropriately certified and always wear surgical gloves. A First Aid kit will also be available. There is also a small exposure to radiation in the use of the DXA. This is similar to that experienced in a short flight and so should not pose a major health concern to you. All experimental procedures will be carried out by qualified staff using procedures that are carried out in accordance with appropriate health and safety guidelines. All equipment is either disposed of or thoroughly cleaned and disinfected between uses.

Appendix A

BENEFITS

You will be provided with the results of your tests. This will give indications about your current health status. This information may be useful for any training programmes that you are involved in and to give you some information about your current health.

WILL MY TAKING PART IN THE STUDY BE KEPT CONFIDENTIAL?

Yes. All information collected during the research will be safely stored in a locked cabinet. Only research staff involved in the project will have access to this data. All data will be anonymised and referred to using a subject code.

WHAT ABOUT THE BLOOD SAMPLES?

This investigation involves the collection of blood samples for analysis of important metabolic variables. These variables will include High Density Lipoprotein cholesterol, Low Density Lipoprotein cholesterol and Triglycerides. Approximately 10ml of blood will be taken from a vien in your forearm (this is equivalent to ONE table spoon of blood). All samples collected will be stored and analysed in accordance with the procedures outlined in the Human Tissue Act (2004). It is also possible that your samples will be stored and used for future related investigations. These investigations will aim to further our understanding of the physiological and metabolic responses to participation in a community health programme.

CONTACT DETAILS

If you have questions about the research in general or about your role in the study, please feel free to contact Dr Barry Drust, Research Institute for Sport and Exercise Sciences, Liverpool John Moores University. Tel. 0151 2314027. Email: B.Drust@ljmu.ac.uk or Kathryn Dunn, Everton Active Family Centre, Goodison Park, Goodison Road, Liverpool, L4 4EL. Tel. 0151 523 8151 Email: k.m.dunn@ljmu.ac.uk.

Appendix B

LIVERPOOL JOHN MOORES UNIVERSITY
CONSENT FORM

The impact of a football in the community health programme on the health status and fitness of men aged 18-35 years.

Dr Barry Drust, Research Institute for Sport and Exercise Sciences
Kathryn Dunn, Research Institute for Sport and Exercise Sciences

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights ☐

3. I understand that any personal information collected during the study will be anonymised and remain confidential ☐

4. I agree to take part in the above study ☐

5. I agree for the removal, storage and use of blood samples both for this and future investigations ☐

6. I agree for any photographs taken during the investigation to be used ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature
Name of Person taking consent *(if different from researcher)*	Date	Signature

Appendix C

LIVERPOOL JOHN MOORES UNIVERSITY PARTICIPANT INFORMATION SHEET

Understanding the barriers to and motivators for men's engagement in health related behaviours through a football in the community programme at an English Premier League Football Club.

Kathryn Dunn, Research Institute for Sport and Exercise Sciences

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important that you understand why the reserach is being done and what is involves. Please take time to read the following information and take time to decide if you want to take part or not. Please ask if there is anything that is not clear or if you would like more information.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to understand the barriers and motivators associated with men when engaging in physical activity and health related behaviours and what impact the Premier League Health programme has had on your life (if any). The results of this investigation will be used to design more effective football in the community based health programmes.

DO I HAVE TO TAKE PART?

No. It is up to you to decide whether or not to take part. Your participation in the study is completely voluntary and you may choose to stop participating at any time without giving a reason. Your decision not to volunteer will not influence the nature of your relationship with any person at Liverpool John Moores University either now, or in the future.

WHAT WILL HAPPEN TO ME IF I TAKE PART?

You will be asked to take part in an interview lasting no more than 1 hour. This will take place at the Everton Active Family Centre, Goodison Park, at a local football facility or in a public place. The aim of the interview is to give you a chance to 'have your say' about the challenges you face in making health related lifestyle choices. Amoungst other things, we will also talk about what does or would motivate you to engage in physical activity and other health related activities and discuss what impact (if any) the Premier League Health programme has had on your life. No sensitive or embarrassing questions will be asked.

Appendix C

ARE THERE ANY RISKS/BENEFITS INVOLVED?

POTENTIAL RISKS

There are no anticipated adverse effects, risks, hazards, discomfort, distress or inconvenience in involvement in this study. Should any unanticipated risk or discomfort occur surrounding sensitive issues to the participant, this will always be approached by the researcher in an empathetic and appropriate manner.

BENEFITS

Taking part in this study may benefit you as it offers you the opportunity to 'have your say' and reflect on your current lifestyle choices and habits. Following the interview, the researcher (Kathryn) is able to give you advice and information on local health services and facilities or even put you in contact with them should you wish.

WILL MY TAKING PART IN THE STUDY BE KEPT CONFIDENTIAL?

Yes. You will be given a pseudonym (false name) to protect your identity. All personal information, audio tapes and manual files will be kept in a locked cabinet which only the principal investigator (Kathryn) will have access to. Files kept on the principal investigators laptop computer will be password protected. Any additional identifiable data (for example, place names or names of people that you mention) will also be altered to ensure you remain anonymous.

CONTACT DETAILS

If you have questions about the research in general or about your role in the study, please feel free to contact Kathryn Dunn, Everton Active Family Centre, Goodison Park, Goodison Road, Liverpool, L4 4EL. Tel. 0151 523 8151 Email: k.m.dunn@ljmu.ac.uk

Thank you for your time.

Appendix D

LIVERPOOL JOHN MOORES UNIVERSITY CONSENT FORM

Understanding the barriers to and motivators for men's engagement in health related behaviours through a football in the community programme at an English Premier League Football Club.

Kathryn Dunn, Research Institute for Sport and Exercise Sciences

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential ☐
4. I agree to take part in the interview ☐
5. I understand that the interview will be audio recorded and I am happy to proceed ☐
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature
Name of Person taking consent *(if different from researcher)*	Date	Signature

Appendix E

Interview Schedule

Phase 1- Introduction
Aim: To explain the structure of the interview: expected time, interview schedule, importance and aims of the interview and reinforce confidentiality for the participant.

Hi_____, thank you for agreeing to participate and finding the time take part in this interview. The main aim of the interview today is to explore your experiences of engaging in physical activity and other health related behaviours both before and before joining the Premier League Health programme. I'm also interested in exploring what motivated you to get involved in Premier League Health and how you are finding the programme so far. I'd like to prompt you to think about aspects of your answers or give examples where you can and are no right or wrong answers.

There are a few things that I'd like to point out before we start the interview;

I am interested in your thoughts, feelings, opinions and experiences about engaging in health and physical activity. I'll also be asking you, at times, about how you feel about the overall men's health programme, what impact it is having on you and what your plans are for the future.

I am also interested in seeking your views about the importance of football and the role of Everton Football Club in your life.

I'd like to stress that all your comments are of interest and of value. I welcome both positive and negative comments as there are no right or wrong responses during this interview.

I would like you to know that your responses you share with me today could help to shape future football in the community and men's programmes and tailor them to suit the needs of men - not just in Liverpool, but worldwide so thank you once again for your time and help. The interview will last between 45-60 minutes.

Audio Recording
Because we'll be covering a lot of topics and so that I can remember everything that has been said I would like to audio record our discussion. All information collected today will be treated strictly confidential. Although it's ok to refer to people by their first name, no one will be identified by their name in any presentation or report arising from this research. You and others to whom you refer will be kept completely anonymous.

Your participation is voluntary and you may withdraw from the discussion at any time if you feel uncomfortable about anything. You do not have to give a reason. Are you ok for me to audio record?

Appendix E

Some minor housekeeping before we get going...

The toilets are located just outside of this door (point to toilet in EAFC) and should you need to go please just let me know and I'll pause the interview to allow you to go. Finally, would you mind turning your mobile phone to 'silent' or switching it off. Great, thank you, let's begin...

Phase 2- Personal Background

Aim: The first part of the interview is just to get an idea of who you are and what your day-to-day lifestyle is like.

- *Can you tell me a bit about yourself...ADD NAME IN HERE*

  Prompts:

  1. *Name*
  2. *Age*
  3. *Family*
  4. *Education*
  5. *Employment*
  6. *Typical day-to-day life*

Phase 3- Pre Programme Barriers

Aim: The next set of questions focuses on understanding what barriers and anxieties you may have related to engaging in physical activity and other health related behaviours.

- *Can I take you back to before you joined the men's health programme. Can you tell me about your typical physical activity habits at that time?*

  Prompts:

  1. *How active were you?*
  2. *Did you enjoy physical activity?*

- *What have your past experiences of exercise and sport been like?*

  Prompts:

  1. *Childhood to present*
  2. *Positive and negative*

- *Can you tell we about the barriers, if any, that were stopping/limiting your participation in physical activity?*

  Prompts:

  1. *Lifestyle*
  2. *Financial*
  3. *Enjoyment*
  4. *Fears*
  5. *Anxieties*

Appendix E

- *Again, going back to before you joined the men's health programme. Can you tell me about your overall general health?*

  Prompts:

  1. *Lifestyle*
  2. *Financial*
  3. *Enjoyment*
  4. *Smoke?*
  5. *Diet*
  6. *Would you go to the GP/dentist etc?*
  7. *Fears/ Anxieties*

- *Again, can you tell me about the barriers, if any, that were preventing you from addressing your health issues?*

  Prompts:

  1. *Support*
  2. *Lifestyle*
  3. *Information about health services*
  4. *Fears*
  5. *Anxieties*

Phase 4- Motivators
Aim: This set of questions will focus on what motivated you to engage in the Premier League Health programme.

- *Can you tell me about why you decided to join Everton's Premier League Health programme?*

- *Can you tell me what you hoped to get out of it?*

  Prompts:

  1. *Where did you hear about it?*
  2. *Why were you interested in it?*
  3. *What was it that appealed to you?*

Phase 5- Role of the Football Club
Aim: This set of questions will focus on the role Everton Football Club plays in your life.

- *How would you describe the role Everton Football Club plays in your life?*

  Prompts:

  1. *EFC fan?*

Appendix E

- *How did the EFC brand influence your decision to join the programme?*
  Prompts:
  1. *If so, why?*
  2. *If not, main reason for joining this programme and not another?*

Phase 6: Impact of engagement in programme
Aim: This part of the interview will focus on your experiences of the Premier League Health programme.

- *Can you tell me about your experiences of the Premier League Health programme so far?*

- *Do you think the programme has had any impact on your life?*
  Prompts:
  1. *Positives- what did you enjoy the most/ fondest memories*
  2. *Negatives- what have been your biggest challenges/least fond memories*
  3. *Self esteem*
  4. *Structure to day to day life?*
  5. *Health improvements/positive behaviour change*
  6. *Access to other health services*

Phase 7: Challenges of engagement in programme
Aim: The aim of this next part of the interview is to find out if you are experiencing any challenges with the Premier League Health programme.

- *Are you experiencing any challenges with the programme?*
  Prompts:
  1. *Access*
  2. *Location*
  3. *Time*
  4. *Activities*
  5. *Lifestyle*
  6. *Is there anything you would change about the programme?*

Phase 8: Future
Aim: The aim of this next section is to find out what you may take away from the programme.

- *What do you think you will take away from the programme*
  Prompts:
  1. *Physical activity*
  2. *Health*
  3. *Education/training/employment*

Appendix E

- *Are there any changes that you have made to your lifestyle through engagement in this programme that you plan to keep up?*

  Prompts:

  1. *Physical activity and Health*
  2. *Diet*
  3. *Structure*
  4. *Education/training/employment*

Phase 9- Other
Aim: Finally, is there anything else you would like to talk about?

Would you like to contribute anything else to our discussion before we finish? Do you have any questions?
(Pause...)
Explain again what will happen to data and confidentiality etc.

Phase 10- End of Interview
Aim: Clarification and appreciation of their time and information they provided.

Thank you for taking the time to meet with me today. Your time and your views are greatly appreciated. All of the information that we have gathered today will be very useful in shaping future directions in the area of football in the community and men's health.