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Author(s): Davison, J., Share, M., Hennessy M. and Stewart-Knox, B.

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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.

24 **Introduction**

25 The number of young people aged 16-24 years in Europe (EU Labour Force Survey,
26 2012) and the United Kingdom (UK) (DOE, 2011) who are currently not in employment,
27 education or training has reached record levels. Contributors to young people becoming
28 unemployed include educational underachievement, problem behaviour (Spielhofer, Benton,
29 Evans et al., 2009; Jimerson, Egeland, Sroufe, & Carlson, 2000), difficult personal and/or
30 family circumstances and poverty (DEL, 2010; Cabinet Office, 1999). Unemployed young
31 people, therefore, constitute a socio-economically disadvantaged group at particular risk of
32 engaging in adverse health related behaviours and associated outcomes (McDade, Chyu,
33 Duncan et al., 2011; Bell & Blanchflower, 2010; McCoy, Kelly, & Watson, 2007). Young
34 people, particularly those from socio-economically deprived backgrounds, have a tendency to
35 consume diets of poor nutritional quality (Ball, McFarlane, & Crawford, 2009; Brown,
36 McIlveen, & Strugnell, 2006; Shepherd, Harden, Rees et al., 2006). Frequent fast food intake
37 is a marker of less healthy eating habits (Larson, Neumark-Sztainer, Story et al., 2008).
38 During adolescence, junk food consumption increases (Kerr, Rennie, McCaffrey et al., 2009;
39 Larson et al., 2008; Bauer, Larson, Nelson et al., 2008) and consumption of fruit and
40 vegetable intake decreases (Larson, Neumark-Sztainer, & Story, 2007) particularly among
41 socio-economically deprived youth (Fraser, Edwards, Cade, & Clarke, 2011). This implies an
42 imperative to consider factors determining food choice in unemployed young people.

43 Qualitative studies of food choice in young people have tended to focus on the school,
44 home, family and the environment. School-based qualitative studies have implied the
45 importance of the availability of healthy food (McKinley et al., 2005), autonomy (Stevenson
46 et al., 2007; Contento et al., 2007) and social factors (Fitzgerald et al., 2010; Contento et al.,
47 2007; Neumark-Sztainer et al., 1999) in the development of eating habits. Qualitative family-
48 based studies conducted in America have also suggested that young peoples' food choices are

49 largely determined by the degree of autonomy afforded to make them (Bassett et al., 2008)
50 and the availability of food in the home (Holsten et al., 2012). A large proportion of existing
51 qualitative studies of young peoples' dietary health perceptions, however, have sampled
52 under-sixteen year olds (Holsten, Deadrick, Kumanyika et al., 2012; Stead, McDermott,
53 Mackintosh, & Adamson, 2011; Hunt, Fazio, McKenzie, & Moloney, 2011; Stevenson,
54 Doherty, Barnett et al., 2007; McKinley, Lowis, Robson et al., 2005; Cullen et al., 2000).
55 Those that have considered those aged sixteen plus years (Fitzgerald, Heary, Nixon, & Kelly,
56 2010; Loannou, 2009; Bassett, Chapman, & Beagan, 2008; Contento, Williams, Michela, &
57 Franklin, 2007; Neumark-Szainer, Story, Perry, & Casey, 1999) have emphasised the
58 importance of social factors in determining the food choices. Food consumed outside the
59 home, particularly junk food, can be an expression of independence and a reflection of
60 emerging social identity (Stead et al., 2011; Loannou, 2009). It is during adolescence that
61 social identity develops (Tarrant, North, Edridge et al., 2001) with potential to impact upon
62 health-related behaviour (Stewart-Knox, Sittlington, Rugkåsa et al., 2005). Peers become an
63 important influence upon dietary behaviour (Wouters, Larson, Kremers, et al., 2010; Larson
64 and Story, 2009; Larson et al., 2008). With this emerging social identity there is likely to be
65 heightened awareness of food and eating where social factors become particularly salient and
66 social cognitive processes may serve to explain food choices, hence, the need to take a
67 broader perspective and explore how young people talk about food and eating, and making
68 food choices in both the social and peer context.

69 Unlike previously reported qualitative studies which have placed adolescent food
70 choice within the context of the home/family (Holsten et al., 2012; Hunt et al., 2011; Bassett
71 et al., 2008) or school (Fitzgerald et al., 2010; Stevenson et al., 2007; Contento et al., 2007;
72 McKinley et al., 2005; Cullen et al., 2000; Neumark-Sztainer et al., 1999), this research has
73 located young people outside of (the constraints of) these 'imposed' environments and within

74 the community support system where the young people engage socially with peers. It is
75 generally accepted that to better understand health related behaviour and how to encourage
76 change will require the collaboration of those in research and practice (Barker and Swift,
77 2009). Community service providers have been studied given they are in contact with the
78 young people up to five days a week and in doing so have built trust as well as gained
79 understanding of the problems encountered by the young people in the course of their daily
80 lives. Service providers may potentially play an important role in acting on the young
81 people's behalf in the implementation of future dietary health intervention. Using this
82 triangulated approach, the aim of this exploratory study has been to gain an understanding of
83 determinants of food choice and dietary health promotion needs of young people who are not
84 in education, employment or training. In order to better understand how to encourage healthy
85 dietary behaviour change, theory needs to be integrated within practice (Barker and Swift,
86 2009). A secondary aim of this exploratory research, therefore, has been to build theory for
87 subsequent testing through quantitative means and from which to inform health promotion
88 practice and policy directed toward encouraging healthy food choice in unemployed young
89 people.

90 Social cognition models take into account how cognitions interact with and impact
91 upon decision making, motivation and behaviour (Barker and Swift, 2009). Such models,
92 therefore, could enable the translation of young peoples' conceptualisation of food into
93 potential food related behaviour. According to social cognitive theory (SCT), behaviour is
94 motivated by incentives to execute the behaviour including the perceived value of the
95 outcome (eg. Health) and expectancies related to the consequences of the behaviour
96 (Bandura, 1989). Expectancies can be concerned with the perceived consequences (control)
97 over the behaviour and/or competence (self-efficacy) which interact to determine behaviour.
98 The notion of agency is integral to SCT and refers to actions that are executed with intention

99 and forethought (Bandura, 2001). Intention and forethought can be influenced directly
100 (personal agency), by others working on one's behalf (proxy agency) or through working as
101 part of a group of interdependent agents (collective agency) (Bandura, 2001 & 1997). That
102 SCT attempts to explain behaviour from conception through to execution renders it a
103 potentially appropriate tool for understanding health behaviour and identifying intervention
104 needs. SCT has been applied previously in survey studies seeking to explain dietary
105 behaviour in young people (Lubans, Plotnikoff, Morgan et al., 2012; Ball et al., 2009;
106 Corwin, Sargent, Rheaume, & Saunders, 1999; Reynolds, Hinton, Shewchuk, & Hickey,
107 1999). Few qualitative studies, however, appear to have used SCT as a framework through
108 which to view and understand dietary health behaviour in young people. This exploratory,
109 qualitative study, therefore, has employed SCT as a lens through which to view determinants
110 and barriers to healthy eating from the perspective of young people aged 16-20 years of age
111 not in education, employment or training (NEET) and their social care providers.

112

## 113 Methods

114 Ethical approval was granted by the University Research Ethical Committee. The
115 study took place in the United Kingdom (Northern Ireland) during 2011. Contact was made
116 initially with co-ordinators of youth service provider settings who facilitated participation of
117 youth service providers and young people availing of such services. Individual interviews
118 with service providers (study 1) took place before commencement of focus group discussions
119 with the young people (study 2). All of the interviews and focus group discussions were
120 moderated by the same researcher 'JD' a female who was aged in her early twenties at the
121 time of data collection. Prior to commencement of the study, individuals read an information

122 sheet and signed a consent form, whereby they agreed that they understood the aims of the
123 research and were willing to participate.

124

125 **Study 1 – Interviews with Service Providers**

126 ***Sampling***

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

132 ***Interview Procedure***

133 The interview method has been used to communicate with service providers to enable
134 them to articulate in confidence the meanings they personally attribute to their experiences
135 and to be candid about their experiences in supporting the young people (Arksey & Knight,
136 1999). Service providers underwent individual qualitative interviews each of which lasted
137 approximately 40 to 60 minutes until no new topics arose. Interviews were held in a quiet
138 room within the organisation centre and conducted by the same researcher (JD). Interviews
139 commenced with open questions which aimed to elicit background information in relation to
140 the organisation: "What is your role here at the centre?"; "What are the demographics of the
141 young people who attend here (gender, age-group)?"; and, "Can you tell me about the various
142 types of programmes offered here?" Topics discussed were: types of health education
143 programmes; main health issues; barriers to promoting health; and, how to promote health in
144 unemployed young people.

145

146 **Study 2 – Focus Group Discussions with Young People**

147 ***Sampling***

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

167

168 ***Focus Group Discussion Procedure***

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

181

182 **Data Analysis**

183 Interview and focus group discussion recordings were transcribed verbatim. Data
184 were thematically content analysed (Miles and Huberman, 1994) by two analysts (JD and BS-
185 K). Focus groups and interviews were content analysed separately and the results
186 subsequently brought together. Transcribed data were read and re-read enabling the analysts
187 to become immersed in the experiences and views of informants and to enable themes to be
188 extracted inductively. Data were organised into emerging coherent and recurring themes
189 which were continually reassessed to refine patterns and interrelationships therein. The two
190 analysts then compared competing themes and sub-themes until consensus was agreed.
191 Themes and sub-themes which emerged from the initial analysis related to perceptions of

192 healthy eating and individual factors including efficacy to eat healthily, control over food
193 acquisition and preparation and addiction issues. Themes related to factors external to the
194 individual related to financial constraints, lower cost of junk/fast food relative to healthy food
195 and the proliferation and proximity of fast food outlets. A further theme related to substance
196 abuse arose exclusively in response to food related topics among those in focus group 3
197 comprised of those who had been homeless but who were living in supported accommodation
198 at the time of the data collection. There was an over-arching theme referred to as a *'spiral'* in
199 which these themes were perceived to interact to constrain the ability of the young people to
200 eat healthily (Figure 1). Once these common themes had been identified and agreed, Social
201 Cognitive Theory (SCT) was employed to construct and understand how young people
202 viewed healthy eating with a view to the design of future intervention.

203

204 **Insert figure 1**

205

206 **Results**

207 **What are the perceived barriers to healthy eating?**

208 **Perception of Healthy Eating**

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

211 'Eating fruit and veg each day' (FG1, P2)

212 'Like fruit and vegetables, fresh (FG2, P3)

213 'Like your meant to have like 1/3 vegetables' (FG3, P3)

214 According to social cognitive theory (SCT) knowledge of behaviour, such as healthy eating,
215 is not enough to for the behaviour to occur. For the behaviour to occur, there must be positive
216 expectancies of the outcome (eg. health) and the goal (eg. health) must be valued (Bandura,
217 1989). Of concern, therefore, the service providers perceived in the young people a lack of
218 appreciation of the value of healthy eating.

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

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

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

223

224 **Efficacy to Make Food Choices**

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

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

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

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

234 The service providers attributed the apparent lack of efficacy to achieve healthy food choices
235 among the young people to the adverse social circumstances they were experiencing and lack
236 of social support.

237 ‘They care about where they are going to sleep at night and what they are going to eat, never mind
238 healthy food’ (PInt 1)

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

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

243

244 **Perceived Control over Food Choice**

245 Humans are predisposed to exert control over their thoughts and actions (Bandura,
246 1989) and accordingly, expectancies of a perceived lack of control over food appeared a
247 major barrier to the young people in attempting to make their own healthy choices. For those
248 in focus groups 1 and 2 who mostly resided with a family member as well as those in focus
249 group 3 who lived in supported accommodation, meals tended to be provided and prepared
250 by others.

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

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

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

254

255 **Interaction between Perceived Control and Self-Efficacy**

256 Expectancies, according to SCT (Bandura, 1989), are associated with perceived
257 control over the behaviour and self-efficacy to accomplish the behaviour. Perceived control
258 and self-efficacy interact to determine behaviour such that where there is low perceived
259 control and low efficacy the behaviour is unlikely to occur. Food choices were framed as

260 beyond the young peoples' control, which together with apparent low self-efficacy meant that
261 they consumed whatever food was most readily available.

262 > 'Just eat what everyone else is' (FG1, P3)

263 > 'Whatever is in the cupboard' (FG1, P2 and FG2, P3)

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

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

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

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

274

275 *Proximity/Availability of Fast/Junk Food*

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

281 > 'Chinese beside the centre (laughs)' (FG1, P1)

282 > 'The chippy is too handy, it is right out the front' (FG2, P2)

283 ‘The shops, there full of junk food on sale’ (FG3, P3)

284 Consistent with the young peoples’ reports, service providers viewed the diets of the young
285 as nutritionally poor and largely comprised of junk food.

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

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

289

290 *Cost of Junk Food Relative to Healthy Food*

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

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

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

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

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

299 ‘There isn’t necessarily always money there to buy (food) and some young people maybe if they are
300 living in hostels would say that they didn’t eat tea’ (PInt 2)
301 ‘the issue would be affording healthy food’ (PInt 3)

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

304 ‘Healthy food is dear’ (FG1, P5)

305 ‘Vegetables and fresh food is far dearer’ (FG2, P2)

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

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

308 ‘... and like that wee chippy across the road there, it makes a fortune from us. It does lunchtime specials
309 for like £2 and if you were to cook it from scratch it would probably cost near a fiver’ (PInt 1)
310 ‘Price of healthy foods compared to crappy foods in low income areas is ... is crazy’ (PInt 4)
311 ‘I do think emm to buy fresh fruit emm and fresh vegetables is a lot more expensive than them going to
312 buy beans and chips’ (PInt 6)

313

314 *Cost of Healthy Food Relative to Drugs*

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

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

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

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

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

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

327 ‘Whenever it comes to the choice between alcohol and cigarettes or fruit and vegetables, the alcohol
328 and cigarettes seem to win every time’ (PInt 6)

329 The service providers saw the drug taking as an inevitable response to emotional discomfort.
330 Drug use was considered by the service providers as a symptom of and a response to the
331 adverse circumstances in which they found themselves and incompatible with healthy eating.

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

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

338

339 **The 'Spiral'**

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

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

350 '... when they are not working and they are not in training, I think it leads to all types of mental health
351 problems too, you can see the roll on effect really. Homeless, living on the benefit system ... and if their
352 diet is poor this is impacting upon their mental health. ... you know there are drugs and alcohol here
353 because they are not looking after themselves and ... it is having an impact on their life as well. It is that

354 they are all kind of linked, they are all interlinked, the physical activity, healthy eating, substance
355 misuse, mental health problems, supported accommodation and the benefits are all linked' (PInt 6)

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

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

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

366

367 **How should healthy eating be promoted?**

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

379 afforded the experiences through which to acquire perceived control and self-efficacy
380 necessary for them to value their health and eat more healthily.

381

382 *Personal Agency*

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

387 '... just sitting there listening to someone talk on (about healthy eating)' (FG1)

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

389 'Just we never do things now ...' (FG3, P5)

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

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

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

397 'If there was stuff to do …' (FG3, P5)

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

400 '... you know the whole aspect of what is involved in a young person, more of a holistic approach (to
401 dietary health promotion)' (PInt2)

402 We have a holistic approach with the young people and we try to address all different aspects of their
403 lives' (PInt 3)

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

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

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

411 'Programs need to be 100% active' (PInt 6)

412

413 *Proxy Agency*

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

423 By the same token, service providers recognised their own role as trusted proxy agents acting
424 on the young peoples' behalf and providing social support necessary to enable the young
425 people to achieve a healthy lifestyle *'We are in a position that sometimes the young people*

426 *trust us more than they trust their families and their social workers' (PInt 3)*. Intervention,
427 according to the service providers, should seek to provide support to break the 'spiral' and
428 alleviate existing social problems and, thereby, motivate the young people to value health.

> 429 '... sometimes they have bigger issues to deal with than (health) education, you know. I think accepting
> 430 that and going with the flow, being supportive and being there for them' (PInt 1)

> 431 'It is the support they need, real support in relation to having to beat it (addiction) instead of the
> 432 knowledge behind it (health)' (PInt 4)

433

434 *Collective Agency*

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

> 438 '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
> 439 fault, ain't it? (FG1, P4)

> 440 'In here we all eat together, like, so we usually follow what others are eating' (FG2, P1)

> 441 'Aye, we went to the chippy yesterday and we are all going today for lunch again' (FG2, P3)

> 442 'Like the other night I made me and her spaghetti Bolognese (refers to P5) and wasn't it lovely? (FG3,
> 443 P2)

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

> 447 'They learn a lot from peer education, you know sharing among themselves their experiences' (PInt 2)

> 448 'it 9dietary health promotion) needs to be needs led, it has to be sort of pushed along by the young
> 449 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,

474 1989). Self-efficacy becomes less important in determining expected outcomes in situations
475 in which there is low perceived control. This implies that where food was acquired and
476 prepared by carers, the young people were denied the experience required to instil in them the
477 perceived self-efficacy required to enable them to take control of their dietary needs. Self-
478 efficacy also depends upon whether the environment is imposed, selected or constructed
479 (Bandura, 1997). An imposed environment, such as that experienced by the young people in
480 the care context, was likely to be associated with low perceived efficacy to make food
481 choices. That meals were provided and prepared by others meant that the young people
482 lacked experience, personal, vicarious or otherwise, needed to develop self-efficacy to make
483 food choices.

484 In keeping with other qualitative studies (Holsten et al., 2012; McKinley et al., 2005)
485 availability of food was perceived a major driver of food choice. The high cost of healthy
486 foods relative to junk food rendered junk food more affordable than other options.
487 Reciprocal causation is a concept inherent in SCT which refers to the interaction between the
488 individual and the environment (Bandura, 1989). Accordingly, the young people in this study
489 referred to the proliferation and proximity of fast food outlets and perceived such an
490 environment to undermine efficacy to make alternative choices. Given the notion that
491 efficacy is enabled and constrained by the environment, reciprocal causation would imply
492 that by making healthier food cheaper and more readily available and junk food more
493 expensive and less available it is possible to encourage more healthy food choices. The
494 dispersion of of fast food outlets should be also taken into account when planning
495 intervention to promote healthy eating in unemployed young people. Junk food consumption
496 is more often under the young person's control and tends to be consumed in the company of
497 peers (Fitzgerald et al., 2010; Wouters et al., 2010; Larson and Story, 2009; Larson et al.,
498 2008; Contento et al., 2007; Shepherd et al., 2006). As implied by previous research (Stead et

499 al., 2011; Loannou, 2009; Neumark-Szainer et al., 1999), food consumed outside the home,
500 particularly junk food, could serve as an expression of independence and emerging social
501 identity for the young people. Likewise, the young people in our discussion groups voiced
502 intentions to eat fast/junk food in the company of their friends. This indicates a need to
503 promote dietary health to young people in their social groups.

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

518 The message pervading all discussion groups and interviews was of perceived lack of
519 agency required to adopt and maintain healthier eating habits. The young people expressed a
520 need to become more involved and to be active in their own dietary health intervention,
521 Agency, according to SCT (Bandura, 1989), can be assumed a function of the value of the
522 outcome of the behaviour, perceived control over the behaviour and efficacy to act. Given the
523 'spiral' of interacting factors implicit in the accounts of the young people and explicit in

524 those of the service providers, intervention to promote agency to achieve healthy food choice
525 among unemployed young people should first seek to address financial issues and provide
526 support to alleviate social problems. The way in which healthy eating was promoted to the
527 young people was also considered detrimental to agency. According to SCT behaviour
528 change can be achieved through experience (actual and/or vicarious), verbal persuasion and
529 feedback (behavioural and/or physiological) (Bandura, 1986). The accounts of both the
530 young people and the service providers instead described attempts at dietary health promotion
531 which tended to rely on verbal persuasion to the neglect of experience and consequent
532 feedback. Verbal persuasion is considered a relatively ineffective means through which to
533 achieve behaviour change since it does not enable feedback (Bandura, 1986). Vicarious
534 learning, when others similar to oneself are observed to possess a skill could prove more
535 effective (Bandura, 1986). Being with peers can afford opportunities for vicarious learning
536 and encourage collective agency. Collective agency is defined as the 'shared belief in
537 collective power to produce desired results' (Bandura, 2001: pp14). Agency is maximised
538 where there is congruence between the culture and the approach to behaviour change
539 (Bandura, 2001). The group oriented youth culture expressed in these findings is inherently
540 collectivist suggesting that the young people would respond to food and health interventions
541 which embrace collective agency.

542 It could be argued that in having employed SCT to interpret themes may have been to
543 the detriment of other potentially important perspectives or meanings contained in these data.
544 In conducting a content analysis initially with no prior assumptions and then applying SCT
545 subsequently only once themes were extracted, however, has rendered this unlikely. That
546 other studies that have applied SCT to understanding food behaviour in young people have
547 largely been quantitative (Lubans et al., 2012; Ball et al., 2009; Corwin et al., 1999; Reynolds
548 et al, 1999) renders it difficult to make comparison with those of the current study. Previous

549 quantitative studies that have applied this model to understand food behaviour in socio-
550 economically deprived youth (Lubans et al., 2012; Ball et al., 2009), have indicated that SCT
551 constructs predict higher fat and energy intake and support the notion that unhealthy eating is
552 associated with low self-efficacy. The perceived importance of healthy eating would also
553 appear an important mediating factor in healthy eating behaviour (Ball et al., 2009). Other
554 aspects of SCT, for example, the path between intention to eat healthily and consumption,
555 have not been explained quantitatively (Lubans et al., 2012). SCT has provided an effective
556 means though which to understand young peoples' perspectives on healthy eating and to
557 establish their dietary health promotion needs. The theory has provided a useful 'top-down'
558 framework with which to interpret themes identified in a 'bottom-up' manner with a view to
559 the design of future intervention. Although the young people held notions of healthy eating,
560 SCT assumes that this is not enough and that for healthy dietary change to occur there should,
561 firstly, be some expectation that the behaviour has worth (of value) and, secondly, that the
562 individual has the ability (perceived control and self-efficacy) to execute the behaviour. As
563 the service providers suggested, the young people we researched had neither of these.

564 This study has succeeded in accessing a relatively small, vulnerable and difficult to
565 reach societal group and this is reflected in what could be considered a limited number of
566 focus groups. The extent of provision for this group is also limited, hence, the small number
567 of service providers. The samples were also subject to gender bias such that the young people
568 were mainly male and the providers mostly female and this is likely to have impacted upon
569 responses. It is beyond the scope of a qualitative study, however, to establish in what ways
570 and to what degree numbers or gender may have influenced the findings. Given such
571 limitations, however, this study can only be considered exploratory and indicative of a need
572 for further in-depth qualitative research with this group. Being exploratory, the focus of the
573 study has been on generating rich data with which to build theory for further testing through

574 future in depth qualitative and survey research. The interviews not only allowed the service
575 providers to voice their opinions on the young peoples' dietary health promotion needs, but
576 also helped to broker a relationship of trust with the researcher prior to the discussions with
577 the young people. Further, as the researcher was of similar age to the discussants and could
578 not be considered in authority, she was able to initiate a natural rapport with the young
579 people. A limitation of focus groups as a method of data collection, however, is the tendency
580 for discussion to reach consensus (Strauss & Corbin, 1998). Such an occurrence would be
581 more likely when discussants are known to one another. That our discussants were known to
582 each other, nevertheless, facilitated discussion and provided a unique insight into their food-
583 related health perceptions. The triangulation study design in which service providers
584 corroborated and extended what the young people conveyed, adds weight to the findings.

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

596

597 **Conclusions**

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

617

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743

744 Figure 1

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