THE CHALLENGE AND IMPACT OF ENGAGING HARD-TO-REACH POPULATIONS IN REGULAR PHYSICAL ACTIVITY AND HEALTH BEHAVIOURS: AN EXAMINATION OF AN ENGLISH PREMIER LEAGUE 'FOOTBALL IN THE COMMUNITY' MEN'S HEALTH PROGRAMME.

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Summary

Objectives: To investigate the challenges that men from hard-to-reach (HTR) populations encounter when attempting to commit to regular participation in physical activity and health behaviours and to explore the psychological and social effects of participation in a twelve week football-led health improvement intervention.

Study Design: A twelve week football specific physical activity intervention targeting men from HTR populations was delivered by Everton Football Clubs' Football in the Community (FitC) scheme as part of a national programme of men's health delivered in/by English Premier League (EPL) football clubs. Men living in homeless shelters and/or recovering from substance misuse were recruited over a period of three months. The programme consisted of a two hour football session, twice weekly, alongside the dissemination of healthy living messages. Football sessions were conducted by a qualified FitC coach.

Methods: This research was conducted during a twelve week period of immersed practitioner-research. Ethnographic and observational methodologies were adopted. Psychosocial issues were discussed with participants through informal client-researcher interactions and data were logged via field notes. Records of attendance were logged. Participants who failed to attend a session were contacted and their reason(s) for non-attendance were recorded. Data were analysed using deductive and inductive reasoning.

Results: Despite the apparent ambition of the participants to regularly participate in the FitC programme, adherence to the programme was poor. Economic, environmental and social barriers to engagement in the programme were apparent. Engagement in the programme resulted in positive psychosocial developments; the development of structure, social interaction and social capital.

Conclusion: Community based football-led health improvement programmes endorsed by professional football clubs appear well positioned to connect with, and attract, men from HTR populations. The evidence suggests that such programmes can improve psychosocial health amongst these populations. However, a bottom-up programme design and management strategy is required in order to reduce the challenges facing HTR participants when attempting to regularly engage in physical activity and health behaviours.

Keywords: Men's health, Hard-to-reach, Football, Health improvement, English Premier League

Introduction

Our paper presents the impact of a gender specific health improvement programme for hard-to-reach (HTR) males (including men experiencing homelessness and/or men recovering from substance misuse) delivered by an English Premier League Football Club. By definition, HTR populations are described as 'those people who are difficult to access and/or engage with due to specific factors such as accommodation, age, ethnicity, gender, income, language, location and religion'.[1,2] Although the term 'HTR' has been the subject of much debate,[3] it is often used within the health sector when referring to individuals who find it difficult to engage in physical activity (PA) and/or positive health behaviours, or who do not access the allied health services that are available to them.[4,5]

Men from HTR populations frequently report poor health statistics[6] and have therefore been highlighted as a particular area of concern for men's health practitioners and professionals.[7] It has been argued that participation in regular PA and engagement with health services can significantly improve the overall health and wellbeing of HTR populations.[8,9] However, people from HTR groups often experience difficulty engaging in PA for a sustained period of time and are reluctant to engage with traditional health services.[10,11,12] At present, there remains a lack of contextual evidence which provides insight into the difficulties experienced by men from HTR groups when attempting to engage in PA and health behaviours.[13] In order to extend our understanding of *why* men from HTR groups experience difficulty engaging in physical activity and health behaviours, it is critical to understand the contextual barriers and challenges that such populations encounter.[14]

For many years, health promotion efforts (targeting a range of health behaviours) 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.[15] According to Ball[16] 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 context of peoples' lives.[17,18,19,20,21]

Collins and Kay's[22] review of the literature on sport and social exclusion amongst HTR groups uncovered social, economic and contextual constraints *(lack of structure, income, skills, social capital and a sense of powerlessness)* as the major barriers to engagement. These barriers resonate with the World Health Organization's Social Determinants of Health.[23] Although social, economic and environmental influences have been identified and recognised as barriers amongst HTR groups, there remains a lack of evidence which gives voice to HTR populations and/or offers an opportunity for them to express their needs and challenges when engaging in sport, exercise, PA and health behaviours.[24]

Sport England[25] argued that it is important to identify what specific health, wellbeing and social benefits HTR populations can accumulate from regular engagement in PA and positive health behaviours and similarly aligned programmes. Recently, Sherry and Strybosch[26] published findings from their longitudinal survey of Australia's Community Street Soccer Programme (CSSP) for HTR populations. The CSSP programme engaged HTR males (n=165)

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 experiences 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 HTR male populations. However as Frisby[27] suggested, we need to *dig deeper* in order to develop rich contextual evidence which examines what lies behind health-related behaviours amongst HTR populations, and more specifically, about the long term effectiveness (or not) of health promotion interventions with these populations.

As highlighted in previous research, 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.[28,29,30,31,32,33,34,35] The Royal Society of Public Health[36] have endorsed the importance of the setting approach for health improvement and White and colleagues'[37] review of men's health in the European member states suggested sport and leisure contexts as channels for connecting men with health promotion activities. 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.[38,39] 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. However, less is known about the impact of programmes engaging HTR men in football settings. Specifically research is needed on the (I) factors that facilitate engagement and the (II) psychosocial effects of participation.

The aim of this research is to examine the distinct challenges that men from HTR populations encounter when attempting to commit to regular participation in a national men's health programme (named Premier League Health) and explore the psychological and social effects of participation in the twelve week physical activity and health intervention using qualitative methodologies (i.e., those that allow for the voices, experiences and insights of HTR populations to be heard).

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 achieve the following; 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.

Methodology

Intervention context

The Premier League Health (PLH) programme was a £1.63 million three year programme of men's health promotion funded by the UK Football Pools and delivered through sixteen English Premier League football clubs' community schemes between 2009 and 2012. The intervention and research described in this paper formed part of Everton in the Community's (the community arm of Everton Football Club) PLH programme. The aim of Everton in the Community's PLH programme was to use the powerful brand of Everton Football Club as a vehicle to motivate and inspire HTR males in Liverpool (United Kingdom), to make positive, healthy lifestyle choices. The programme was housed within the grounds of Everton Football Club and operated from both the football stadium and sporting venues within the local community.

After obtaining ethical approval, HTR populations were recruited for participation in a twelve week football-specific physical activity intervention. Initially, two HTR populations were identified which are under-represented in research investigating men's health improvement delivered in football settings; (I) men experiencing homelessness and (II) men recovering from drug addiction (it was acknowledged that these populations may not be mutually exclusive categories and that some participants may fall into both groups.). 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, North West England, who were working in partnership with Everton in the Community's (EitC) 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 aged 18-35 years, although adult men beyond 35 years were also 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 HTR, enrolled on the football-specific physical activity intervention. The majority of the participants were smokers, were living in homeless shelters and/or had a history of drug-use (i.e., all participants described themselves as 'recovering' and had not taken drugs for at least six months) and did not regularly participate in any form of structured physical exercise.

The football-specific physical activity intervention consisted of a two hour football session, twice weekly, alongside the dissemination of healthy living messages. Football sessions were delivered in a local community football facility and were conducted by a qualified FitC coach. Typically, each session involved a short informal talk from a health service provider (e.g., smoking cessation, sexual health, cancer awareness) followed by a standardised warm-up, fitness activities, skills practice and concluded with a small-sided game.

Although this paper is concerned with engagement and impact of this twelve week intervention, it is important to note that an exit route was provided to all participants. Following completion of the twelve week intervention, participants were provided with the opportunity to enrol in the on-going weekly activities of the broader PLH programme and engage in a range of weekly physical activity sessions; football, circuit training and boxing (developed in conjunction with the project participants). These activities took place at

Everton Football Club and the surrounding area, three times a week, fifty weeks of the year, between 18:00-20:00hrs.

Methodological context

Frisby[40] suggested that qualitative methodologies that allow for voices, experiences and insights to be heard, offer a greater understanding of HTR populations. In order to meet the aims of the research, the researcher adopted a practitioner-cum-researcher role throughout the study.[41,42,43] This approach has its origins in Public Health research,[44] but to the best of our knowledge, has not been utilised in men's health improvement programmes delivered in football-led settings. In executing this approach, the researcher adopted the principles of ethnography and observational research[45] in order to gain a deeper understanding of the day-to-day realities and challenges of the participants. Tierney[46] 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[47]:

> *"...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..."*

Moreover, such approaches have fidelity with the formulation practice-based evidence (PBE) in Public Health. Ammerman and colleagues[48] have argued:

> "*The most threatening Public Health challenges today are chronic and complex and require joint effort from academic researchers in partnership with clinical and public health practitioners to identify and implement sustainable solutions that work in the real world. Practice-based research offers researchers and practitioners an underutilized way forward, an opportunity to work together to design and test feasible, evidence-based programmes."*

With the goal of meeting the research aims, the researcher was immersed in the planning and delivery of the programme from the outset and subsequently engaged in a four week period of regular casual conversation and active participation with programme participants in order to develop relationships, trust and rapport. Throughout the following eight weeks, psychosocial issues were discussed with all programme participants through informal client-researcher interactions.

Through the adoption of ethnographic methods, a period of down-time was established within the physical activity programme (generally down-time occurred immediately 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 participants. Data were collated through logged researcher observations and field notes.[49] Records of attendance were also logged and participants who failed to attend a session were contacted via telephone. 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 in a bespoke men's health programme.[50,51]

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.[52] Initial ideas and thoughts were recorded. Following this, qualitative data (including all field notes and informal dialogue and/or

interaction with participants) were analysed through deductive and inductive reasoning in order to extrapolate a meaningful understanding of the participants' behaviours and voices.[53] 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.[54,55,56,57,58] Furthermore, evidence highlighting the psychosocial impact of engagement in football specific PA interventions for HTR populations has been highlighted.[59,60,61,62,63] The findings of previous research, therefore, provided a basis for the theoretical and contextual themes used for analysis in this study.

The analysis of qualitative data is inevitability influenced by the theoretical framework, epistemological commitments, personal characteristics and preconceptions of the researcher.[64] Practitioner-research, therefore, requires careful planning in order to minimise the risk to participants and to navigate issues of consent, confidentiality, misinterpretation and misrepresentation of data. These issues were addressed in accordance with ethical guidelines[65] at each stage of this research by the authors. The merits of member checking are subject to debate in the literature. Consulting participants offers a further means of validating the findings (i.e., to verify that the interpretations and findings drawn are correctly represented[66]). However, Silverman[67] asserts that participant validation is not always desirable. Although it could be considered a potential limitation of the study, member checking was not conducted within this research as the research team felt the process would upset the practitioner-researcher balance that the first author was attempting to establish and maintain. Instead, data and themes were presented by the researcher to a senior colleague by means of co-operative triangulation.[68] 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.

Data are represented through a series of themed verbatim extracts that capture the voice and experiences of the participants. The colloquial 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.

Results

The results of this study are separated in this section into two distinct categories centered on the aims of this study;

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

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

Challenges to engagement in the twelve week Premier League Health intervention

Engaging HTR men with unhealthy lifestyles in health improvement programmes is an important Public Health priority.[69] However, despite the apparent ambition of the participants to regularly participate in the football-led health improvement programme, regular adherence was poor. In total, 34 participants signed up to the programme, however, 11 dropped out during the course of the study. The average percentage of attendance of

remaining participants to training sessions throughout the programme was 58±7%. The majority of the programme participants reported that regular engagement and adherence to the programme 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 and these are further developed in the following sections.

Economic Challenges: Budgetary restraints are a significant barrier for participating in sports activities for people of low income.[70] Similarly, it became increasingly evident that financial constraints were a significant challenge for the 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 posed 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 [practitioner]. I've got no money to get there. Sorry." (Ben)*

This financial challenge was also evidenced and illustrated 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 [job seekers allowance]."(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*".[71] 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 telephone conversation between the researcher and a participant Ben, 24, explained that:

> "*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 PA engagement is widely recognised.[72] 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 lives). 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, exclaimed:

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

Participants commonly stated that they had other situational obligations to attend to during the time that they hoped to attend the PLH 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, an unemployed participant said:

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

A range of social issues are more prevalent among homeless populations than in the general population causing what has been described as 'chaos' within the lives of people experiencing homelessness. The participants' apparent chaotic lifestyle also influenced engagement in this[73] 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, stated:

"Sorry I've not been there [at sessions] 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)

(II) Psychosocial impact of engagement in the twelve week Premier League Health intervention

Despite the economic, environmental and social barriers to engagement in the intervention, when participants did engage in the programme, 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. These three themes were 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.[74,75] During the twelve 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 exemplars typify the stories of other participants 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.[76] 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.[77] 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, explained:

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

Klee[78] 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[79] 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[80] 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 explained:

> "*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*:*

> *"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 twelve week intervention three other participants also made reference to the friendships that they had gained as a result of engaging in the programme.

Discussion

In line with Sherry[81] who reported that the complex lives of the participants' 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 PLH twelve 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. 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 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) PLH sessions. Furthermore, due to the timing and the venue of the programme it is probable that some men who wanted to enrol on the programme, couldn't. This could potentially lead to feelings of disappointment and/or failure. It can be argued that in order to facilitate enrolment and sustained engagement, an empathic level of understanding and more informed practice is required by men's health practitioners/professionals who engage, (or who are considering engaging) HTR populations. This understanding is required 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 the 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 participants' community support workers in order to minimise the occurrence of obligatory meetings being scheduled during the same time as the programme. Therefore, in order to reach the 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[82] 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.

Following engagement in the twelve week intervention it became apparent that some participants wanted to continue their involvement in the programme. Sixteen participants enrolled in the broader PLH programme following completion of the intervention. The findings of this study highlight that community-based football programmes endorsed by professional football clubs appear well positioned to connect and attract HTR populations and the evidence suggests that such programmes can improve psychosocial health amongst these populations[83] and keep them involved in ongoing positive health related activities.

This research employed a practice-based evidence approach which combined perspectives of both research and practice and is particularly suited for offering applied perspectives to complex health issues.[84] The areas investigated in this research are guided by theory and applied approaches to research in complex public health settings. As such, 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 to HTR, and in doing so, help to reach this important group of constituents with actives designed to enhance their holistic health and wellbeing.

The findings presented in this paper are limited to those who took part in a twelve week football-led health improvement programme in the North West of England and, like all qualitative research, are not intended to be representative of all men who are experiencing homelessness and/or recovering from drug addiction. The research therefore, does not intend to suggest that the findings presented in this paper are representative or generalizable, but highlights (I) important challenges to engagement in physical activity and health related behaviours that were common across participants' experiences and (II)

psychosocial impact of engagement in the FitC programme. These findings should be taken into consideration to inform future policy, practice and research in this area.

Further contextual and immersed research with HTR populations is needed to dig deeper in order to enhance understanding of the constraints that HTR men encounter when attempting to engage in regular physical activity and health promoting activities.[85] It would seem appropriate, therefore, to explore the experiences of men experiencing homelessness and men recovering from drug addiction across different geographical areas and also to investigate 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 HTR male populations. Furthermore, future research needs to focus on those groups who are (I) (as yet) unreached and (II) those that are considered unreachable. Further research is also required to examine the impact of engagement in Football in the Community physical activity and health programmes on positive health related behaviours in order to contribute to understanding within this underserved area of research.[86] 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.

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Ethical Approval

This work was approved by the Research Ethics Committee, Liverpool John Moores University and the participants gave informed consent prior to participation.

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Competing interests

None declared.

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