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Title: Caught in a 'spiral'. Barriers to healthy eating and dietary health promotion needs from the perspective of unemployed young people and their service providers
Publication year: 2015
Journal title: Appetite
Link to original published version: http://dx.doi.org/10.1016/j.appet.2014.11.010
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Caught in a ‘spiral’: barriers to healthy eating and dietary health promotion needs from the perspective of unemployed young people and their service providers

Abstract

The number of young people in Europe who are not in education, employment or training (NEET) is increasing. Given that young people from disadvantaged backgrounds tend to have diets of poor nutritional quality, this exploratory study sought to understand barriers and facilitators to healthy eating and dietary health promotion needs of unemployed young people aged 16-20 years. Three focus group discussions were held with young people (n=14). Six individual interviews and one paired interview with service providers (n=7). Data were recorded, transcribed verbatim and thematically content analysed. Themes were then fitted to social cognitive theory (SCT). Despite understanding of the principles of healthy eating, a ‘spiral’ of interrelated social, economic and associated psychological problems was perceived to render food and health of little value and low priority for the young people. The story related by the young people and corroborated by the service providers was of a lack of personal and vicarious experience with food. The proliferation and proximity of fast food outlets and the high perceived cost of ‘healthy’ compared to ‘junk’ food rendered the young people low in self-efficacy and perceived control to make healthier food choices. Agency was instead expressed through consumption of junk food and drugs. Both the young people and service providers agreed that for dietary health promotion efforts to succeed, social problems needed addressed and agency encouraged through (individual and collective) active engagement of the young people themselves.

Key Words: food choice; diet; nutrition; Social Cognitive Theory; qualitative; focus groups; interview; socio-economic deprivation; NEET; young people.
Introduction

The number of young people aged 16-24 years in Europe (EU Labour Force Survey, 2012) and the United Kingdom (UK) (DOE, 2011) who are currently not in employment, education or training has reached record levels. Contributors to young people becoming unemployed include educational underachievement, problem behaviour (Spielhofer, Benton, Evans et al., 2009; Jimerson, Egeland, Sroufe, & Carlson, 2000), difficult personal and/or family circumstances and poverty (DEL, 2010; Cabinet Office, 1999). Unemployed young people, therefore, constitute a socio-economically disadvantaged group at particular risk of engaging in adverse health related behaviours and associated outcomes (McDade, Chyu, Duncan et al., 2011; Bell & Blanchflower, 2010; McCoy, Kelly, & Watson, 2007). Young people, particularly those from socio-economically deprived backgrounds, have a tendency to consume diets of poor nutritional quality (Ball, McFarlane, & Crawford, 2009; Brown, McIlveen, & Strugnell, 2006; Shepherd, Harden, Rees et al., 2006). Frequent fast food intake is a marker of less healthy eating habits (Larson, Neumark-Sztainer, Story et al., 2008). During adolescence, junk food consumption increases (Kerr, Rennie, McCaffrey et al., 2009; Larson et al., 2008; Bauer, Larson, Nelson et al., 2008) and consumption of fruit and vegetable intake decreases (Larson, Neumark-Sztainer, & Story, 2007) particularly among socio-economically deprived youth (Fraser, Edwards, Cade, & Clarke, 2011). This implies an imperative to consider factors determining food choice in unemployed young people.

Qualitative studies of food choice in young people have tended to focus on the school, home, family and the environment. School-based qualitative studies have implied the importance of the availability of healthy food (McKinley et al., 2005), autonomy (Stevenson et al., 2007; Contento et al., 2007) and social factors (Fitzgerald et al., 2010; Contento et al., 2007; Neumark-Sztainer et al., 1999) in the development of eating habits. Qualitative family-based studies conducted in America have also suggested that young peoples’ food choices are
largely determined by the degree of autonomy afforded to make them (Bassett et al., 2008) and the availability of food in the home (Holsten et al., 2012). A large proportion of existing qualitative studies of young peoples’ dietary health perceptions, however, have sampled under-sixteen year olds (Holsten, Deadrick, Kumanyika et al., 2012; Stead, McDermott, Mackintosh, & Adamson, 2011; Hunt, Fazio, McKenzie, & Moloney, 2011; Stevenson, Doherty, Barnett et al., 2007; McKinley, Lowis, Robson et al., 2005; Cullen et al., 2000). Those that have considered those aged sixteen plus years (Fitzgerald, Heary, Nixon, & Kelly, 2010; Loannou, 2009; Bassett, Chapman, & Beagan, 2008; Contento, Williams, Michela, & Franklin, 2007; Neumark-Szainer, Story, Perry, & Casey, 1999) have emphasised the importance of social factors in determining the food choices. Food consumed outside the home, particularly junk food, can be an expression of independence and a reflection of emerging social identity (Stead et al., 2011; Loannou, 2009). It is during adolescence that social identity develops (Tarrant, North, Edridge et al., 2001) with potential to impact upon health-related behaviour (Stewart-Knox, Sittlington, Rugkåsa et al., 2005). Peers become an important influence upon dietary behaviour (Wouters, Larson, Kremers, et al., 2010; Larson and Story, 2009; Larson et al., 2008). With this emerging social identity there is likely to be heightened awareness of food and eating where social factors become particularly salient and social cognitive processes may serve to explain food choices, hence, the need to take a broader perspective and explore how young people talk about food and eating, and making food choices in both the social and peer context.

Unlike previously reported qualitative studies which have placed adolescent food choice within the context of the home/family (Holsten et al., 2012; Hunt et al., 2011; Bassett et al., 2008) or school (Fitzgerald et al., 2010; Stevenson et al., 2007; Contento et al., 2007; McKinley et al., 2005; Cullen et al., 2000; Neumark-Sztainer et al., 1999), this research has located young people outside of (the constraints of) these ‘imposed’ environments and within
the community support system where the young people engage socially with peers. It is generally accepted that to better understand health related behaviour and how to encourage change will require the collaboration of those in research and practice (Barker and Swift, 2009). Community service providers have been studied given they are in contact with the young people up to five days a week and in doing so have built trust as well as gained understanding of the problems encountered by the young people in the course of their daily lives. Service providers may potentially play an important role in acting on the young people’s behalf in the implementation of future dietary health intervention. Using this triangulated approach, the aim of this exploratory study has been to gain an understanding of determinants of food choice and dietary health promotion needs of young people who are not in education, employment or training. In order to better understand how to encourage healthy dietary behaviour change, theory needs to be integrated within practice (Barker and Swift, 2009). A secondary aim of this exploratory research, therefore, has been to build theory for subsequent testing through quantitative means and from which to inform health promotion practice and policy directed toward encouraging healthy food choice in unemployed young people.

Social cognition models take into account how cognitions interact with and impact upon decision making, motivation and behaviour (Barker and Swift, 2009). Such models, therefore, could enable the translation of young peoples’ conceptualisation of food into potential food related behaviour. According to social cognitive theory (SCT), behaviour is motivated by incentives to execute the behaviour including the perceived value of the outcome (eg. Health) and expectancies related to the consequences of the behaviour (Bandura, 1989). Expectancies can be concerned with the perceived consequences (control) over the behaviour and/or competence (self-efficacy) which interact to determine behaviour. The notion of agency is integral to SCT and refers to actions that are executed with intention
and forethought (Bandura, 2001). Intention and forethought can be influenced directly (personal agency), by others working on one’s behalf (proxy agency) or through working as part of a group of interdependent agents (collective agency) (Bandura, 2001 & 1997). That SCT attempts to explain behaviour from conception through to execution renders it a potentially appropriate tool for understanding health behaviour and identifying intervention needs. SCT has been applied previously in survey studies seeking to explain dietary behaviour in young people (Lubans, Plotnikoff, Morgan et al., 2012; Ball et al., 2009; Corwin, Sargent, Rheaume, & Saunders, 1999; Reynolds, Hinton, Shewchuk, & Hickey, 1999). Few qualitative studies, however, appear to have used SCT as a framework through which to view and understand dietary health behaviour in young people. This exploratory, qualitative study, therefore, has employed SCT as a lens through which to view determinants and barriers to healthy eating from the perspective of young people aged 16-20 years of age not in education, employment or training (NEET) and their social care providers.

Methods

Ethical approval was granted by the University Research Ethical Committee. The study took place in the United Kingdom (Northern Ireland) during 2011. Contact was made initially with co-ordinators of youth service provider settings who facilitated participation of youth service providers and young people availing of such services. Individual interviews with service providers (study 1) took place before commencement of focus group discussions with the young people (study 2). All of the interviews and focus group discussions were moderated by the same researcher ‘JD’ a female who was aged in her early twenties at the time of data collection. Prior to commencement of the study, individuals read an information
sheet and signed a consent form, whereby they agreed that they understood the aims of the research and were willing to participate.

**Study 1 – Interviews with Service Providers**

**Sampling**

Those involved actively and directly in the provision of services directed toward engaging with young people to enable them back into education, training or employment were considered eligible to participate. The resultant sample comprised 7 individuals (6 female and 1 male), three of whom were youth project managers and four who were coordinators.

**Interview Procedure**

The interview method has been used to communicate with service providers to enable them to articulate in confidence the meanings they personally attribute to their experiences and to be candid about their experiences in supporting the young people (Arksey & Knight, 1999). Service providers underwent individual qualitative interviews each of which lasted approximately 40 to 60 minutes until no new topics arose. Interviews were held in a quiet room within the organisation centre and conducted by the same researcher (JD). Interviews commenced with open questions which aimed to elicit background information in relation to the organisation: “What is your role here at the centre?”; “What are the demographics of the young people who attend here (gender, age-group)?”; and, “Can you tell me about the various types of programmes offered here?” Topics discussed were: types of health education programmes; main health issues; barriers to promoting health; and, how to promote health in unemployed young people.
Study 2 – Focus Group Discussions with Young People

Sampling

All young people aged between 16 to 20 years old, both male and female, attending NEET support schemes, were considered eligible to participate. Contact was made with three of the participating service providers from Study 1 via telephone and permission to conduct the focus groups with the young people obtained. Study information sheets were emailed to service providers who then issued them to all centre attendees with an invitation to take part. At the time of data collection all of the young people recruited were attending NEET based provision directed toward creating positive experiences, enabling them to overcome problems and become economically independent. The three focus groups were recruited to represent attendees at each of the three types of provider institutions: alternative educational; community; and, voluntary sectors. Focus group one (n=6) comprised young people undergoing full-time training with an alternative education provider. Focus group two (n=3) comprised those attending a part-time community-based initiative, receiving training in policy decision-making processes to improve their employability. Of these, one was in foster care, another had been expelled from school and the other had left school following pregnancy. Focus group three (n=5) comprised young people living in supported accommodation aged 14-25 years, attending a drop-in voluntary scheme which focuses on helping young people to overcome individual barriers to training and employment (e.g. social and education disadvantage). The resultant sample consisted of 14 young people aged between 16 to 20 years (10 male and 4 female).
**Focus Group Discussion Procedure**

Focus group discussion has been selected for the purpose of engaging with the young people in the expectation that it would be the method most likely to elicit rich insight into how they operated within the group dynamic (Morgan, 1998). That discussants were known to each other further increased the chances of elucidating social issues associated with health behaviour. The young people took part in three focus group discussions, each of which lasted approximately 40 minutes. Focus group discussions were held in a quiet room within the organisation centre and facilitated by a moderator (JD). Discussion commenced with word associations related to health: “what is the first thing that comes into your head when I mention the word health?” Associations were then revisited to engage discussion. Provisional topics used to guide discussion were: importance of healthy eating; barriers to healthy lifestyle; and, addressing and promoting healthy lifestyle until no new topics arose. Discussions were recorded and transcribed verbatim.

**Data Analysis**

Interview and focus group discussion recordings were transcribed verbatim. Data were thematically content analysed (Miles and Huberman, 1994) by two analysts (JD and BS-K). Focus groups and interviews were content analysed separately and the results subsequently brought together. Transcribed data were read and re-read enabling the analysts to become immersed in the experiences and views of informants and to enable themes to be extracted inductively. Data were organised into emerging coherent and recurring themes which were continually reassessed to refine patterns and interrelationships therein. The two analysts then compared competing themes and sub-themes until consensus was agreed. Themes and sub-themes which emerged from the initial analysis related to perceptions of
healthy eating and individual factors including efficacy to eat healthily, control over food
acquisition and preparation and addiction issues. Themes related to factors external to the
individual related to financial constraints, lower cost of junk/fast food relative to healthy food
and the proliferation and proximity of fast food outlets. A further theme related to substance
abuse arose exclusively in response to food related topics among those in focus group 3
comprised of those who had been homeless but who were living in supported accommodation
at the time of the data collection. There was an over-arching theme referred to as a ‘spiral’ in
which these themes were perceived to interact to constrain the ability of the young people to
eat healthily (Figure 1). Once these common themes had been identified and agreed, Social
Cognitive Theory (SCT) was employed to construct and understand how young people
viewed healthy eating with a view to the design of future intervention.

Insert figure 1

Results

What are the perceived barriers to healthy eating?

Perception of Healthy Eating

For the young people concepts of healthy eating were limited and largely associated
with consumption of fruit and vegetables.

‘Eating fruit and veg each day’ (FG1, P2)

‘Like fruit and vegetables, fresh (FG2, P3)

‘Like your meant to have like 1/3 vegetables’ (FG3, P3)
According to social cognitive theory (SCT) knowledge of behaviour, such as healthy eating, is not enough to for the behaviour to occur. For the behaviour to occur, there must be positive expectancies of the outcome (eg. health) and the goal (eg. health) must be valued (Bandura, 1989). Of concern, therefore, the service providers perceived in the young people a lack of appreciation of the value of healthy eating.

‘I don’t think they see what they eat, their food habits, as being an issue and something they should address’ (PInt 2)

‘Their diet wouldn’t take priority over the amount of other issues that young people have’ (PInt 3)

‘A lot of them just don’t have an awareness of healthy eating at all’ (PInt 5)

**Efficacy to Make Food Choices**

Self-efficacy is the expectancy that one can successfully execute behaviour to bring about a particular outcome (Bandura, 1997). Lack of efficacy to engage in a healthy lifestyle appeared an obstacle to the young people who could not ‘be bothered’ to make healthy food choices.

‘Don’t think I could be bothered (to search out healthy food)’ (FG1, P2)

‘I wish I could think like better and change, but it’s hard, it’s easy to eat bad foods and snacks ... whether you could be bothered or not’ (FG2, P2)

‘We are not eating properly because of our drug habits, at the weekends when we take drugs we don’t be bothered to eat…we don’t have an appetite’ (FG3, P2)

The service providers attributed the apparent lack of efficacy to achieve healthy food choices among the young people to the adverse social circumstances they were experiencing and lack of social support.
They care about where they are going to sleep at night and what they are going to eat, never mind healthy food’ (PInt 1)

‘They get up and eat unhealthily because their family situation is really poor ... nobody around them to support them’ (PInt 4)

‘Young people coming through who have been in care or children homes ... family breakdown ... they have poor diets, they bring all that with them’ (PInt 6)

Perceived Control over Food Choice

Humans are predisposed to exert control over their thoughts and actions (Bandura, 1989) and accordingly, expectancies of a perceived lack of control over food appeared a major barrier to the young people in attempting to make their own healthy choices. For those in focus groups 1 and 2 who mostly resided with a family member as well as those in focus group 3 who lived in supported accommodation, meals tended to be provided and prepared by others.

‘I don’t know what I eat but my Mum makes it’ (FG1, P4)

‘I never cook for myself, my Granny would’ (FG2, P1)

‘We just eat what’s on offer in here, I had stew earlier and it was soup yesterday’ (FG3, P2)

Interaction between Perceived Control and Self-Efficacy

Expectancies, according to SCT (Bandura, 1989), are associated with perceived control over the behaviour and self-efficacy to accomplish the behaviour. Perceived control and self-efficacy interact to determine behaviour such that where there is low perceived control and low efficacy the behaviour is unlikely to occur. Food choices were framed as
beyond the young peoples’ control, which together with apparent low self-efficacy meant that they consumed whatever food was most readily available.

‘Just eat what everyone else is’ (FG1, P3)

‘Whatever is in the cupboard’ (FG1, P2 and FG2, P3)

‘You open your fridge, right, and you go there’s noodles and there’s a big greasy burger, so you pull the burger out first and eat that because it is tastier and then you have the noodles after’ (FG3, P4)

Likewise, the service providers considered lifestyle and food choices to be influenced by circumstances beyond the young peoples’ control. Living conditions were perceived to exacerbate the lack of perceived control and self-efficacy experienced by the young people, particularly if residing in care homes or hostels where food preparation was prohibited.

‘They (the young people) come from a children’s home where everything (food acquisition and preparation) is done for them’ (PInt 1)

‘They have kind of been looked after up until a point ... and they have learnt no life skills whatsoever, so they don’t know how to cook ... shop’ (PInt 6)

Proximity/Availability of Fast/Junk Food

The food environment, specifically the neighbourhood food infrastructure and economy was perceived by the young people to limit perceived control and self-efficacy to eat healthily. ‘Fast/junk’ food was considered more easily available than healthy alternatives. The proliferation and proximity of take-away food outlets was perceived to be a driver of fast/junk food choice.

‘Chinese beside the centre (laughs)’ (FG1, P1)

‘The chippy is too handy, it is right out the front’ (FG2, P2)
Consistent with the young peoples’ reports, service providers viewed the diets of the young as nutritionally poor and largely comprised of junk food.

‘Their diets tend to be atrocious, they eat quite a lot of junk’ (PInt 3)

‘... spend their benefits on alcohol and cigarettes and eating comes way down the line you know, then it’s just making do ... a lot of them, eat junk food’ (PInt 6)

Cost of Junk Food Relative to Healthy Food

As one would expect, the economic environment was considered a major constraint upon food intake. Perceived control over food choices was determined by the amount of money available at a particular time.

‘How much money I have got’ (whether eats or not) (FG1, P3)

‘Just don’t really have the money (to eat healthily)’ (FG2, P3)

‘We just eat whatever we can afford’ (FG3, P5)

The problem of lack of subsistence encountered by the young people was acknowledged by the service providers.

‘There isn’t necessarily always money there to buy (food) and some young people maybe if they are living in hostels would say that they didn’t eat tea’ (PInt 2)

‘the issue would be affording healthy food’ (PInt 3)

That ‘healthy’ food was considered by the young people to be more expensive than ‘junk’ food was perceived to undermine any efficacy to make healthier choices.

‘Healthy food is dear’ (FG1, P5)
‘Vegetables and fresh food is far dearer’ (FG2, P2)

‘You can’t afford to have a healthy diet’ (FG3, P5)

The notion that healthy food cost more than junk food was echoed by the service providers.

‘... and like that wee chippy across the road there, it makes a fortune from us. It does lunchtime specials for like £2 and if you were to cook it from scratch it would probably cost near a fiver’ (PInt 1)

‘Price of healthy foods compared to crappy foods in low income areas is ... is crazy’ (PInt 4)

‘I do think emm to buy fresh fruit emm and fresh vegetables is a lot more expensive than them going to buy beans and chips’ (PInt 6)

Cost of Healthy Food Relative to Drugs

Drugs were deemed cheaper than food and more easily available. Recreational drug taking was viewed as a means by which to limit food consumption.

‘You don’t have an appetite, drugs take the feeling for food away from you and even when you stop taking them, like, it takes a couple of days before you want to eat again’ (FG3, P3)

‘I didn’t eat anything in 2 days and then last night I had three rounds of toast just’ (FG3, P2)

‘I would rather have the drugs (than food) (FG3)

Drug and alcohol consumption was considered by the service providers to be a major health problem and a barrier to healthy eating for the young people. Service providers corroborated that the young people took drugs and could go for prolonged periods taking drugs instead of eating.

‘It can be a full weekend without food, they just continue on with the drugs and obviously there is that suppressant of having to eat, so some of them can go through a whole weekend without eating’ (PInt 4)

‘Whenever it comes to the choice between alcohol and cigarettes or fruit and vegetables, the alcohol and cigarettes seem to win every time’ (PInt 6)
The service providers saw the drug taking as an inevitable response to emotional discomfort. Drug use was considered by the service providers as a symptom of and a response to the adverse circumstances in which they found themselves and incompatible with healthy eating.

‘Where do I start? Drugs, alcohol, mental health, emm emotional health as well and the ones that are independent, do not eat properly either’ (PInt 1)

‘..they wanted us to keep their subsistence right until the end of the week so that they had all their money. It wasn’t really for food or anything like that, it was for drink and drugs or if they didn’t get into the hostel, it was to buy more alcohol to keep them warm at night round by the Royal Mail or wherever they lie, or to buy glue’ (PInt 3)

The ‘Spiral’

The young people framed healthy eating within the context of other, predominantly adverse life experiences ‘You don’t know how bad it actually is for us like, it’s like we have nothing going for us, nothing ever goes right’ (FG3, P3). This was a situation that was recognised by the service providers. Adverse economic and social circumstances, lack of social support and drug/alcohol consumption, were likened to a ‘spiral’ which rendered the young people with no perceived control and lacking in self-efficacy to make healthy food choices. Junk food and drug consumption were perceived to further impact upon mental health which in turn exacerbated social problems.

‘It is a spiral for a lot of them. They eat unhealthily ... so that leads to mental health problems ... aren’t getting involved in social activities...’ (PInt 4)

‘... when they are not working and they are not in training, I think it leads to all types of mental health problems too, you can see the roll on effect really. Homeless, living on the benefit system ... and if their diet is poor this is impacting upon their mental health. ... you know there are drugs and alcohol here because they are not looking after themselves and ... it is having an impact on their life as well. It is that
they are all kind of linked, they are all interlinked, the physical activity, healthy eating, substance misuse, mental health problems, supported accommodation and the benefits are all linked’ (PInt 6)

The young people were understood by the service providers to live in the ‘here’ and ‘now’ focussed on ‘survival’ rather than health. Support was required to enable the young people to get into the ‘right place’ in order that they may want to take care of their health.

‘So I think it is that motivation you know ... for these young people it is just about survival, and it is today and where am I going to be tomorrow, not 20 years down the line...I don’t even think they see a future for themselves sometimes as well like. Everything is just about now and surviving now at the minute’ (PInt 1)

‘I think they need to be in the right place before they can start to take care of themselves and start realising the next step... mental health would be the first priority ... but once they are at that stage, yes’ (PInt 5)

How should healthy eating be promoted?

Inter-related themes were concerned with the need for the young people to be active and involved in dietary health promotion activities both individually and collectively. Inherent to social cognitive theory is the notion of agency which refers to actions that are executed with intention and forethought (Bandura, 2001). Agency is a function of perceived control, self-efficacy, cognitive appraisal and emotional reactions (Bandura, 1989) which together inform expected outcomes. Efficacy to execute a behaviour such as healthy eating can be influenced directly, through personal agency, by proxy (through others working on one’s behalf) or by collective agency (working as part of a group of interdependent agents) (Bandura, 2001 & 1997). Both the young people and their service providers affirmed the notion integral to SCT that intervention to promote healthy eating should seek to encourage agency at the personal, proxy and collective level. In doing so, the young people could be
afforded the experiences through which to acquire perceived control and self-efficacy necessary for them to value their health and eat more healthily.

Personal Agency

According to what the young people reported, dietary health promotion was delivered to the young people by means of an ‘education’ model which relied exclusively on lectures precluded any possibility of participation in the process. The young people seemed distanced by such an approach.

‘... just sitting there listening to someone talk on (about healthy eating)’ (FG1)

‘Sometimes people just come in and blab on to us (about healthy eating)’ (FG2, P3)

‘Just we never do things now ...’ (FG3, P5)

There was the suggestion among the young people that by being passive recipients of services, they were denied personal agency and prevented from being active agents fully involved in their own dietary health promotion intervention process. Practical and interactive approaches towards learning were recommended and preferred.

‘Like us actually doing something. Not just sitting there listening to someone talk on (about healthy eating), but us being involved’ (FG1, P5)

‘Show us how to cook...show us different foods and how to use them’ (FG2, P1; P3)

‘If there was stuff to do ...’ (FG3, P5)

Given the ‘spiral’ of diverse interacting adverse circumstances service providers advocated a more ‘holistic’ approach to dietary health intervention.

‘... you know the whole aspect of what is involved in a young person, more of a holistic approach (to dietary health promotion)’ (PInt2)
We have a holistic approach with the young people and we try to address all different aspects of their lives’ (PInt 3)

In particular, service providers recognised the imperative for active rather than passive ‘practice-based’ approaches to intervention in order to develop a sense of agency among the young people.

‘They won’t learn (about healthy eating), certainly not from sitting down in the classroom and listening ... learning through practice based, there is no way their concentration would remain otherwise’ (PInt 2)

‘Not a lecture style approach, maybe like a lets all find out the information together kind of approach...so it is almost like a team work style approach’ (PInt 4)

‘Programs need to be 100% active’ (PInt 6)

Proxy Agency

Whereas service providers were considered by the young people to be appropriate proxy agents to act on their behalf ‘I enjoy it. We learn at our level, they teach us, they are just like us’ (FG1, P4). In contrast, other individuals (e.g. health care professionals), usually enlisted from outside the organisation, encountered in the context of dietary health promotion were perceived to look down on them ‘The way they look at it is we are bums’ (FG3) agency, and as such, not appropriate proxy agents. The view that outside providers were inappropriate to act as proxy agents was affirmed by the service providers ‘It mightn’t be because they are older...they just maybe aren’t that in touch with youth culture and stuff’ (PInt1).

By the same token, service providers recognised their own role as trusted proxy agents acting on the young peoples’ behalf and providing social support necessary to enable the young people to achieve a healthy lifestyle ‘We are in a position that sometimes the young people
trust us more than they trust their families and their social workers’ (PInt 3). Intervention, according to the service providers, should seek to provide support to break the ‘spiral’ and alleviate existing social problems and, thereby, motivate the young people to value health.

‘... sometimes they have bigger issues to deal with than (health) education, you know. I think accepting that and going with the flow, being supportive and being there for them’ (PInt 1)

‘It is the support they need, real support in relation to having to beat it (addiction) instead of the knowledge behind it (health)’ (PInt 4)

Collective Agency

Discourses referred to the social context of eating and suggested that there was a collective aspect to the young people’s food choices. The pronoun ‘we’ was used extensively when referring to food related activities.

‘Us, a barrier like, we are! We eat, we choose what we eat, so if we don’t eat good food, then it’s our fault, ain’t it? (FG1, P4)

‘In here we all eat together, like, so we usually follow what others are eating’ (FG2, P1)

‘Aye, we went to the chippy yesterday and we are all going today for lunch again’ (FG2, P3)

‘Like the other night I made me and her spaghetti Bolognese (refers to P5) and wasn’t it lovely? (FG3, P2)

In keeping with the notion that you young people should cooperate together in the food context, service providers unanimously advocated collective, peer-led approach to dietary health promotion.

‘They learn a lot from peer education, you know sharing among themselves their experiences’ (PInt 2)

‘it (dietary health promotion) needs to be needs led, it has to be sort of pushed along by the young people ... intensive led by how they want to shape their learning’ (PInt 3)
Discussion

Young people find themselves out of education, employment or training (NEET) as a result of poverty, difficult personal and/or family circumstances (DEL, 2010) and educational underachievement (McDade et al., 2011; Spielhofer et al., 2009; Jimerson et al., 2000). The story told by the young people in this study, which was corroborated and elaborated upon by the service providers, unsurprisingly, therefore, was one of economic deprivation, enduring social problems and poor psychological wellbeing which together rendered healthy eating related issues of relatively low priority. Social Cognitive Theory (SCT) attests that for behaviour to occur it needs to be valued and the outcome associated with positive expectancies (Bandura, 1997). The perceived lack of importance placed on food and health, therefore, is likely to deter healthy dietary behaviour in these young people.

When talking about food, the young people consistently referred to a lack of autonomy and control. As previous qualitative research has suggested the young people perceived themselves to have little control over food choices in the home (Stevenson et al., 2007; Bassett et al., 2008; Contento et al., 2007) and those in the parental role were perceived as gatekeepers, who through control of both food acquisition and preparation, determined the young people’s food choices. SCT holds that the likelihood of a given behaviour is dependent upon experience of the behaviour (in this case eating), the outcome (health) as well as the resultant (positive or negative) feedback (Bandura, 1989). According to SCT, beliefs about ability to exercise control over circumstances interact with self-efficacy (Bandura, 1989). Self-efficacy which is the notion that one can successfully execute behaviour to bring about a particular outcome (Bandura, 1997) develops through experience which can be personal (mastery), vicarious (observation), verbal (persuasion) or biological (feedback) (Bandura,
Self-efficacy becomes less important in determining expected outcomes in situations in which there is low perceived control. This implies that where food was acquired and prepared by carers, the young people were denied the experience required to instil in them the perceived self-efficacy required to enable them to take control of their dietary needs. Self-efficacy also depends upon whether the environment is imposed, selected or constructed (Bandura, 1997). An imposed environment, such as that experienced by the young people in the care context, was likely to be associated with low perceived efficacy to make food choices. That meals were provided and prepared by others meant that the young people lacked experience, personal, vicarious or otherwise, needed to develop self-efficacy to make food choices.

In keeping with other qualitative studies (Holsten et al., 2012; McKinley et al., 2005) availability of food was perceived a major driver of food choice. The high cost of healthy foods relative to junk food rendered junk food more affordable than other options. Reciprocal causation is a concept inherent in SCT which refers to the interaction between the individual and the environment (Bandura, 1989). Accordingly, the young people in this study referred to the proliferation and proximity of fast food outlets and perceived such an environment to undermine efficacy to make alternative choices. Given the notion that efficacy is enabled and constrained by the environment, reciprocal causation would imply that by making healthier food cheaper and more readily available and junk food more expensive and less available it is possible to encourage more healthy food choices. The dispersion of fast food outlets should be also taken into account when planning intervention to promote healthy eating in unemployed young people. Junk food consumption is more often under the young person’s control and tends to be consumed in the company of peers (Fitzgerald et al., 2010; Wouters et al., 2010; Larson and Story, 2009; Larson et al., 2008; Contento et al., 2007; Shepherd et al., 2006). As implied by previous research (Stead et
food consumed outside the home, particularly junk food, could serve as an expression of independence and emerging social identity for the young people. Likewise, the young people in our discussion groups voiced intentions to eat fast/junk food in the company of their friends. This indicates a need to promote dietary health to young people in their social groups.

This constellation of problems, which was underpinned by adverse social circumstances and associated lack of social support, was likened by the service providers to a ‘spiral’ which rendered the young people ineffective in achieving health outcomes. This notion of circularity is in keeping with SCT (Bandura, 1989; Bandura, 1997) which asserts that strong negative emotions, such as those experienced by the young people in response to adverse social circumstances, would be detrimental to perceived control and self-efficacy required to successfully adopt healthy eating practices. As a consequence of being caught in this ‘spiral’ of interlinked circumstances, the young people were apparently denied the personal, vicarious or biological experiences and resultant feedback through which they could acquire a sense of efficacy, perceived control and concomitant goal orientation required to seek health. Drugs and alcohol were apparently consumed instead of food and used a means through which to curb appetite. Substance abuse was perceived by the service providers to impact upon mental health and well-being which in turn was perceived to exacerbate socio-economic problems and deter healthy eating.

The message pervading all discussion groups and interviews was of perceived lack of agency required to adopt and maintain healthier eating habits. The young people expressed a need to become more involved and to be active in their own dietary health intervention, Agency, according to SCT (Bandura, 1989), can be assumed a function of the value of the outcome of the behaviour, perceived control over the behaviour and efficacy to act. Given the ‘spiral’ of interacting factors implicit in the accounts of the young people and explicit in
those of the service providers, intervention to promote agency to achieve healthy food choice among unemployed young people should first seek to address financial issues and provide support to alleviate social problems. The way in which healthy eating was promoted to the young people was also considered detrimental to agency. According to SCT behaviour change can be achieved through experience (actual and/or vicarious), verbal persuasion and feedback (behavioural and/or physiological) (Bandura, 1986). The accounts of both the young people and the service providers instead described attempts at dietary health promotion which tended to rely on verbal persuasion to the neglect of experience and consequent feedback. Verbal persuasion is considered a relatively ineffective means through which to achieve behaviour change since it does not enable feedback (Bandura, 1986). Vicarious learning, when others similar to oneself are observed to possess a skill could prove more effective (Bandura, 1986). Being with peers can afford opportunities for vicarious learning and encourage collective agency. Collective agency is defined as the ‘shared belief in collective power to produce desired results’ (Bandura, 2001: pp14). Agency is maximised where there is congruence between the culture and the approach to behaviour change (Bandura, 2001). The group oriented youth culture expressed in these findings is inherently collectivist suggesting that the young people would respond to food and health interventions which embrace collective agency.

It could be argued that in having employed SCT to interpret themes may have been to the detriment of other potentially important perspectives or meanings contained in these data. In conducting a content analysis initially with no prior assumptions and then applying SCT subsequently only once themes were extracted, however, has rendered this unlikely. That other studies that have applied SCT to understanding food behaviour in young people have largely been quantitative (Lubans et al., 2012; Ball et al., 2009; Corwin et al., 1999; Reynolds et al, 1999) renders it difficult to make comparison with those of the current study. Previous
quantitative studies that have applied this model to understand food behaviour in socio-economically deprived youth (Lubans et al., 2012; Ball et al., 2009), have indicated that SCT constructs predict higher fat and energy intake and support the notion that unhealthy eating is associated with low self-efficacy. The perceived importance of healthy eating would also appear an important mediating factor in healthy eating behaviour (Ball et al., 2009). Other aspects of SCT, for example, the path between intention to eat healthily and consumption, have not been explained quantitatively (Lubans et al., 2012). SCT has provided an effective means through which to understand young peoples’ perspectives on healthy eating and to establish their dietary health promotion needs. The theory has provided a useful ‘top-down’ framework with which to interpret themes identified in a ‘bottom-up’ manner with a view to the design of future intervention. Although the young people held notions of healthy eating, SCT assumes that this is not enough and that for healthy dietary change to occur there should, firstly, be some expectation that the behaviour has worth (of value) and, secondly, that the individual has the ability (perceived control and self-efficacy) to execute the behaviour. As the service providers suggested, the young people we researched had neither of these.

This study has succeeded in accessing a relatively small, vulnerable and difficult to reach societal group and this is reflected in what could be considered a limited number of focus groups. The extent of provision for this group is also limited, hence, the small number of service providers. The samples were also subject to gender bias such that the young people were mainly male and the providers mostly female and this is likely to have impacted upon responses. It is beyond the scope of a qualitative study, however, to establish in what ways and to what degree numbers or gender may have influenced the findings. Given such limitations, however, this study can only be considered exploratory and indicative of a need for further in-depth qualitative research with this group. Being exploratory, the focus of the study has been on generating rich data with which to build theory for further testing through
future in depth qualitative and survey research. The interviews not only allowed the service providers to voice their opinions on the young peoples’ dietary health promotion needs, but also helped to broker a relationship of trust with the researcher prior to the discussions with the young people. Further, as the researcher was of similar age to the discussants and could not be considered in authority, she was able to initiate a natural rapport with the young people. A limitation of focus groups as a method of data collection, however, is the tendency for discussion to reach consensus (Strauss & Corbin, 1998). Such an occurrence would be more likely when discussants are known to one another. That our discussants were known to each other, nevertheless, facilitated discussion and provided a unique insight into their food-related health perceptions. The triangulation study design in which service providers corroborated and extended what the young people conveyed, adds weight to the findings.

This triangulated explorative qualitative study has enabled ‘multi-dimensional’ understanding of issues of salience to healthy eating among young people not in employment, education or training and adds to a growing body of evidence for the importance of the local environment in dietary behaviour and the need and a need for further multilevel research that takes into account the environment (Ball, Timperio & Crawford, 2006). Ecological models (Sallis and Owen, 2002; Stokols, 1996) consider the interaction between individual factors and the social, physical and macro environment in facilitating healthy dietary behaviour change (Larson and Story, 2009). The spiral of circumstances perceived to impact upon the young people we studied implies such an interaction. A spiral of individual, social and environmental (micro and macro) appear to interact to constrain health eating in this group and which could be tested in future research.

**Conclusions**
This exploratory research highlights the importance of researching young peoples’ food choices within the context of their daily lives. Lack of control over food acquisition and preparation, financial constraints, lower cost of junk/fast food relative to healthy food, proliferation and proximity of fast food outlets together limited the ability of the young people to eat healthily irrespective of whether inside or outside of the home environment. Perceptions of healthy eating were also seen as rooted to the adverse social circumstances in which the young people found themselves. Both the young people and service providers emphasised the imperative to address the ‘spiral’ of interrelated psycho-social and economic problems in order for dietary health to become valued by the young people and higher among priorities. Our data suggest that this could be achieved through policies directed toward alleviating problems associated with food poverty, such as lack of social support. There was also agreement between the young people and their service providers that dietary health promotion should seek to address the apparent lack of perceived control and efficacy that appears to hamper attempts to achieve a healthy diet. Both the young people and the service providers emphasised the need for young people to be active agents in their own dietary health intervention process favouring an active and social (peer-led) approach. These findings will inform the design of a questionnaire with which to establish the extent of these issues and provide theoretical insights into the dietary health promotion needs of young people who are not in education, employment or training (NEET).

**References**


Figure 1: Representation of SCT applied to dietary health perceptions.

- Adverse social and economic circumstances
- Lack of social support
- Substance abuse
- Efficacy to make food choice
- Perceived control over food acquisition and preparation
- Addiction
- Financial Constraints
- Cost of junk vs healthy food
- Proliferation and proximity of fast food outlets