

# The Healthy Foundations Lifestage Segmentation

*Research Report No. 2: The qualitative  
analysis of the motivation segments*



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# Acknowledgements

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# Preface

The Healthy Foundations Life-Stage Segmentation Model uses consumer insight to inform local and national health improvement activities. The deeper level of understanding of both motivations and environmental influences provided by the Healthy Foundations survey can also be used when developing capacity to deal with identified local health needs.

Healthy Foundations takes an evidence based approach to understanding some of the population differences that influence behaviour and have an impact on health with a particular focus on health inequalities.

The model is based upon a random sample of 4,928 people across the ages of 16-74 in England, along with 52 focus groups and 45 in-depth immersion interviews. The model identifies five segments of different people with very different health behaviours and attitudes. These are Health Conscious Realists; Balanced Compensators; Hedonistic Immortals; Live for Today's and Unconfident Fatalists.

# Healthy Foundations in Action

There is clear evidence linking the impact of risk-taking behaviours to premature morbidity and mortality. There are also subsequent high costs to the individual, society and the NHS. The Healthy Foundations study has identified significant examples of multiple risk-taking behaviours in the key health segments it has defined. This information has been used to give a better understanding of lifestyles, particularly in the areas of smoking, alcohol and diet.

## The varying healthcare needs of segment profiles

The various segment profiles described in this report require different interventions and services, according to their specific needs.

Any redesign of interventions and services should meet these needs, and help inform workforce planning in the public health sector.

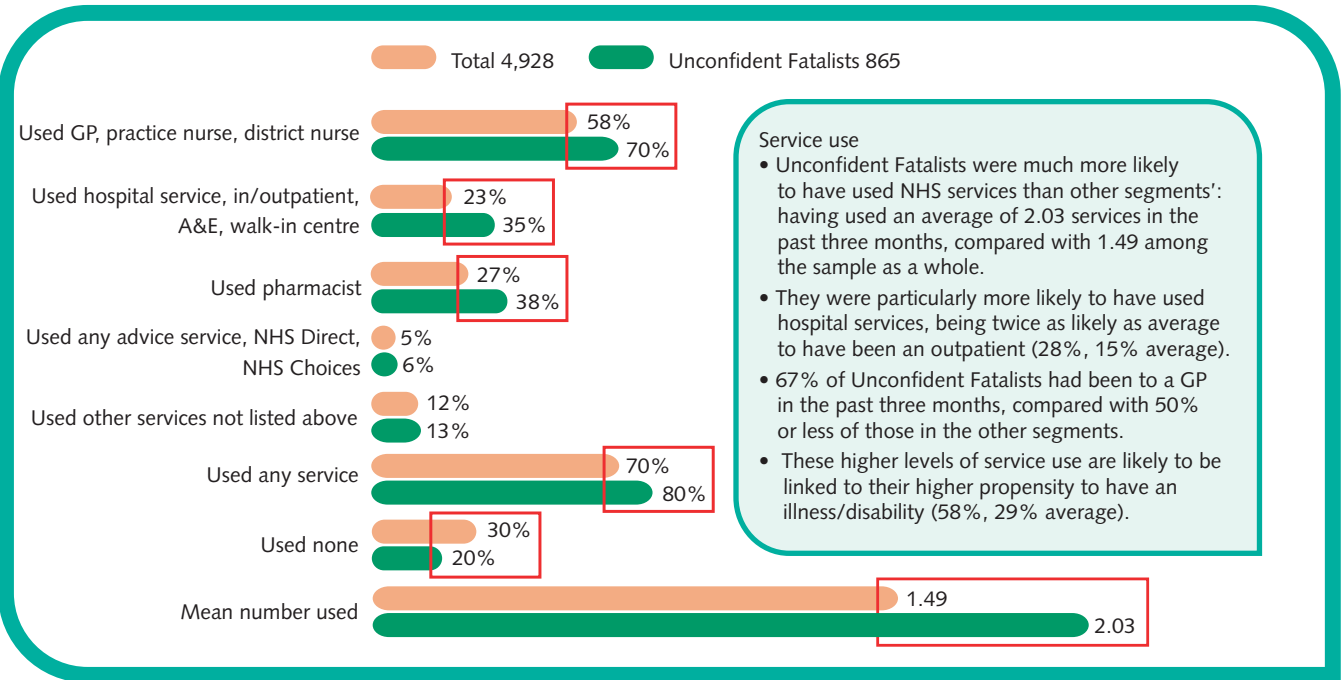
## High impact users

For example, the Healthy Foundations dataset identifies the segment Unconfident Fatalists as:

- living in deprived environments;
- experiencing the lowest confidence to engage in health-seeking behaviours; and
- experiencing the highest incidence of chronic disease.

The service utilisation data from the survey highlights Unconfident Fatalists as significantly greater users of health services. Their uptake of primary and secondary care services also exceeds that of other groups (see figure 1).

Figure 1: Service use for Unconfident Fatalists over three months

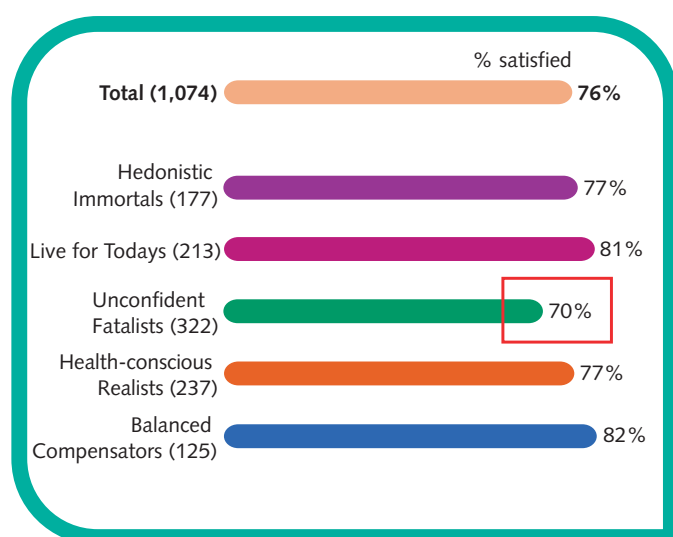


However, despite the evidence of greater service utilisation, Unconfident Fatalists have the worst health outcomes among the segments. They are also less satisfied with the services they have used (see figure 2).

High impact users of secondary care cost the NHS billions of pounds annually. The Healthy Foundations insights offer an understanding of the health-seeking motivations of this group who, despite high presentation to primary care and high recorded chronic disease, are also accessing secondary care.

This intelligence informs the appropriate targeting of interventions by assisting with the reform of services. This includes identifying training needs and the redesign of services, where relevant – resulting in increasingly efficient and cost-effective programmes with improved health outcomes.

**Figure 2: Satisfaction with service use among the heaviest service users**



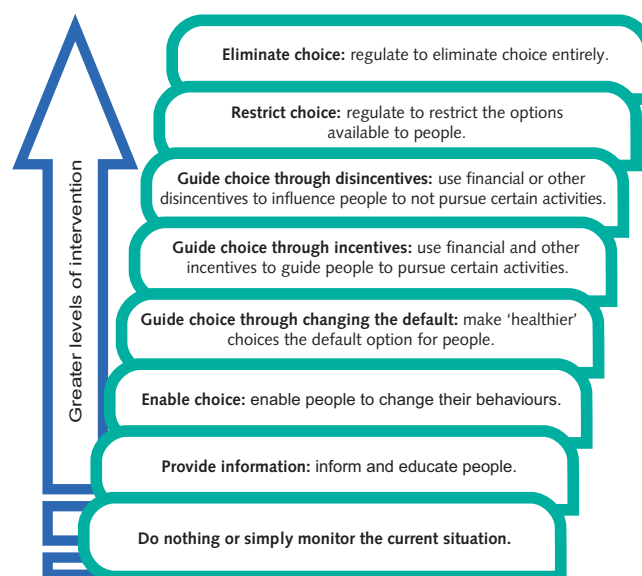
Base: Users of 3+ services in the past three months

## Addressing the training needs of the workforce

It is essential that front-line staff, service providers and health commissioners understand the different interventions required of them. Healthy Foundations health motivation segmentation can be used to aid this, as it clearly illustrates the difference in motivation and intensity of intervention required.

As set out in the public health White Paper, *Healthy Lives, Healthy People*,<sup>1</sup> the Nuffield Council on Bioethics' 'intervention ladder' (see figure 3) is critical in informing the commissioning and delivery of interventions.

**Figure 3: A ladder of interventions**



## Putting 'every contact counts' into practice

Guidance from the National Institute for Health and Clinical Excellence (NICE) recommends an 'every contact counts' approach to accessing behaviour change intervention. This will ensure that there is an appropriate response to public and patient motivational differences.

<sup>1</sup> HM Government, *Healthy Lives, Healthy People: Our strategy for public health in England*, November 2010.

The Healthy Foundations cluster map (see page 24) will be useful for highlighting the difference in health care needs and the response required for successful outcomes.

### A holistic approach to cross-issue working

In addition to data on health status, behaviour and attitudes, the Healthy Foundations survey includes information on psychological concepts such as:

- self-esteem;
- locus of control (the extent to which people believe that they can control events that affect them); and
- personal aspiration.

There is also data on the environmental impact of social and material deprivation on these segments, including information on:

- housing;
- household employment;
- benefits status;
- social capital; and
- views about their neighbourhood.

This variety of information helps build a holistic assessment of people's motivations and their ability to change within their social and economic environments. It also helps us to understand how these factors vary by lifestage – another variable captured in this study. These insights can lead to more effective interventions.

The drivers of poor health-seeking behaviours include:

- low self-efficacy;
- low self-esteem;
- fatalism;
- material and social deprivation; and
- diminished control over personal circumstances.

These factors can lead to other negative-impact behaviours that get in the way of a person's ability to develop social networks, plan for the future, set goals, make pension provision, re-train and develop new skills.

Looking at people's lives in the context of these drivers of behaviour will result in more holistic and successful interventions.

### How motivation can influence behaviour

The Healthy Foundations survey provides a rich insight into how these motivations can influence behaviour.

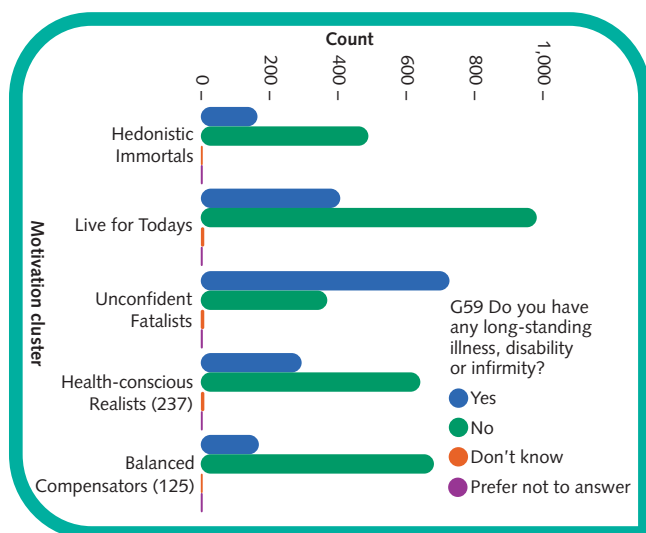
For example, the General Health Questionnaire (GHQ-12), which provides a measure of mental health, was included in the survey. According to this questionnaire, a respondent who scored 4 and above on a 12-point scale could have mental health problems. Analysing this by segment type revealed that over a third of Unconfident Fatalists scored highly on this measure, nearly double the proportion of other segments.

In addition, Unconfident Fatalists from the most deprived areas were most likely to be receiving treatment for depression (data showed that 25% of those from the most deprived areas said they were, compared with 19% of those from the mid-deprivation group).

and 11% from the least deprived areas). Unconfident Fatalists from the least deprived areas were still more than twice as likely as any other segment to say that they were receiving treatment for depression.

In terms of physical health, this segment was also much more likely to report a limiting, long-standing illness and to be receiving disability living allowance (see figure 4).

**Figure 4: Data on long-standing illness, disability and infirmity**



This data shows the strong relationship between personal motivation, material deprivation and mental and physical wellbeing within this segment. As a result, just targeting their current behaviours – e.g. smoking or alcohol use – may not be the best starting point with this group. A higher level intervention, targeting the circumstances that produced these behaviours, would be more likely to result in better health outcomes for them. For example, this could be using cognitive behavioural approaches to improve their self-esteem, encouraging them to undertake positive health-seeking behaviours, coupled with improvements to their social and material circumstances. In addition, improving

this segment's ability to plan for their future and to take more control over their lives will have a positive effect in other areas.

### Targeting the individual as a whole

Generating a holistic understanding of demotivated people living in deprived circumstances is a realistic starting point in developing effective, joined-up interventions which target individuals rather than their risky health behaviours.

The movement of provision of public health to the local authority provides an excellent opportunity to develop a comprehensive and strategic approach to doing this.



# Executive Summary

As a general observation, the qualitative data validate the findings from the quantitative phase of research. Each of the five segments broadly conformed to the motivation profile suggested by the quantitative data.

Equally, however, the qualitative research has provided considerably more detail and depth of insight in relation to the psychological and social dynamics of each segment, as well as clear guidance in relation to possible intervention approaches.

The Healthy Foundations (HF) segmentation increasingly suggests that there is a spectrum of motivation in terms of positive orientation towards healthy behaviour, even though each of the segments presents specific issues in relation to behaviour and attitudes. This spectrum appears to proceed from the Health-conscious Realists (HCRs), who may have the greatest potential to live 'healthily', through the Balanced Compensators (BCs), Hedonistic Immortals (HIs) and Live for Todays (LfTs), culminating in the Unconfident Fatalists (UFs), who perhaps present the most significant challenge for those seeking to improve health outcomes.

The following sections look at each of the five HF segments in turn.

## Health-conscious Realists

Respondents from this segment consistently feel good about themselves; they are independent, self-motivated and comfortable with control and exercising choice. HCRs are realistic, disciplined and goal-driven. This segment is not fatalistic but instead believes that health is the foundation of a good life – and that a healthy life is enjoyable and easy to achieve. These respondents prioritise feeling good about themselves over looking good to others and are typically uninterested in risk-taking, although they enjoy challenges.

This is a strongly resilient segment, which believes that 'tough times' drive personal development and challenges require an independent, stoical response. Consequently, this segment sees itself as in control of health choices. Most believe that they have 'always' been HCRs: 'once an HCR, always an HCR'.

In relation to interventions, this segment is independent-minded and rejects prescriptive or 'nanny-state' interventions. Government involvement in presenting health advice and information is seen as acceptable, but local branding is preferred, even if a service is sponsored by the NHS. They consistently welcomed the idea of health checks, but are very serious about their health and often critical of primary care quality and the lack of a relationship with a GP. This is a segment which recognises that it broadly embraces healthy behaviour and so supports enforced changes



and state interventions which change what they perceive as 'irresponsible behaviour' and do not affect them. Overall, this is a 'hands-off' segment, which sees itself as capable of making health decisions. It can be assisted, but not instructed to try various interventions.

## Balanced Compensators

Respondents from this segment have core goals in terms of looking and feeling good. They have an aspirational outlook, with goal-setting, planning and control over health as norms. BCs are prepared to take remedial action in relation to health and risky behaviour if necessary. This effective, compensatory response to perceived damage produced by risky behaviour is central to the segment's outlook on health.

This is a resilient segment, which believes resilience is the product of both upbringing and strong support networks among family and friends. Therefore, influences are relatively few, since this segment sees itself as largely in control of its health choices. Most believe that they had either 'always' been BCs or emerged from the LfT segment (when they were younger and wilder). Many assume that they will naturally develop into HCRs (even though this segment was viewed as quite unexciting).

In relation to interventions, this segment is strongly affected by factors such as quality of environment and access to facilities. These respondents typically reject prescriptive interventions (for example, the idea of mentoring was received very negatively), and in many cases wanted information only – and to be left to make their own decisions. Wellness is an appealing idea to BCs (the notion of health checks was consistently

welcomed) and a linked approach to health interventions was received positively. Although enforced changes and state interventions which change what they perceive as 'irresponsible behaviour' and so do not affect them are supported, respondents typically resist compulsion and government branding of health advice, and also reject information along these lines. This is a segment which sees itself as able to make its own decisions about health issues.

## Hedonistic Immortals

Respondents from this segment did not see health as a core concern. Pleasure is their priority and the focus is typically on the 'here and now'. HIs feel a disinclination to plan or consider consequences: they embrace risk, feel in control of their health and are uninterested in a healthy lifestyle per se. HIs can be enticed into bad behaviour relatively easily. The HI view of health is relatively compartmentalised, with exercise, diet, avoiding damage and cosmetic factors as the driving considerations. Overlapping bad behaviours seemed common.

This is a segment which *can* show resilience, but often requires support to do so. These respondents are easily distracted and influenced by the social groups that surround them, e.g. support and friendship networks. Respondents typically believe that they are more resilient than they were in the past, but actual behaviour contradicts this view.

In relation to interventions, this segment fundamentally mislead themselves in relation to health status and need a 'wake-up' call in order to initiate change. HIs are strongly affected by factors such as quality of environment and convenient, easy, access to

facilities: they like instant results. They typically support prescriptive state interventions, but not for themselves. HIs want tailored, personalised approaches, with clear goals and targets to achieve, and reject any approach which focuses on 'problems'. Wellness is an appealing idea, and the notion of health checks was welcomed, provided that these are conveniently delivered, personalised and 'fun' in nature. Equally, a linked approach to health interventions was positively received – but some respondents are concerned that tackling too much would inevitably lead to failure. HIs believe support, health advice and information should be presented through a trusted brand (NHS), and that it should be local in delivery and 'enjoyable' in character. Overall, they seemed to need reward-focused incentives in order to consider changing health behaviour.

### Live for Todays

Respondents from this segment typically live in the 'here and now' – there is very little evidence of planning or goal-setting. In the main, LfT lifestyles are chaotic and unstructured; values shift and fatalism is strong. Individuals are typically focused on 'keeping busy', the pursuit of pleasure and presenting a successful face to the world, a social front. Individual control over health is poorly understood, leading to delusional appraisals and assessments. LfTs make few efforts to be healthy and are generally uninterested in health issues.

This is a segment which shows little evidence of resilience in relation to life challenges, with respondents often seeking distraction from problems through risky or damaging behaviour. Equally, LfTs are unreliable judges of their own capacity for resilience, many assuming that they are independent-minded when this is

clearly not the case. Key influences on health behaviours are friends and family. Environment is also important and many LfTs find it hard to distance themselves from their established localities and current social situations. Overall, LfTs are seemingly happy to take significant risks with their health (and more broadly also), but rarely acknowledge this inclination.

In relation to interventions, these respondents are strong supporters of relatively draconian interventions, but not for themselves. There was mild interest in the idea of health checks – on the basis that knowledge may drive change – but this thinking was not well-developed. LfTs find it hard to identify a realistic starting point for change. This segment is expert in generating a 'smoke-screen' around the idea of change. LfTs were, however, interested in interventions which offer structure – since this is seen as a specific weakness in LfT lifestyles. Most like and trust the NHS brand – so interventions should be delivered through local channels, but branded as NHS. Finally, LfTs typically supported a linked approach to interventions, recognising that many of their own behaviours are overlapping and mutually supporting.

### Unconfident Fatalists

Respondents from this segment show a strong focus on the 'here and now', since the future seems daunting. UFs are typically pessimistic, fatalistic in outlook and trying to escape from the problems of everyday life through unhealthy behavioural choices. Most do not believe that they can be either healthy or happy, and they lack any sense of control over health (since illness seems inevitable). All exhibit low self-esteem and general dissatisfaction with their lives, feeling trapped in a vicious circle of psychological problems

and damaging behaviours. Aspirations are low. UFs are often negatively affected by traumatic life events and many demonstrate repetitive and obsessive patterns of behaviour.

This is a segment which shows very little evidence of resilience in relation to life challenges. In many cases respondents try to cope alone and become isolated – leading to withdrawal, eventual inertia, the use of damaging behaviour as a compensatory escape mechanism and depression. Influences on health behaviours were essentially personal in nature – poorly managed stress, low self-esteem, lack of motivation and a depressive outlook all combine to drive (in some cases) compulsive unhealthy behaviour. UFs were easily influenced into adopting negative behaviours by their peers.

In relation to interventions, these respondents are aware of their problem behaviours, but not motivated to make changes. UFs are fundamentally immobile in relation to health status and need a 'wake-up' call in order to initiate change. State of mind is important: stress and depression shape most responses to health challenges and a critical challenge lies in creating an appetite for change among UFs. Overall, UFs are sceptical about state interventions in relation to health, although many UFs clearly believe that compulsion may be the only way to initiate change in their own behaviour.

UFs typically want sensitively handled, tailored, personalised approaches, with clear goals and plenty of ongoing support and monitoring. This segment is timid and frequently 'backs off' from services – and only NHS primary care seemed to offer a realistic starting point for change. Equally, it is important for UFs to see that similar 'people like me' are engaged with any health interventions. UFs, however, are typically inclined to respond negatively; so, since many like and trust the NHS brand, interventions should be delivered through local channels, but branded as supported and funded by the NHS.

### Summary of intervention approaches for each segment

Intervention	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
<b>Context: their health motivations</b>	This group recognises the need for change. Need to address low levels of self-esteem, fatalism, lack of control and motivation, and low mood through high-intensity intervention. This group does aspire to lead a healthy lifestyle.	This group lives in the present, with a fatalistic, short-term outlook. Unhealthy behaviours are a response to stress, escapism or lack of planning. This group lacks self-reliance and does not recognise a need for change. Needs high-intensity intervention.	Reducing negative risk behaviour must be associated with enjoyable aspects of healthy behaviour, through medium-intensity interventions. Anything enjoyable is perceived as 'healthy' regardless of the risk or outcome.	Enhancing health and wellness is important to this group, who are aware of multiple health issues and responsive to messages highlighting the risky behaviour they sometimes engage in. This group engages in 'compensatory' health behaviours. Medium/low-intensity intervention needed.	In control of their health, this group feels they are healthy, with high levels of resilience and independence. They perceive no need to compensate for risks, as they do not take them often enough. Low-intensity intervention needed.
<b>Approach</b>	Present change as worthwhile. Support/hand-hold, take small steps and tackle mental health issues.	Ongoing monitoring, mentoring, evaluation, hands-on or practical approaches are best.	Tailored information reflecting their priorities. 'Sell' positive links between health and their lifestyle.	Encouragement to maintain positive behaviour and awareness that the risky behaviour may not be compensated for by compensatory behaviours.	Non-prescriptive approach. 'Maintain wellness' rather than prevent illness. Primary care setting preferred.
<b>Personal interventions</b>	Behaviour change supporting a private one-to-one environment. Packaged support sensitive to needs: psychological interventions, e.g. IAPT (Improving Access to Psychological Therapies) Programme, then introduced to lifestyle. Structured single-issue programmes. Free health checks.	Health check – explicit personalised 'real status' away from a health setting to increase personal knowledge. Peer-led interventions such as health trainers.	External trigger/ wake-up call. Personal and clear advice related to specific need. Incentives, e.g. free gym pass for completion of health diary.	Health check available across gyms, primary or secondary care. Mentoring rejected by this group; however, they welcome advisory roles for behaviour change with their own friends. Supported self-management materials.	Wellness health check outside medical/ill-health context, e.g. local authority well-being service. Personal and clear advice. Supported self-management materials.

## Summary of intervention approaches for each segment

Intervention	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
<b>Format – multiple or single-issue approach</b>	Co-ordinated approach to multiple issues, but considering each issue in a staged approach. Each single issue should then be delivered in a structured format.	Co-ordinated approach to multiple issues, but considering each single issue on a stage-by-stage basis. Each single issue should then be delivered in a structured format.	Multiple health issues approach understood. Individual support to empower and set goals that include rewards, celebration and enjoyment, e.g. physical health and good looks.	Multiple health issues approach understood – but have to be health issues of concern to them, e.g. no point bundling other issues with anti-smoking advice as most of them don't smoke. Non-prescriptive approach as segment will be proactive regarding healthy behaviours. Facilitate signposting of individual support for lifestyle interventions delivered away from medical settings.	Multiple health issues approach. Non-medical, facilitative approach building on their existing positive attitudes and behaviour.
<b>Community/ environmental interventions</b>	Lack of desire/ motivation to utilise.	Strong support for these interventions but not motivated to utilise.	Regeneration and environmental interventions, including cycle lanes and parks.	Value positive environment, facilities and infrastructure that support a healthy lifestyle. Regeneration, cycle lanes.	Environmental interventions, including cycle lanes and parks.
<b>Facilities</b>	Lack of desire to utilise facilities.	Affordable facilities desirable but require support to plan and structure lifestyle. May be signposted to as part of co-ordinated approach to issues (once they have acknowledged their need to change).	Gyms and enjoyable activities, e.g. dance.	Affordable/free gyms, swimming, family/friend fun days. Community events, e.g. Olympics and health events.	Activities for the family.

### Summary of intervention approaches for each segment

Intervention	Unconfident Fatalists	Live for Todays	Hedonistic Immortals	Balanced Compensators	Health-conscious Realists
<b>Communications</b>	<p>NHS branding.</p> <p>Peer testimonials by others who can demonstrate how 'people like us can change'. (Risk message must be supported by intervention offer.)</p>	<p>Government/NHS branding.</p> <p>Believe GP best source of health advice. Need clear advice to understand and acknowledge need for change.</p> <p>Peer testimonials by others who can demonstrate how 'people like us can change'. Need to clarify behaviour risk levels and need for change before embarking on intervention.</p> <p>Information on short-term/current risk, supported by a gym fitness plan.</p>	<p>Government/NHS branding.</p> <p>Communications around physical appearance (e.g. smoking and tooth loss) and messages that stress the pleasure of pursuing healthy behaviour.</p> <p>More likely than other segments to express a preference for more 'informal' sources of information about health and lifestyle, such as family, friends, newspapers, magazines and websites. Services need to be 'sold' to this segment.</p>	<p>Government/NHS branding not appropriate and needs to be local.</p> <p>Wellness messages.</p> <p>Clear signs and information on local facilities are important, as segment will respond once aware of availability.</p>	<p>Government/NHS branding not appropriate and needs to be local.</p> <p>Information availability rather than prescriptive messages, focusing on control and individual free ability/choice to respond to information and set goals as a result.</p>
<b>Engagement</b>	<p>Face-to-face engagement through known/trusted channels.</p>	<p>Won't 'shop around' for information/advice, so need to go to them. Friends are viewed as positive influencers.</p>	<p>Prefer to be engaged through multiple channels/influencers.</p>	<p>Already engaged with health, so prefer facilitation through a range of sources building on their existing positive attitudes and behaviour. In control of own health, prefer to search for own information via internet, friends and family.</p>	<p>Already engaged with health/services, so prefer facilitation-based approaches building on their existing positive attitudes and behaviour.</p>
<b>Service utilisation and satisfaction</b>	<p>Heavy utilisation (but least satisfied service users). Highest levels of ill-health/lifestyle illnesses.</p>	<p>Low level of service use (despite some health issues). This includes low levels of screening attendance. Average levels of satisfaction.</p>	<p>Average levels of service use and satisfaction.</p>	<p>Very low levels of service use (but they are the healthiest group). Average levels of satisfaction.</p>	<p>Average levels of service use, despite older age. Average levels of satisfaction.</p>



# 1 Introduction and Background to the Healthy Foundations Programme

This report presents the full findings from an in-depth qualitative research project undertaken by Research Works Ltd in 2009. The research was commissioned as part of the Department of Health's (DH) Healthy Foundations Programme which has developed a segmentation of the adult population of England based on behaviour, attitudes and lifestyle. As with all good segmentations, the Healthy Foundations Programme provides a powerful tool in understanding subgroups of the population and focusing resources where they are most needed. Segmentation approaches which go beyond demographics and factor in attitudinal and psychographic data (a person's overall approach to life, including personality traits, values and beliefs) produce a more rounded picture of individuals and are a good starting point for developing tailored interventions.

When segmenting a population, the aim should be to define a small number of groups so that all members of a particular group are as similar to each other as possible and are as different as possible from the other groups. A good segmentation should:

- build on current knowledge;
- provide a language for understanding people;
- add value and greater sophistication when developing and targeting interventions; and
- not be too complicated and should be accessible to local practitioners who should be able to re-create the segments in their own research.

With these guidelines in mind, DH has developed a segmentation of health-related attitudes and behaviour.

Over the past two years, a number of research studies have been conducted to construct the segmentation. These have included:

- reviews and consultations with internal DH staff, strategic health authority (SHA) and primary care trust (PCT) representatives, public health research experts, marketing segmentation experts, statisticians and social researchers from the public and private sectors; and

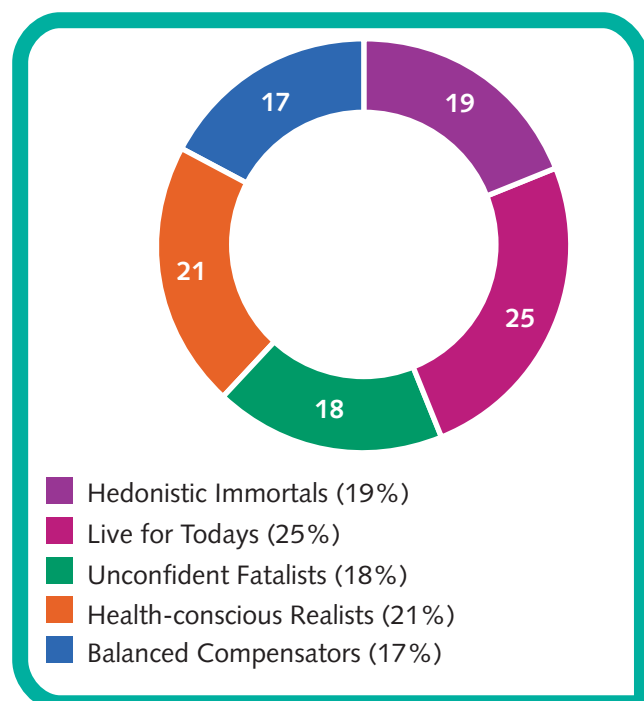
- a large-scale quantitative survey (a random sample of 4,928 people aged 12–75 years in England) to construct and size the segments; the results and analysis from the quantitative survey generated the segment definitions.

## The motivation segments

The survey research data (described in the quantitative report) was subjected to a cluster analysis which identified five key segments as shown in figure 1.1.

These groups can be found within every social stratum in society – from the most deprived to the most affluent. A fuller qualitative and quantitative description of each segment can be found in the research reports available on the DH website.

**Figure 1.1: The five motivation segments**



Brief descriptions of each group are given in the 'pen portraits' that follow.

### Unconfident Fatalists

Overall, they feel fairly negative about things, and don't feel good about themselves. A significant proportion feel depressed. They feel that a healthy lifestyle would not be easy or under their control. Generally, they don't feel in control of their health anyway. They are quite fatalistic about health and think that they are more likely than other people of the same age to become ill. Their current lifestyles aren't that healthy, and their health isn't currently as good as it could be. They know that their health is bad and that they should do something about it, but feel too demotivated to act.

### Live for Todays

They definitely like to 'live for today' and take a short-term view of life. They believe that whatever they do is unlikely to have an impact on their health, so 'what's the point?'. They tend to believe in fate, both where their health is concerned and for other things in life. They value their health but believe that leading a healthy lifestyle doesn't sound like much fun, and think it would be difficult. They don't think they are any more likely than anyone else to become ill in the future. They tend to live in more deprived areas which gets them down, and they don't feel that good about themselves, but they feel more positive about life than the Unconfident Fatalists. They are the segment who are most likely to be resistant to change and don't acknowledge that their behaviour needs to change, unlike the Unconfident Fatalists.



### **Hedonistic Immortals**

These are people who want to get the most from life and they don't mind taking risks – as they believe that this is part of leading a full life. They feel good about themselves and are not particularly motivated by material wealth or possessions, or how they look. They know that their health is important to avoid becoming ill in the future, but feel quite positive about their health at the moment and don't think they'll be becoming ill any time soon. Maybe because of that they don't really value their health right now. They are not fatalistic about their health and don't have a problem with leading a healthy lifestyle, believing that it would be fairly easy and enjoyable to do so. They say they intend to lead a healthy lifestyle. However, they feel that anything that is enjoyable, such as smoking and drinking, cannot be all bad.

### **Health-conscious Realists**

These are motivated people who feel in control of their lives and their health. They generally feel good about themselves, but have more internally focused aspirations to better themselves, learn more and have good relationships, rather than just aspiring to looking good and acquiring wealth. They tend not to take risks and take a longer-term view of life, and that applies to their health too. Their health is very important to them, and they feel that a healthy lifestyle is both easy to achieve and enjoyable. They also take a realistic view of their health: of all the segments, they are the least fatalistic about their health, and don't think they are any more or less likely than other people to become ill. Unlike the Balanced Compensators, they don't use compensatory mechanisms. This may be because they are so health conscious that there's no need for them to balance out health behaviours.

### **Balanced Compensators**

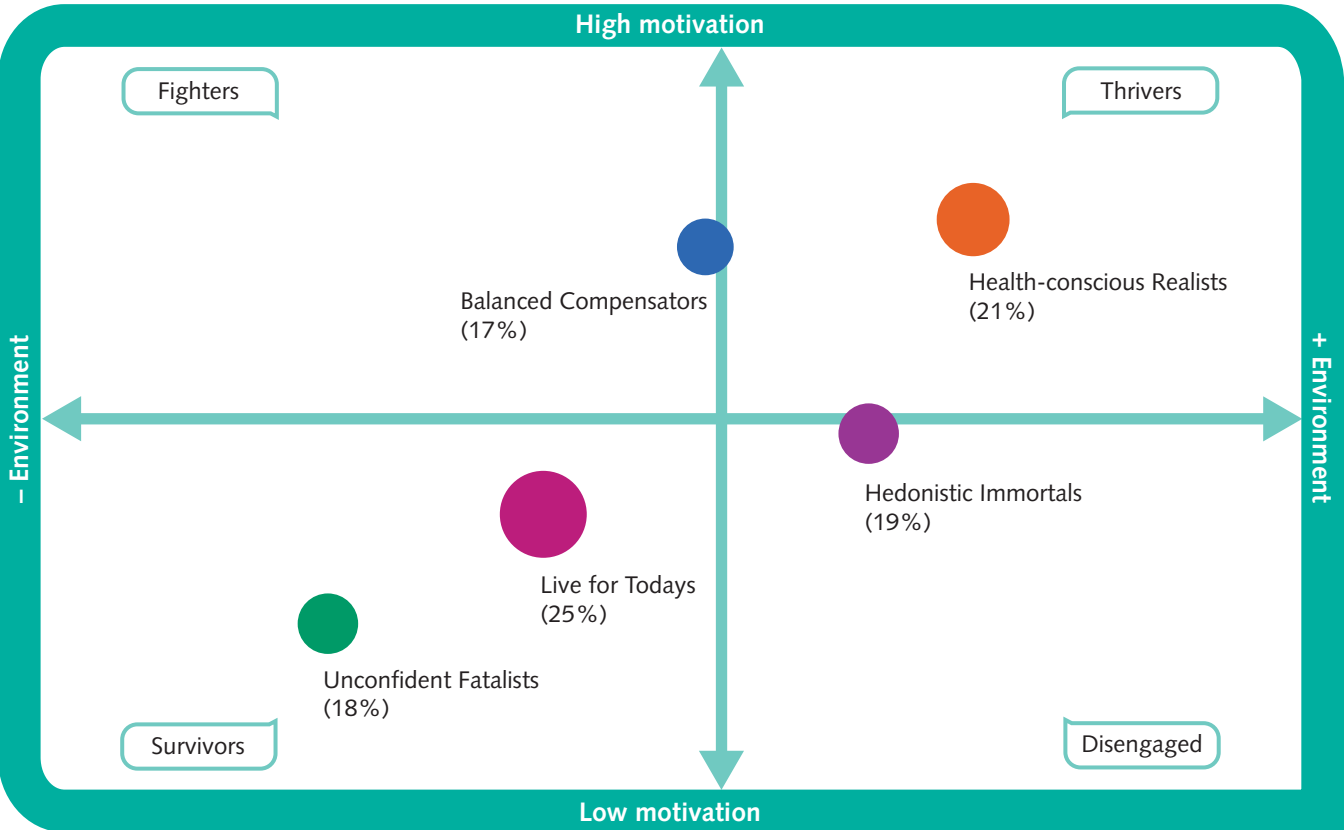
They are positive and like to look good and feel good about themselves. They get some pleasure from taking risks. However, they don't take risks with health. Health is very important to them, and something they feel in control of. A healthy lifestyle is generally easy and enjoyable. They are not fatalists when it comes to health and understand that their actions impact on their health both now and in the future. They believe they are much less likely to become ill than their peers. If they do take some health risks, they will use compensatory mechanisms to make up for this, such as going for a run in the morning having eaten a big meal or drunk too much the night before.

Figure 1.2: Summary of motivational differences between the motivation segments

Motivational construct	Segment				
	Health-conscious Realists	Balanced Compensators	Live for Todays	Hedonistic Immortals	Unconfident Fatalists
Value health	High	High	Med	Low	Med
Control over health	High	High	Med	Med	Low
Healthy lifestyle is easy/enjoyable	High	High	Low	Med	Low
Health fatalism	Low	Med	High	Low	High
Risk-taking	Low	High	Med	High	Med
Short-termism	Low	Med	High	Low	High
Self-esteem	High	High	Med	High	Low

Key  More positive motivation  More negative motivation

Figure 1.3: A cluster map of motivation segments



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)

## Analysis by deprivation

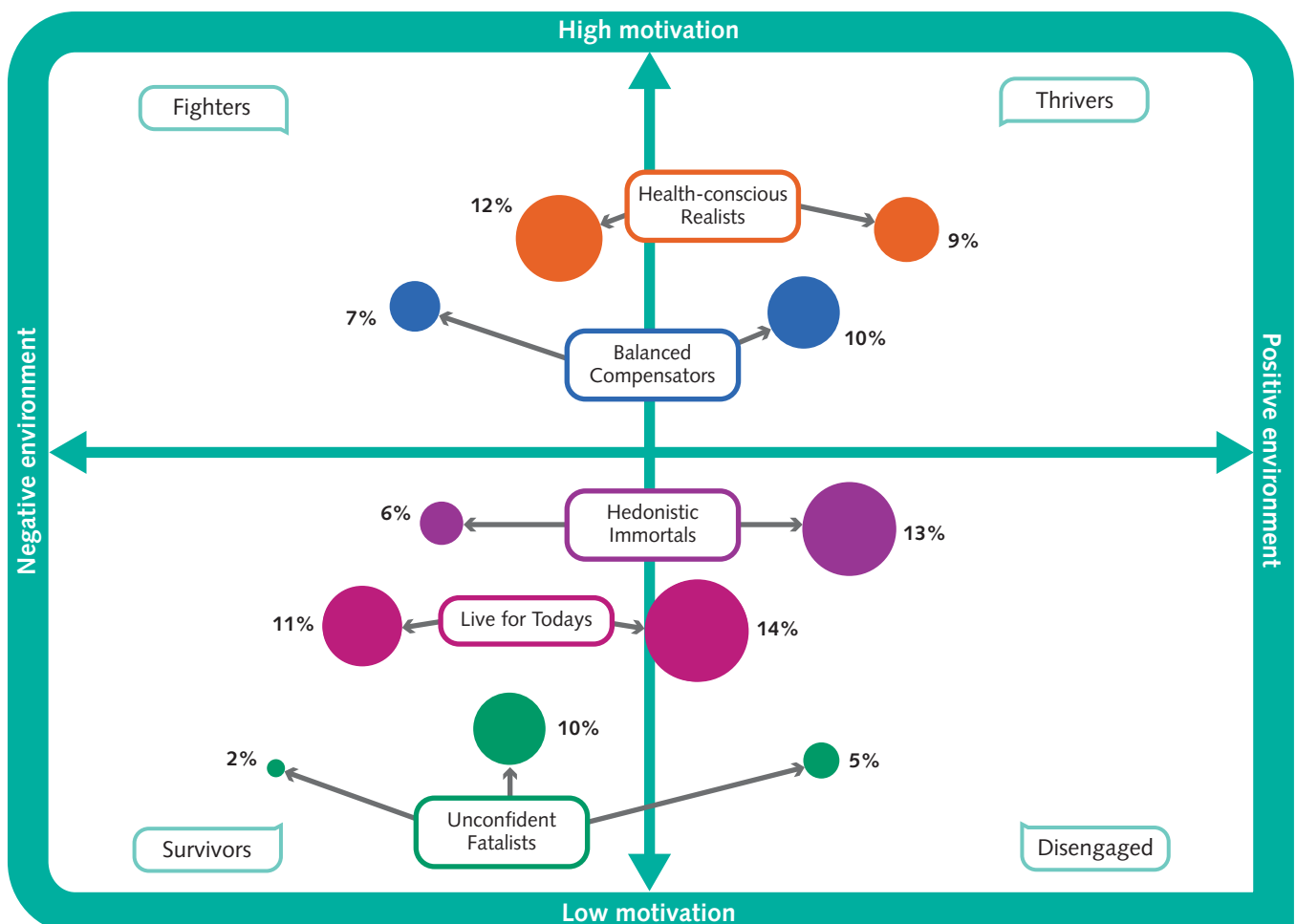
These five segments are present in all areas of England, including the most affluent and the most deprived areas. The five segments have been further divided by levels of deprivation, using the Indices of Multiple Deprivation (IMD), resulting in 11 distinct segments (see figure 1.4).

The percentages next to each segment bubble represent the percentage of the adult population in England. Even the smallest segment – the Unconfident Fatalists living in the most deprived areas of England – represents approximately 800,000 adults aged 16–74 (2% of the adult population).

The segmentation captures the dynamics between an individual's personal motivation to live healthily (the **motivation** dimension of the segmentation) and how these motivations vary within the context of their social and material circumstances (the **environment** dimension of the segmentation). The segmentation also captures the variation in these measures by lifestyle.

Looking at figure 1.4, the quadrant names 'fighters', 'survivors', 'thrivers' and 'disengaged' summarise the general state of the segments within each quadrant.

Figure 1.4: Dividing the motivation segments by Indices of Multiple Deprivation



**Survivors** (Hedonistic Immortals, Live for Todays and Unconfident Fatalists living in more deprived areas) tend to be people living in negative health environments who have a lower level of motivation to look after their health. Within this group there will be many people with unhealthy behaviours, and a higher proportion than average will have poor health. Their position on the motivation scale indicates that they feel less control over their health and have less confidence in their ability to do anything about improving it or preventing ill-health. Their position on the environment dimension indicates that they will be living in more deprived circumstances, which will make it more difficult for them to change their lifestyle. Moreover, in some of the most deprived communities in England, the social norms make it difficult for those wishing to change. For example, levels of smoking prevalence can be over 50% in some areas, making the process of giving up much more difficult. If one of the main purposes of segmentation is to target resources where they are needed, then these segments would clearly be a priority for appropriately tailored interventions and services.

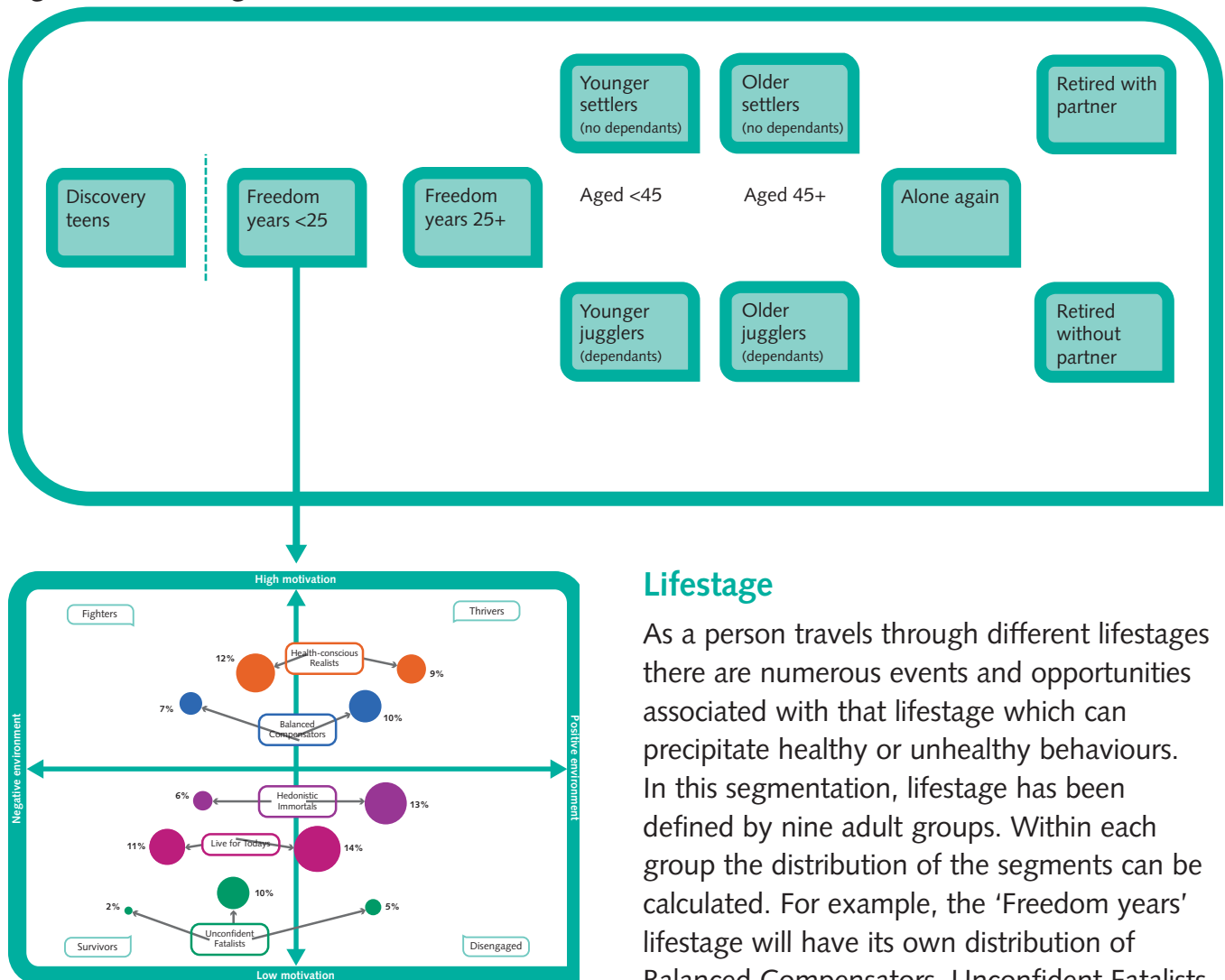
**Fighters** (Health-conscious Realists and Balanced Compensators living in poor areas) are people living in negative health environments, but who are standing above their norms and have a higher level of motivation to look after their health. These segments live in the same conditions as the 'survivors' group; indeed, some of them may be in the same family. There may be a number of reasons why they have managed to maintain a healthier lifestyle and exhibit a degree of resilience to the deprivation surrounding them. Whatever the reasons

which emerge from research, this group has great potential to influence their 'survivor' group peers.

**Disengaged** (Hedonistic Immortals, Live for Todays and Unconfident Fatalists who are living in less deprived areas) are people living in more positive health environments who, for a range of reasons, have a low level of motivation or ability to look after their health.

**Thrivers** (Health-conscious Realists and Balanced Compensators who are living in less deprived, more health-positive environments) are people who have a higher level of motivation to look after their health and feel more able to do so. They are surrounded by the resources and positive norms to help make that happen.

Figure 1.5: Lifestage



## Lifestage

As a person travels through different lifestages there are numerous events and opportunities associated with that lifestage which can precipitate healthy or unhealthy behaviours. In this segmentation, lifestage has been defined by nine adult groups. Within each group the distribution of the segments can be calculated. For example, the 'Freedom years' lifestage will have its own distribution of Balanced Compensators, Unconfident Fatalists, and so on.

## A national or a local-level segmentation?

The segmentation was initially designed to be used at national level but, as the project developed, additional tools and resources have stretched its application for use at local level.

## The Healthy Foundations tools and resources

### The online reporting tool

The online reporting tool is a web interface which displays the data in an accessible form and permits the user to conduct their own analysis by region, lifestage and motivation segment.

### Reports and summaries

This document is the report of the qualitative survey and provides the background to all of the Healthy Foundations work. A large scale quantitative study, which was used to construct the segmentation, was conducted prior to this report. A full report on the quantitative findings can also be found on the NSMC/One Stop Shop website. A summary of all the Healthy Foundations projects is also available online.

### Synthetic estimates

Applying the same methodology as the Health Survey for England, synthetic estimates of the distribution of the segments within a local area will be calculated.

### The allocation algorithm – ‘the profiler’

The original questionnaire for this study was just over an hour long. Using just 19 questions from the study it is possible to allocate respondents to one of the five motivation segments to an accuracy of 88%. Using just six questions it is possible to allocate respondents to one of the five motivation segments to an accuracy of 67%. Either of these small questionnaires can be added to existing national and local health and lifestyle questionnaires to identify the segment grouping for each respondent (see appendix 13).

### The Target Group Index

The existing one-hour questionnaire, while having many useful attitudinal and behavioural measures, cannot cover all aspects of people's health and lifestyles. To augment the Healthy Foundations survey, the data has been fused with the Target Group Index (TGI) survey. TGI is a large-scale consumer survey which has been in operation for over 20 years and which provides insight into consumer buying behaviour, consumption of media, what people do in their spare time, etc. Fusing the Healthy Foundations survey with TGI will help build up a more holistic view of people's lives.

### Geodemographics

Another way to augment the existing data set and add more detail to the resulting segments is to merge the data set with a geodemographic tool. As postcode data is collected for each individual, this can be the bridge to profile people by geodemographic variables. Several new projects are aiming to combine the Healthy Foundations segmentation with existing geodemographic data sets such as MOSAIC, ACORN, People and Places and OAC to further enhance the geographic targeting of segments at local level.

### Training

A nationwide regional training programme was rolled out between April and June 2010.

## The qualitative study

While the survey provided considerable quantitative detail on the attitudes and behaviour of each segment, it was necessary to develop an even more in-depth understanding of the segments to analyse the barriers to change as well as to explore the possibilities for action and development. A large-scale qualitative study was commissioned to advance the understanding of the segments and to provide actionable insights to assist practitioners in using the segmentation in their health improvement activities. The remainder of this report describes the findings from the qualitative study.

## 2 Research Objectives

The objectives for the qualitative research were to:

- complement the quantitative data and explore in more depth the relationship between lifestage, Index of Multiple Deprivation and personal motivations across the segments;
- develop a more in-depth, citizen-centric, holistic view of the motivation, lifestyles and behaviour of each segment 'in their own words' and 'through their eyes';
- seek to understand the reasons for an individual falling into entrenched patterns of poor health-related behaviour and attitudes;
- examine people's general attitudes towards life and to discover their priorities and aims;
- explore attitudes towards health in general and to discover what people perceive as constituting 'health';
- gain in-depth perceptions of 'health' in people's day-to-day lives, including where health fits into their overall outlook and view of life;
- explore the concept of resilience;
- explore the relevance of the key constructs of motivation in people's lives, such as: fatalism and self-efficacy, short-termism, risk-taking, self-esteem and levels of aspiration;
- understand more about how social norms form and operate to provide barriers or leverage for behaviour change;
- gain insight as to people's views of what health interventions can do for them in terms of, for example, costs, benefits and possible drawbacks;
- provide general guidance as to the efficacy (or otherwise) of multiple health-related issue interventions; and
- test the efficacy of potential intervention strategies and their uses.



# 3 Method and Sample

An iterative and multi-method approach was undertaken, which involved two phases:

- focus group sessions; and
- immersion depth interviews and video 'pen portraits', filmed simultaneously.

For detail about the recruitment of the sample, see section 4.

## 3.1 Focus groups

Fifty-two focus groups were conducted over three months, broken down across the sample as follows:

- **14 Balanced Compensators:** Liverpool, Croydon, St Albans, Exeter, South London, Norwich and Slough;
- **10 Live for Todays:** Newcastle, Leeds, Sheffield, St Albans and Central London (respondents from Lewisham);
- **10 Unconfident Fatalists:** Durham, Newcastle, Birmingham, Brighton and Norwich;
- **10 Hedonistic Immortals:** St Albans, Lewisham, Croydon, Leeds, Birmingham, Hull, Brighton and Slough;
- **8 Health-conscious Realists:** Hull, Bristol, Brighton, Manchester, Nottingham and St Albans.

Groups of between two and eight respondents were undertaken (with an average of six

attendees in each session). All lifestages and Index of Multiple Deprivation (IMD) areas were represented across the segments (see section 3.3 for a full breakdown of the sample including attitudinal segment, IMD, lifestage and gender).

This approach gave a robust sense of the shared characteristics of each Healthy Foundations (HF) sample segment and their perspective on the world around them while allowing enough research 'space' to achieve a reasonably detailed understanding of each individual respondent.

The development of topic guides was a rigorous process. Initially, topic guides were developed to cover all themes in the questionnaire. When piloted, however, it made for an overly long guide with groups taking up to three hours to complete, well beyond an ideal focus group length (see appendix 1 for the latest version of this pre-pilot guide).

As a result, the topic guides were reviewed and amended to make them more focused and fruitful in terms of responses and data generated. The guides were significantly shortened and a further series of exercises and stimuli were used to generate findings.

The following test of the topic guides found groups much more productive, with respondents more engaged and able to formulate meaningful answers.

Throughout the discussion (see appendices 2–6 for the topic guides used for each section),

interactive exercises were used to explore attitudes and behaviours as follows.

- A verification exercise (see appendices 7–11) made it possible to explore the key attitudes of each HF segment by asking how respondents felt about a series of attitudinal statements typical of their segment, as well as some which are descriptive of the others. This was helpful in establishing personal meanings and sets of attitudes across segments. Insight was also gained into how and why respondents did not share the same attitudes and behaviours of other HF segments.
- A 'key life events' exercise enabled issues such as resilience to be explored (see appendix 12 for the stimulus). The exercise also illuminated the ways in which respondents' belief frameworks affected behaviours and choices, and clarified how specific events had influenced the development of attitudes.
- All respondents were asked to complete a health diary for the seven days prior to attending the focus group session. Entries focused on health decisions, but also explored what respondents might see as significant health-related influences. In this way, health behaviours were registered as they occurred (as opposed to recalled reporting, which is the method more typical of a focus group setting) and this allowed an exploration of the motivations underlying many aspects of health decision making. The diary approach also encouraged respondents to reflect on their own behaviour and this clearly assisted them to develop a clearer understanding of the gap between perceptions and actual behaviour.

- Five separate focus group guides were developed (one for each segment) to account for differences across segments, although the core structure of the guide remained intact so as to gather comparative data.

### 3.2 Filmed immersion interviews

Following the focus group stage of the research, nine respondents from each HF segment were selected to participate in immersion depth interviews, with 45 immersion interviews completed in total. Six per segment were selected on the basis that they best exemplified the core characteristics of the particular HF sample segment. The remaining three respondents explored more 'peripheral' cases: these were respondents who, for example, exhibited general attitudes and behaviours of their segment while overlapping with another segment to a degree.

All participants in the filmed immersion interviews were judged capable of participating effectively in an extended immersion depth interview situation after observing their participation in a focus group. For example, respondents were required to be literate, as the immersions involved reading a written stimulus. In addition, respondents chosen were relatively eloquent and able to express their views coherently. In order to conduct the immersion depth interviews, researchers spent approximately half a day with selected respondents in their household, observing their lifestyle, health behaviours and attitudes, as well as environment factors e.g. the neighbourhood and the perceived quality of the environment, for instance, the amount of green spaces available in the area, where respondents could walk and/or take exercise.

The immersions explored recurring issues from the focus groups. They enriched the data by focusing upon one individual to gain information that was too sensitive to capture in focus groups – for example, about risky sexual behaviour, drug use and living conditions. In addition, further research questions generated by the focus groups were answered in the immersions.

After the analysis and delivery of findings for the focus group stage of each HF segment, the data was examined with the DH project team before proceeding to the immersion interview phase of research. This meant it was possible to revise and input further segment-specific issues into the topic guides used per segment. As with the focus group guides, five separate immersion interview guides were developed by including questions and issues that had been salient to a specific segment in order to allow for differences within each segment, although the overall core structure of the guide was retained.

Broadly, the additional areas explored in the immersion interview were as follows.

- **Resilience:** This topic was explored in detail in the focus groups. The immersions aimed to explore how respondents compared to their family and friends, and how they are different to those who have gone off the rails.
- **Norms/social influences:** The focus groups illuminated the influence of peers and in particular of upbringing on health choices, so this was explored in more detail in the immersions.
- **Segment movement:** Respondents discussed at what point they began to act like other people in their segment, what made this happen, and how they made the transition into their segment (if they had made a transition). This section of the discussion also explored what segments respondents believed they belonged to previously and what they might become in the future.
- **Attitudes towards other segments:** Respondents compared themselves with other segments and their views of other segments were explored. This included a discussion about which segments their family and friends were in, and with whom respondents were most comfortable spending time.
- **Interventions:** In addition to the health checks and single versus linked approach materials previously covered in the focus groups, respondents were prompted with a range of different intervention styles.
- **Sources of advice/support/information:** Respondents were asked who should provide the services they favoured.

Specific segments also had tailored themes:

- Balanced Compensators were asked more information about risk-taking, in order to explore whether any additional risks were taken than those reported in the groups. In addition, they were asked about the idea of mentoring less motivated groups than themselves;
- Live for Todays' self-esteem was explored in a more direct manner, as was the influence of stress. Risk-taking was also broached again. The idea of a 'realistic starting point' for this segment to become engaged in their health/services was explored. Responses to cognitive behavioural therapy (CBT) as an intervention and previous uses of services were also discussed;
- Unconfident Fatalists were also asked about a 'realistic starting point' and their previous use of services, and CBT. Motivation and stress were also explored;
- Hedonistic Immortals were asked about motivation and risk-taking;
- Health-conscious Realists were asked about their current or previous interactions with GPs or mainstream services because of indications from the focus groups that they did not readily engage with services.

Two pilot immersions were undertaken for each segment, so that the project team could review the effectiveness of the topic guide. After each pilot, the team suggested additional questions or alterations to the guide.

The final filmed output comprises a DVD containing clips from each segment to illustrate key findings. In addition, the clips are available

as audio visual files that can be used for training purposes or as part of internal DH presentations. As the immersions were undertaken according to the Data Protection Act 1998 and respondents were informed that the research will remain confidential, this tool is not for public use. The data is only to be used by DH internally.

### 3.3 Sample

The full sample structure is given in the subsections below.

#### 3.3.1 Balanced Compensators – 14 groups

1. Freedom years, under 25, male, IMD 1–3
2. Freedom years, under 25, female, IMD 1–3
3. Freedom years, under 25, male, IMD 4–6
4. Freedom years, under 25, female, IMD 4–6
5. Younger jugglers, male, IMD 1–3
6. Younger jugglers, female, IMD 1–3
7. Younger jugglers, male, IMD 4–6
8. Younger jugglers, female, IMD 4–6
9. Older settlers, male, IMD 4–6
10. Older settlers, female, IMD 4–6
11. Alone again, male, IMD 1–3
12. Alone again, female, IMD 1–3
13. Alone again, male, IMD 4–6
14. Alone again, female, IMD 4–6

### 3.3.2 Live for Todays – 10 groups

15. Freedom years, under 25, male, IMD 1–3
16. Freedom years, under 25, female, IMD 1–3
17. Freedom years, under 25, male, IMD 4–6
18. Freedom years, under 25, female, IMD 4–6
19. Younger jugglers, male, IMD 1–3
20. Younger jugglers, female, IMD 1–3
21. Younger jugglers, male, IMD 4–6
22. Younger jugglers, female, IMD 4–6
23. Alone again, male, IMD 4–6
24. Alone again, female, IMD 4–6

### 3.3.3 Unconfident Fatalists – 10 groups

25. Freedom years, under 25, male, IMD 3–5
26. Freedom years, under 25, female, IMD 3–5
27. Younger jugglers, male, IMD 1–2
28. Younger jugglers, female, IMD 3–5
29. Younger jugglers, male, IMD 6
30. Younger jugglers, female, IMD 6
31. Older settlers, male, IMD 3–5
32. Older settlers, female, IMD 3–5
33. Alone again, male, IMD 6
34. Alone again, female, IMD 6

### 3.3.4 Hedonistic Immortals – 10 groups

35. Freedom years, under 25, male, IMD 1–3
36. Freedom years, under 25, female, IMD 1–3
37. Freedom years, under 25, male, IMD 4–6
38. Freedom years, under 25, female, IMD 4–6
39. Younger jugglers, male, IMD 1–3
40. Younger jugglers, female, IMD 1–3
41. Younger jugglers, male, IMD 4–6
42. Younger jugglers, female, IMD 4–6
43. Alone again, male, IMD 4–6
44. Alone again, female, IMD 4–6

### 3.3.5 Health-conscious Realists – 8 groups

45. Younger jugglers, male, IMD 1–2
46. Younger jugglers, male, IMD 3–6
47. Younger jugglers, female, IMD 3–6
48. Older settlers, female, IMD 1–2
49. Older settlers, male, IMD 3–6
50. Older settlers, female, IMD 3–6
51. Alone again, male, IMD 3–6
52. Alone again, female, IMD 3–6

The immersion interviews undertaken represented a range of lifestages and IMD areas for each segment. In addition to the nine immersions for each segment, the following immersions for Unconfident Fatalists were conducted:

53. Alone again, male, IMD 6, **Norwich**

54. Alone again, male, IMD 6, **Norwich**

55. Alone again, female, IMD 6, **Newcastle**

56. Alone again, female, IMD 6, **Newcastle**

These were undertaken to explore whether environment (in addition to IMD) had an impact on the poor health behaviour of Alone again men, as opposed to Alone again women whose behaviour appeared to be healthier.



## 4 Sampling/Recruitment Comments

Respondents were recruited using the following key criteria:

- Index of Multiple Deprivation (IMD);
- lifestage; and
- attitudinal segment.

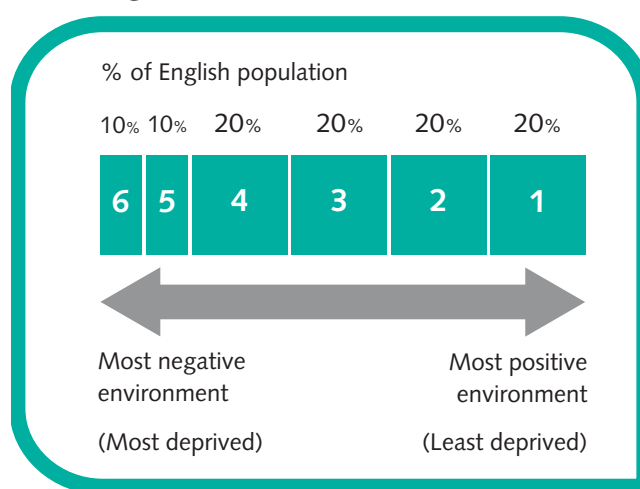
Our use of these criteria was refined iteratively as the research progressed.

### 4.1 Index of Multiple Deprivation

Respondents were chosen from areas within specific IMD categories. The IMD combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows areas to be ranked relative to one another according to their respective levels of deprivation. The IMD index was used by DH in the quantitative study because it deemed this to be the most appropriate measure of environment, as it is well known and judged to be objective. This research divided IMD into six categories based on analysis of the best framework for understanding health behaviour.<sup>2</sup>

GfK provided IMD ratings for the areas to be researched and respondents were recruited from specific, linked postcodes.

**Figure 4.1: Distribution of English population according to IMD, 2009**



Source: *The Healthy Foundations Lifestage Segmentation*, June 2009.

In the early stages of research, it became clear that IMD alone was not an effective and exact enough measure of environment to enable us to recruit the range of respondents needed for this research. It is possible for affluent people to live within high IMD areas (considered to be more deprived). As a result, there is a risk of recruiting individuals not typical of a deprived area, such as middle-class professionals and students.

In order to further refine the recruitment, an additional criterion was added: socio-economic group (SEG). SEG is an occupational grouping, through which respondents are assessed according to the occupation of their head of household. This grading was specifically adapted for this research so that assessment was, in fact, based on the respondents' own

<sup>2</sup> The Healthy Foundations Lifestage Segmentation – Research Report No 1: *Creating the segmentation using a quantitative survey of the general population of England*.

occupations. The two criteria were combined as follows:

- respondents in IMD categories 1–3 were required to fall into SEG categories A, B or C1; and
- respondents in IMD categories 4–6 were required to fall into SEG categories C2, D or E.

This approach ensured that respondents more closely matched expectations from their IMD area. So, respondents from IMD categories 1–3 were expected to be non-manual workers and respondents from IMD categories 4–6 were expected to be manual workers or individuals in receipt of welfare benefits, for example, because they were unemployed.

## 4.2 Lifestage

Lifestages were constructed based on those suggested by the initial hypothesis. A validated lifestage model was constructed following the Healthy Foundations survey. The lifestages are based on a number of different elements:

- age;
- presence of children;
- presence of partner;
- whether people have significant caring responsibilities; and
- working status (whether retired or not).

The following tables describe the variables which contribute to the lifestage categories.

### Lifestage definitions

Category	Where this is derived from	Category	Where this is derived from
Discovery teens	• Any respondent aged 12–15	Younger jugglers	• Age 16–44 • Have children in the household or have caring responsibilities • Not retired
Freedom years under 25	• Age 16–24 • Have no partner in household and have never had a partner • Have no children in the household and no children outside the household • Have no caring responsibilities • Not retired	Older jugglers	• Age 45–64 • Have children in the household or have caring responsibilities • Not retired
Freedom years 25 and over	• Age 25+ • Have no partner in the household and have never had a partner • Have no children in the household and no children outside the household • Have no caring responsibilities • Not retired	Alone again	• Age 18+ (the majority are over 30) • Have no partner in the household • Have no children in the household • Have no caring responsibilities • Not retired • Have had a partner in the past or have children outside the household
Younger settlers	• Age 16–44 • With partner • Have no children in the household • Have no caring responsibilities • Not retired	Retirement with partner	• Retired • With partner
Older settlers	• Age 45–64 • With partner • Have no children in the household • Have no caring responsibilities • Not retired	Retirement without partner	• Retired • Have no partner in the household



### Socio-economic groupings

- A: Non-manual. Professional people, very senior managers in business or commerce or top-level civil servants.
- B: Non-manual. Middle management executives in large organisations, with appropriate qualifications. Principal officers in local government and civil service. Top managers or owners of small business concerns, educational and service establishments. Retired people, previously grade B.
- C1: Non-manual. Junior management, owners of small establishments, and all others in non-manual positions. Jobs in this group have very varied responsibilities and educational requirements. Retired people, previously grade C1.
- C2: All skilled manual workers, and those manual workers with responsibility for other people. Retired people, previously grade C2, with pensions from their jobs.
- D: All semi-skilled and unskilled manual workers, and apprentices and trainees to skilled workers. Retired people, previously grade D, with pensions from their jobs.
- E: All those entirely dependent on the state long-term, through sickness, unemployment or old age, or for other reasons. Those unemployed for a period exceeding six months (otherwise classified on previous occupation). Casual workers and those without a regular income.

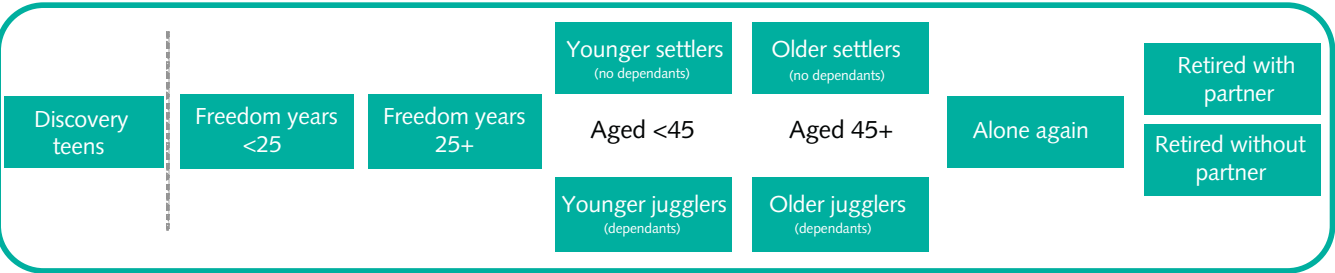
Source: Adapted from *Occupation Groupings: A Job Dictionary*, MRS, 1991.

Based on the quantitative findings, the following lifestages (developed by the Department of Health (DH) and GfK NOP) were used in the sampling for this qualitative study. The screening questions to determine lifestages were identical to those used in the quantitative questionnaire.

At the beginning of this research, the Alone again sample were recruited within an age

range that started at 18 years. However, groups of individuals aged from 18 years through to their 70s were not found to be suitably homogeneous for qualitative methods to be effective. In the interests of more homogeneous and productive focus groups, the minimum age for the Alone again segment was increased to 35 years.

Figure 4.2: The Healthy Foundations Lifestage Segmentation



Source: The Healthy Foundations Lifestage Segmentation, June 2009.

4.3 Attitudinal segment

The attitudinal segments were based on a quantitative algorithm provided by GfK NOP. Initially, respondents were asked a series of questions from a shortened version of the algorithm (see appendix 14) to ascertain their attitudinal segment. This delivered around 58% accuracy. If respondents fitted the appropriate segment in this phase of questioning, they were asked further questions about lifestage to ensure they met the quota criteria.

In the first phase of the research (looking at Balanced Compensators), respondents were recruited to fit the required lifestage and permission was acquired to re-contact them by telephone. Between two and four days later, a researcher asked them to complete the full algorithm (see appendix 13) in order to check their attitudinal segment. If respondents fitted the correct segment for that phase of recruitment, they were selected.

This method of recruitment yielded a very low success rate in terms of obtaining respondents whose responses to the shortened version of the attitudinal algorithm were consistent with their responses to the full version. The research team hypothesised that responses to the attitudinal questions in the algorithm might

change over even a relatively short space of time. Therefore, recording responses on the day would probably to be more successful. In addition, it was felt that asking the respondents questions over the telephone, as opposed to asking them to complete the algorithm questions themselves, had the potential to bias responses.

To address this, respondents were asked to record their responses to the 19 questions from the full algorithm (see appendix 14) and these responses were inputted by researchers. This more effective approach considerably improved success rates during recruitment.

4.4 Data analysis

The purpose of this section is to describe the Research Works Ltd ‘content analysis’ approach. Content analysis is best described by Wendy Gordon and Roy Langmaid in their landmark qualitative research text from 1988:

*“In addition to the continuous development and refinement of hypotheses which evolve as the project proceeds, the practitioner needs to re-immense themselves in the qualitative interviews and organise or structure the content in a form relevant to the objectives of the study.”<sup>3</sup>*

3 W. Gordon and R. Langmaid, *Qualitative Market Research: A Practitioner's and Buyer's Guide*, Gower, 1988, p.134.

In short, Research Works Ltd adopted a content analysis approach to ensure a consistent and robust approach to analysis.

The data from the group discussion and immersion depth interview stages were analysed via the same process. Each segment was analysed in turn. Once completed, the analysis provided an internal analysis of the motivation segment and an external analysis between motivation segments.

#### 4.4.1 Stage one: detailed field notes

Each moderator listened to the audio or audio-visual recordings of their interviews and wrote detailed notes, including quotes. This approach was favoured because it was felt that audio and visual recordings would provide richer detail than written transcripts in terms of the tone and temperature of the discussion.

#### 4.4.2 Stage two: transferring data to analysis framework

An analysis structure was agreed by the project team. The key topics were identified (mirroring each section of the topic guide, which reflected key themes from the quantitative research) as follows:

##### Verification of the segment

##### Immersion – Lives

- Image
- Aspiration
- Key life events/resilience
- Risk-taking behaviour

##### Immersion – Health

- Factors influencing health choices
- Views about overall health

##### Interventions – Service delivery

- Approach
- Creating the ideal service

Each researcher collated their findings for each topic, disaggregating the data about each topic area in terms of the key sample variables: lifestage, environment and motivation segmentation – as shown in table 4.1.

**Table 4.1: Topic area 1: verification of the segment**

	IMD 1–3		IMD 4–6	
	Male	Female	Male	Female
Freedom years				
Younger jugglers				
Older settlers				
Alone again				

The data was assessed in terms of frequency of mention, content, tone, and emphasis. Respondents in groups often have different opinions or beliefs. A minority view in one group, for example, may not be a minority view when the findings from the whole sample have been analysed. Minority or ‘outlying’ views are an important dimension of qualitative findings.

Overall, the aim was to develop an understanding of the spectrum of views about a topic and what informed majority, minority or even individual points-of-view. Therefore, all views contributed to the understanding of the research question.

New themes and grids were developed for strong themes that emerged but did not ‘fit’ the headings from the topic guide, so they are also included in the findings. For example, Balanced Compensators frequently mentioned family, so a new family theme was developed. Researchers then revisited their data to ensure they had noted any references to family.

### 4.4.3 Stage three: comparison of data

The analysis process included a comparison between the two data sets: direct reports from the group discussions and indirect observations from the immersion depth interviews. The immersion depth interviews comprised:

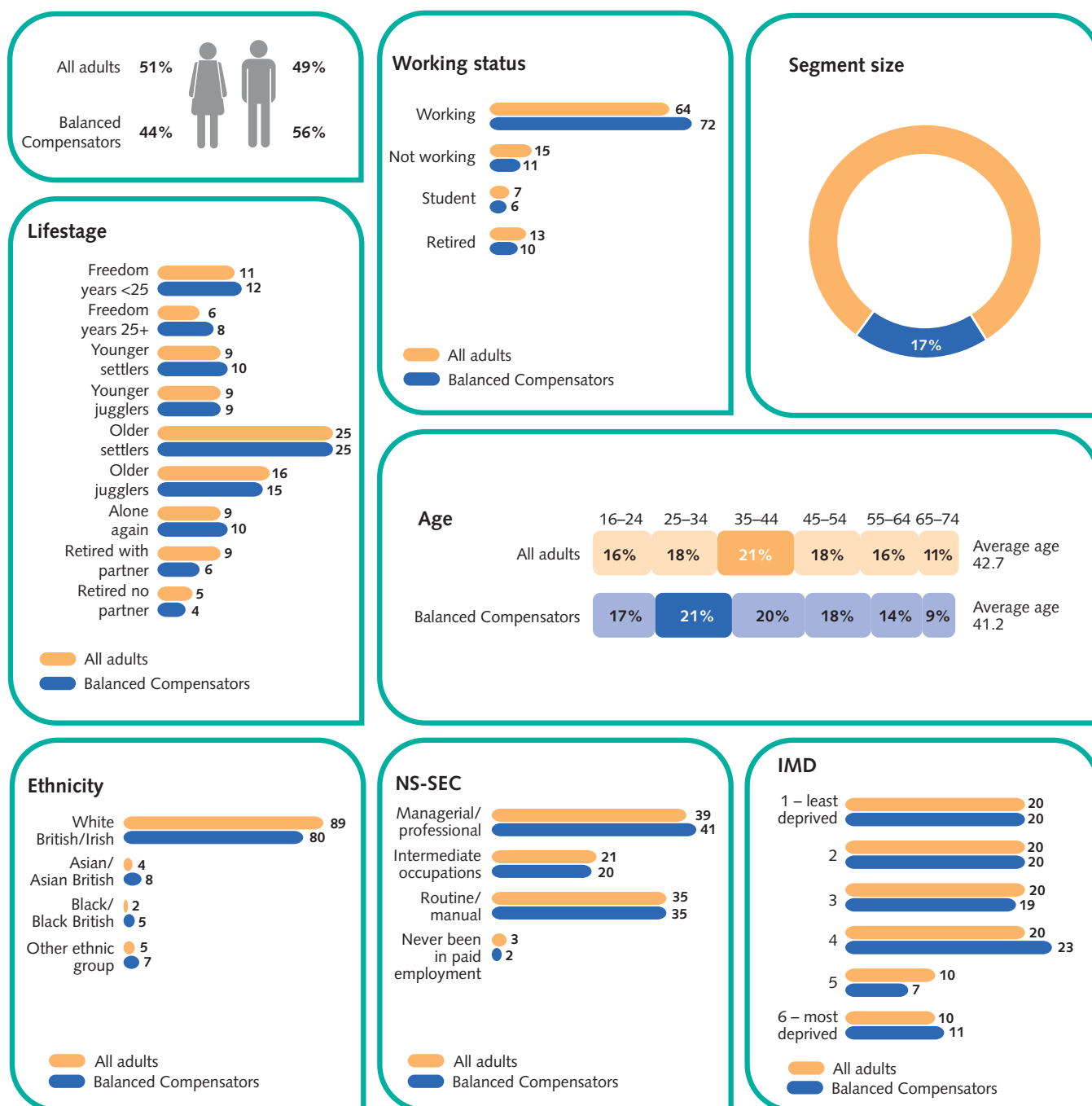
1. **filming:** to capture peripheral lifestyle data in order to contextualise attitudes towards health;
2. **immersion:** an interview focusing on core themes to provide greater depth about sensitive issues such as mental and sexual health, as well as risk-taking behaviour; and
3. **interventions:** focusing on ideas for supporting individuals to make positive changes to their health.

This comparison provided a clear understanding of actual, as opposed to claimed, behaviour. As part of the ongoing analysis process, the team discussed differences in findings and suggested explanations for them.

By conducting analysis in a group, the analysis team discussed themes as they emerged, including points of consensus and divergence as well as inconsistencies.

# 5 Balanced Compensators

Figure 5.1: Balanced Compensators: demographics/lifestage



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Balanced Compensators (unwtd 843/wtd 852/ess 433)

Balanced Compensators (BCs) represent 17% of the overall sample. A large proportion (41%) is in managerial/professional occupations, compared with 39% of the overall sample. BCs are the second youngest segment and have the highest proportion of people in paid work.

## 5.1 Verification

This section summarises the findings of the verification exercise undertaken with respondents. Respondents were asked how they felt about a series of attitudinal statements typical of their segment, as well as some which were descriptive of others.<sup>4</sup> The aim of this exercise was to explore the segment in more depth, for instance, how homogenous it was, and to contrast it with others.

The qualitative research confirmed that this segment is motivated by two central ideas: looking good and feeling good. Good health was clearly a key objective, although the perceived value of looking good and feeling good extended to all areas of lifestyle:

*"I think good health is all to do with the feeling and how well you like yourself."*  
(Female, Freedom years, IMD 4–6, Lewisham)

*"Looking good is an important part of life; it's first impressions which count both in and out of business."*  
(Male, Alone again, IMD 4–6, Exeter)

The two ideas were felt to be closely connected. Most respondents believed that to feel good psychologically, they have to feel they look good physically. There was a strong belief that feeling good increases motivation and positive self-esteem:

*"If you look good, you generally feel good about yourself and then you get a lot more done. If you don't look good, you tend to feel de-motivated and lose confidence."*

(Male, Freedom years, IMD 1–3, Liverpool)

*"When you feel good, that rubs off on people."*  
(Female, Older settler, IMD 4–6, Lewisham)

BCs generally felt they achieved their key goals of looking good and feeling good on an ongoing basis, and were proud of this:

*"The difference between successful people and unsuccessful people is just that they go out and do it instead of talking about it."*  
(Male, Freedom years, IMD 1–3, Liverpool)

*"I have days when I look at myself and think 'yes, you look okay'."*  
(Female, Alone again, IMD 1–3, Liverpool)

*"I do like to look good and make the effort. People think I'm a lot younger than 53."*  
(Female, Older settler, IMD 4–6, Slough)

Looking good was perceived to be achieved by maintaining physical fitness and what were seen as 'healthy' behaviours. Evidence of this segment's perceived success in maintaining healthy behaviours was a clear belief that they were less likely than other people of the same age to become ill:

*"I believe I am more likely than other people of the same age to get ill' are the words of a hypochondriac, or someone who is behaving in a way that would bring ill health upon themselves."*

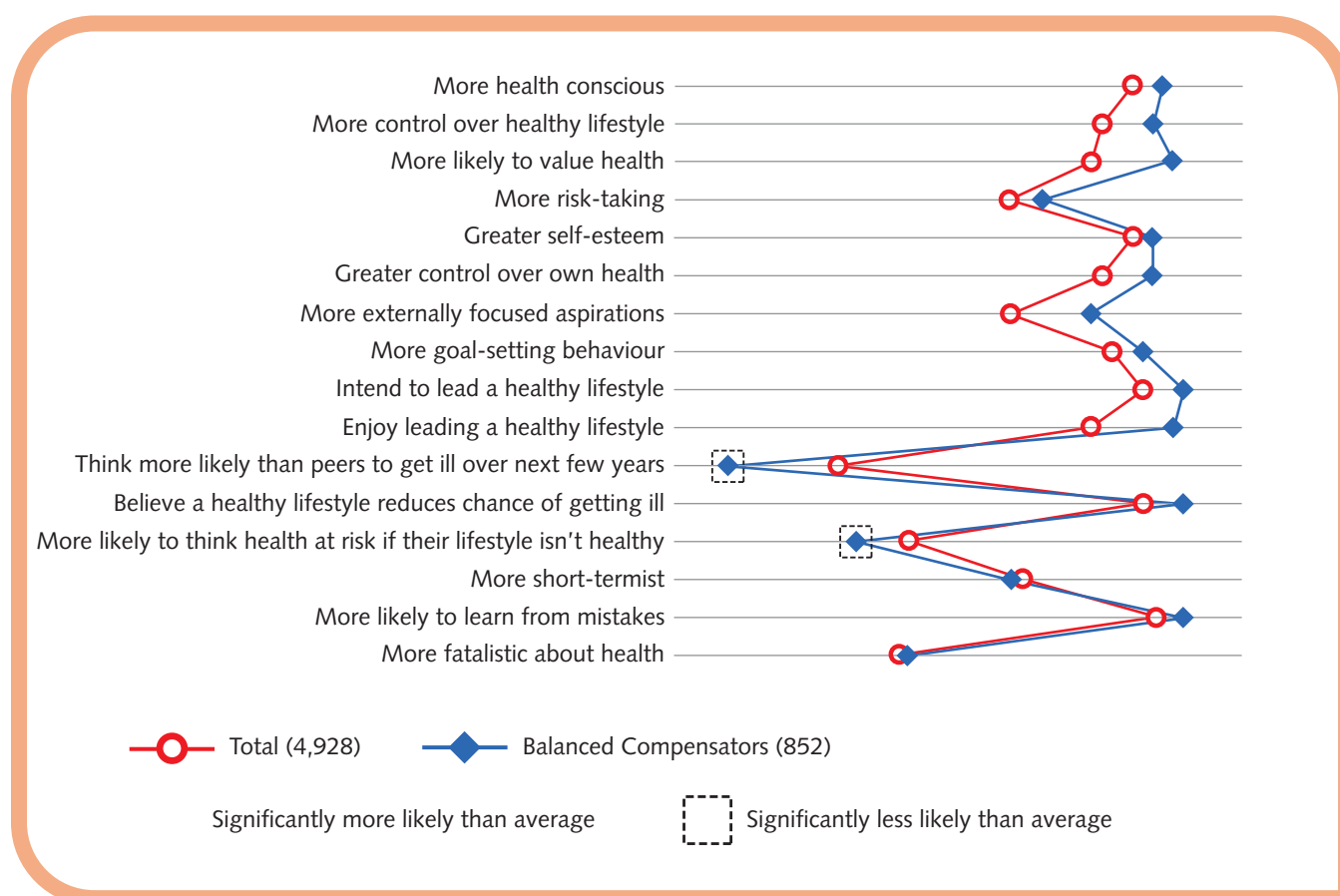
(Male, Alone again, IMD 1–3, Exeter)

BCs were strongly motivated to achieve and maintain their health goals because they actually enjoy living a healthy lifestyle and want to maintain control:

<sup>4</sup> These attitudinal statements were taken directly from the quantitative research questions in Research Report No. 1.



Figure 5.2: Balanced Compensators: motivations



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Balanced Compensators (unwtd 843/wtd 852/ess 433)

*"I do it because I enjoy it but also because of how it makes me feel. I've done it most of my life."*

(Male, Older settler, IMD 4–6, Liverpool)

*"I know exactly what I'm doing with my health. It's become second nature to me to live like this."*

(Female, Younger juggler, IMD 4–6, St Albans)

BCs typically employ a compensatory mechanism which they perceive as assisting in maintaining control. If they undertake an activity which they feel is 'unhealthy', then they typically redress this by balancing it with a 'healthy' action at another point in time:

*"I went out on Sunday to afternoon tea, sandwiches, cakes, cream...the wrong things,*

*so I went to the gym on Monday and I watched those calories, how many calories I was burning up and I did work twice as hard."*

(Female, Alone again, IMD 4–6, Liverpool)

The dynamic process that drives motivation among BCs is summarised in figure 5.3. The important role of compensation can be clearly seen.

One respondent summarised a typical compensation situation as follows:

*"Some days I did things to make up for the bad days. On Wednesday, chicken and chips when I woke up – but fruit and football at the end of the week made up for it."*

(Male, Alone again, IMD 4–6, Lewisham)

BCs assume, therefore, that they can take risks (including limited risks with their health) and accept a 'controlled' amount of risk-taking behaviour.

BCs show an ability to maintain a medium to long-term outlook regarding their health and behaviour, which seems unique to this segment. The need to achieve balance, through compensatory behaviour, means that the idea of 'living for today' does not generally appeal to them:

*"It's all right taking risks but it's how it affects other people isn't it...? If something happened to me, somebody's got to look after me. Who?"*  
(Female, Alone again, IMD 1–3, Liverpool)

*"When I stopped going to the gym and being quite spontaneous for a spell, I put on lots of weight and I hated the feeling of not having a routine."*  
(Female, Freedom years, IMD 4–6, Lewisham)

The level of control that BCs exercise over health and lifestyle means they are less inclined to demonstrate fatalism as a major facet of their outlook on life. There is, however, an

acceptance that fate might 'intervene' in extreme cases, such as cancer:

*"If you lead a healthy lifestyle then you can prevent illness from happening to you later in life, but only to a point – life has lots of surprises."*

(Female, Freedom years, IMD 1–3, Lewisham)

*"However hard you try to eat, do the right things, I've seen very very healthy people who've done all the right things be struck down."*

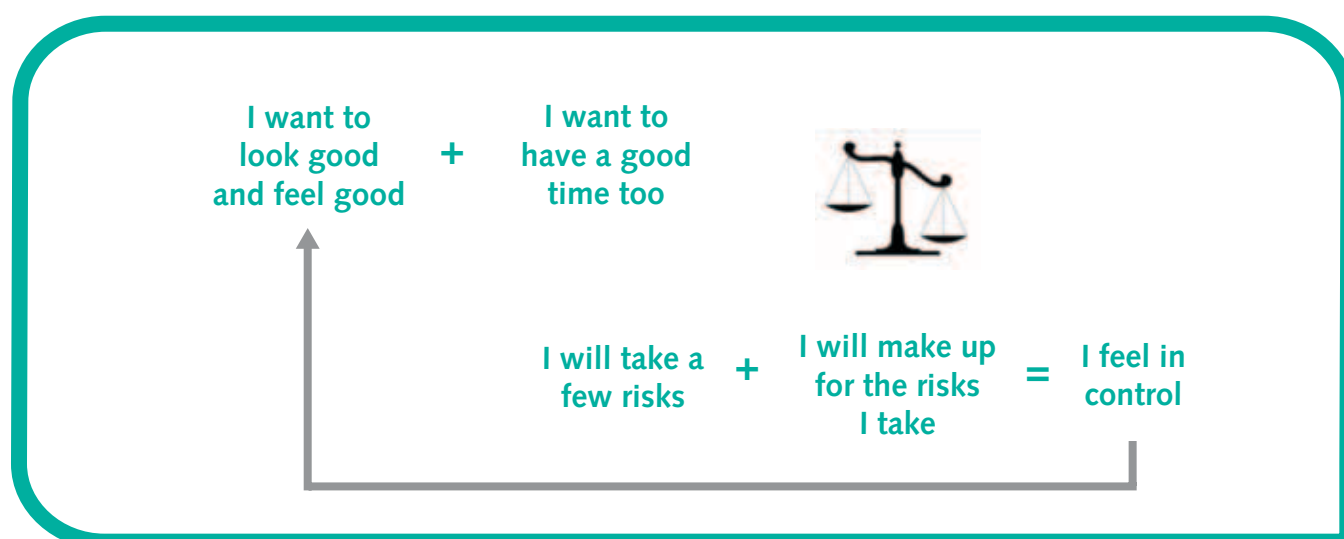
(Female, Alone again, IMD 1–3, Liverpool)

A spectrum of balanced compensatory behaviour emerged from analysis, as shown in figure 5.4.

The sample provided evidence of a range of risk-taking behaviours and linked compensatory activity, which can be summarised in three segments:

- **More rigid:** some respondents showed no evidence of risk-taking behaviour at all. This was especially common in the Alone again lifestage, where respondents typically had more time to devote to a healthy lifestyle.

Figure 5.3: Balanced Compensators: motivational patterns





- **Average:** respondents often indulged in, for example, binge-drinking at the weekend, which was then balanced by exercise and diet during the week. Men were on the whole typically heavily exercise-focused, while women were predominantly diet-focused.
- **More flexible:** this group included the least risk-averse respondents and reported engaging in some obviously risky behaviours, such as using illegal drugs. This phenomenon was particularly evident in the Freedom years lifestage.

## 5.2 Environment

BCs valued positive environments, which they characterised in terms of 'friendly' people, plenty of facilities, outdoor spaces and safe communities. Rural and suburban areas were considered 'healthier' in terms of being 'green' and safe. In urban areas crime is perceived as more of a problem:

*"Personally I've been mugged twice walking home, and that was during the day."*  
(Male, Freedom years, IMD 4–6, Slough)

*"The main problems around here are gun crime, gang culture and drugs."*

(Female, Freedom years, IMD 4–6, Lewisham)

Facilities and physical infrastructure were also clearly important factors in terms of helping BCs to maintain healthy lifestyles. This segment is sufficiently motivated to actively seize opportunities to make positive choices if these present themselves. If faced with what they see as a failing environment (for example, a run-down area or an area with perceived social deprivation), BCs typically disassociate themselves from such surroundings:

*"If you don't want to be in a place, you don't have to be."*

(Female, Freedom years, IMD 4–6, Lewisham)

More specifically, Freedom years men from IMD 4–6 preferred not to be identified with their home town and typically socialised elsewhere:

*"I always go out in Windsor, that's where all my friends are."*

(Male, Freedom years, IMD 4–6, Slough)

Figure 5.4: Balanced Compensators: range of risk-taking



Equally, some Freedom years women from IMD 4–6 had deliberately created a ‘street persona’ which demonstrated their independence from South London gang culture:

*“You can tell who’s got the power and who you wouldn’t mess with and those who are weak and easy prey to pick on.”*

(Female, Freedom years, IMD 4–6, Lewisham)

Overall, in terms of environmental factors and their influence on health behaviour and attitudes, differences between BCs from IMD 1–3 and IMD 4–6 were difficult to determine, a finding which supports the quantitative data:

- For the most motivated HF segments, IMD has less of an impact on health behaviours.
- IMD has a much stronger influence among the less motivated HF segments.

## 5.3 Key drivers

### 5.3.1 Aspiration

As a group, younger BCs typically aspire to a happy, healthy and successful life. Consequently, most devise solid, achievable plans to ensure the achievement of their goals:

- Freedom years respondents were typically ambitious about their careers, but were also often thinking about a future family scenario. Those from IMD 4–6 *expected* to be ‘upwardly mobile’, were confident about achieving their career aims and associated financial security with hard work:

*“I try to do my own thing myself and set my own targets.”*

(Female, Freedom years, IMD 4–6, Lewisham)

*“Everything takes a lot of hard work. If you really want something for your future then you have to work for it. Nothing falls at your feet.”*

(Female, Freedom years, IMD 4–6, Lewisham)

- Younger jugglers frequently have to make concessions in terms of their personal aspirations in order to prioritise providing for their families:

*“I’d love to travel the world and see it all, but I know that can’t be done with a young child, so it gets stored away and replaced with more immediate goals like work and mortgage payments, the things that matter now.”*

(Female, Younger juggler, IMD 1–3, Exeter)

The levels of personal aspiration decreased among older BCs and this was strongly influenced by lifestage:

- Older settlers: most were looking forward to a comfortable, relaxing and somewhat modest retirement:

*“I’d like to spend time with the grandchildren and just slow things down and grow old gracefully!”*

(Female, Older settler, IMD 4–6, Slough)

However, for some, aspiration had continued, with many working actively towards travelling or moving abroad.

- Alone again respondents were working to maintain what they had already achieved, as well as focusing upon independence and an active lifestyle which includes a sense of purpose (for example, volunteering):

*"I just want a healthy, peaceful, worthwhile life, that's all I want. Enough money to pay my bills and be happy with. A warm house in the winter, plenty of food in."*

(Female, Alone again, IMD 1–3, Liverpool)

BCs were positive as to the likelihood of achieving their aspirations. Most seemed good at planning and adapting. Freedom years from IMD 4–6 made plans further into the future. Younger jugglers typically adapted their goals:

*"Thinking in the present, but keeping one eye on the future."*

(Male, Younger juggler, IMD 4–6, Norwich)

*"I used to run myself into the ground for my job, but over the years I learned that if you do that, you make yourself ill."*

(Female, Younger juggler, IMD 4–6, St Albans)

BCs were generally good at setting realistic, achievable goals. Most were not primarily motivated by wealth or material possessions (as indicated in the quantitative study undertaken by the Department of Health) but rather by an aspiration towards comfort and stability. Goals were typically traditional in nature: for example, a good job, a stable family unit and car and home ownership:

*"A comfortable life was what I aspired to. I just wanted to be able to support my wife and kids, and have the house and the car."*

(Male, Alone again, IMD 4–6, Lewisham)

*"Healthy, loads of money, good job, family, nice car, house, five wives!"*

(Male, Freedom years, IMD 1–3, Liverpool)

### 5.3.2 Resilience

The qualitative data strongly supports the quantitative findings: BCs consistently demonstrate resilience when faced with negative situations.

Pages 46 and 47 show extracts from the 'key life events' exercise undertaken by respondents. They illustrate BCs' essentially positive responses to negative life events.

In the main, the following factors were driving resilience among BCs:

- a strong family background: Freedom years typically respected their parents and did not want their behaviour to affect them adversely. They often referred to their upbringing as an important factor in influencing their own apparent strength of character:

*"If you have an ounce of inner strength to start with, that can carry you through the harder times...that initial strength would be based on upbringing."*

(Female, Younger juggler, IMD 1–3, Exeter)

- high personal levels of independence, motivation and self-belief:

*"People that are always reliant on other people tend to fall apart, or spend their lives being unhappy."*

(Male, Alone again, IMD 1–3, Lewisham)

- for Freedom years and Alone again, IMD 4–6, an ability to remove themselves from negative situations and to resist unhealthy peer pressure:

*"I was stuck in a serious rut, I was getting home from work every day feeling unfulfilled and trapped. One day I finally decided to hand in my notice, and I disappeared to Australia for three months."*

(Male, Alone again, IMD 1–3, Exeter)

*"It's your body, isn't it, so why should you let other people dictate when you should eat? You know what suits you."*

(Female, Alone again, IMD 4–6, Liverpool)

DRINKERS IN THE FAMILY	SAD	I DON'T DRINK AT ALL
SMOKERS IN FAMILY CANCER	I HATED IT	HAVE NEVER SMOKED

Made conscious decision  
not to smoke or drink

<i>Drinkers in the Family</i>	<i>Sad</i>	<i>I don't drink at all</i>
<i>Smokers in family Cancer</i>	<i>I hated it</i>	<i>Have never smoked</i>

*Made conscious decision not to smoke or drink*

GRANDMA'S DEATH	MADE ME FEEL MORE NEGATIVE ABOUT MYSELF SUCH AS THINGS I TOOK FOR GRANTED.
AFTER FEELING GLUM & DOWN HAS TO PICK MYSELF UP & BE POSITIVE AROUND ALL FAMILY.	

Failed Exams	Shocked me	Reassessed where I stand. Need to get in gear.
Failed exams	Shocked me	Reassessed where I stand. Need to get in gear.

Divorce (my own).	Stress, worry (about future) learning curve. Effects on my career / future.	More positive, confident in myself and in relationships
Divorce (my own).	Stress, worry (about future) learning curve. Effects on my career/future	More positive, confident in myself and in relationships

HUSBAND ILL	BAD	MADE ME STRONGER
Husband ill	Bad	Made me stronger

<del>My friend</del> Changing my friends	I was no longer the child my mum knew I was as a rebellious	Opened my eyes to fight back in life.
Changing my friends	I was no longer the child my mum knew, I was responsible	Opened my eyes to fight back in life

DEATH OF BOTH MY MOTHER AND HUSBAND.	I WAS 14 WHEN MY MOTHER DIED - AND 40 WHEN MY HUSBAND DIED - MADE ME SELF-RELIANT	ALONE, BUT NOT LONELY. BECAME VERY SELF-RELIANT AND STRONGER.
Death of both my mother and husband.	I was 14 when my mother died - and 40 when my husband died - made me self-reliant	Alone, but not lonely. Became very self-reliant and stronger



### 5.3.3 Risk-taking behaviour

Risk-taking behaviour seems strongly influenced by lifestage.

- Freedom years clearly do take risks with their health, but in a limited, non-destructive manner (for example, by constraining risky behaviour like drinking to the weekend):

*"I did a parachute jump. I'd say it was a risk. It was quite scary going up there but I knew it was all right, I knew there was minimal risk that it can go wrong."*

(Male, Freedom years, IMD 1–3, Liverpool)

- Younger jugglers showed a dramatic reduction in risk-taking behaviour (both positive and negative) because of the responsibilities of family life:

*"With age comes responsibility."*

(Male, Younger juggler, IMD 4–6, Norwich)

- Alone agains demonstrated very little evidence of risk-taking behaviour. At their lifestage, most felt the emphasis is on looking after themselves and maintaining positive behaviours:

*"I'm a banker. I practise risk assessment every day, perhaps that's why I apply it to my everyday life as well"*

(Male, Alone again, IMD 1–3, Exeter)

Among BCs, positive risk-taking behaviour was associated with embracing challenges – for example:

- physical challenges, such as roller coasters, bungee jumping, skydiving and combat sports; and
- achieving personal goals – for example, setting up a business or aiming to attain professional status:

*"...something you strive for knowing that you're going to be successful in achieving it."*

(Female, Alone again, IMD 1–3, Liverpool)

For older BCs, negative risk-taking behaviour was mainly associated with their youth and younger years. It was seen as a period of their life which had been left behind and to which none wanted to return.

Freedom years demonstrated a range of negative risk-taking behaviour, mostly focused around binge-drinking. This had led to memory loss and taking personal risks such as travelling home alone:

*"There's been times when I've been so drunk, I've been so emotional and out of control"*

(Female, Younger juggler, IMD 4–6, Lewisham)

These negative behaviours were also closely connected with the use of class A drugs. A common risky behaviour reported by all BC lifestages was driving too fast.

For BCs, however, uncontrolled self-destructive risk-taking was unappealing because it typically means:

- relinquishing control:

*"I just don't want to have more [drink] because I don't want to feel out of control. I don't want to feel ill, I certainly don't want to have a hangover."*

(Female, Alone again, IMD 4–6, Liverpool)

- health 'balance' is more difficult to achieve:

*"I think take-away food is the worst. They're so fattening and then you have some wine with them..."*

(Female, Older settler, IMD 4–6, Slough)

- potential damage to health:

*"In relation to health, anything in excess is a risk."*

(Male, Alone again, IMD 1–3, Exeter)

BCs tended to make a specific and deliberate choice to be 'out-of-control' for a strictly limited period of time. They would only take health risks during this period and all were confident they could compensate appropriately:

*"Resilience is all about observing oneself and re-prioritising. It's like putting things back in order again."*

(Male, Alone again, IMD 1–3, Exeter)

*"Although if I went to a party I would drink more than if I wasn't at a party, I would still control what I drank. I wouldn't binge."*

(Female, Alone again, IMD 4–6, Liverpool)

Due to a strong belief in their 'compensatory' mechanism, BCs can seemingly resist peer pressure and navigate broader cultural norms:

*"I have not allowed peer pressure to affect my way of life"*

(Male, Older settler, IMD 4–6, Liverpool)

*"If I benchmark myself against other people who are my age and the same life-stage as me then yes, I am doing well health-wise."*

(Female, Younger juggler, IMD 1–3, Exeter)

## 5.4 Factors influencing health choices

Since negative behaviour was a relative rarity for BCs, most of their energy was focused upon achieving healthy choices in terms of diet and exercise. The diary extracts demonstrate motivations underlying these decisions.

Poor choices often generated feelings of guilt and linked compensatory behaviour. The diary extracts below are some examples of compensatory behaviour where guilt is the motivating factor:

Number 3 decision: Took the grandchildren to McDonalds, but decided I wouldn't have anything to eat there  
 Why did I make this decision? I'm always sorry if I eat McDonalds I was glad I didn't.

Number 3 decision: Took the grandchildren to McDonalds, but decided I wouldn't have anything to eat there.  
Why did I make this decision?  
I'm always sorry if I eat McDonalds  
I was glad I didn't.

(Female, Alone again, IMD 4–6, Liverpool)

Number 3 decision: Grilled chicken + salad for dinner

Why did I make this decision?

Felt healthy/good after run - wanted to keep it up.

*Number 3 decision: Grilled chicken + salad for dinner*

*Why did I make this decision?*

*Felt healthy/good after run – wanted to keep it up*

(Male, Younger juggler, IMD 1–3, Croydon)

Number 1 decision: 50 push ups before shower in the morning (7.30am)

Why did I make this decision?

TRYING TO WAKE UP NATURALLY.  
RATHER THAN HAVING A COFFEE (8.30).

*Number 1 decision: 50 push ups before shower in the morning (7.30am)*

*Why did I make this decision? Trying to wake up naturally rather than having a coffee (8.30)*

(Male, Freedom years, IMD 1–3, Liverpool)

Number 2 decision: Did some yoga at home

Why did I make this decision?

I am having back problems at the moment that I think are linked to sitting at a desk all day. I think yoga will help

*Number 2 decision: Did some yoga at home*

*Why did I make this decision?*

*I am having back problems at the moment that I think are linked to sitting at a desk all day. I think yoga will help*

(Male, Freedom years, IMD 4–6, Slough)



Number 1 decision: Went out for lunch and back to a friends. Wouldn't let her drive me home. I walked.  
 Why did I make this decision?  
Wanted to work off my lunch

*Number 1 decision: Went out for lunch and back to a friends. Wouldn't let her drive me home. I walked.*

*Why did I make this decision?*

*Wanted to work off my lunch*

(Female, Alone again, IMD 4–6, Liverpool)

Number 1 decision: Went running for 3 miles  
 Why did I make this decision?  
Wanted to burn off the calories I had put on from the previous day

*Number 1 decision: Went running for 3 miles*

*Why did I make this decision?*

*Wanted to burn off the calories I had put on from the previous day*

(Male, Freedom years, IMD 1–3, Liverpool)

Number 2 decision: MAINTAINED LIQUID INTAKE - WATER  
 Why did I make this decision?  
NEEDED TO REHYDRATE TO COMPENSATE FOR NIGHT BEFORE

*Number 2 decision:*

*Maintained liquid intake - water*

*Why did I make this decision?*

*Needed to re-hydrate to compensate for night before*

(Female, Alone again, IMD 4–6, Liverpool)

Number 4 decision: WENT TO McDONALDS AFTER PUB  
WITH FRIENDS BUT DIDN'T BUY ANYTHING.

Why did I make this decision?  
I feel McDONALDS food gives me SPOTS.

*Number 4 decision: Went to McDonalds after pub  
with friends but didn't buy anything*

*Why did I make this decision?*

*I feel McDonalds food gives me spots*

(Male, Alone again, IMD 4–6, Lewisham)

BCs openly acknowledged the effects of poor health choices on their medium to long-term prospects of looking and feeling good. Some were able to defer a realisation of the implications of their behaviour, but only temporarily. Most quickly returned to address the negative impacts of poor health choices.

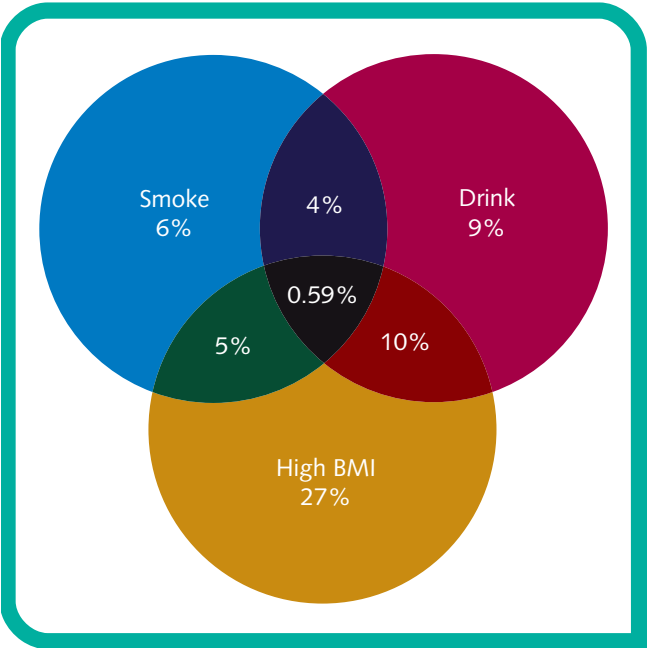
The qualitative research revealed very little evidence of overlapping behaviours (polybehaviours) among this segment. The main area of overlap between healthy and risk-taking behaviour was centred on binge-drinking, which often led to other 'bad' behaviours such eating unhealthily, smoking and the use of class A drugs:

*"Massive drinking sessions and then kebabs on the way home."*

(Female, Younger juggler, IMD 1–3, Exeter)

This lack of overlapping behaviours is confirmed by the quantitative data which reveals that less than 1% of BCs smoke, drink and have a high body mass index (BMI) (the lowest of all five HF segments), as illustrated by figure 5.5.

Figure 5.5: Balanced Compensators: overlapping behaviours



Source: Research Report No.1

Some 38% of BCs (the highest percentage in all five HF segments) do not smoke, drink or have a high BMI.

## 5.5 Interventions

### 5.5.1 Views about overall health

BCs were broadly happy with their current health behaviour and showed little inclination to make major changes:

*"I'm doing the best I can."*

(Male, Older settler, IMD 4–6, Liverpool)

*"I certainly think about my health a lot, I think about what I should and shouldn't be doing all the time."*

(Female, Younger juggler, IMD 1–3, Exeter)

Their typical focus was on enhancing or adjusting current behaviour – for example, by taking more exercise, drinking more water and eating more fruit:

*"Didn't eat as much fruit as I had intended."*

(Male, Younger juggler, IMD 4–6, Norwich)

### 5.5.2 Intervention approaches

BCs were happy to take responsibility for their health and most wanted to be empowered to maintain control of what were seen as currently healthy lifestyles. Consequently, if opportunities are offered to make healthy choices, BCs will be positive about seizing them.

Environmental interventions could create opportunities for BCs to make more consistently healthy choices. For example, there was clear interest in:

- a greater number of better-quality cycle paths;
- attractive, accessible, open spaces;
- convenient and reasonably-priced sports facilities (e.g. free swimming or cheap gym memberships).

*"Build and expand on what we already have."*

(Male, Younger juggler, IMD 4–6, Norwich)

*"We have the Olympics coming up – that's a perfect opportunity for developments to be made."*

(Male, Alone again, IMD 1–3, Exeter)

It seemed important that BCs feel able to make their own choices, so prescriptive interventions are unlikely to be appealing. For example, one prescriptive stimulus used in the focus groups was the Vitality service (a local, NHS-funded service offering free advice and support to help with losing weight, stopping smoking and taking more exercise – see appendix 15 for more information), but this was consistently perceived as 'not for me'. Rather, it was for:

- 'unhealthy' people (i.e. people who are overweight, drink too much and smoke);
- people who need strong guidance (an approach which BCs find patronising).

Additionally, the overall tone of the Vitality service was seen to have an unwelcome 'American' feel:

*"People react badly to authoritative demands, especially from the state."*

(Male, Alone again, IMD 1–3, Exeter)

*"You'd have to present it in a way that people don't feel like you're pushing them to do it."*

(Male, Freedom years, IMD 1–3, Liverpool)

It was felt that positive advice regarding single health issues could also be offered as a way of informing healthy choices (particularly regarding diet and exercise). However, only information would be required by BCs. This segment seems unlikely to use a service for their perceived health needs – which were essentially about maintaining health, as opposed to improving it:

*"I'd tell them where to stick it [health check and advice], I don't need anything like this."*

(Female, Freedom years, IMD 4–6, Lewisham)

*"People who go to these things [health checks and advice] already have a problem."*

(Male, Alone again, IMD 1–3, Exeter)

More positively, it seemed that a health check concept might be able to effectively support BCs to maintain control over their health. The idea of a 'health check' made sense to BCs because they:

- care about their health;
- understand that ageing affects health;
- value an opportunity to monitor their progress;
- are sufficiently motivated to address any specific personal issues.

*"Ideally we could have a full health check, where everything is looked at and we are given an MOT."*

(Female, Younger juggler, IMD 1–3, Exeter)

Broadly, BCs understand and aspire to 'wellness'. A 'wellness' service clearly had appeal, but for most it was associated with other (less healthy) people's needs. The exception to this were Alone again women, who reported real value in the expected 'social' element of a wellness service and felt that they had time to devote to such an enterprise.

A 'wellness' service would need to be delivered in a suitable 'wellness' setting, such as a gym, pharmacy, Sure Start centre, community centre, shopping centre – and well away from settings related to 'illness', such as a GP surgery.

For BCs, the ideal intervention would be built around 'facilitation' and offer positive options within communities. BCs wanted to choose

services and infrastructure, while a 'health check' would support them to identify health issues. This approach could be complemented by providing supporting information to help address the single issue health issues which have been identified.

## 5.6 Balanced Compensators: immersion depth analysis

### 5.6.1 Resilience

Irrespective of IMD or lifestage, the majority of respondents believed that they have always been resilient individuals, with effective support networks (in terms of family or friends) in place throughout their lives:

*"I think family and friends always taught me, because I've always been in the environment where we're supporting each other, and that's how it should be."*

(Male, Freedom years, IMD 1–3, Liverpool)

Virtually all had contended with serious life events (death of close family member or friend, accidents, illness and brushes with the law) and cited these moments as both drivers for, as well as evidence of, personal resilience:

*"My partner had a coronary and got an infection, went out of his mind and went through a fifth floor window in a hospital and died... What it has done is made me a lot stronger."*

(Female, Alone again, IMD 1–3, Liverpool)

Most felt that their chosen social networks are comprised of like-minded people who will provide support and advice if one of the group goes 'off the rails'. Some (particularly in IMD 4–6) noted that they have, over time, lost contact with past friends who do not share their lifestyle choices or attitudes towards health:



*"There have been times where one or another of us has gone down the route of drinking a lot or taking a bit too much of this, that or the other for various reasons – like maybe breaking up with the girlfriend. It's for the rest of us to put an arm round and say 'have a think about this', so we look after each other in that respect."*

(Male, Alone again, IMD 4–6, Lewisham)

Equally, many had observed poor health behaviours and choices among family members and had taken a conscious decision to avoid those behaviours in their own lives. Avoiding the health mistakes that parents and grandparents had made was a common theme among BCs:

*"My father also used to drink a lot and smoke but now has cut down. I don't smoke because my father did."*

(Male, Freedom years, IMD 1–3, Liverpool)

Respondents from IMD 4–6 were more likely to have experienced problems with serious issues such as crime or drugs. But these individuals had, nonetheless used these situations as a learning stimulus for change and growth:

*"Trouble with the police stopped me going down a road I shouldn't have gone down."*

(Male, Alone again, IMD 4–6, Lewisham)

In terms of being different from others who have maintained poor health behaviours, respondents typically believed that they have a greater ability to initiate change in behaviour and maintain positive behaviours once these have been established. If this means changing social group, then most would do so.

The basis for resilience, it was felt, is awareness of consequences, the personal strength to change behaviour and an ability to be

comfortable in deviating from local norms (including changing social set if necessary).

### 5.6.2 Risk-taking behaviour

All respondents had indulged in a range of risky behaviours, from driving too fast, binge-drinking, smoking and unprotected sex, through to regular use of illegal drugs. Interestingly, BCs consistently included financial choices (such as speculation on the stock market and business decisions) among their reported risky behaviours. Some even saw travel and 'being abroad' as inherently risky.

Respondents from IMD 4–6 were more likely to have indulged in the most risky behaviours such as drug use and unprotected sex. For those from IMD 1–3, bad diet choices, excessive consumption of alcohol and smoking were the most typical areas of risk.

Virtually all BCs believed that they have their risk-taking inclinations under control and are aware of the potential for risky behaviour in future scenarios. Most admitted to some ongoing risk-taking (social smoking, inadequate exercise, occasional drug use), but saw this as essentially controlled:

*"Today, you wouldn't do what you did in the sixties. You'd be brain dead if you did it today."*

(Male, Older settler, IMD 4–6, Liverpool)

The Juggler lifestage clearly affected the perceived opportunities to take risks, with respondents reporting that the presence of children had affected their choices in relation to health behaviour and risk-taking in general. BC Jugglers strongly believed that they would not wish their children to repeat their own mistakes in relation to health:

*"My son started playing with [cigarette] papers and trying to roll them and I want him to have the choice to be more ambitious than that!"*

(Female, Younger juggler, IMD 1–3, Exeter)

Alone again respondents swung between a sense that they can now 'please themselves' regarding health and risk-taking and a concern that they might become a burden on family and friends if risk-taking behaviour makes them ill.

In general, respondents from IMD 4–6 seemed more prepared to accept those risks and behave as they wish:

*"Occasional use of a few drugs but it is occasional...it's become a lot less frequent."*

(Male, Alone again, IMD 4–6, Lewisham)

### 5.6.3 Norms/social influences

A majority of the sample believed that their parents and upbringing had provided the basis for their current attitudes and behaviour. In some cases this influence had been negative – where parents had behaved negatively and offered a powerful model for 'how not to act' – but in most instances, respondents felt that their family had given them positive guidance:

- by exposing them to alcohol early and generating a sensible approach to alcohol use;
- by promoting sensible eating habits and a negative image of gluttony;
- by being active and encouraging an active lifestyle;
- by promoting the benefits of education.

Respondents from IMD 4–6 clearly had more problems in handling peers and social groups. Many believed that their friends are a 'bad influence' in terms of health.

Freedom years respondents were clearly more strongly influenced by their friends, as well as media exposure to TV celebrities and sporting heroes:

*"People on TV are healthy influences to me, as are people at the gym"*

(Male, Freedom years, IMD 4–6, Slough)

Jugglers are constrained by what they feel is reasonable and sensible to do, given the responsibilities of children and home life.

Older settlers and Alone again respondents were influenced by the views and opinions of health professionals. These groups have more contact with healthcare providers and therefore receive more advice than younger segments. Equally, these older segments seemed more prepared to avoid friends who promote bad behaviour of any type, whether it is related to health or simply stressful in nature.

*"My friends are a bad influence – Friday night I was meeting up with some old university friends...the pressure was there to stay out and drink. I didn't get home until 5.30 in the morning and the next day, I was no good."*

(Male, Alone again, IMD 4–6, Lewisham)

### 5.6.4 Segment movement

All respondents agreed with the BC description, seeing themselves as generally unwilling to take risks and not inclined to be fatalistic.

Respondents in the Freedom years segment believed that they have 'always' been BCs, based on family influences and the types of friends and activities chosen during childhood years.

Respondents in other segments typically identified a change to BC status as a consequence of life circumstances:

- after 'settling down' with a partner;
- after having children;
- after being diagnosed with a serious illness;
- upon changing career/job.

Before becoming a BC, most of these latter respondents felt that they had been 'wilder' and probably more likely to be classified as a Live for Today (LfT) or a Hedonistic Immortal (HI).

None of the sample believed that they would be likely to return to their 'old' lifestyles and attitudes. All felt that key drivers such as self-determination, willpower and dislike of risk would keep them in the BC segment.

*"You wake up. You can't keep smoking. You can't keep doing what you're doing and stressing yourself out living stupidly. You just can't do it anymore because you will die, simple as that."*

(Female, Younger juggler, IMD 1–3, Exeter)

### 5.6.5 Attitudes towards other segments

Most of the respondents believed that they probably have friends in every one of the HF segments, although most then went on to say that they prefer to spend more time with individuals who are similar to themselves in terms of attitude and behaviour.

BCs were generally dismissive of Unconfident Fatalists (UFs), although some of the older respondents expressed a little sympathy for the segment. UFs were the segment that BCs seem least likely to spend time with or to know socially.

Conversely, HIs was the segment that many respondents seemed inclined to approve of and even aspire towards – typically endorsing the segment's upbeat attitude in relation to getting

the most out of life. Most, however, were clearly unhappy with the idea of taking more risks and all admitted that they care about how they look. Nonetheless, HI seemed a more exciting and potentially enjoyable posture than what was seen as the 'sensible' BC situation adopted by these respondents. Interestingly, HI was the segment that many believed they had occupied before taking more control of their behaviour (and perhaps some of the approval for HIs was based on nostalgia for a 'wilder' youth).

Equally, some respondents believed that they had been LfTs in their younger days. Now, however, they typically rejected the short-term outlook of the LfTs and disapproved of the lack of structure apparent in LfT behaviours and life choices. Many felt that they know LfTs and some have even tried to offer advice and support for change. The LfT outlook was strongly linked to younger people by these respondents and sometimes characterised as 'typically teenage' in posture and philosophy.

Finally, Health-conscious Realists (HCRs) were often seen as a 'bit dull' by these BCs. The option to take no risks at all and a lack of interest in looking good made the HCR segment seem rather worthy to many (especially younger) BC respondents. Older BCs could typically see how HCR might be a natural progression for themselves, given that the instinct and opportunity for risk-taking was seemingly diminishing with age. Even among these respondents, however, there was a sense that taking no risks at all might mean giving up fun altogether.

Overall, it was clear that BCs saw themselves as a sensible compromise between the ascetic discipline of HCRs and the wild excess of HIs. There was little indication that BCs wanted to move towards other segments, apart from

some older respondents who saw greater control over health behaviour as a natural and rational aspect of the ageing process.

### 5.6.6 Interventions: environmental factors

Free access to exercise classes and facilities was welcomed across the BC sample. It was generally seen as a sensible option which would produce very positive long-term outcomes for the quality of national health. These respondents were typically, however, already focused on exercise as a straightforward method of compensating for bad behaviour. Consequently, the idea of being able to satisfy this need without cost was always likely to be appealing at a personal, as well as an altruistic, level.

Mass condom distribution was also positively received. It was believed that, with AIDS and sexually transmitted infections on the rise, this would represent real encouragement to act safely in relation to sex.

The idea of measuring BMI and providing healthy food vouchers to those who improve their BMI received a more mixed reaction. While some saw this as a good idea for poorer people in particular, it was clear that many of these BCs felt that it was a step too far and beyond the remit of the state.

Equally, banning junk food advertising was dismissed as unlikely to have any real impact. Respondents felt that the visible presence of junk food throughout supermarkets means that it will still be purchased despite an advertising ban.

### 5.6.7 Interventions: health checks

Respondents were prompted with stimulus about health check service called the GO

Men's Health Check (see appendix 16 for full details). The idea of measuring and monitoring BMI was well received and a variety of health-focused locations such as the gym, GP or hospital were all believed to offer suitable opportunities for a valuable check-up. In relation to compulsory health programmes, however, there was consistent scepticism about the practicality and likely success of such an approach. Many respondents feared that linking compulsory action to health checks would discourage those who actually need help from seeking it.

On a personal basis, older BCs welcomed the idea of having regular health checks and saw this as a sensible method of ensuring their ongoing quality of life.

### 5.6.8 Interventions: single and linked approaches

Overall, there was a positive response to the idea of a linked approach to dealing with health issues. It was seen as sensible to look at behaviours which might be influential when considering an issue such as alcohol misuse, for example. Some respondents thought it would be helpful to examine this behaviour in relation to drug use, mental health and smoking, all of which were believed to play a part in maintaining damaging habits and behaviours.

The only questions concerning a linked approach to intervention focused on the possibility of taking on too much by looking broadly at behaviour and thereby missing the opportunity to take practical action in relation to a single key aspect of lifestyle. Some respondents were worried that it would be easy to give up when faced by a complex series of interlocking and mutually supporting behaviours.



### 5.6.9 Interventions: mentoring

BCs expressed an immediate and powerful aversion to the term 'mentoring' in relation to themselves, as it seemed to many to imply interference, control and 'nannying'. All were, however, very positive about the idea of gentle support and encouragement – and, indeed, most of the sample admitted to having offered support and advice to friends and family in the past.

The issue, therefore, seems to be one of tone – BCs clearly exhibited their sense of personal control and potential for influence when considering the idea of mentoring. Few believed that mentoring would be appropriate for themselves, since most believed that they 'knew best' in relation to their own health. If the concept were presented in a more mutual and supportive context, then it seems likely that BCs would embrace it. Certainly, at present, most seem to both take and give advice as part of the normal management of their health choices and issues.

When considering other people, however, respondents were very open to the idea of mentoring. It appeared the segment had a natural inclination to mentor and support those around them to become more healthy:

*"I'd like to help someone improve their life and motivate them to become healthier. It would make me feel good about myself."*

(Female, Younger juggler, IMD 4–6, St Albans)

BCs reported that they had recently:

- encouraged friends to attend the gym;
- advised friends about which gym classes to take;
- counselled friends if they engaged in self-destructive activities;

- advised students to have health checks;
- helped a friend to stop smoking; and
- motivated family members to lose weight and become fitter through exercise – leading by example.

Typically, BCs preferred an advisory role as opposed to what they viewed as proactive 'help'. Essentially, the segment understood that people had diverse needs and motivations and were reluctant to force their own way of life on others:

*"You've got to be very careful how you help people, because in the long run it's down to themselves and you don't want to nag."*

(Female, Alone again, IMD 1–3, Liverpool)

### 5.6.10 Interventions: enforced changes

There was consistent support for the ideas of enforcing a zero drink-driving limit and charging for alcohol-related accident and emergency admissions. These were seen as unacceptable and irresponsible behaviours which ought to be penalised – and which more sensible members of the public (such as these BCs) should not have to support by providing services.

In relation to other enforcement approaches, however, the BCs were less enthusiastic. Some – such as keeping alcohol under the counter, 'alcohol kills' stickers and banning junk food advertising – were seen as unlikely to be successful because they rely on bad behaviours being easily deterred and assume a sense of shame on the part of target consumers. As individuals who often take a conscious decision to indulge in bad behaviour, these respondents were very aware that it takes more than minor social barriers to alter choices. Spraying the smell of oranges in retail

environments was seen as a charming idea, but marginal in terms of producing worthwhile behavioural change.

Equally, few reacted well to the idea of compulsory health programmes. Most believed that choice and education are fundamental factors in designing approaches to managing health behaviours. All agreed that they would simply opt out of a compulsory system and choose access points that allow them to retain a measure of control.

Overall, BCs were reluctant to relinquish control over their health decisions and typically rejected major state interventions unless they enable the 'sensible' (like themselves) to opt out.

#### 5.6.11 Interventions: national state interventions

There was wholehearted and broad support for the idea of standardising food/drink labelling. This was seen as an initiative which would provide them with better and more consistently available information in order to make choices about health. BCs could clearly see real benefits for themselves in such an intervention.

Funding local outreach projects received a less enthusiastic response, although several BCs supported the idea in principle at least. It was obvious, however, that few of the respondents believed this to be an initiative aimed at themselves.

Some felt that using the Samaritans branding for health advice gives a negative and overly serious aspect to the intervention. It was felt that making the outreach element more positive and local in tone would encourage more people to become involved.

#### 5.6.12 Interventions: sources of advice/support/information

These respondents were determinedly independent in relation to sources of advice and information. Most preferred to do their own searching for health information, using the internet, friends/family and trusted resources such as the local gym.

Few believed that government would be a first choice as provider of advice, information or support: most assumed that there would be a political agenda associated with government-sponsored advice. Most of the respondents were happy to trust the NHS brand, but this was seen as mainly concerned with the treatment of illness rather than the promotion of healthy behaviour choices.

Overall, BCs seem unlikely to welcome strong government branding on interventions. This is a segment which sees itself as knowledgeable and capable in terms of making choices about health – and adept at compensating when damaging behaviours have occurred.

## 5.7 Balanced Compensators: summary of focus group and immersion depth findings

This segment demonstrates a number of **consistent characteristics**:

- **core goals**, in terms of looking and feeling good;
- **an aspirational outlook**, with goal-setting and planning as norms;
- a sense of **control over its health**;
- general **satisfaction** with its current state of health;
- a **feeling of control over health issues** and a preparedness to take remedial action if necessary;
- a feeling of **control over risky behaviours**; and
- an **effective compensatory response** to address perceived damage produced by risky behaviour.

This is a **resilient segment**, which believes that its resilience is the product of both upbringing and strong support networks among family and friends. These respondents are not afraid to change their social set if they believe that it is a bad influence on their own behaviour. Respondents typically believed that their own resilience had been established by important (and often traumatic) life events.

**Influences upon health status are relatively few**, since this segment sees itself as largely in control of its health choices. Celebrities and sports stars have some influence on younger members, while the needs of family affect Jugglers and the views of healthcare professionals are important to older lifestages.

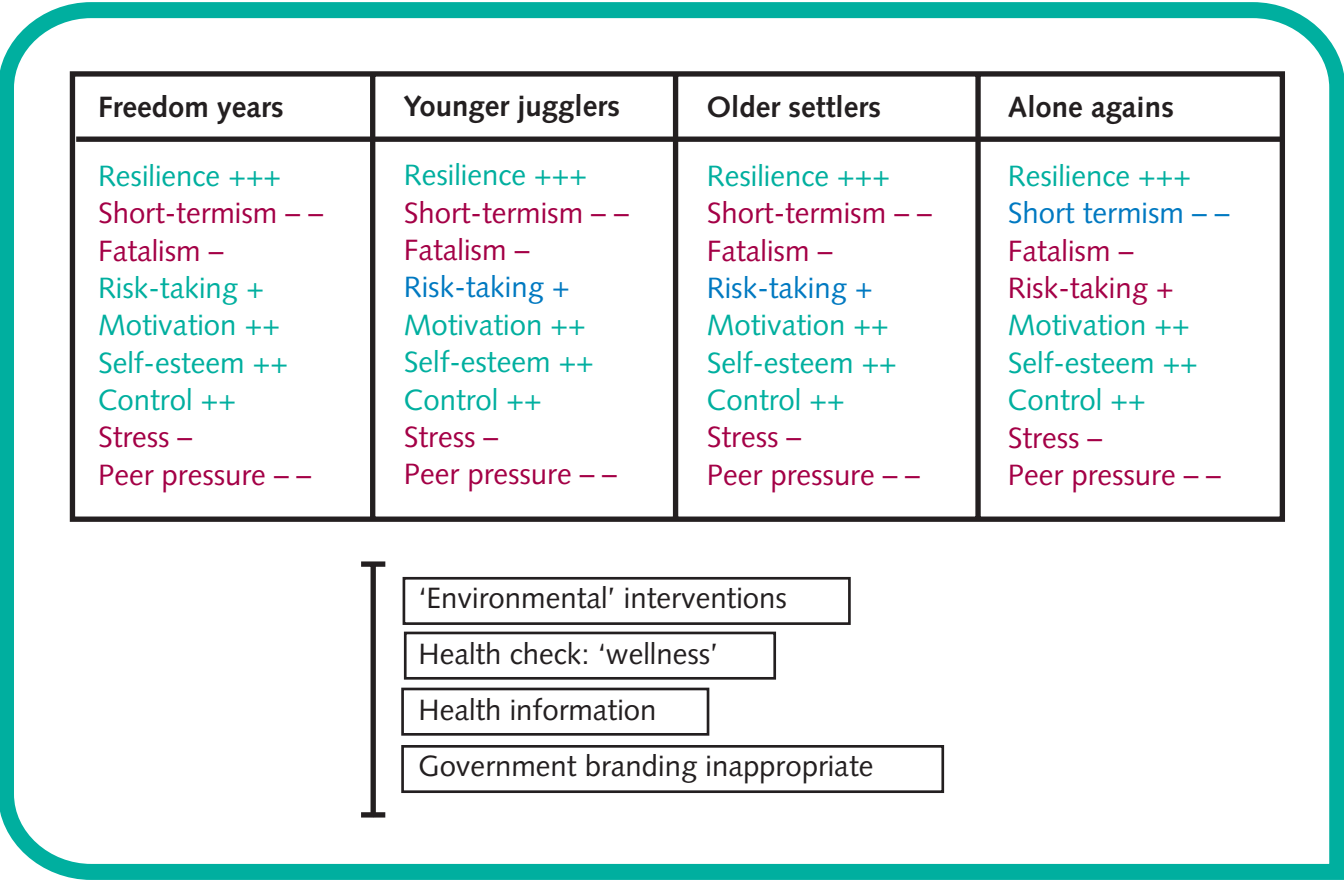
Most believed that they had **either 'always' been BCs or emerged from the LfT segment** (when they were younger and wilder). Many aspired towards the HI outlook (seen as more exciting), but assumed that they would naturally develop into HCRs (even though this was viewed as quite unexciting).

In relation to **interventions**:

- this segment is strongly affected by factors such as **quality of environment** and **access to facilities**;
- they typically **reject prescriptive or 'nanny-state' interventions**, since they want to maintain control over health decisions;
- in many cases they wanted **information only**, and then to be left alone to make their own decisions;
- **wellness is an appealing idea** and the notion of health checks was consistently welcomed as relevant;
- a **linked approach to health interventions was positively received**, but mostly because this segment already sees itself as already operating a similar approach: this approach was seen as 'too hard' for non-BCs;
- the **idea of mentoring was immediately rejected** and BCs would clearly need a much softer, more informal and supportive presentation of such a concept.

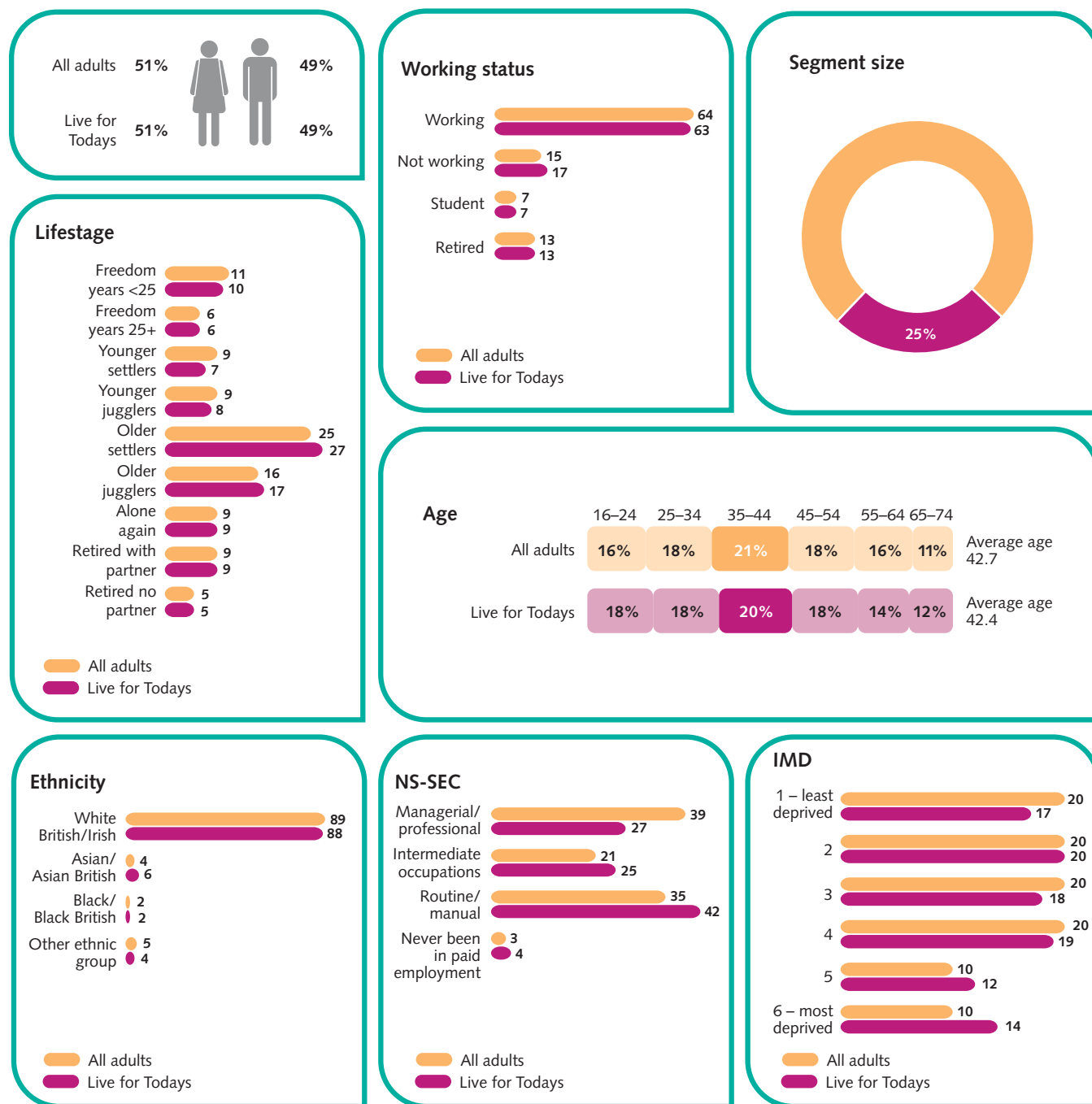
- **enforced changes** which punish obviously irresponsible behaviours (drink driving, for example) were supported, but respondents **rejected compulsion in most cases**, preferring to retain control over their health choices;
- **national state interventions**, such as standardised food labelling, were supported, because they would help BCs to make better-informed choices; and
- **government branding of health advice and information was rejected**: this is a segment which sees itself as independent and able to make its own decisions about health issues.

Figure 5.6: Balanced Compensators: lifestages and motivations



# 6 Live for Todays

Figure 6.1: Live for Todays: demographics/lifestage



Base: All respondents (unwtd 4,928, wtd 4,928, ess 2,496)/Live for Todays (unwtd 1,396/wtd 1,256/ess 642)

Live For Todays (LfTs) represent one quarter (25%) of the overall sample. A large proportion of respondents are in routine/manual occupations (42%). LfTs cover all demographic groups and tend to live in more deprived areas.

## 6.1 Verification

The research itself indicates that expectations of this segment might be influenced by the commonly used label 'Live for Today', which assumes that respondents would be upbeat and fun-loving in their approach to life and health. It appears, however, that the term may be misleading: the segment were certainly not as carefree as this label suggests (for reasons that are outlined later).

Respondents typically focused on the here and now – and actively avoided thinking about the past or the future, assuming a very short-term outlook on life:

*"Everything happens for a reason. Don't look back and just deal with the present. You can look forward but you're never going to know what will happen."*  
(Female, Freedom years, IMD 1–3, Croydon)

This process involved distracting themselves through the pursuit of pleasure and generally 'keeping busy' (although this activity was rarely constructive and seemed mainly to revolve around passing time):

*"I'll occupy myself with a cleaning task or something, then once I'm finished I feel good about myself again."*  
(Female, Alone again, IMD 4–6, Lewisham)

Plans were either immediately focused or, in fact, non-existent:

*"If you don't make plans, things don't go wrong...I can't complain if things don't turn up how I don't want them to turn out."*  
(Male, Freedom years, IMD 1–3, Leeds)

LfTs were not an obviously homogenous group, although clear common attitudinal patterns gradually emerged from the research.

The LfT lifestyle tends to be chaotic and unstructured. This type of lifestyle was claimed as a choice by some, but for most seemed to be a consequence of external circumstances or influences (such as a chaotic upbringing, having children or poor mental health):

*"I'm not massive on the future...I'm not massively ambitious, I like to enjoy myself."*  
(Female, Alone again, IMD 4–6, Lewisham)

*"I never have time to enjoy things, it's always grabbing things and running between places and tasks."*  
(Female, Younger juggler, IMD 1–3, Leeds)

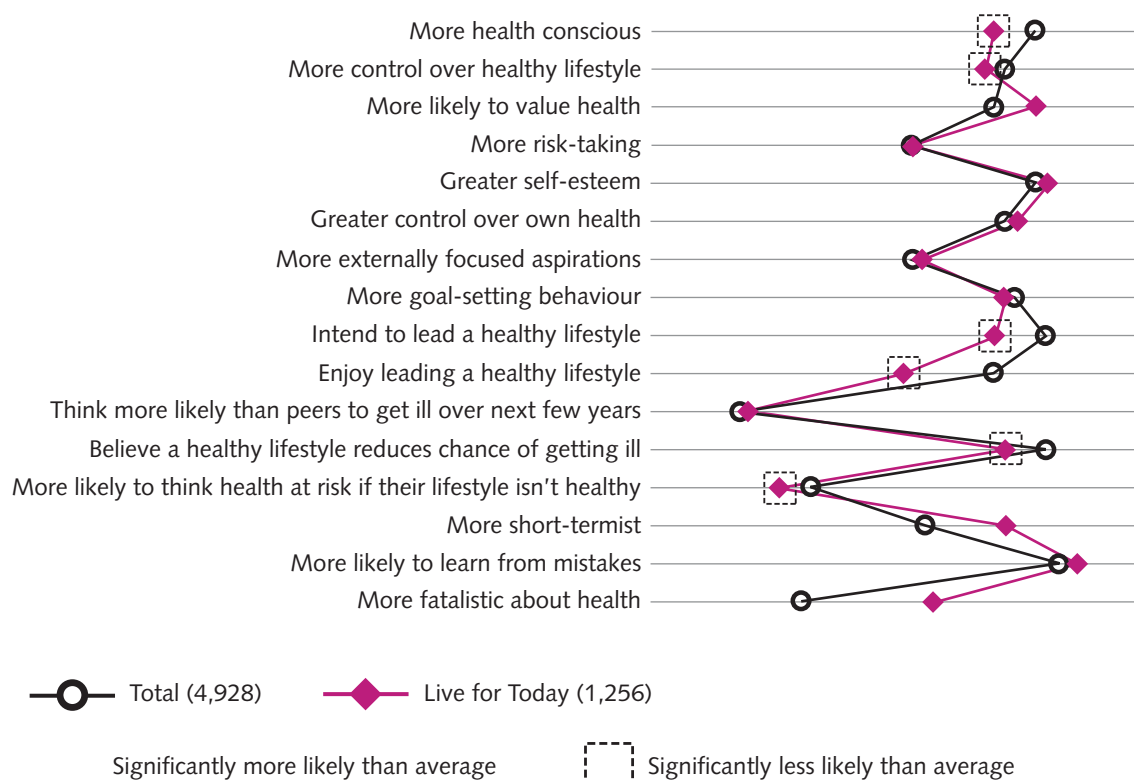
Respondents tended to present a positive image of themselves – superficially, most appeared to be outgoing and highly sociable. However, this was not always an accurate representation of the inner thoughts and feelings of LfTs, as is shown in figure 6.3 (see page 66).

Respondents typically agreed that they like to see themselves as 'living for today'. For LfTs, this is not a way of life, but more a state of mind:

*"It's all about enjoying the now. You never know what's around the corner and there's no point in worrying too much about it."*  
(Male, Younger juggler, IMD 4–6, Newcastle)



Figure 6.2: Live for Todays: motivations



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Live for Todays (unwtd 1,396/wtd 1,256/ess 642)

Unlike Balanced Compensators (BCs), for example, LfTs do not express a consistent philosophy regarding life and health. LfT values were clearly variable and shifted noticeably between respondents:

*"Going to the gym, sometimes I get in the 'health mode', I go up and down."*  
 (Male, Freedom years, IMD 1–3, Leeds)

Respondents generally agreed with the attitudinal statement 'What happens with my health is decided by fate':

*"You hear about footballers and athletes dropping dead, and then you hear about people who smoke sixty a day living to their eighties. There's just no way of knowing."*  
 (Male, Younger juggler, IMD 4–6, Newcastle)

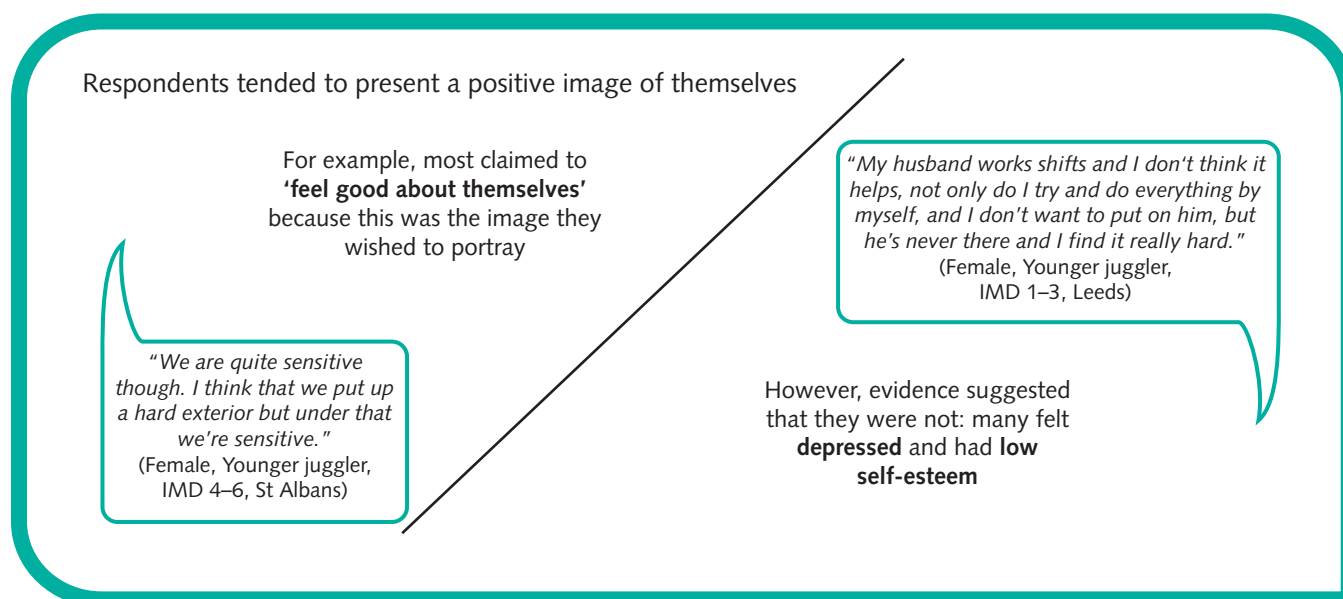
*"We all have cancerous cells within us... it's just random who gets it."*  
 (Female, Freedom years, IMD 1–3, Croydon)

Respondents tended to feel that they can control their health, but cannot control the onset of illness, which they see as decided by fate. There was a lack of recognition of the extent to which 'control' (i.e. 'what I personally do') might influence the possibility of future illness:

*"I had cancer cells removed a few years ago and was supposed to go back every three months but never did. I just think 'if my time is up, it's up.'"*  
 (Female, Younger juggler, IMD 4–6, St Albans)



**Figure 6.3: Live for Todays: positive images**



*"It depends if you're looking at serious illness, because that comes down to fate."*  
(Male, Freedom years, IMD 1-3, Leeds)

Belief in fate and an essentially short-termist outlook means that LfTs are unlikely to make any significant efforts to look after their health. In their own eyes, respondents:

- did not think they are any more likely than anyone else to get ill in the future:  
*"I compare to everyone else I know and I don't think I'll get sick."*  
(Female, Younger juggler, IMD 4-6, St Albans)
- generally focus on the here and now, rather than worrying about the future:  
*"You never know what's going to happen."*  
(Male, Freedom years, IMD 4-6, Lewisham)
- did not think a healthy lifestyle would be generally easy or enjoyable to achieve:  
*"I find being healthy really difficult to achieve, there's so much temptation out there, and healthy food is so expensive."*  
(Female, Alone again, IMD 4-6, Lewisham)

The interplay of these elements is summarised in figure 6.4.

Interestingly, LfTs did not see themselves as risk-takers, in spite of their own reports of a high level of poor health behaviours. From their own perspective, respondents were simply enjoying themselves and coping, as best they can, with the many challenges presented by everyday life. Cumulatively, however, it was clear that their behaviour is likely to prove damaging in the longer term (for example, through drinking excessively, smoking, poor diet and no exercise):

- "I'm supposed to take an hour break away from my computer screen in work for health and safety but I don't. Usually I'll eat my lunch at my desk and then split the hour up to take cigarette breaks."*  
(Female, Freedom years, IMD 4-6, Sheffield)
- "One of the worst things is going to a café for breakfast then having a Chinese or something in the evening and you know that you haven't eaten anything of any nutritional value whatsoever that day!"*  
(Male, Freedom years, IMD 4-6, Lewisham)

Figure 6.4: Live for Todays: fatalism and short-termism

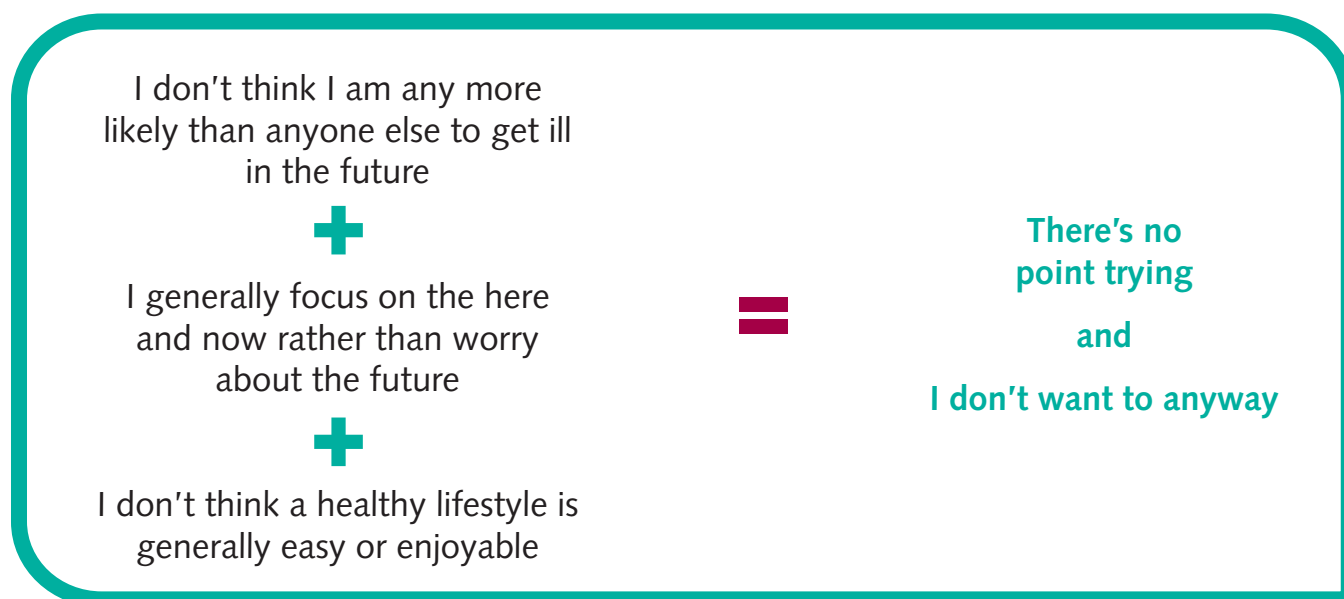
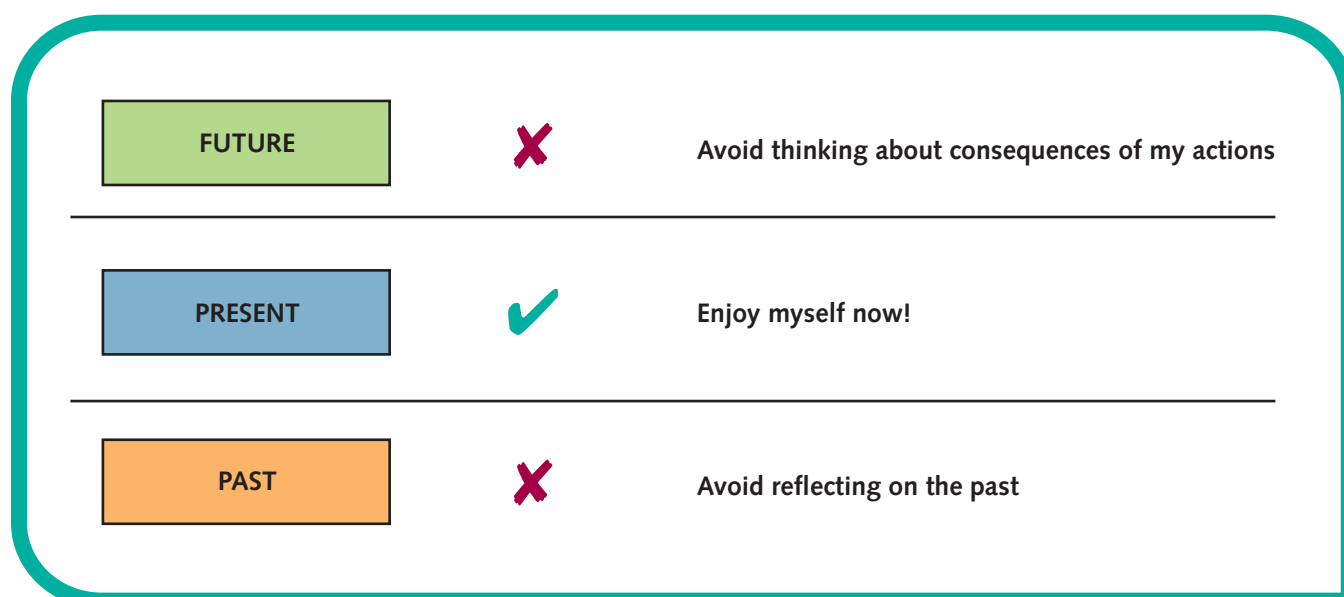


Figure 6.5: Live for Todays: past, present and future



These quotes illustrate some of the ways in which respondents are damaging their health long term, while their views regarding life priorities are shown in figure 6.5.

## 6.2 Environment

There were significant differences in the ways that respondents from IMD 1–3 and IMD 4–6 perceived their local areas. Equally, health

behaviours certainly appeared to be affected by the environment.

Respondents from IMD 1–3 typically viewed their local area very positively – often on the basis of what were seen as good schools and facilities, shopping and pubs. Many had moved into their area because they saw potential for a positive environment to enhance their lives:

*"There's loads for the kids to do. There's rugby clubs, cricket clubs, running clubs, football clubs, there's so much going on."*

(Female, Younger juggler, IMD 1–3, Leeds)

*"I love Croydon. People put it down but I love it a lot!"*

(Female, Freedom years, IMD 1–3, Croydon)

Those, however, who had physically moved home were often unable to psychologically and socially 'move on' from established friends and family, frequently claiming to miss their old life. New environments seemingly offer less opportunity for socialising (which inevitably, for this segment, involves drinking and smoking at the very least), meaning that many in this segment are (if unwillingly) at less risk of harm to their health.

IMD 4–6 respondents were clearly aware that their local environments might be seen as deprived, but nonetheless, all identified strongly with their own area. Despite obvious evidence to the contrary, respondents typically defended their local area (almost regarding it as their 'territory') and none felt that they would be likely to leave in the short term:

*"I couldn't see myself anywhere else you know? It's where I've grown up, I know my way around, I like it here."*

(Male, Younger juggler, IMD 4–6, Newcastle)

*"If you live there you're known and you know how it is so you kind of adjust to it."*

(Male, Freedom years, IMD 4–6, Lewisham)

Transport and community were key perceived positive factors:

*"It has a high crime rate, and it's a bit too rowdy, but it's multicultural and the transport is very good."*

(Female, Alone again, IMD 4–6, Lewisham)

The concept of 'roots' was also considered very important. Social groups (i.e. family and friends) were evidently interdependent and individuals remained loyal to their roots, unwilling to risk losing established support networks:

*"If you lose family and partners it can be much harder, because you rely on those people to get you through things."*

(Male, Alone again, IMD 4–6, Sheffield)

Respondents relied heavily on the social aspect of their lives (which again would involve drinking and smoking at a minimum) to 'escape' from life challenges:

*"In terms of dealing with it, I'd go to the pub, and spend time with my mates."*

(Male, Freedom years, IMD 1–3, Leeds)

Differences between LfTs from IMD 1–3 and IMD 4–6 were clear, supporting the quantitative findings that:

- for the most motivated HF segments, IMD has less of an impact on health behaviours; and
- IMD has a much stronger influence among the less motivated HF segments (including LfTs).<sup>5</sup>

5 The Healthy Foundations Life Stage Segmentation Report No.1, March 2011.

## 6.3 Key drivers

### 6.3.1 Short-termism

Planning by LfTs tends to be reactive in nature, rather than proactive. LfTs tend to respond to immediate necessity and are often forced by circumstances to 'make a plan':

*"Getting a job before Christmas so I can buy presents for my family."*

(Male, Alone again, IMD 4–6, Sheffield)

*"If someone asks me to come out for a few drinks I'm there every time, and there's always someone asking to come out for drinks."*

(Male, Younger juggler, IMD 4–6, Newcastle)

Reluctance to plan seemed to be linked to emotional states such as pessimism, fear of failure and an unwillingness to take responsibility:

*"I always say, if I don't plan then I can't fail."*

(Male, Freedom years, IMD 1–3, Leeds)

*"People are getting laid off everywhere. I can't help thinking I'll be next and there's not much you can do about it."*

(Male, Younger juggler, IMD 4–6, Newcastle)

*"I'm not that bothered about getting a job. Health-wise, I'm not sure if I'm up to it – I think they realise that."*

(Male, Alone again, IMD 4–6, Sheffield)

Where plans were devised, these tended to be highly aspirational and almost escapist in nature, rather than realistic and achievable:

*"I'm going to find myself a place in Florida or Spain. It's so expensive over here and it's not even worth it."*

(Female, Younger juggler, IMD 1–3, Croydon)

*"Something in sport or music..."*

(Male, Freedom years, IMD 4–6, Lewisham)

*"I want to go to university to study interior design, and go to the Caribbean...but boy will it take a long time...I'm scared of planning."*

(Female, Freedom years, IMD 1–3, Sheffield)

The possibility of leading a healthy lifestyle was also located in unfounded aspiration – it *would* be enjoyable, if only it *could* be achieved:

*"We don't really have a choice, the healthy options are always so expensive and it's hard to tell if they're just 'appearing healthy' with packaging."*

(Female, Alone again, IMD 4–6, Lewisham)

*"It's not easy at all, especially when you work full time and have children...it's massively difficult."*

(Male, Younger juggler, IMD 1–3, Croydon)

*"I used to go to the gym five times a week and I loved it. But now, when I weigh it up, I just don't have time for the gym. It's the first thing that slides."*

(Female, Younger juggler, IMD 1–3, Leeds)

LfTs' daily lives are strongly characterised by a lack of structure and routine. The following extracts are from the 'Key Life Events' exercise undertaken with respondents (see appendix 12) – and they clearly illustrate a lack of structure and negative impacts linked to this:

<i>Started work at bar</i>	<i>Consumed copious amounts of free booze</i>	<i>Made me fatter and stupider</i>
<i>Started work at bar</i>	<i>Consumed copious amounts of free booze</i>	<i>Made me fatter and stupider</i>

(Male, Freedom years, IMD 4–6, Lewisham)

<i>Going to University</i>	<i>Eating habits / Sleep's Habits Changing</i>	<i><del>Lethargic</del> Lethargic, gained weight until started serious sport</i>
<i>Going to university</i>	<i>Eating habits/sleeping habits changing</i>	<i>Lethargic, gained weight until started serious sport</i>

(Male, Freedom years, IMD 4–6, Lewisham)

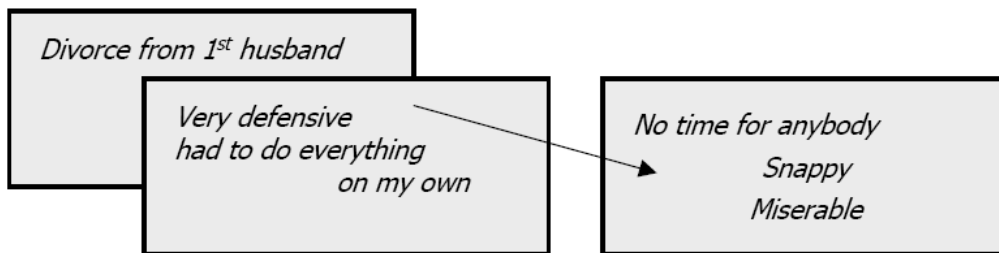
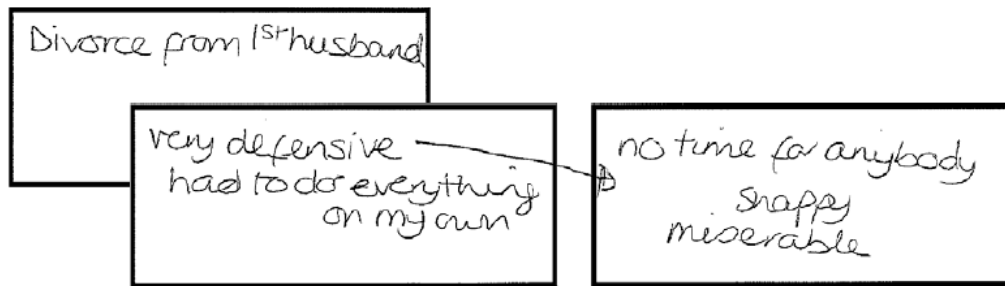
<i>Divorce</i>	<i>Take over responsibility Take on all chores/tasks. low self esteem.</i>	<i>- <del>stressed</del> - stressed. - under pressure } low tolerance levels</i>
<i>Divorce</i>	<i>Take over responsibility. Take on all chores/tasks. Low self esteem</i>	<i>-Stressed } low -Under pressure } tolerance levels</i>

(Female, Younger juggler, IMD 1–3, Leeds)

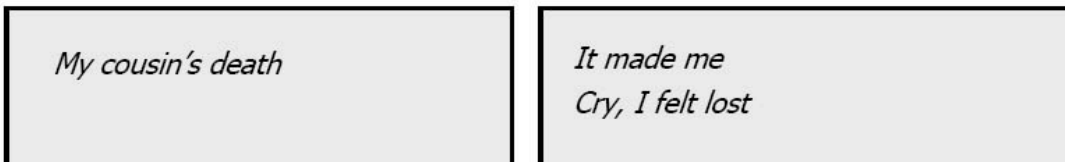
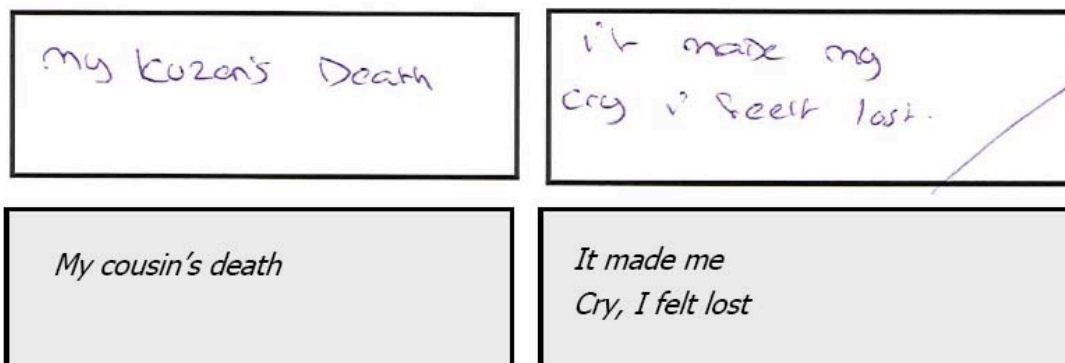
### 6.3.2 Resilience

The qualitative data supports the quantitative conclusions that LfTs do not show resilience when faced with negative situations. Respondents frequently reported depression and an inability to cope when dealing with

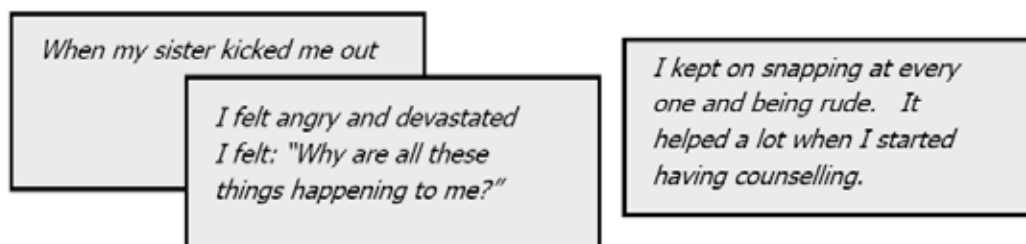
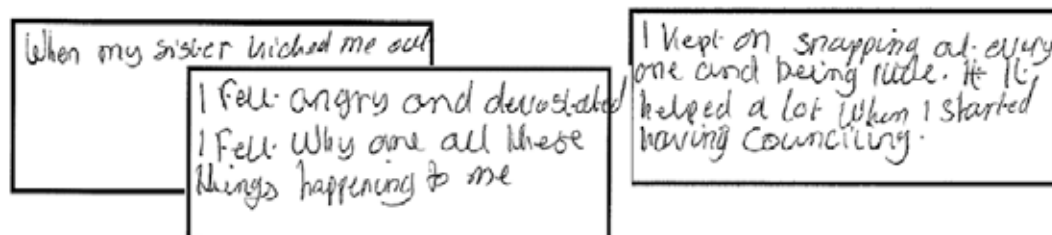
challenges. This is illustrated in the ‘Key Life Events’ extracts overleaf.  
  
 This lack of resilience can strongly reinforce poor health choices, as many LfTs typically resort to alcohol, drugs, eating and smoking as a means of escape:



(Female, Younger juggler, IMD 1–3, Leeds)



(Female, Freedom years, IMD 4–6, Sheffield)

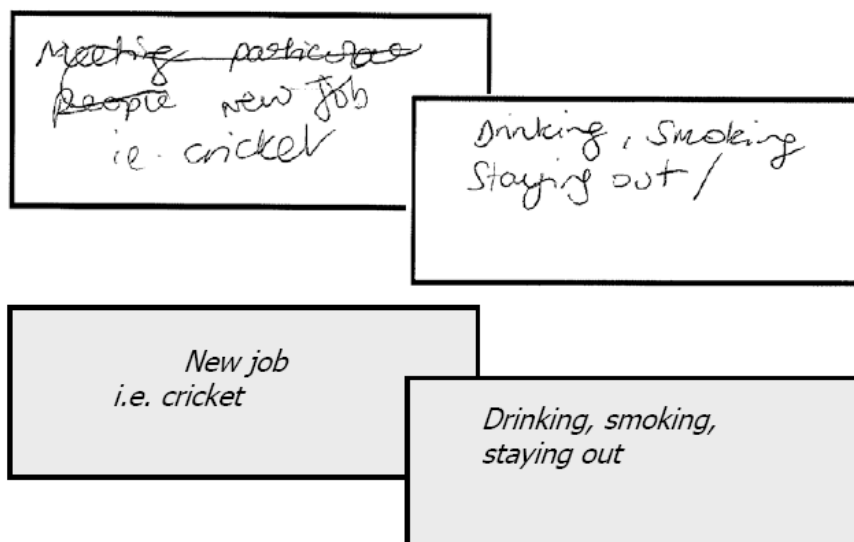


(Male, Freedom years, IMD 4–6, Lewisham)

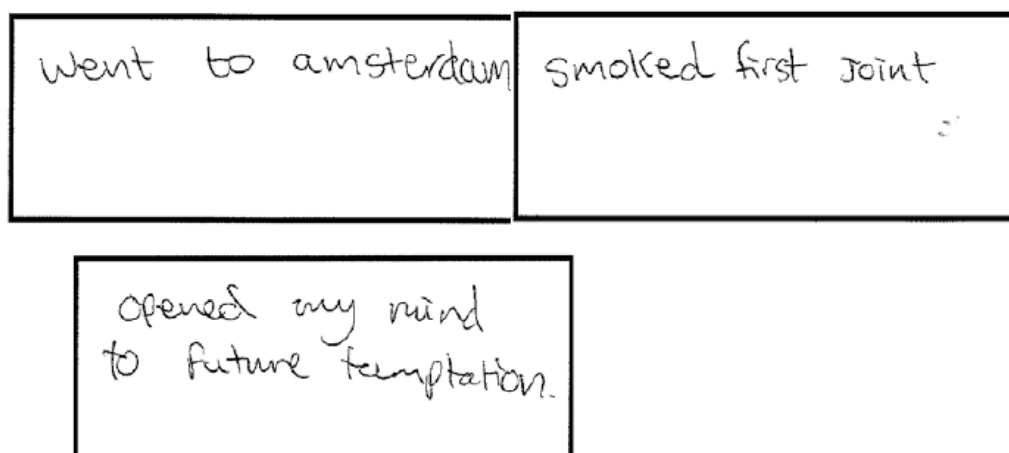


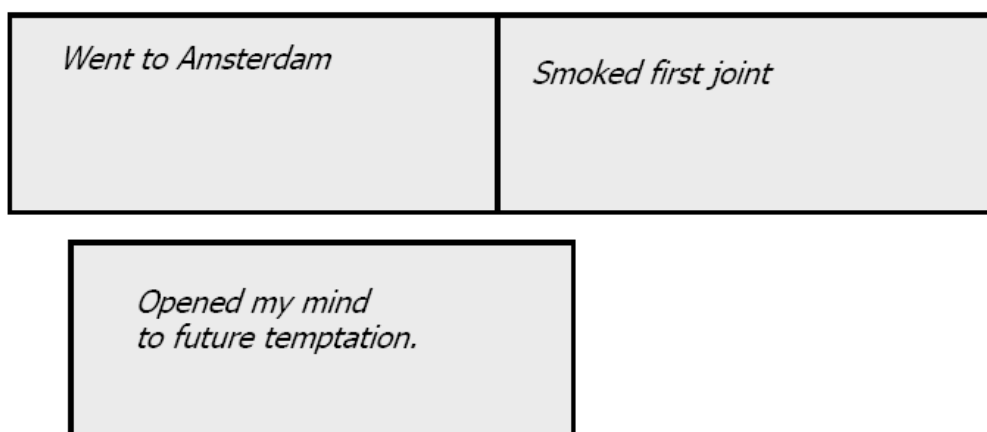


(Female, Younger juggler, IMD 4–6, St Albans)



(Female, Younger juggler, IMD 4–6, St Albans)





(Male, Freedom years, IMD 4–6, Lewisham)

Lifestage also seemingly affects levels of resilience. Those with families were more likely to be cutting down on bad behaviours (if not *valuing* their own health):

*"I couldn't behave like that with the little one, you know what I mean? I've got responsibilities and purpose now. Back then I was a loose cannon."*

(Male, Younger juggler, IMD 4–6, Newcastle)

Alone again and Freedom years were the most disengaged lifestages within this segment, with Freedom years most likely to be taking overt risks with their health:

*"What's the point, I've got no chance anyway."*

(Male, Freedom years, IMD 4–6, Lewisham)

*"When it comes to my health, I just don't think about it, simple as that..."*

(Male, Alone again, IMD 4–6, Sheffield)

*"Healthy food just doesn't taste as nice as unhealthy food. If I had the time to have a fry-up every morning I would, because that's what I like to eat. It's the same thing with exercise – watching TV's a lot more enjoyable than swimming...I think I'm too young to think about long-term things at the moment."*

(Female, Freedom years, IMD 1–3, Croydon)

The LfT response to negative life situations can typically be characterised as follows.

Most start with expressions of low self-esteem and poor coping ability. When something bad happens, they seek immediate distraction from problem issues in order to 'feel better':

*"I'll just take each day as it comes and try to keep busy because if you stop and sit down and think you can become overwhelmed – but you don't really have the choice to stop, you have to keep going for the kids."*

(Female, Younger juggler, IMD 1–3, Leeds)

However, it is clear that this distraction is only temporary in nature and the problems tend to persist, which leads to further reduced self-esteem and an inability to cope without direct assistance (showing low levels of self-reliance):

*"Drinking at the time is really good, but the next day I get this thing called 'beer fear'. I get paranoid and I worry about things: I get anxiety."*

(Male, Freedom years, IMD 1–3, Leeds)

### 6.3.3 Fatalism

A strong belief in fate combined with a lack of motivation for independent or control-focused behavioural choices was evident across the segment.

Respondents in IMD 4–6 were generally resigned to the circumstances they are born into:

*"Society will never let me achieve."*  
(Male, Freedom years, IMD 4–6, Lewisham)

A sense of fatalism often shaped views of relationships and friends:

*"I believe in fate in circumstances, like meeting people. I met my husband at university, though where I attended wasn't my first choice. If I had got my first choice then I wouldn't have met him."*  
(Female, Younger juggler, IMD 4–6, St Albans)

Even those who were successful in their careers believed this to be a fortuitous accident rather than the results of their own efforts and achievements:

*"Some things feel like fate, like the job I got."*  
(Male, Freedom years, IMD 1–3, Leeds)

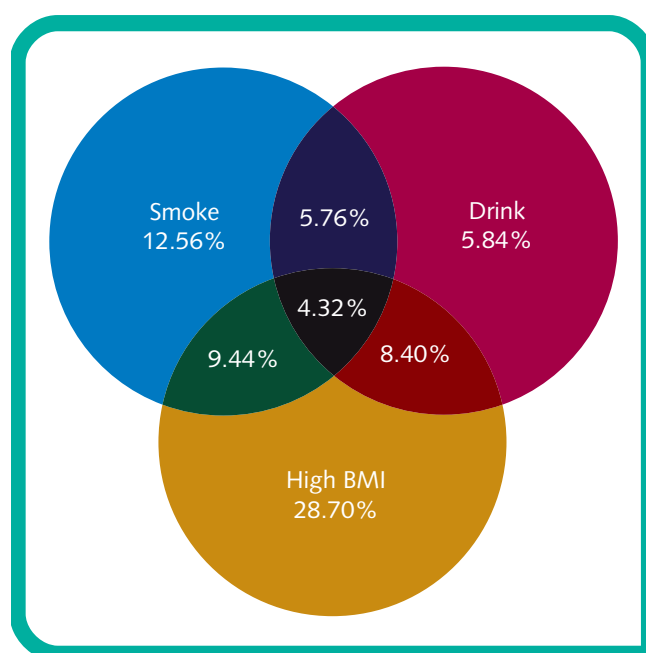
Fatalism was often used as an excuse for poor health choices. Respondents typically recognised that they could maintain 'health' if they decided to exercise, diet and limit smoking and drinking.

However, most used fatalism as a rational barrier to making this decision – as is shown in figure 6.7 opposite.

### 6.4 Factors influencing health choices

Overlapping 'poor' health behaviours was common in this segment. The extent of overlapping behaviour is substantiated by the quantitative data, as illustrated in figure 6.6.

**Figure 6.6: Live for Todays: overlapping behaviours**



Source: Research Report No.1

Over 4% of LfTs (the highest of all five segments) smoke, drink and have a high body mass index (BMI).

Some of the poor decisions made by respondents are illustrated by the diary extracts shown below, and include:

- smoking, driven by perceived stress and social influences;
- heavy drinking, particularly binge drinking, which is used as a means of 'escape' and strongly maintained by habit;
- junk food and takeaways, often replacing cooked meals through a lack of planning; and
- limited exercise, generally blamed on lack of time, energy and money.

Figure 6.7: Live for Todays: diaries: factors influencing health choices



Number 4 decision: Smoked quite a lot.

Why did I make this decision?

Going out into smoking area when my mates did

Number 4 decision: Smoked quite a lot

Why did I make this decision?

Going out into smoking area when mates did

(Male, Freedom years, IMD 4–6, Lewisham)

Number 1 decision: Instead of having an hours lunch break, I split it up to have more cigarette breaks

Why did I make this decision?

Because I can eat my lunch at my desk I can use the time for cigarettes

Number 1 decision: Instead of having an hours lunch break, I split it up to have more cigarette breaks

Why did I make this decision?

Because I can eat my lunch at my desk I can use the time for cigarettes

(Female, Freedom years, IMD 4–6, Sheffield)

Respondents were clearly unhappy about undertaking a diary exercise which illuminated a series of poor health choices. This drove some to suggest that they would like to change their behaviour:

*"I'd like to start eating more fruit and vegetables...just have a more balanced diet, really."*

(Female, Younger juggler, IMD 4–6, St Albans)

*"I want to change things, I already am, but it's slow and the rewards are hard to notice."*

(Male, Younger juggler, IMD 1–3, Croydon)

Some did, in fact, change their behaviour for the duration of the diary exercise:

*"To be honest, I tried to be more healthy for this diary, I'm looking forward to treating myself a bit now."*

(Male, Younger juggler, IMD 1–3, Croydon)

Others clearly attempted to avoid reality, either by not completing the exercise or by eventually admitting that they had lied about their behaviour in the diary:

*"Where I couldn't think of any more health decisions, I put that I ate some fruit in... I never eat fruit!"*

(Male, Alone again, IMD 4–6, Sheffield)

Number 1 decision: Hang over.

Why did I make this decision?

Drink to get over my problems but made the wrong choice.

Number 1 decision: Hang over.

Why did I make this decision?

Drink to get over my problems

(Female, Freedom years, IMD 1–3, Croydon)

Number 4 decision: TOO MUCH ALCOHOL

Why did I make this decision?

SATURDAY MY GOING OUT DAY.

Number 4 decision: Too much alcohol

Why did I make this decision?

Saturday my going out day

(Male, Alone again, IMD 4–6, Sheffield)

Number 3 decision: I had a kebab for dinner

Why did I make this decision?

because I was in a rush to go out

Number 3 decision: I had a kebab for dinner

Why did I make this decision?

Because I was in a rush to go out

(Male, Freedom years, IMD 4–6, Lewisham)

Number 1 decision: Eating too much biscuits and chocolates

Why did I make this decision?

My husband wasn't at home for dinner so I couldn't bother to cook for myself

Number 1 decision: Eating too much biscuits and chocolates

Why did I make this decision?

My husband won't be at home for dinner so I couldn't be bothered to cook for myself

(Female, Younger juggler, IMD 4–6, St Albans)

Number 1 decision: Visited the gym. Did a low tolerance workout, to ease my conscience

Why did I make this decision?

To 'pretend' I'm healthy

Number 1 decision: Visited the gym. Did a low tolerance work-out to ease my conscience (which is spelt incorrectly in the hand written note – conscious)

Why did I make this decision?

To "pretend" I'm healthy

(Male, Younger juggler, IMD 1–3, Croydon)



Although the diary had alerted many respondents to their unhealthy choices, none intended to make changes as a consequence of the exercise. LfTs were evidently unwilling to sacrifice the behaviour that offers vital rewards in the form of pleasure and comfort:

*"I want to give up smoking but I don't want to give up smoking."*

(Male, Freedom years, IMD 4–6, Lewisham)

*"I tried to stay in the other Friday, but I got bored out of my head and I had to meet up with my mates at the pub. Then that was it, I was off on the drinks again."*

(Male, Freedom years, IMD 1–3, Leeds)

Key triggers for many poor health choices were emotional in nature (such as stress and depression) – the impacts of this are shown in figure 6.8 below.

*"I just feel that when I rush I tend to grab the wrong foods and be led by my emotions too much."*

(Female, Younger juggler, IMD 1–3, Leeds)

*"I learned that if I'm feeling negative I'll eat what I'm not supposed to."*

(Female, Younger juggler, IMD 4–6, St Albans)

*"It's when I get bored I do the wrong things."*

(Male, Younger juggler, IMD 4–6, Newcastle)

These emotional triggers typically generated a desire for escape, which is generally met through comfort eating, smoking, drug use and drinking excessively:

*"Smoking gets you away from everyone and it's a good stress reliever – it's a mental thing."*

(Male, Freedom years, IMD 1–3, Leeds)

*"If you're broke you can just sit in your room with a joint and get wasted and watch some documentary about monkeys. You don't care!"*

(Male, Freedom years, IMD 4–6, Lewisham)

Many of the poor health choices made were linked and respondents were especially strongly influenced by social cues for bad behaviour.

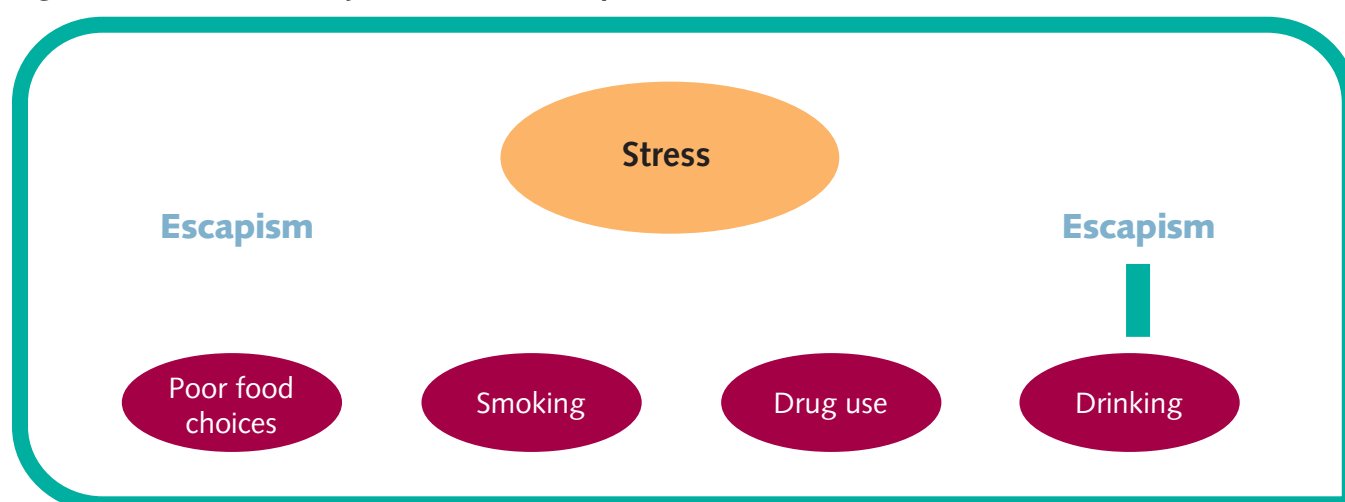
LfTs reported moments of 'guilt' when they recognise that making more positive health choices would be beneficial. Unfortunately, most end up feeling even more guilty because they:

- 'put off' changes:

*"I've done small things, but not really enough to make a difference, especially at this age."*

(Female, Alone again, IMD 4–6, Lewisham)

Figure 6.8: Live for Todays: stress and escapism



- or fail to maintain changes:

*"Trying to diet, not planning for the week with food and then just having a take away instead."*

(Female, Younger juggler, IMD 1–3, Leeds)

## 6.5 Interventions

### 6.5.1 Views about overall health

LfTs neither wish to, nor truly believe that they can, change their health choices. They enjoy their lifestyle now and do not want to consider the future consequences of their current actions. Their chosen lifestyle helps them cope, their social networks support both themselves and their behaviour, while motivation for change is lacking because of:

- a strong belief in fate:

*"Even healthy people die, which makes me think 'what's the point'."*

(Male, Younger juggler, IMD 4–6, Newcastle)

- low self-esteem:

*"I genuinely can't rely on myself to change, I'll fall back into it."*

(Male, Alone again, IMD 4–6, Sheffield)

### 6.5.2 Intervention approaches

LfTs are, therefore, quite clearly in denial about their health, which manifests itself as a lack of motivation regarding healthy behaviour. To motivate LfTs will require assistance with willpower, the offer of alternative coping strategies, as well as practical support (for example, in terms of time management).

Crucially, many in this segment also lack the strength to structure their lives or take control of their health. Most lack self-reliance. In terms of support, LfTs will require constant

monitoring and a consistent support structure to help them maintain positive behaviours:

*"What I need is a structure, something that will work for me, something personalised, something that goes as far as to plan my supermarket shopping and what to buy and how to cook it!"*

(Male, Alone again, IMD 4–6, Sheffield)

Single issue services were of particular interest to these respondents, because these seemed realistic, achievable and practically focused upon specific aspects of behaviour. Some respondents had heard about single issue services and showed interest (particularly regarding smoking and diet). Equally, the idea of personalised advice was appealing:

*"Practical advice and guidelines on how and what to eat."*

(Male, Alone again, IMD 4–6, Sheffield)

Positive, practical advice regarding single issues could also be offered as a way of more generally informing healthy choices (particularly regarding diet and exercise):

*"I'd like a cook book question [service] online where someone could answer back and respond to you in a reasonable amount of time."*

(Female, Younger juggler, IMD 1–3, Leeds)

A majority of respondents, however, seemed unlikely to spontaneously choose to change unhealthy behaviour – and so would be unlikely to seek out services of their own accord. Additionally, it seems that LfTs' poor health choices are often based on broader emotional foundations – meaning that progress on a single behavioural issue might be limited and service users could relapse easily.

Respondents reacted positively to the idea of a health check, which most felt might provide reassurance and motivation. Many had concerns about their health, but were not currently taking steps to address these anxieties and were unsure exactly what could be done. A health 'MOT' was an appealing idea because it might provide reassurance that they are, in fact, 'well'.

If given 'the facts' about their personal health, many felt that they would be motivated to change their health behaviour.

As with BCs, it would be important for this service to be easily accessible and situated away from an obviously 'medical' setting.

It seemed that a structured mentoring service (such as Vitality) could provide LfTs with the necessary support. The benefits of this type of service would be to provide:

- structure (in the form of scheduled appointments, dedicated staff and a 'programme' to follow);
- support (in the form of personal mentoring); and
- evaluation (in terms of helping to maintain motivation).

For LfTs, the ideal intervention would combine:

- a service which increases knowledge about, and awareness of, personal health issues and consequently inspires change. For example, a 'health check' service to identify specific personal issues;
- a service which provides ongoing support for making positive health changes – including monitoring progress and motivating further change. 'Hands on' practical support will be required (for example, cookery classes); and

- a service which provides psychological interventions to address problems with stress, depression and poor self-esteem (such as counselling, coping strategies, parenting classes and life coaching).

## 6.6 Live for Todays: immersion depth analysis

### 6.6.1 Resilience

In the main, respondents seemed to spend time with 'people like themselves', although most believed that they could stand apart from their social group if necessary. Their own reports, however, show that many of their friends are living classically LfT lifestyles – chaotic and concerned with immediate gratification:

*"Compared to my friends and family I am similar – friendly, sociable, like a laugh, and don't take things too seriously."*

(Male, Freedom years, IMD 1–3, Liverpool)

A majority of the respondents believed that they are healthier and better-organised than most of their friends, although actual behaviour and life experience seems to contradict this assertion, with many reporting significantly damaging behavioural choices (contracting Hep C through drug use, binge drinking, pregnant with no partner).

Those in the Younger juggler lifestage were clearly affected by the constraints of caring for children and had seemingly curbed some of the worst excesses of their past behaviour:

*"I felt motivated to prove myself as more than a scummy mummy and not live on benefits."*

(Female, Younger juggler, IMD 4–6, St Albans)

LfTs typically see their friends and immediate social group as the most important influences on their own behaviour. Nonetheless, independence was seen as an important aspect

of their own character – and all believed that they were able to resist falling into the same traps as their friends. This perception, however, appeared largely to be a delusion.

### 6.6.2 Risk-taking behaviour

These respondents showed a fairly cavalier attitude towards risk. Most assumed that smoking and drinking to excess were basic, normal behaviours, becoming risky only when the participant is later unable to remember actions and consequences. Bad diet was also seen as a norm and a minor, rather than significant, lifestyle problem:

*“That’s what does it for me, I love my shots, I’d rather just stand there all night and drink cheap shots for £1. But if I had to choose it’d be Malibu and pineapple – sometimes I get in some right states. If I can’t remember what happened then I know I’ve had a good night!”*

(Female, Freedom years, IMD 4–6, Sheffield)

True risk was often judged in terms of drug use, physical harm and criminal behaviour. Lengthy binges of drinking and drug-taking (often lasting many days) were seen as moderately risky – more so for the older segments of the sample.

Other reported ‘risky’ behaviours included shop-lifting, squatting and being arrested during public demonstrations.

Those in IMD 4–6 were clearly more inclined towards extremely risky behaviour – while older segments such as Alone again were evidently trying to cut back on the worst aspects of risky living:

*“All the risk-taking that I did do, has now disappeared by living in Sheffield, that mentality has now left me.”*

(Male, Alone again, IMD 4–6, Sheffield)

Overall, this segment’s toleration of risk seems significant and its assessment of what constitutes risky behaviour is at odds with many of the other segments. The LfT lifestyle seems extreme and its judgements questionable.

### 6.6.3 Self-esteem

Younger LfTs clearly had more issues with self-esteem than their older counterparts. Freedom years respondents reported that their self-esteem generally depends on social reinforcement from friends and from competitive activities such as exercise or academic work. In the main, the younger LfTs in this sample displayed relatively low self-esteem.

Those in the Younger juggler lifestage typically based their self-esteem on family issues and bringing up children successfully was seen as a major boost to self-esteem.

Alone again respondents were typically the strongest in terms of self-esteem. Most believed that they have overcome many challenges and achieved enough to generate a satisfactory level of self-esteem.

Overall, self-esteem clearly seems to be a factor in shaping LfT behavioural choices. So much of their validation is seemingly based upon the norms of their social set that it is difficult for them to stand aside and be truly independent in terms of lifestyle choices:

*“Life would be shite without your mates, I’d have nothing to do and be bored...”*

(Male, Younger juggler, IMD 4–6, Newcastle)

### 6.6.4 Norms/social influences

The central influences for LfTs are social in nature – friends are vital in defining what is



acceptable and what is not in relation to behaviour:

*"If we think one or the other is slipping we pull each other up – because we know where each of us has come from."*

(Male, Alone again, IMD 4–6, Sheffield)

Generally, respondents felt that the influence of their friends in benign and positive – but older LfTs clearly took issue with this view and recognised that they were regularly led astray by their friendship networks.

Wholly positive influences were felt to be family and parents in particular. Although some parents may have behaved less well in some areas, the overall influence of parents was seen as orientated towards healthy choices and a sensible lifestyle.

Wholly negative influences focused on local environments, where examples of the worst types of behaviour could often be seen on a daily basis:

*"You can't go walking around because of how bad the gangs are – you couldn't go to local park for fear of being attacked by gangs of teenagers drinking there – in the daytime!"*

(Female, Freedom years, IMD 4–6, Sheffield)

Interestingly there was little variation in this factor between those living in IMD 1–3 and those from IMD 4–6. Both segments felt that their local areas had been peopled by bad influences and examples of damaging behaviour.

### 6.6.5 Segment movement

A majority of the sample agreed wholeheartedly with the LfT segment description. Most felt that they have always been LfTs and saw little evidence of other segment influences in their history. Equally,

most believed that they would continue to live the LfT lifestyle and expressed no aspirations to shift to any other segment.

Most noted that LfT qualities had first manifested themselves during teenage years and carried on unaffected by life events. Older LfTs had few questions about their short-term view of lifestyle issues and believed that it would be possible to make positive changes without abandoning the LfT philosophy, which is seen to have many beneficial qualities ('living now' being the essential trait).

### 6.6.6 Attitudes towards other segments

Interestingly, although most respondents believe that they are core LfTs and mainly associate with other LfTs, they were able to identify with other segments and spot other segments among their friends and family members.

Some respondents believed that they showed Unconfident Fatalist (UF) characteristics early in their lives, but these have been superseded by what are seen as the more fun-loving positive aspects of the LfT outlook.

Others were inclined to aspire towards Hedonistic Immortal (HI) status, which seems familiar but more positive in nature and linked to greater control over health behaviours.

None were interested in becoming a Health-conscious Realist (HCR), which was seen as an admirable outlook, but extremely dull and linked to a variety of worthy behaviours which seemed unattractive to most respondents. Few in the sample believed that they know any HCRs or have any HCRs among friends or family.

The BC segment seemed more appealing to some, since it was assumed that BCs would

typically be younger and more sociable. Respondents, however, were not especially comfortable with the idea of over-focusing on looking good or on the obvious appetite for risk that is shown by BCs.

### 6.6.7 Stress

There was a variable response to this issue, with some respondents describing themselves as 'stressed-out', while others claimed to be generally 'laid-back'.

Overall, it seemed that LfTs like to think of themselves as generally calm and in control, although they are, in fact, stressed quite easily – at which point they react in a relatively extreme manner. Freedom from stress seems to be an aspiration, which is seemingly rarely achieved.

LfTs seem to be most commonly stressed by other people, particularly partners and family members. Structure in life and a positive environment were seen as essential elements in helping to maintain a stress-free existence.

### 6.6.8 Interventions: environmental factors

A majority of respondents strongly supported most of the interventions suggested, including free exercise facilities across the LfT sample, which embraces exercise as a positive behaviour in any form. Equally, the idea of linking BMI to healthy food vouchers was seen as good (although some respondents in IMD 4–6 were unfamiliar with the concept of BMI). Condom distribution was also supported.

While there was some scepticism about whether initiatives like those being considered would change the behaviour of hard-core unhealthy consumers, these respondents typically focused on the potential positives in

terms of financial benefits and possibilities for health change.

Interestingly, it was unclear as to whether any of the LfTs would actually take advantage of these interventions themselves – some, indeed, seemed unclear about their own current behaviour (which may suggest a level of delusional or magical thinking about health issues).

### 6.6.9 Interventions: health checks

There was muted interest in the idea of health checks. Although the potential benefits were apparent to most respondents and the prospect of the structure offered by a health check process had real appeal, respondents also made it clear that their likelihood of participation was low.

Barriers to interest were:

- Convenience – would all the checks take place in the same venue?
- Cost – will it be free?
- Time – how long would the check take?

Some respondents were interested in knowing more about themselves and felt that this might be a basis for future action. It is clear, however, that there is an element of delusion in this thinking – since there was no clear understanding of how a better assessment of their health might prompt change.

### 6.6.10 Interventions: realistic starting point

LfT reactions to this issue were very illuminating. Essentially, most of the respondents recounted a long list of different issues and variables and cited all as important for initiating behaviour change.



Typical starting points included:

- establishing a structure in their lifestyle;
- accessing more affordable facilities;
- taking more exercise;
- talking to someone about health issues;
- making simple changes to diet and exercise;
- more time away from childcare responsibilities;
- a formal fitness and diet plan; and
- reducing stress.

Few of these responses were obviously shaped by, or linked to, variables such as gender, lifestage or IMD.

It was clear that LfTs are extremely hard to ‘pin down’ in relation to realistic starting points for change. The segment’s responses showed a strong element of delusional and unfocused thinking around the issue. Equally, there is an implicit resistance to change in this ‘smokescreen’ response to the issue of initiating change.

### 6.6.11 Interventions: using services for change

Freedom years respondents from IMD 1–3 claimed to be regular users of a variety of services, including stopping smoking programmes, counselling, and local exercise facilities. These respondents believed that they had benefited significantly from this support.

None of the other respondents had made any use of services, other than their GP – and none believed that they would be interested in seeking out services in the future. All believed that their GP is the best source of health advice

and felt that they would always visit a GP for help in this area.

### 6.6.12 Interventions: enforced changes

LfTs revealed that some of them had actually been caught drink driving or been admitted to A&E with alcohol-related injuries. There was a recognition that such behaviour is unacceptable and, initially, there was strong support for enforced changes at a relatively draconian level.

Conversely, many did not believe that changes such as selling alcohol under the counter, ‘alcohol kills’ stickers and banning junk food advertising would have much effect on real behaviour.

All were aware that their own poor behaviour choices had been made with full knowledge of the risks and potential consequences – and this had made no difference to the outcome. In the main, respondents seemed to be answering on behalf of society in its broader sense, rather than for themselves.

After consideration, it became clear that LfTs are, essentially, in favour of a libertarian stance on health risks, with individuals responsible for their own choices and behavioural outcomes.

### 6.6.13 Interventions: national state interventions

There was a very lukewarm response to these ideas. A majority of respondents believed that enough nutritional information was already available for consumers to make effective choices. This was of little interest.

Equally, although one respondent had been helped by counselling, there was a feeling that it would be hard to justify the cost of a major outreach campaign. Respondents wondered how ‘at-risk’ people would be defined and identified.

#### 6.6.14 Interventions: providing structure

There was a broadly positive reaction to the idea of basing interventions around providing structure. LfTs clearly lack structure in their lives and often complain about lack of time to innovate or consider change.

The idea that, for example, an exercise programme would have goals and targets administered in a highly structured manner had real appeal to Freedom years respondents.

There was a sense that structure might help to support willpower, which is seen as an area of weakness for LfTs.

#### 6.6.15 Interventions: cognitive behavioural therapy

There was very limited interest in this idea. Although one respondent reported positive experiences with counselling, the general feeling was that cognitive behavioural therapy (CBT) seemed overly serious as an intervention and was inappropriate for the type of issues involved.

#### 6.6.16 Interventions: sources of information

While there was little overt support for a stronger government involvement in health promotion and interventions, respondents were clearly very comfortable with the NHS brand (DH is rather distant) as an underpinning theme for future interventions.

All assumed that there would be a local element to initiatives or programmes in different areas (either provided by local authorities or specific local facilities such as gyms) – but the core funding and endorsement should be provided by the NHS. For many, the obvious place to seek help in relation to health is the GP practice.

#### 6.6.17 Interventions: single and linked approaches

These respondents typically recognised that health behaviours are linked – and that one issue often drives another (stress and drinking, for example). Some were genuinely interested in the Vitality concept and saw this as a sensible way to deal with a person, rather than simply tackling a single aspect of behaviour.

On a more practical level, LfTs were keen to deal with as much as possible of their own problem behaviour in a single relationship and through one venue. There was a strong belief that single interventions were much more likely to be abandoned or negatively affected by other areas of behaviour or lifestyle.

### 6.7 Live for Todays: summary of focus group and immersion depth findings

This is a segment which shows **little evidence of resilience** in relation to life challenges.

In many cases respondents simply seek distraction from problems through risky or damaging behaviour. Lifestage is also important in relation to resilience, with Jugglers typically showing more resilience as a consequence of their family responsibilities. Equally, LfTs are unreliable judges of their own capacity for resilience, with many assuming that they are independently minded when this is clearly not the case.

**Influences on health behaviours were friends and family** – with social group vital in terms of validating the self-esteem of LfTs.

Environment is also important and many LfTs find it hard to distance themselves from their established locality and its associated social set. It is consequently difficult for LfTs to 'move on'. For many in this segment their social life is a principle method of escape from life's challenges and problems.

This segment demonstrates a number of **consistent characteristics**:

- individuals typically **live in the 'here and now'** and have a very short-term outlook;
- there is very **little evidence of planning or goal-setting**;
- lifestyles are **chaotic and unstructured**;
- **values shift** and **fatalism is strong**;
- individuals are typically **focused on 'keeping busy'** and the **pursuit of pleasure**;
- individuals typically attempt to **present a successful face to the world**;
- the extent of **individual control over health is poorly understood**, leading to delusional appraisals and assessments;
- individuals make **few efforts to be healthy and are generally uninterested in health issues**.

LfTs are seemingly happy to take significant risks with their health (and more broadly also), but rarely acknowledge this inclination. Equally, many are clearly struggling with management of stress, even though they

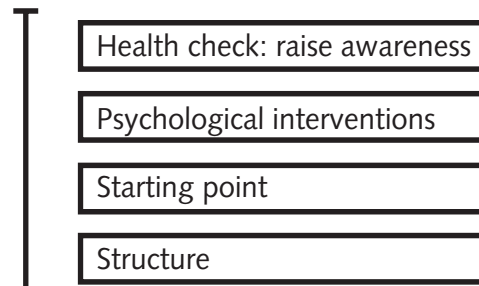
typically describe themselves as laid-back in character and outlook.

In relation to **interventions**:

- these respondents are strong **supporters of relatively draconian interventions**, but do not seem to relate the potential impacts of these to their own behaviour;
- there was **mild interest in the idea of health checks** on the basis that knowledge may drive change – but this thinking was not well-developed;
- it is **hard to identify a realistic starting point** for change – LfTs were expert in generating a 'smoke-screen' around this issue;
- there was **little evidence of use of services** (beyond the GP);
- LfTs' extreme behaviour makes them the **target for many of the enforced changes** – which made some respondents uncomfortable;
- there was little interest in national state interventions;
- LfTs were, however, **interested in interventions which give structure** – since this is seen as a specific weakness in LfT lifestyles;
- there was **no interest in CBT**, which was seen as too serious an intervention approach;
- most **like and trust the NHS brand** – so that interventions should be delivered by local channels, but branded as supported/funded by the NHS; and
- LfTs typically **supported a linked approach** to interventions, recognising that many of their own behaviours are overlapping and mutually supporting.

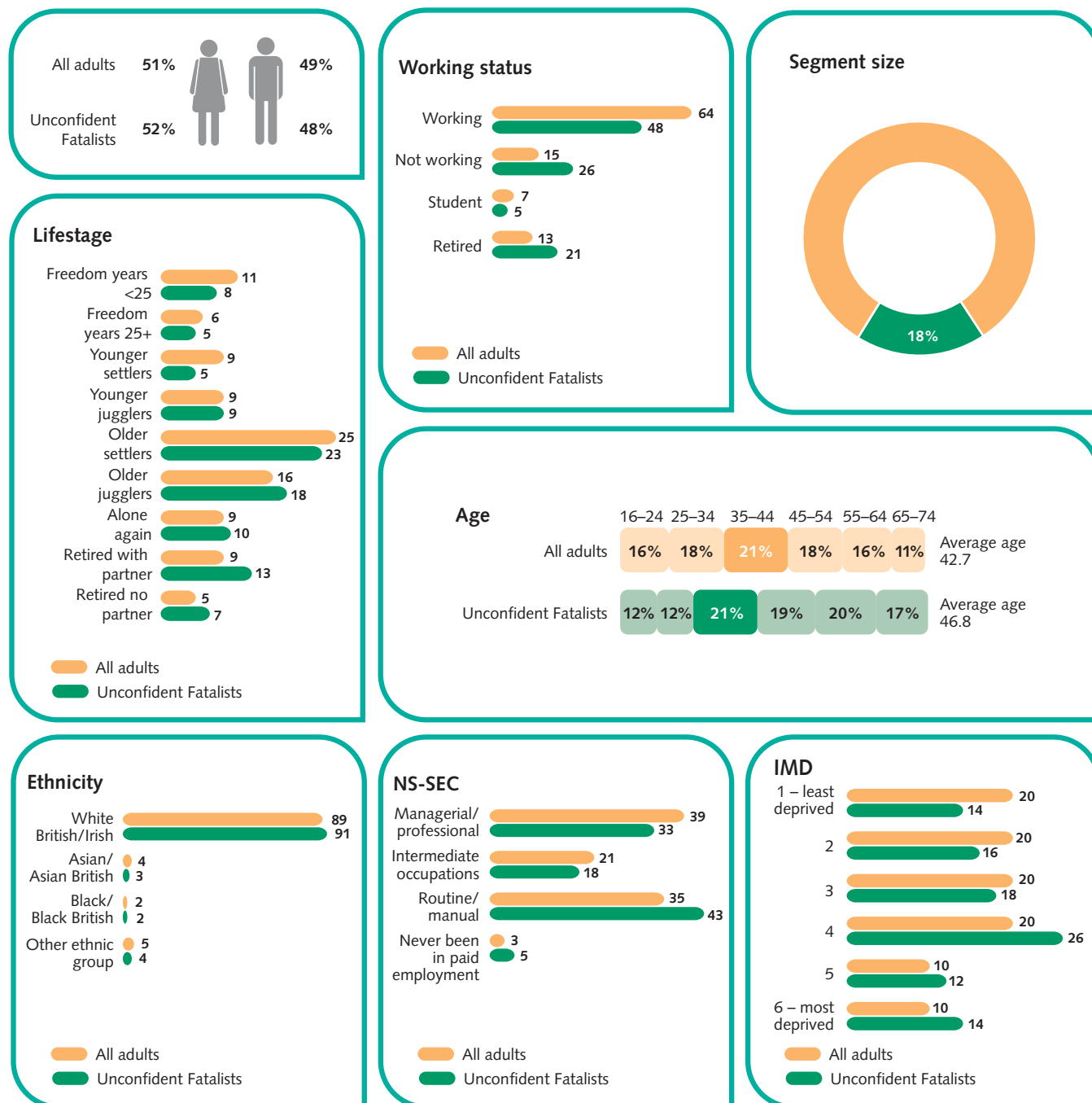
Figure 6.9: Live for Todays: lifestages and motivations

Freedom years	Younger jugglers	Alone agains
Resilience Short-termism ++ Fatalism ++ Risk-taking ++ Motivation – Self-esteem – – Control Stress + Peer pressure ++	Resilience Short-termism + Fatalism ++ Risk-taking + Motivation – Self-esteem Control Stress ++ Peer pressure +	Resilience Short-termism + Fatalism ++ Risk-taking ++ Motivation – Self-esteem + Control Stress + Peer pressure +



# 7 Unconfident Fatalists

Figure 7.1: Unconfident Fatalists: demographics/lifestage



Base: All respondents (unwtd 4,928, wtd 4,928, ess 2,496)/Unconfident Fatalists (unwtd 1,101/wtd 866/ess 488)

Unconfident Fatalists (UFs) represent 18% of the overall sample. In terms of age, they are the second oldest segment. They tend to live in the most deprived areas and are the least likely to be in paid work (26%).

## 7.1 Verification

Respondents typically focused on the 'here and now' rather than 'worrying about the future'. Most perceived little value in worrying about the future since they are fully occupied with present concerns – and the future, for many, appears daunting:

*"If I look further than the next few days then I would completely freak out so I just focus on the here and now."*

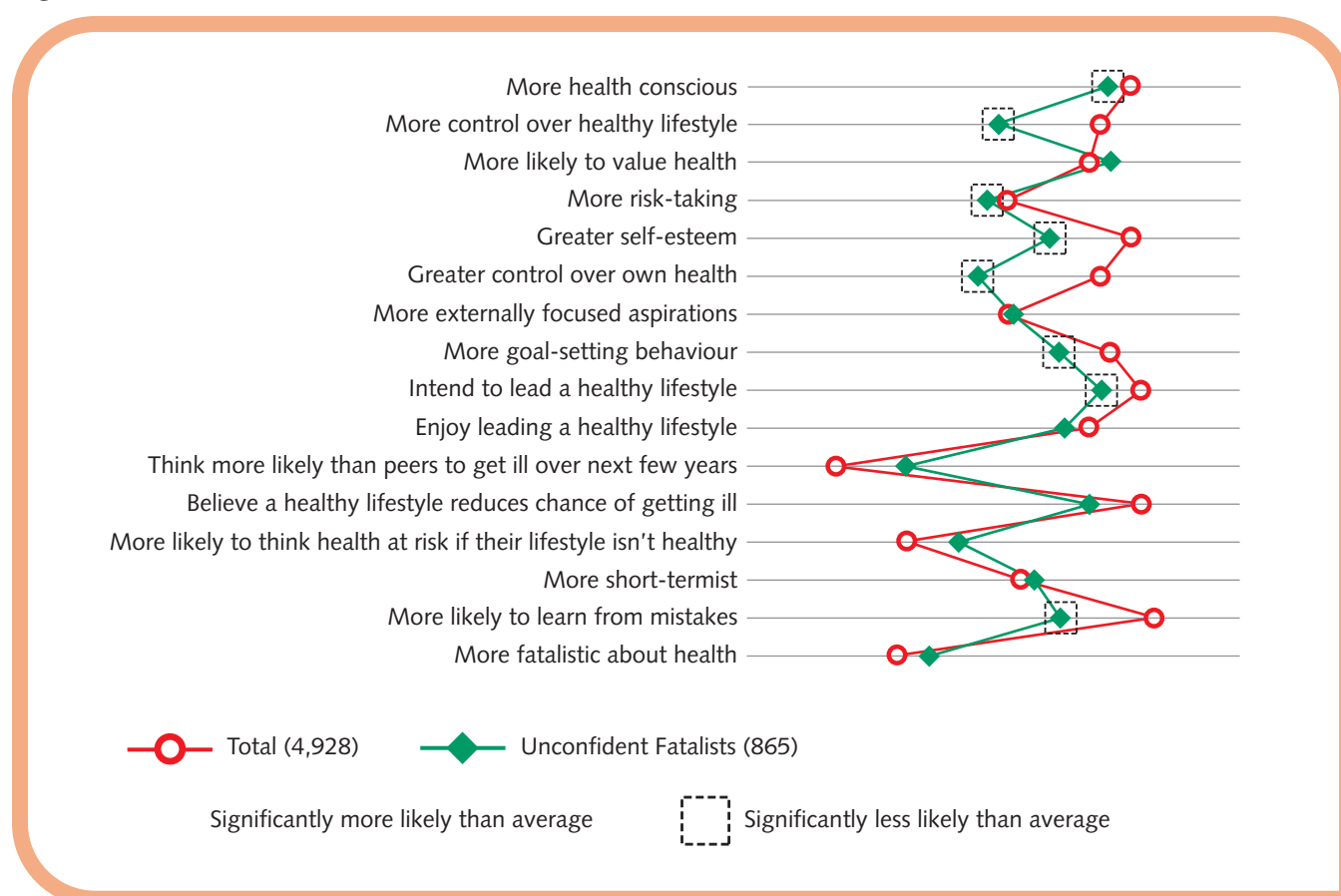
(Female, Younger juggler, IMD 3–5, Brighton)

*"I just don't think about it. I mean, why worry about something you can't do anything about?"*

(Female, Alone again, IMD 6, Norwich)

For UFs, the future generally holds little appeal and most feel powerless to control what might happen. Respondents expressed a strong belief that life events are controlled by fate and, consequently, there is little point in looking too far forward:

Figure 7.2: Unconfident Fatalists: motivations



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Unconfident Fatalists (unwtd 1,101/wtd 866/ess 488)



*"I know seemingly healthy people who just suddenly dropped dead from a heart attack."*

(Male, Alone again, IMD 6, Newcastle)

*"I just feel I need to get on with what's happening now, because one day it could all just change."*

(Female, Older settlers, IMD 3–5, Brighton)

Views about the future were pessimistic, so respondents preferred not to think about it:

*"When I'm older I'm going to be ill."*

(Female, Freedom years, IMD 3–5, Brighton)

*"The way I see it, I'm 37 and I've lived two thirds of my life and it's just a question of getting through to 60 as best I can."*

(Male, Alone again, IMD 6, Newcastle)

Behaviour was often driven by a desire to escape from the stresses and strains of everyday life (typically by means of unhealthy behavioural choices):

*"Stress makes me drink more."*

(Female, Freedom years, IMD 3–5, Brighton)

*"Drink helps you get through another day. It deadens the pain."*

(Male, Alone again, IMD 6, Newcastle)

'Health' was valued, not for its own sake, but as a way of potentially facilitating a sense of happiness, which most respondents admitted they do not currently enjoy. Many in this segment appreciated that achieving a healthy lifestyle *would* be enjoyable and understood the benefits this could bring. A majority, however, believed that it would be very difficult to achieve a healthy lifestyle:

*"You can do anything if you've got your health. If you ain't got it, you can't do what you would have liked to do. I know there's a lot of things I'd like to do and I can't, and that's what annoys me."*

(Female, Alone again, IMD 6, Norwich)

*"You've been to work all day and then you come home to the kids and you're too knackered to go to the gym. There's no time. You need 28 hours in the day."*

(Male, Younger juggler, IMD 6, Newcastle)

There was little optimism that a healthy lifestyle is achievable: many believed that it is their 'lot' in life to be both unhealthy and unhappy – and currently it is 'too late' to make a significant difference:

*"I've got what I've got and you just have to put up with it don't you? It's no good going back or trying to go forward, we were all healthy once."*

(Female, Alone again, IMD 6, Norwich)

*"I have no control about my health, things are dictated to me and I just have to work around it as best as possible."*

(Female, Younger juggler, IMD 6, Brighton)

Many respondents were currently unwell and most believed they were more likely than others to get ill in the future:

*"Well, I'm overweight which makes me at risk of a heart attack due to high blood pressure. Also diabetes could be just around the corner."*

(Male, Older settler, IMD 3–5, Birmingham)

*"I've got a lot of health problems compared to friends my age. I seem to be falling apart sooner."*

(Male, Younger juggler, IMD 1–2, Durham)

Although respondents valued the notion of health, they did not correspondingly value themselves or, indeed even 'feel good' about their own lives. Women, in particular, displayed very low levels of self-esteem:

*"I automatically thought 'I don't like anything about myself.'"*

(Female, Alone again, IMD 6, Norwich)

*"I would feel a lot better about myself if I could get some weight off."*

(Female, Alone again, IMD 6, Norwich)

Male UFs, across all lifestages, expressed considerable dissatisfaction with their lives:

*"My life is a complete failure as far as I'm concerned – I'm living in a shit hole of a house, I'm a weekend dad, I've got a shit job."*

(Male, Alone again, IMD 6, Newcastle)

*"Now that I don't have a job and I'm bumming around, drinking cider, eating junk food...I realise how important it was, and how I threw it all away."*

(Male, Freedom years, IMD 3–5, Birmingham)

*"My mum and dad never had much but they were better persons than what are round here now. Life was a lot better. You got brought up better..."*

(Male, Younger juggler, IMD 6, Newcastle)

What were perceived as immediate risks to health were, however, typically avoided because – in the UF frame of mind – this would be 'tempting fate':

*"You can give fate a helping hand."*

(Male, Alone again, IMD 6, Durham)

Respondents were, however, also realistic. Most appreciated that they are taking long-term risks with their health, through poor choices made with regard to behaviours such as eating, smoking and heavy drinking:

*"I eat a lot of crap food and drinking alcohol, that's a risk because I may block my arteries."*

(Male, Freedom years, IMD 3–5, Birmingham)

The exception to this were the youngest Freedom years groups, who clearly took immediate risks in terms of using drugs, having unprotected sex and binge drinking:

*"I've gone clubbing and gone home with lads that I don't even know and had unprotected sex before, that's a risk."*

(Female, Freedom years, IMD 3–5, Brighton)

*"I started doing acid, pills, and weed by the time I was thirteen."*

(Male, Freedom years, IMD 3–5, Birmingham)

Overall, respondents appeared to feel trapped in a vicious circle of events and behaviours (illustrated by figure 7.3 overleaf).

UFs typically see themselves as stressed and depressed about everyday life, which leads to them making poor health choices. As a result, these feelings are compounded which reinforces the unhappiness. This consequently confirms that life is depressing and stressful. Breaking out of this negative cycle, however, appears to be very challenging for most UFs and seems even more difficult as personal health and wellbeing deteriorates. Equally, healthy living, in itself, was not perceived as a positive factor in overcoming deep fatalism; and most see little value in attempting change.

## 7.2 Environment and IMD

It was very clear that male, IMD 6 respondents were making the most damaging health choices – with the Alone again males demonstrating the most extreme behaviours.

In IMD 1–5, male respondents consistently reported:

- drinking too much;
- propensity towards junk food;
- very little exercise; and
- smoking.

Common themes regarding lifestyles emerged: IMD 1–5 males typically had leisure interests and socialised with friends regularly. Most also had sufficient money to escape their surroundings if necessary (for example, by going to college or travelling abroad), which meant they were not as likely to ‘give up’ on life.

Male respondents in IMD 6 reported consistently extreme behaviours:

- drinking regularly and heavily;
- eating nothing but fatty food;
- no exercise; and
- heavy smoking (20–30 cigarettes a day).

These respondents were typically on a low income, socially isolated and many had simply ‘given up’ on their lives:

*“You just think, fuck it I’ll get some cans in.”*  
(Male, Alone again, IMD 6, Durham)

These behaviours are summarised in figure 7.4.

For women, IMD appears to have less of an impact on behaviour. IMD 6 women from Norwich were more positive as regards life than their male IMD 6 counterparts from Newcastle. Behaviour was apparently consistent between women from IMD 3–5 (Brighton) and IMD 6 (Norwich) – and typically seemed less extreme in nature (for example, comfort eating and comfort drinking):

*“I think I use alcohol to relax more than I should do in the evening times.”*  
(Female, Alone again, IMD 6, Norwich)

An important difference between men and women is that the latter are often strongly rooted in families and enjoy a range of social contacts through children, as well as an ongoing role as mother or grandmother. This role led women to feeling needed, which in turn appeared to add to their sense of self-value:

**Figure 7.3: Unconfident Fatalists: the vicious circle**

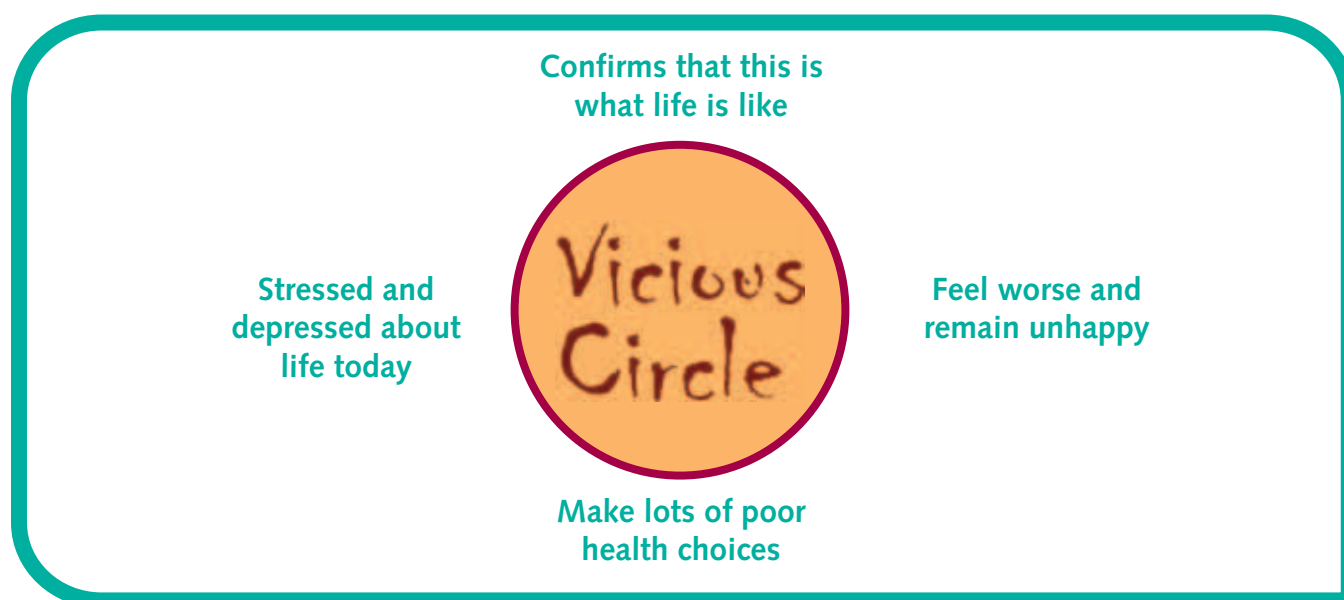


Figure 7.4: Unconfident Fatalists: IMD and health behaviour

IMD 1–5	IMD 6
<ul style="list-style-type: none"> <li>• Drinking too much</li> <li>• Weakness for junk food</li> <li>• Very little exercise</li> <li>• Smoking</li> </ul> <p>However, have interests, socialise and have money to escape (e.g. college or travel)</p>	<ul style="list-style-type: none"> <li>• Drinking regularly and heavily</li> <li>• Eating nothing but fatty food</li> <li>• No exercise</li> <li>• Heavy smoking (20–30 a day)</li> </ul> <p>Very low income, socially isolated – and have ‘given up’</p>

*“My children are the reason I get out of bed every day. If I didn't have them, I don't know what I'd do.”*

(Female, Younger juggler, IMD 3–5, Brighton)

*“It's so nice to hear it because I'm hearing my words back at me from years ago...I get a lot of pleasure from my grandchildren.”*

(Female, Alone again, IMD 6, Norwich)

The focus group findings suggested that, for men, health choices typically deteriorate as their level of deprivation increases. Once again, this supports the quantitative findings that:

- For the most motivated HF segments, IMD has less of an impact on health behaviours.
- IMD has a much stronger influence among the less motivated HF segments (including UFs).

Additional immersion depth interviews were conducted with UF men and women in IMD 6 and this work confirms that men have a much harder time maintaining any positivity as their level of deprivation increases. The female respondents, although equally fragile in terms of many of their attitudes, typically received valuable support from their families and social groups which compensated for some of the impacts of deprivation. Equally, many women

seemingly ‘carried on’ for the sake of their families – living vicariously, although without any personal motivation. Men, by contrast, lacked this focus and seemed to quickly decline into inertia, depression and destructive health behaviours.

In sum, two main categories of UFs emerged:

- ‘given up’ – those who no longer had an interest in making improvements to their lives or health (male IMD 6); and
- ‘not yet given up’ – those who still feel they have purpose and enjoyment from life (female respondents and male IMD 1–5).

## 7.3 Key drivers

### 7.3.1 Aspiration

Respondents' career aspirations were typically domestic in nature: for example, owning a house and car or having a family. UFs also tended to have encountered major disappointments or trauma in their lives, such as:

- Accident:

*"Big operation on my knee due to sports injuries...made me feel less importance for sports." [respondent describing his loss of interest in sports following an injury]*

(Male, Freedom years, IMD 3–5, Birmingham)

- Failure to achieve career aspirations:

*"I'm a qualified joiner but I'm in a crap job at the moment."*

(Male, Younger juggler, IMD 6, Newcastle)

- Relationship breakdown:

*"My life collapsed when I got divorced and I was on the piss all the time."*

(Male, Alone again, IMD 6, Newcastle)

- Unexpected pregnancies:

*"I wanted kids later than it happened. I had two kids by the time I was twenty one which is far too early."*

(Male, Younger juggler, IMD 6, Newcastle)

*"There was always something major going on, something that got in the way of my aspirations."*

(Female, Older settler, IMD 3–5, Brighton)

Consequently, any personal aspirations had been quickly shelved and, across the sample, a sense of negativity and resignation prevailed:

*"I've got nothing to live for!"*

(Male, Alone again, IMD 6, Newcastle)

Respondents often expressed disappointment that their lives had not turned out the way they had anticipated. In fact, some had actually achieved their aspirations, but still felt disillusioned:

*"Being a cable joiner was all I knew, and it's all I know now. The money used to be brilliant, but not anymore."*

(Male, Freedom years, IMD 3–5, Birmingham)

*"I've done two courses now and at the end of each one I've realised that I no longer want to do it."*

(Female, Freedom years, IMD 3–5, Brighton)

Others had long since given up on aspiration and expressed little sense of self-worth:

*"I've not achieved what I wanted to achieve. I live in a council house. If I had my own house I'd have something to leave the kids."*

(Male, Younger juggler, IMD 6, Newcastle)

*"I never thought I'd be ill. I always thought I'd be the oldest surviving, but I'm not so sure any more."*

(Female, Older settler, IMD 3–5, Brighton)

Crucially, UFs do not expect to achieve much in life – and this is reflected in their approach when attempting to make health changes:

*"I stopped smoking for a while, but it just made me feel worse, and more stressed."*

(Male, Freedom years, IMD 3–5, Birmingham)

*"I gave up smoking for a year and then again for two years. It just made me worse, more aggravated."*

(Male, Older settler, IMD 3–5, Birmingham)

*"I am too set in my ways. To change my ways would be hard. I've tried to give up smoking etc...but it wasn't for me. Haven't got the willpower."*

(Male, Younger juggler, IMD 6, Newcastle)



### 7.3.2 Resilience

The qualitative data supports the quantitative findings: UFs were not resilient when faced with negative situations.

In the main, respondents withdrew and tried to cope with their problems alone. This led to them becoming fiercely independent, but with a tendency to become isolated.

A degree of resilience was forced upon some in the sample by having children (which was often the only positive life event mentioned by respondents).

This typical lack of resilience, evident across the UF sample, is illustrated by continual references to depression:

*"At the moment I'm on sickness benefits due to having a long-term illness which is called sarcoidosis, which affects my lungs. It's pretty debilitating...I don't have a lot of energy. Basically, I was working but I couldn't keep up with it and I went self-employed so I could do the hours I wanted. Then, due to this credit crunch, the work dried up. That's where it all went amiss really. The illness got worse and I started drinking too much, that caused the depression – or the depression was caused by what was happening. It's a bit hard to work*

*out whether it's the drink that depresses you or...y'know?"*

(Male, Alone again, IMD 6, Norwich)

*"I never got my feelings back. I stopped worrying, stopped thinking...I've just got no feelings."*

(Female, Alone again, IMD 6, Newcastle)

*"My little girl gets upset and the other day she said to me before she went to school, 'Mummy I love you, please don't cry today.'"*

(Female, Younger juggler, IMD 3–5, Brighton)

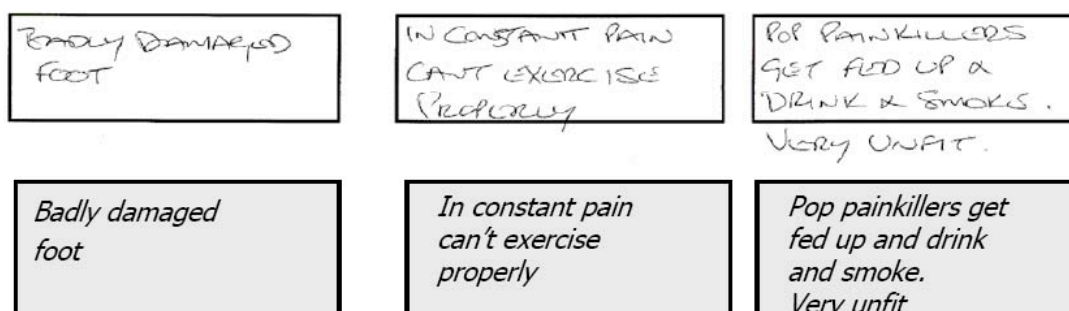
*"The only day I ever felt good about myself was on my wedding day."*

(Female, Younger juggler, IMD 6, Norwich)

The usual UF response to negative life events was to:

- withdraw and try to cope alone;
- do nothing to change the situation; and
- seek escape through damaging health choices.

This reduced self-esteem and exacerbated depression.



(Male, Alone again, IMD 6, Newcastle)



BROTHERS DEATH	DEVASTATED ME	DIDNT CARE, GOT INTO BETTER, TOOK DRUGS.
Brothers death	Devastated me	Didn't care, got into bother, took drugs

(Male, Younger juggler, IMD 6, Newcastle)

Gained Independence keep barriers up.	Very down/go in on myself shut people out
Gained independence keep barriers up.	Very down/go in on myself, shut people out

(Female, Alone again, IMD 6, Norwich)

HAVE BECOME A DAD	FELT RESPONSIBLE OPENED MY EYES	'MORE MATURE' MORE PATIENT BECOME MORE IN TOUCH WITH EMOTIONS. FELT PROUD
Become a dad	Felt responsible opened my eyes	'More mature' more patient become more in touch with emotions Felt proud

(Male, Younger juggler, IMD 6, Newcastle)

HAVING MY CHILDREN	Grew up v quick (me) Gave me different perspective on life Post natal depression Best thing to have happened to me, kind of	MORE CONFIDENT RESPONSIBLE STRONGER!
Having my children	Grew up quickly (me) Gave me a different perspective on life Post natal depression Best thing to have happened to me, kind of	More confident Responsible Stronger!

(Female, Younger juggler, IMD 3–5, Brighton)

### 7.3.3 Fatalism

UFs typically believed that they were living a life that is, on the whole, determined by fate:

*"Your life is planned out. Your lifestyle, like your life, how long you live, or what happens to you, is already planned."*

(Female, Alone again, IMD 6, Norwich)

*"I think all our lives are mapped out and there is a certain path for most people in life."*

(Female, Younger juggler, IMD 3–5, Brighton)

Even respondents who chose not to overtly express their fatalism in this type of language actually displayed very fatalistic approaches to life:

*"You get to 35 and your metabolism changes and you just pile on the weight."*

(Male, Alone again, IMD 6, Newcastle)

In this context, there was perceived to be little point in making an effort to live healthily:

*"Even fit people can get heart attacks."*

(Male, Alone again, IMD 6, Newcastle)

*"Some people who smoke and drink don't get cancer, but those who don't equally come down with cancer."*

(Female, Younger juggler, IMD 3–5, Brighton)

UFs felt powerless to affect their own lives positively. At best, many were content to remain where they were at this stage in life. Positive events in life were seen as the product of luck, rather than their own achievement – while negative ones were viewed as driven by fate and largely out of their control:

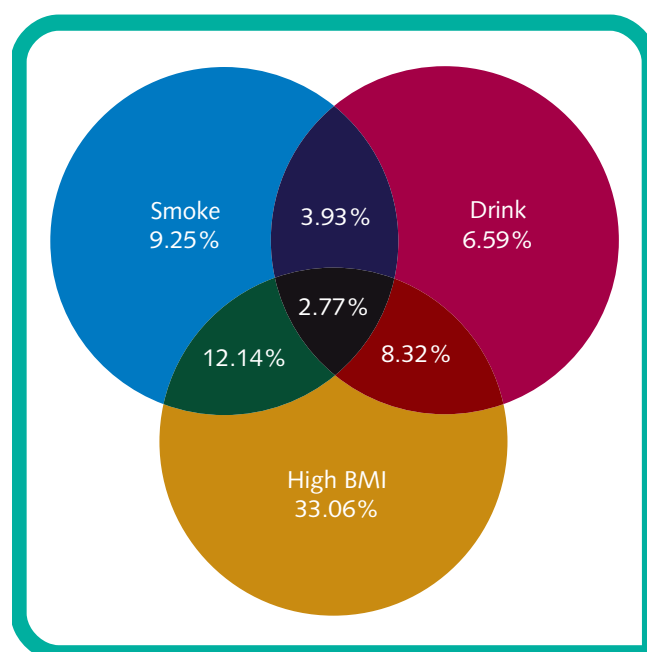
*"Lady luck has to be about fate as well, sometimes you have it and sometimes you really don't, it's like you're bound to get with certain people, like it's pre-written."*

(Male, Older settler, IMD 3–5, Birmingham)

### 7.4 Interventions

Poor health behaviour was common amongst UFs. The extent of overlapping behaviour is substantiated by the quantitative analysis, illustrated by figure 7.5.

**Figure 7.5: Unconfident Fatalists: overlapping behaviours**



Source: Research Report No.1

In the quantitative data, UFs demonstrate slightly less overlapping behaviour than Live for Todays (LFTs). However, the qualitative evidence suggests that UF overlapping behaviour is more consistent and routine in nature.

The following diary extracts illustrate some of the drivers for these poor health decisions:

- poor diet, because of a lack of motivation to cook meals and an inclination towards comfort eating;
- heavy drinking was often chosen as a means of escape from depression;
- smoking – out of habit and a lack of motivation to change; and

- no exercise, because of low motivation and a fear of being judged.

UFs were not surprised by their diary entries, although most found the process of completion and review sobering. All were aware that their health choices were poor, but most did not feel that they were likely to make changes:

Number 3 decision: Took car to the chip shop for tea  
Why did I make this decision?  
Could not be bothered to walk around or be bothered to cook anything

Number 3 decision: Took car to the chip shop for tea  
Why did I make this decision?  
Could not be bothered to walk around or be bothered to cook anything

(Male, Alone again, IMD 6, Newcastle)

Number 4 decision: to eat chocolate bar.  
Why did I make this decision?  
because I felt down.

Number 4 decision: To eat chocolate bar.  
Why did I make this decision?  
Because I felt down.

(Female, Younger juggler, IMD 6, Norwich)

Number 4 decision: TO OPEN A BOTTLE OF WINE  
Why did I make this decision?  
WANT TO TAKE EDGE OFF HOW I AM FEELING. I KNOW ITS NOT GOOD OR HEALTHY THO.

Number 4 decision: To open a bottle of wine  
Why did I make this decision?  
Want to take the edge off how I am feeling. I know it's not good or healthy though

(Female, Younger juggler, IMD 6, Norwich)

Number 4 decision: Had good drink

Why did I make this decision?

Reading about the soldiers in  
N.O.T.W spoilt my day. father was in  
ARMY

Number 4 decision: Had a good drink

Why did I make this decision?

Reading about the soldiers in [News of the  
World] spoilt my day. Father was in the army

(Male, Alone again, IMD 6, Newcastle)

Number 1 decision: HAD A CIGARETTE AS SOON  
AS I WAKE UP

Why did I make this decision?

HABIT

Number 1 decision: Had a cigarette as soon  
as I woke up

Why did I make this decision?

Habit

(Male, Alone again, IMD 6, Newcastle)

Number 1 decision: I should move more

Why did I make this decision?

I'm stiff + overweight

Number 1 decision: I should move more

Why did I make this decision?

I'm stiff and overweight

(Female, Alone again, IMD 6, Norwich)

*"I'm a realist, I'm doing more to harm myself than any other people in this room. I know the consequences but I enjoy it."*

(Male, Freedom years, IMD 3–5, Birmingham)

*"I know what the problems are with myself, with my lifestyle, but I really can't see many ways of changing it because I'm not going to spend an hour or so preparing a healthy meal when I get home knackered from work..."*

(Male, Alone again, IMD 6, Newcastle)

Some were very critical of their choices and consequently felt guilty:

*"Every time I sit down to a meal I wrestle with myself about what I should and should not be eating."*

(Female, Younger juggler, IMD 3–5, Brighton)

*"My chest is fucked. I realised when I didn't have that cigarette first thing in the morning I felt a lot better. But then I'm still smoking."*

(Male, Younger juggler, IMD 6, Newcastle)

*"I know I should have walked, but found all sorts of reasons such as time, convenience and the heavy shopping bags not to do so."*

(Male, Alone again, IMD 6, Newcastle)

Repetitive and obsessive behaviours were highlighted:

*"If I'm in the house I might have seven meals a day."*

(Male, Alone again, IMD 6, Newcastle)

*"I've got to have a tab last thing before I go to bed...God knows why..."*

(Male, Alone again, IMD 6, Newcastle)

However, no respondent had devised a plan for future changes:

*"What can you do about your health? Nothing really, besides die..."*

(Male, Older settler, IMD 3–5, Birmingham)

*"The percentage of women who get breast cancer is unbelievable, I saw it on the news and it got me thinking...but I'm still being careless."*

(Female, Older settler, IMD 3–5, Brighton)

It seemed that the root cause of poor health choices among UFs is their state of mind (illustrated in figure 7.6 opposite), which most described as 'depressed'. Their fatalism was part of, and linked to, this ongoing psychological state of depression.

Typical health choices, which were often linked, included poor food choices, no exercise, drinking to excess, drug use and smoking.

UFs were realistic about the impact that their choices are having upon their health. However, most did not feel empowered to make any changes.

Some expressed a need for practical knowledge and 'know how':

*"I've got no idea how I could change. I love my beer, I don't know how many times I've tried to quit the fags..."*

(Male, Younger juggler, IMD 6, Newcastle)

Others were waiting for an external trigger:

*"This is something I really want. Maybe I need the truth, or a crisis. To finally open my eyes and make me act."*

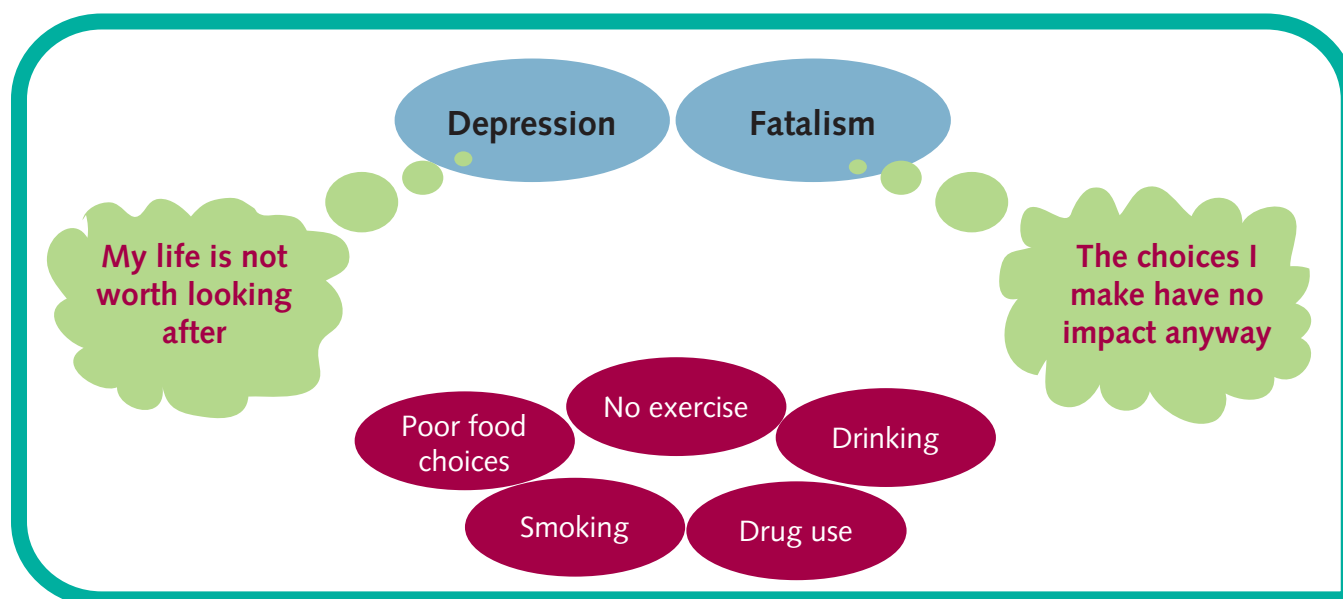
(Male, Alone again, IMD 6, Newcastle)

*"Something will click...Then I'll go from being very unhealthy to completely healthy."*

(Female, Alone again, IMD 6, Norwich)



Figure 7.6: Unconfident Fatalists: root cause of poor health



Many respondents had tried to make changes and failed:

*"Weight is a constant bane of mine. I always seem to be fighting it and I never get anywhere, and it is an uphill struggle all the time."*

(Female, Alone again, IMD 6, Norwich)

*"I gave it up [smoking] for a year, and then again for two years, it just made me worse, more aggravated."*

(Male, Older settler, IMD 3–5, Birmingham)

#### 7.4.1 Views about overall health

UFs expressed a theoretical wish to change their lifestyles – in reality, however, a number of major barriers to change were identified:

- dependence on poor health choices for 'escape';
- social exclusion and isolation (e.g. choosing to spend time and deal with issues alone); and
- lack of motivation due to:

- a strong belief in fate
- a belief that they are incapable of succeeding
- low self-esteem
- depression.

#### 7.4.2 Intervention approaches

Unlike LfTs, UFs are well aware of their issues with health. Importantly, however, they typically lack a basic level of motivation for change.

The first challenge for intervention in this segment will be to create an appetite for change – and to achieve this, an external trigger may be required.

To make changes, UFs need to be persuaded that it is worth making the effort to improve health and genuinely take control of it. Ongoing support will be vital to encouraging self-belief and fostering a positive outlook.

For UFs who have not completely 'given up' (see section 7.2 for an explanation of 'given



up' and 'not yet given up'), a health check might be able to act as an external 'trigger'. Many consistently worried about their health – and therefore the idea of an 'MOT' was appealing, because it might provide reassurance:

*"If somebody could say 'You're going to be fine for the next 12 months', I'd stop worrying about it."*

(Female, Younger juggler, IMD 3–5, Norwich)

Many believed that knowing the real status of their health could motivate them to make necessary changes. However, some expressed reluctance to undergo an examination because of embarrassment and for fear of what they might discover:

*"I guess I'm just a coward. If I do that now then I'll be sitting around thinking about it."*

(Male, Freedom years, IMD 3–5, Birmingham)

To be effective, this type of service would need to be positioned away from a formal medical setting and delivered alongside clear reassurance that full support will be available to deal with the results. Otherwise, it is quite possible that UFs might become further depressed by the outcomes and fail to act on the results positively.

For UFs who have not 'given up', a linked issue intervention made most sense. The informal nature of 'Vitality' (see appendix 15), a linked issue service shown to respondents as stimulus, appealed to some women. If the service tackled mental health issues such as stress and depression, it could certainly be of interest:

*"When you're depressed you don't eat, you drink, you don't exercise. The mental issues create a circle effect I suppose."*

(Female, Younger juggler, IMD 6, Norwich)

The tone of the 'Vitality' stimulus was criticised for appearing rather 'too good to be true' – particularly by men, who felt it was generic and 'nothing new':

*"I hate generalisations, I would dismiss leaflets like this."*

(Male, Older settler, IMD 3–5, Birmingham)

*"I've heard it all before, it's the same old message. It's just not motivating."*

(Male, Alone again, IMD 6, Durham)

Since many UFs tend to be solitary by nature, some were uncomfortable about the idea of accessing group services:

*"I'd rather talk to my doctor on my own."*

(Female, Alone again, IMD 6, Norwich)

For UFs who have 'given up', linked issue interventions were seen as intimidating and off-putting. For this group, smaller steps seemed appropriate. Smoking may be a useful example of a single issue intervention which has the potential to start a more general conversation about health.

Conversely, single issue interventions were less appealing to those who have not 'given up' completely. Respondents had typically used services like this already for weight loss and smoking, and had failed to make long-term changes through this approach. A single issue approach was considered unlikely to impact on overall health.

Among those UFs who have apparently 'given up' on health (mostly from the segment Alone again), it was felt that the emphasis should be on starting a dialogue about health. This could be achieved through a single service, offering the potential to open up additional channels into other areas of health once an individual is fully engaged.

For UFs who have not 'given up', the ideal intervention would be a service that combines:

- creating an appetite for change, for example, through a health-check offer;
- a focus on empowering UFs to take control of their health and provision of significant follow-up support; and
- attention to psychological and mental health issues, in particular, stress and depression.

The service would also need to provide coaching to encourage and maintain willpower and motivation (perhaps through a health trainer).

## 7.5 Unconfident Fatalists: immersion depth analysis

### 7.5.1 Resilience

This segment shows very little evidence of resilience. Typically, a traumatic or shocking life event (death of a loved one, illness, difficult home circumstances) has produced a massively negative outcome. In many cases respondents believed that they had 'fallen apart' and had no idea how to pick themselves up. Few seem to have sought help and many admitted to 'bottling things up', sometimes in order to protect loved ones, with ultimately disastrous consequences:

*"When my husband died I just stopped bothering. I lost interest in everything, I didn't go out much. I closed down."*

(Female, Alone again, IMD 6, Newcastle)

Respondents from IMD 1–5, however, did express some more positive sentiments about their behaviour and life choices. Even though most had lived complicated and often desperate lives, there was some evidence that they believed there was a potential 'way out'.

Respondents from IMD 6 typically reported more chaotic and abusive childhood and home situations, with alcohol and violence not uncommon factors. Their prospects were often limited and the outlook apparently bleak. Female respondents in this segment, although affected by similar problems to their male counterparts, were evidently dealing more effectively with their situations, deriving purpose and support from their families to drive resilience. Men were much less resilient, clearly less well supported and more likely to resort to the extremes of unhealthy behaviour in their social groups.

Some, especially from IMD 1–5, had clearly achieved a good deal in relation to their careers, but even so these respondents tended to interpret the time spent in this area as largely wasted and contributing to poor outcomes in other aspects of their lives.

A positive home and family environment certainly seems to have helped some respondents to challenge their natural inclinations towards negativity. Left alone (as male, Alone again respondents typically were), lack of resilience has pushed some UFs into what they admit is a lonely, damaging and chaotic lifestyle.

### 7.5.2 Self-esteem

It was clear that a number of factors affected UFs' self-esteem, both positively and negatively:

- Age: some Older settlers and Alone agains clearly believed that they were 'past it' and that opportunities to change or take control have declined.
- Work: experiences at work strongly affect UFs, especially those in the Freedom years and Younger juggler lifestages. Success in this area was cited as a major driver for higher self-esteem, while failure at work had evidently brought some respondents very low. Those who were unemployed in IMD 6 seemed the most pessimistic about this issue.
- Body image: UFs seem to respond to negative situations by gaining weight, and this clearly affects self-esteem, creating a 'vicious circle' of damage.
- Family: those with supportive families (even in otherwise difficult IMD 6 environments) used this positive experience to fight against the negative feelings that otherwise afflicted them. Some live for a visit from their children.
- Illness: UFs typically believed that they were fated to become ill and saw any illness as confirmation of this belief. Many used their ill-health as a justification for inertia or a reason why change was not possible.
- Mental health: many in the sample were affected by feelings such as guilt and regret. In their discussion of their lives, it was common to hear respondents describe themselves as 'wasters', 'closed down', 'lost' or 'past it'.

### 7.5.3 Motivation

A majority of the sample admit that they lack motivation generally, and especially in relation to health issues. Most simply 'can't be bothered' to make any effort in that direction:

*"I move from the bed to the sofa. I can spend all day watching TV. Maybe pop up the shop and buy a bottle of cider."*

(Male, Alone again, IMD 6, Norwich)

A few in IMD 1–5 have shown motivation in their work lives and even achieved some level of success – but even these respondents believed that they do not show the same motivation when it comes to health choices.

The only thing that seems to motivate UFs is other people: typically, friends and family. Clearly the input and support of people can make some impact on UFs' otherwise relentless negativity – and the more socially isolated that UFs are, the more negative they seemingly become. Those with close families were clearly faring better than those who were alone.

Fatalism affects motivation. Some respondents clearly believed that there is little point in making much effort, since success is unlikely:

*"I'm not really too bothered about doing anything – if it's going to happen, it's going to happen."*

(Male, Younger juggler, IMD 6, Newcastle)

For some, the prospect of work offers motivation, giving them a focus for effort as well as the input of colleagues.

Finally, some had been motivated by health scares – becoming out of breath after exercise or being diagnosed with a major condition (such as diabetes) had driven some to take remedial action. Pressure from health professionals also has some impact, but the resulting efforts can be very short-lived, especially if beneficial results are not quickly apparent.

### 7.5.4 Norms/social influences

A majority of the sample cited problematic family backgrounds as having contributed to their own attitudes and behaviour around the issue of health. Divorce, smoking, alcohol abuse and parental ill-health were all common factors in making the respondents feel less than positive about their family's contribution to their own health. Few felt that they had experienced a good-quality upbringing. In some cases, siblings had been potent 'bad influences' in relation to alcohol or drug use.

Positive influences tend to be partners or close friends who encourage positive behaviours, particularly in relation to diet and exercise:

*"Without Sarah I wouldn't have even started, and without her I wouldn't be able to continue. I wouldn't go running by myself."*

(Female, Younger juggler, IMD 3–5, Brighton)

Workmates can also influence attitudes, with some respondents believing that they became sick of the 'banter' at work and took action as a consequence.

Many respondents, however, were happy to admit that they were easily influenced by the people around them – and for those in IMD 6 in particular this often relates to smoking, junk food, excessive alcohol use and drugs. Peer pressure can be strong, even among those in older lifestage segments.

### 7.5.5 Segment movement

Interestingly, while respondents in IMD 6 typically agreed with the segment description of UF and clearly felt 'that is me', there was much less agreement among those in other IMD segments. Some clearly believed that they might be LfTs or Hedonistic Immortals (HIs), many taking issue with the idea that they were more likely to get ill than other people. Others

disagreed with the notion that they do not feel good about themselves – especially those who had recently adopted a healthier lifestyle (for example, taking up running).

The 'core' UFs from IMD 6, however, believed that they had always been UFs and had exhibited the critical traits of fatalism and general lack of care.

Those who could pinpoint a specific moment when they became a UF typically cited a life event, such as becoming unemployed, falling ill, living alone or stopping a healthy activity (such as participation in sport).

The locus of change for UFs was typically between UF and LfT – with some respondents believing that they were probably now LfTs or were LfTs in the past. For UFs the LfT segment and outlook represents an aspiration in terms of positivity and getting more out of life.

### 7.5.6 Attitudes towards other segments

Looking at the other segment descriptions typically made many respondents affirm their own UF status. Interestingly, few believed that their own social circle was made up of other UFs – most seemed to believe that many of their friends were either LfTs or HIs. Some had a close friend who they believed was another UF and with whom they typically indulged in 'total UF' behaviour when spending time together.

Otherwise, UFs seem to like LfTs because they enjoy themselves and do not worry about tomorrow. More negatively, UFs did recognise that LfTs can live very wasteful and pointless lives, with fatalism and lack of consideration for others as areas of real difficulty. Nonetheless, moving from LfT to UF was clearly seen as a move downwards in terms of healthy attitudes and behaviour.



Some UFs also admired HIs, with their happy acceptance of risk and lack of concern about looks or material possessions. Most UFs, however, saw that segment as unattainable, since it would require more confidence and self-possession than most believed they could muster.

Balanced Compensators (BCs) were seen as a very sensible compromise between healthy living and 'having some fun'. Many respondents would aspire towards this segment in an ideal world, but typically believed that they lacked the personal commitment, strength and organisation necessary to achieve BC status.

In the main, Health-conscious Realists (HCRs) were dismissed as 'fanatics' by UFs, who saw their focus on control over health as unnatural and possibly even unhealthy! A few respondents wondered whether their own difficult parents might have been HCRs and caused their own development into UFs as a consequence.

### 7.5.7 Stress

All respondents believed that they got stressed regularly and quickly. Few felt that they were able to speak about their stress and most simply 'bottled it up'.

Typical drivers for stress included:

- Work: respondents with a job reported that they worried a lot about work issues and typically took their stress out on partners and families.
- Money: financial issues were an issue for those in higher IMD segments.
- Family members: the health and attitudes of close family clearly caused stress for some respondents with ill-health, alcohol abuse and drug use generating ongoing concern for some.

- Life situation: some in IMD 6 were simply stressed by having no job, income or apparent purpose in life.

UFs clearly find it difficult to deal with stress – and particularly to speak about their stress to others. Some tackle this by taking regular exercise and 'getting out of the house'. Others socialise or resort to drinking. Few believed that they were dealing with their stress in a healthy fashion.

### 7.5.8 Interventions: environmental factors

There was shallow enthusiasm for the ideas of free exercise facilities and healthy food vouchers. Most respondents, however, were clear that they would be unlikely to become involved in such schemes. A few (mainly younger respondents) were interested in better access to exercise facilities, but these were typically already involved in some level of regular exercise. Those who currently took no exercise were not motivated by the prospect of free facilities.

Some believed that it was wrong for the government to intervene with free food vouchers, even if this was linked to losing weight.

Overall, there was a strong element of cynicism in reactions to these ideas. In the respondents' experience, people are unwilling to change their behaviour and the government's good intentions generally come to nothing. Ultimately, many respondents felt that it was the individual's own responsibility to look after their health and the state should not be involved.

### 7.5.9 Interventions: health checks

There was strong support, in principle, for the idea of health checks (see appendix 16). It was

obvious, however, that very few of the respondents would have the confidence to take advantage of such a scheme. Many were nervous that they would be engaging with fitter, slimmer, healthier people who might judge them negatively.

Privacy and a sensitive, one-to-one environment would be essential to entice most UFs into using a health-check service. Most also believed that checks should be carried out by health professionals.

Other UFs, who saw themselves as 'ill', dismissed the idea as being 'for healthy people who want to stay healthy'. Many in this group said they already had regular checks at their GP practices or in hospital.

Overall, although many UFs recognised the value of health checks, it was clear that most would find it difficult to overcome a number of significant barriers in order to attend.

### 7.5.10 Interventions: realistic starting point

It was difficult to get the respondents to seriously consider a realistic starting point for change. Some were simply uninterested in change at any price; others felt that it might, in fact, take a serious illness to genuinely prompt a desire for change.

Those who were prepared to consider a starting point typically felt that they would need the support of 'people like them' in terms of life situation. Having someone who understood how they felt about themselves was seen as important in giving value to a change initiation process. These more positive respondents were typically from IMD 1–5 and believed that a group setting and a mentoring option would increase the likely success of any programme.

Respondents from IMD 6 were extremely hard to interest in the idea of initiating any change at all. Most felt that 'small steps' would offer the most realistic option for making changes – although, for some, this suggestion was seemingly a defensive stance, intended to help them to avoid change if possible. There was much procrastination, with respondents typically believing that changes in situation or work might act as a stimulus for action.

Others in this segment were honest and believed that they would have to be shocked into considering different ways of approaching their health. Some felt that in order to 'do anything' they would have to be subject to compulsion through the NHS.

There was a general sense that any change programme would have to be tailored to the individual and involve considerable monitoring and mentoring. Respondents were quite certain that, left alone for any period of time, they would revert to their old habits.

Overall, the most effective and realistic starting point for change would be NHS primary care services. Input from this source would, at least, be likely to get the attention of respondents.

### 7.5.11 Interventions: using services for change

In the main, this segment finds it hard to engage with services and is inclined to 'back off', given the smallest opportunity. One respondent who was having counselling decided to stop because her counsellor went on maternity leave (and has never re-started).

The only service consistently accessed is the GP (although not among Freedom years respondents, who see themselves as 'not having got ill yet'). A majority of respondents felt that they would take notice of advice from



their GPs, although they still believed that they would inevitably slip back into their 'old ways'.

Many UFs are typically timid in relation to accessing services, worried that they will stand out or be criticised for being overweight, for example. Thus, some suggested that a gym would be a practical place to start making changes, but that it would have to be a specialist facility which only dealt with people like themselves. The more forceful and demanding a service is, the less appealing it is to a majority of UFs.

Some UFs clearly do not trust their existing service providers and regularly opt out of aspects of their care (by not taking medication or missing appointments, for example).

Some use the internet to seek information and advice regarding their specific issues (such as mental health and obesity), but these respondents were typically terrified by the results obtained and not inclined to repeat the exercise.

Overall, it is difficult to identify a typical service access point, beyond the GP, which would attract UFs who are considering making changes. It seems that, in many cases, the NHS will have to initiate and maintain change, using an initial 'shock' followed by regular monitoring.

### 7.5.12 Interventions: enforced changes

UFs were less enthusiastic about change being enforced through ideas such as compulsory health programmes and charging for alcohol-related accident and emergency (A&E) admissions. In many cases, they knew people who would be (in their view) unfairly affected by such measures.

There was considerable scepticism about initiatives such as keeping alcohol under the counter, 'alcohol kills' stickers and banning junk food advertising, since many respondents were aware that many of their own health choices were poor, but they still went on making them. The assumption that reducing product profile and heightening risk information will change behaviour was seen as naïve by most UFs.

Overall, UFs dismissed most of this material as unlikely to have any significant effects on behaviour. They are very conscious that they persist in their own health behaviours in spite of a clear recognition that some are very harmful indeed.

### 7.5.13 Interventions: national state interventions

Respondents were ambivalent about the idea of state interventions. While some could see that standardising food labelling was a sensible idea – and might help some very 'faddy' consumers – there was a belief that most food is already fairly fully labelled in terms of nutritional content and that anyone who wants this information is likely to be able to find it.

Equally, while education and information were supported in principle, these respondents were clear that these were not likely to make any difference to their own behaviour.

More broadly, there was distrust of the state becoming involved in health choices, even though some respondents in IMD 6 were certain that these sorts of interventions are the only way to force them to make changes.

Nonetheless, UFs were certain that it is individual motivation that will drive change in health behaviour – and that the state can only do so much before people reject the level of control involved.

### 7.5.14 Interventions: cognitive behavioural therapy

This intervention was not discussed with some respondents, since their earlier responses indicated that it might be an area of some sensitivity.

Those without experience of cognitive behavioural therapy (CBT) were cautiously positive about the idea, although it was clearly viewed as just another alternative therapy (similar to acupuncture). Respondents were conscious that their own problems had a psychological component and that this aspect of their lifestyle might need addressing. Certainly it was seen as something worth considering.

Those with experience of CBT typically dismissed the idea, as 'it failed'. These respondents seemed to resent the perceived level of personal intrusion generated by CBT and preferred to 'stay as they are'.

### 7.5.15 Interventions: sources of information

There was consistent support for the idea of services being funded by the NHS and/or the Department of Health and branded as 'NHS-supported', in order to give them credibility and relevance for this audience. These respondents certainly trust the NHS and the brand generates respect among this segment.

Specific programmes, initiatives and schemes, should, however, be run by local organisations, such as local councils, gyms or youth clubs. This, it was felt, would make them less 'Stalinist' and state-focused in character and encourage more people to take part.

It is unclear, however, whether UFs would genuinely be inclined to participate – given

their sensitivity to being 'in the spotlight' at any level regarding health issues.

Nonetheless, many in this sample were actually strongly state-focused in terms of potential impacts on their own behaviour and (despite feeling uncomfortable with the idea of compulsion) believed that only a fairly straightforward compulsory scheme administered by NHS primary care services would be likely to change the status quo in relation to their own health.

### 7.5.16 Interventions: single and linked approaches

Respondents supported a linked approach as the best method for making changes – in theory at least. Many recognised that their behaviours are all, at some level, linked to others and can be mutually reinforcing.

In relation to themselves, however, there was general agreement that it would be more realistic to start with a single issue intervention and then progress from that point.

Most believed that their own problems were based on one major problem area (such as diet) and that this would need to be addressed as a priority. There was a consensus that trying to 'tackle everything at once' would be bound to fail – and quite quickly.

This is very much a 'one step at a time' segment, which believes that it has so many challenges to contend with that it often feels it does not know where to start.

Many respondents clearly feel that, if some progress were made in one area, then this could be used as a platform for support and ongoing change. It should be recognised, however, that UFs are typically pessimistic and fatalistic – so that the underlying assumption in

many of their responses to the intervention topics is that they will fail.

## 7.6 Unconfident Fatalists: summary of focus group and immersion depth findings

This segment demonstrates a number of **consistent characteristics**:

- there is **strong focus on the 'here and now'**, since the future seems daunting;
- these respondents are **pessimistic and fatalistic** in outlook;
- they try to **escape from the problems of everyday life** through unhealthy behavioural choices;
- they **do not believe that they can be either healthy or happy**;
- they **lack any sense of control over health** and illness seems inevitable;
- they **exhibit low self-esteem** and general dissatisfaction with their lives;
- they are **typically trapped in a vicious circle** of psychological problems and damaging behaviours;
- **aspirations are low** and respondents are often affected by traumatic life events; and
- they typically demonstrate **repetitive and obsessive patterns of behaviour**.

This is a segment which shows **very little evidence of resilience** in relation to life challenges. In many cases respondents try to cope alone and become isolated – leading to withdrawal, eventual inertia, the use of damaging behaviour as a compensatory escape mechanism and depression. Difficult family backgrounds have evidently contributed to this situation, with many respondents reporting traumatic events which caused them to 'fall apart'.

**Influences on health behaviours were essentially personal in nature** – poorly managed stress, low self-esteem, lack of motivation and a depressive outlook all combine to drive (in some cases) compulsive unhealthy behaviour. Overlapping bad behaviours seemed common and UFs were easily influenced by their peers into adopting bad behaviours.

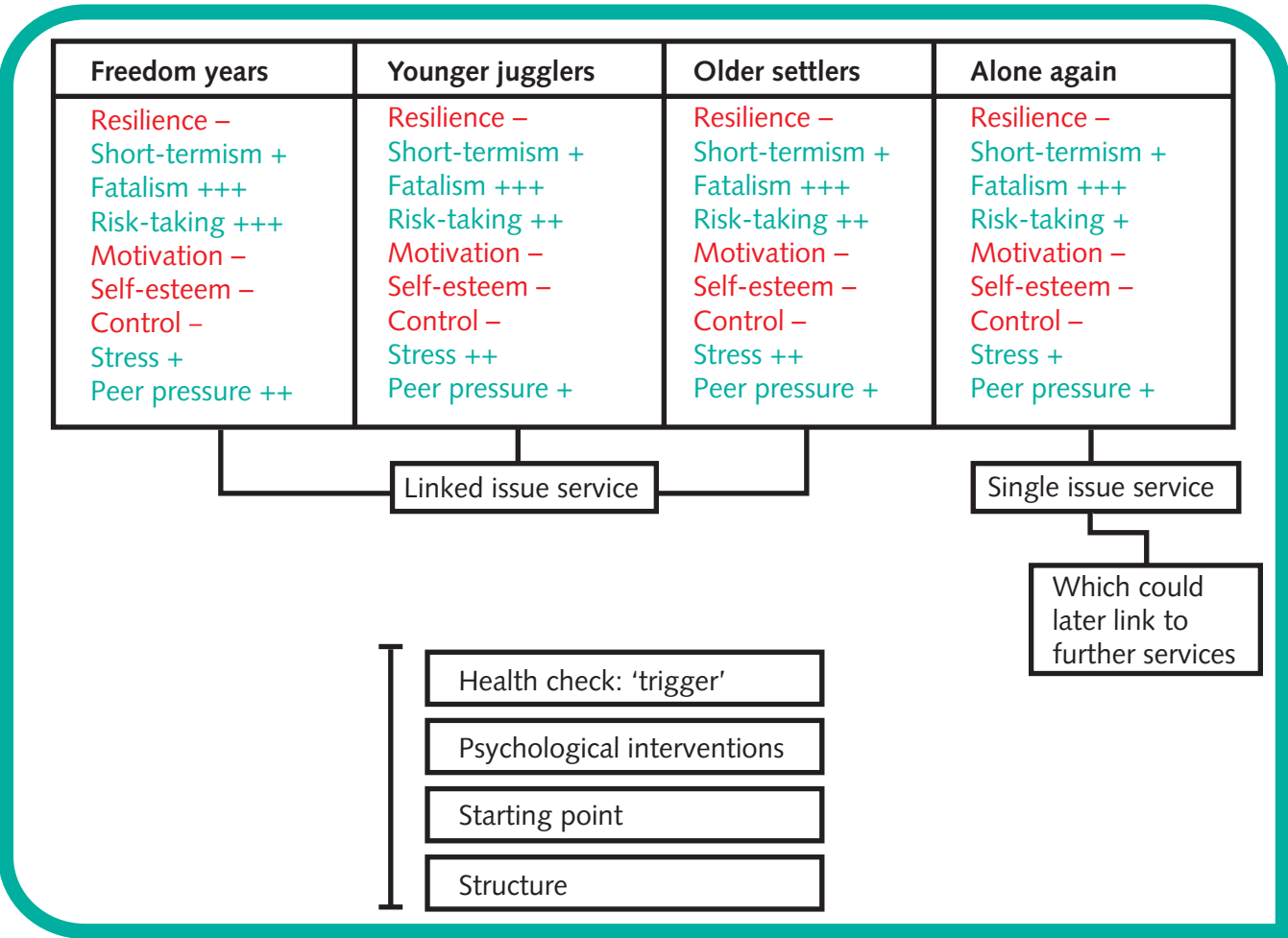
**UFs recognised themselves in the segment description** and quickly assessed their segment status as the lowest in terms of healthy behaviour and outlook. Most aspired to LfT status and admired the LfTs' ability to enjoy themselves in the present moment. Some would like to be BCs, but believed that to be an unrealistic aspiration. HCRs were dismissed as health 'fanatics' to be feared. Overall, the UFs clearly saw the segment descriptions as confirming that (as many assumed) they were the least successful and attractive group in the current health 'universe'.

In relation to **interventions**:

- these respondents are **aware of their problem behaviours**, but not motivated to make changes;
- this segment is **fundamentally immobile and unmotivated** in relation to its health status and needs a 'wake-up' call in order to initiate change;
- **state of mind is important**: stress and depression shape most responses to health challenges;
- the critical challenge lies in **creating an appetite for change**;
- overall, UFs are **sceptical about state interventions** in relation to health, believing that only individual motivation can make a difference;
- nonetheless, many UFs clearly believe that **compulsion may be the only way to initiate change** in their own behaviour;
- UFs typically **want sensitively handled, tailored, personalised approaches**, with clear goals and plenty of ongoing support and monitoring;
- UFs are **timid and frequently 'back off' from services** – only NHS primary care seemed to offer a realistic starting point for change;
- it is important for UFs to **see that similar 'people like them' are engaged with any interventions** targeted at themselves;
- UFs are **inclined to respond negatively to interventions** – some, for example, had found CBT intrusive and unhelpful;

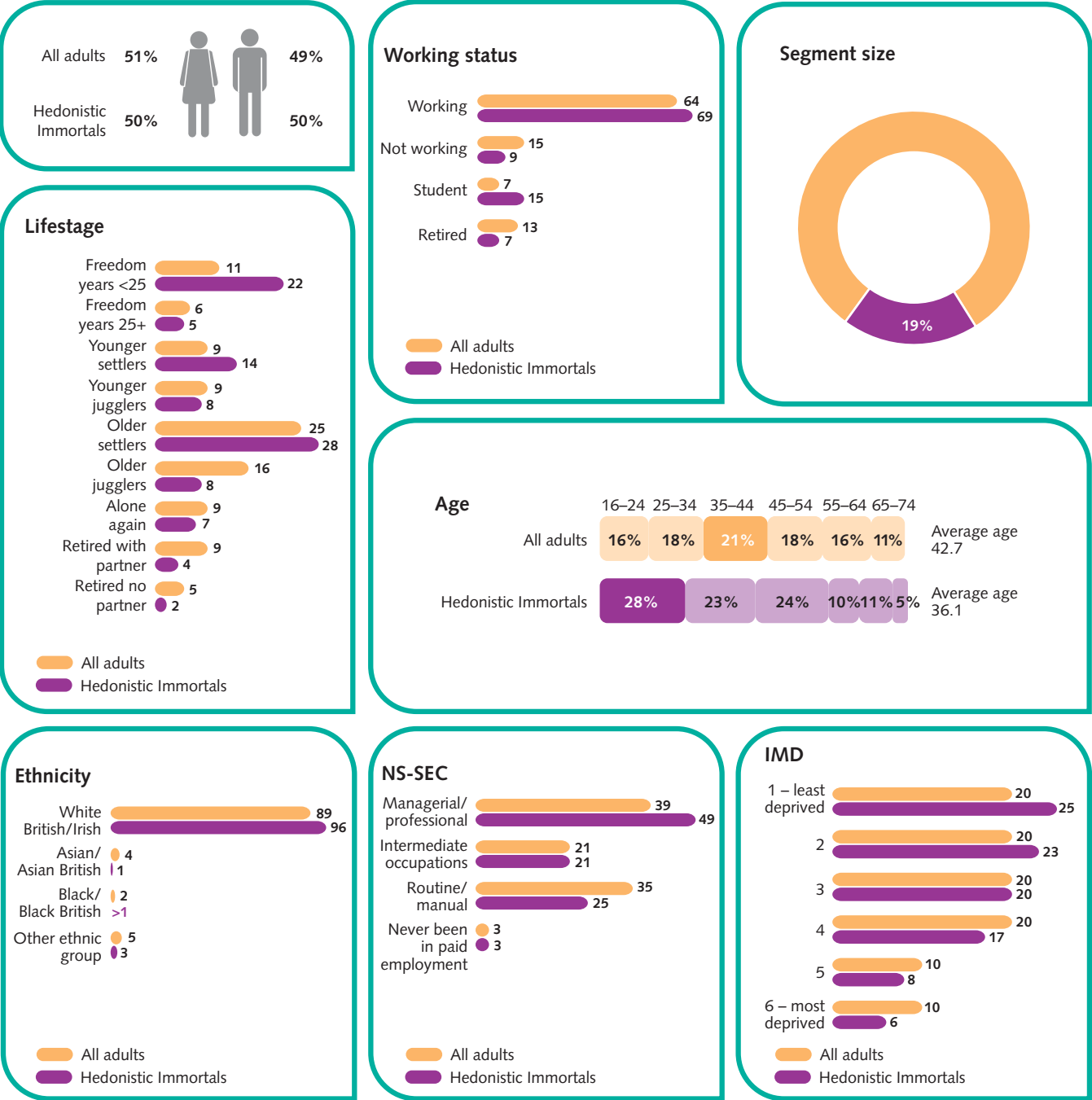
- most **like and trust the NHS brand** – so interventions should be delivered by local channels, but branded as supported/funded by the NHS;
- broadly, many UFs believe that they will never make any effort to change **until they receive a health shock** – probably delivered by the NHS as a consequence of illness;
- it may, therefore, be necessary to **use the machinery of a primary shock to initiate change** before serious health impacts are manifested; and
- equally, it should be recognised that **UFs will require considerable resources in terms of ongoing support and monitoring**, as any opportunity to withdraw and resume established behaviour seems likely to be taken.

Figure 7.7: Unconfident Fatalists: lifestages and motivations



# 8 Hedonistic Immortals

Figure 8.1: Hedonistic Immortals: demographics/lifestage



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Hedonistic Immortals (unwtd 652/wtd 910/ess 400)



Hedonistic Immortals (HIs) represent 19% of the overall sample. They are also a relatively younger segment compared with the others and most reside in less deprived areas.

## 8.1 Verification

HIs were the only segment to disagree with the statement *"If you don't have your health you don't have anything."* Health was not, typically, valued in itself, but was rather seen as facilitating an enjoyable, pleasurable, lifestyle. Enjoying life was a clear priority, even if this is at the expense of health:

*"You want to be healthy while having a fun life...but you don't have to be healthy to have a fun life."*

(Male, Alone again, IMD 4–6, Lewisham)

*"There's more important things in my life than good health. I'd rather the other people in my life had good health."*

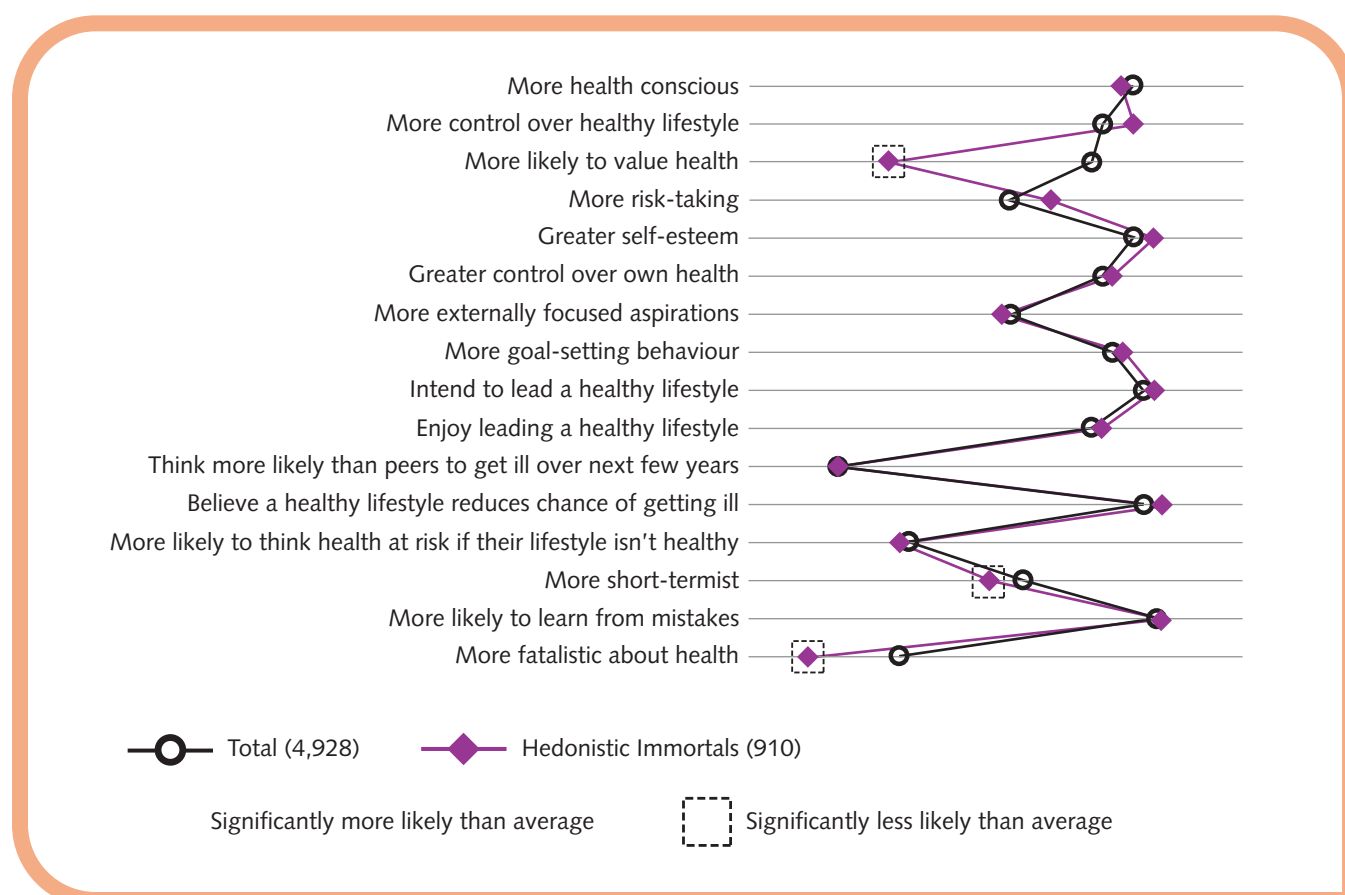
(Female, Freedom years, IMD 1–3, Croydon)

Respondents typically focused on the 'here and now'. This was expressed in terms of adopting a spontaneous approach to life:

*"Taking life one day at a time."*

(Male, Alone again, IMD 4–6, Lewisham)

Figure 8.2: Hedonistic Immortals: motivations



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Hedonistic Immortals (unwtd 652/wtd 910/ess 400)

*"Generally I'm quite a spontaneous person who doesn't think about the consequences of things – and this comes down to daily decisions."*

(Female, Freedom years, IMD 1–3, Croydon)

*"You still live for the moment though, because no one knows what's going to happen tomorrow."*

(Male, Younger juggler, IMD 4–6, Nottingham)

*"The money I earn is the money I spend. I don't save or anything like that."*

(Male, Freedom years, IMD 4–6, Slough)

Planning for the future was seen as both worrying and unappealing:

*"Just deal with what happens now and we'll deal with the future when it comes around."*

(Female, Younger juggler, IMD 4–6, Nottingham)

*"I'll worry about the future when I'm living it."*

(Male, Freedom years, IMD 1–3, Leeds)

The possible consequences of personal behaviour were not closely scrutinised. Although there was an awareness of consequences, respondents appeared to believe they were immune from the worst outcomes:

*"I never use condoms."*

(Male, Freedom years, IMD 1–3, Leeds)

*"There's a new drug out at the moment – Methadone – that no one knows anything about. We're all taking it, but it could be rotting us all from the inside."*

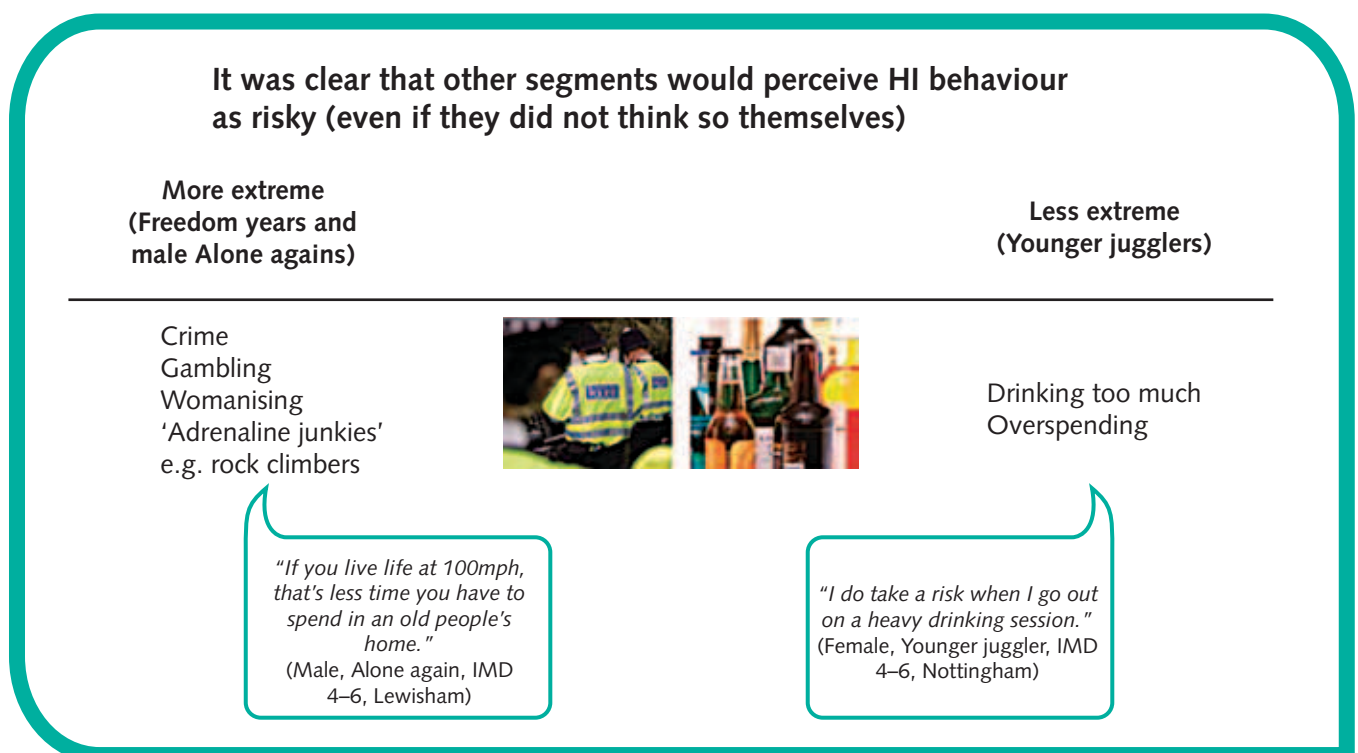
(Male, Freedom years, IMD 1–3, Leeds)

There were mixed responses to the statement 'I feel good about myself'. Men generally agreed that they did feel good about themselves:

*"I can do what I want."*

(Male, Freedom years, IMD 1–3, Leeds)

**Figure 8.3: Hedonistic Immortals: risk**



*"I feel good the way I am – whether it's business or health. I feel comfortable with my lot."*

(Male, Alone again, IMD 4–6, Lewisham)

However, women's views in particular were influenced by cosmetic considerations:

*"I put 'ish'." [Response to the statement 'I feel good about myself']*

(Female, Alone again, IMD 4–6, Brighton)

*"It's sort of half and half. Sometimes I do feel good about myself but then something happens and makes me frustrated...but at other times things go well and I feel great."*

(Female, Younger juggler, IMD 4–6, Nottingham)

In terms of health, all felt that they were no more likely than others to get ill in the future. Typically, HIs felt that their health status was 'average':

*"I feel quite average health-wise and there's nothing in my family to make me think I'm more likely than others to get ill."*

(Female, Freedom years, IMD 1–3, Croydon)

However, this assessment was clearly based more on hope than on expectation:

*"I like to think that I'm a little less likely [than others to get ill in the future]..."*

(Female, Younger juggler, IMD 1–3, Croydon)

*"I just let my metabolism save me. I'm putting on a bit of weight now, but I'll sort it out later."*

(Male, Freedom years, IMD 1–3, Leeds)

From an external (i.e. not HI) perspective, HI behaviour seems obviously risky, even if respondents did not think so themselves. The Freedom years and male Alone again segments took the most extreme risks, including crime, gambling, promiscuous sexual

behaviour and 'adrenaline sports' such as rock climbing.

Younger jugglers were less extreme, but still reported some risky choices: for example, drinking too much and consistently overspending:

HIs strongly believed that they were in control of their health, although with less control over potential illness:

*"If you push yourself you can get fit – if you really want to."*

(Male, Freedom years, IMD 1–3, Leeds)

*"I'm in control of what I eat, I'm in control of what I do, but I'm not in control if there was anything wrong with me."*

(Female, Younger jugglers, IMD 1–3, Croydon)

This belief in fate, however, was not used as an excuse for inaction:

*"I do believe in fate, but you don't tempt fate. I wouldn't say my health is decided by fate."*

(Female, Younger juggler, IMD 4–6, Nottingham)

*"It's how you approach it, you have to change the path by your own actions."*

(Female, Freedom years, IMD 1–3, Croydon)

Typically, HIs believed that a healthy lifestyle would be neither easy nor enjoyable. A majority of respondents expected that a healthy lifestyle would be both boring and difficult:

*"If you pack in everything you enjoy, there's nothing to live for."*

(Male, Alone again, IMD 4–6, Lewisham)

*"I'm trying really hard, but I'm struggling. I think I use the gym as an excuse to eat more junk food and I can't stop myself!"*

(Female, Younger juggler, IMD 4–6, Nottingham)

Life choices were cited as barriers to living a holistically healthy lifestyle. Overall, 'life' was seen as more important and more interesting than 'health':

*"If you live life at 100mph, that's less time you have to spend in an old people's home."*  
(Male, Alone again, IMD 4–6, Lewisham)

## 8.2 Environment and IMD

HIs typically valued positive environments which make them feel good. In their own areas, respondents wanted green spaces, clean environments and 'fresh air'. The number of HIs who valued 'the outdoors' and enjoyed outdoor pursuits was striking. For example, many respondents enjoyed golf, walking, football, gardening or horse-riding.

In IMD categories 1–3, all respondents were happy in their areas (Leeds and Croydon) and intended to stay. Within IMD categories 4–6, responses to the environment depended on lifestage:

- Freedom years respondents were generally bored with their areas (Brighton and Slough) and had vague plans for adventures elsewhere, such as going travelling or moving abroad. Younger jugglers were settled in Nottingham, but envisaged moving somewhere 'better' and 'quieter' in the future:

*"I might move to Skegness to be closer to my family."*  
(Male, Younger juggler, IMD 4–6, Nottingham)

- Alone again men from Lewisham also wanted to leave their area for a quieter life elsewhere. Women from Brighton wanted to remain near their families and to continue enjoying their surroundings:

*"My best moments of the day are walking the dogs and going up high and looking out. It's not what money can buy, it's spiritual and enriching."*

(Female, Alone again, IMD 4–6, Brighton)

IMD did not appear to have much of an impact on diet or exercise choices, which were inconsistent across the sample. There was, however, more evidence of smoking and heavy drinking among Freedom years and Alone again segments from IMD categories 4–6:

*"I'm living a shitty lifestyle – drinking, smoking and not eating particularly well."*  
(Male, Alone again, IMD 4–6, Lewisham)

A comparison (shown in figure 8.4) of the Freedom years segment illustrates how respondents in IMD categories 4–6 incorporate unhealthy behaviours into their identity:

- IMD 1–3 female respondents reported drinking as part of an enjoyable night out. Male respondents were orientated towards recreational drugs, but maintained their studies (if students) or work.
- IMD 4–6 female respondents described their identity as revolving around drinking and/or smoking. Male respondents also reported behaviour such as drinking, unprotected sex and other risk-taking as part of their identity (i.e. 'this is who I am').

## 8.3 Key drivers

### 8.3.1 Short-termism

HIs often expressed vague plans for the future, which provide a focus for life choices. These plans, however, were often undeveloped and unclear. Typically, different lifestages noted different priorities:

- Freedom years were keen on planning their holidays:  
*"I want to do my 3rd year at uni and then head to Ibiza to work in the summer. That's as far as I want to plan."*  
(Male, Freedom years, IMD 1–3, Leeds)
- Younger jugglers were focused on providing stability for their families:  
*"I'm quite steady at the moment. I've just moved house and I'm staying in the same job for now."*  
(Male, Younger juggler, IMD 4–6, Nottingham)
- Alone agains maintained their lifestyles and saw the future as belonging to their grandchildren:  
*"I would like to see my little girl grow up."*  
(Male, Alone again, IMD 4–6, Lewisham)
- Freedom years displayed the most risky behaviour, especially in terms of health risks. For example, many admitted binge drinking, unprotected sex and drug use:  
*"I'm not supposed to smoke weed because I'm asthmatic. But I don't see that as a risk because it's helping me with my sickness."*  
(Male, Alone again, IMD 4–6, Lewisham)
- For Younger jugglers, the drive to take risks is significantly curtailed by parenthood. However, respondents reported 'letting their hair down' when they can:  
*"I still get bladdered every now and then after football."*  
(Male, Younger juggler, IMD 1–3, Leeds)
- For Alone again men, risk-taking (for example, drinking heavily and taking drugs) increases, while women in this lifestage often tested their physical limits (for example, through climbing ladders and exercise which tests stamina):

8.3.2 Risk-taking behaviour

As with other segments, risk-taking behaviour was influenced by lifestage:

Figure 8.4: Hedonistic Immortals: Freedom years

		IMD 1–3	IMD 4–6
Freedom years	Female:	drinking as part of an enjoyable night out	a drinking/smoking identity
	Male:	taking recreational drugs, but studying	drinking, unprotected sex and other risk-taking



*"I may drink 15 pints in a session down the pub, but it doesn't seem like a risk to me at the time. I enjoy it."*

(Male, Alone again, IMD 4–6, Lewisham)

An overview of risky behaviour is given in figure 8.5.

For HIs, risk-taking is about escaping from the monotony of everyday life:

*"Life is boring and humdrum so you've got to do something to add a bit of excitement."*

(Male, Alone again, IMD 4–6, Lewisham)

Although most recognised that their behaviour is risky, there was a tendency to believe that they were somehow 'immune' from potential consequences:

*"I smoke doob quite regularly but I don't see it as taking a risk because my mind's not susceptible."*

(Male, Freedom years, IMD 1–3, Leeds)

*"I enjoy smoking. I think it depends if you have a propensity to cancer."*

(Female, Alone again, IMD 4–6, Brighton)

### 8.3.3 Resilience

Unlike other segments, HIs were not keen to talk about their negative life experiences. However, there was diary evidence of a quieter type of resilience.

HI resilience was slow to manifest, but seemed to develop over time. When a negative event happens, respondents appear to 'plummet' into depression. They then begin to slowly rebuild (as shown in figure 8.6) with distinct steps on the path to recovery:

*"You have to put breakfast on the table, they have to go to school and then before you know, a week has passed and you think it's not so bad any more."*

(Female, Younger juggler, IMD 1–3, Croydon)

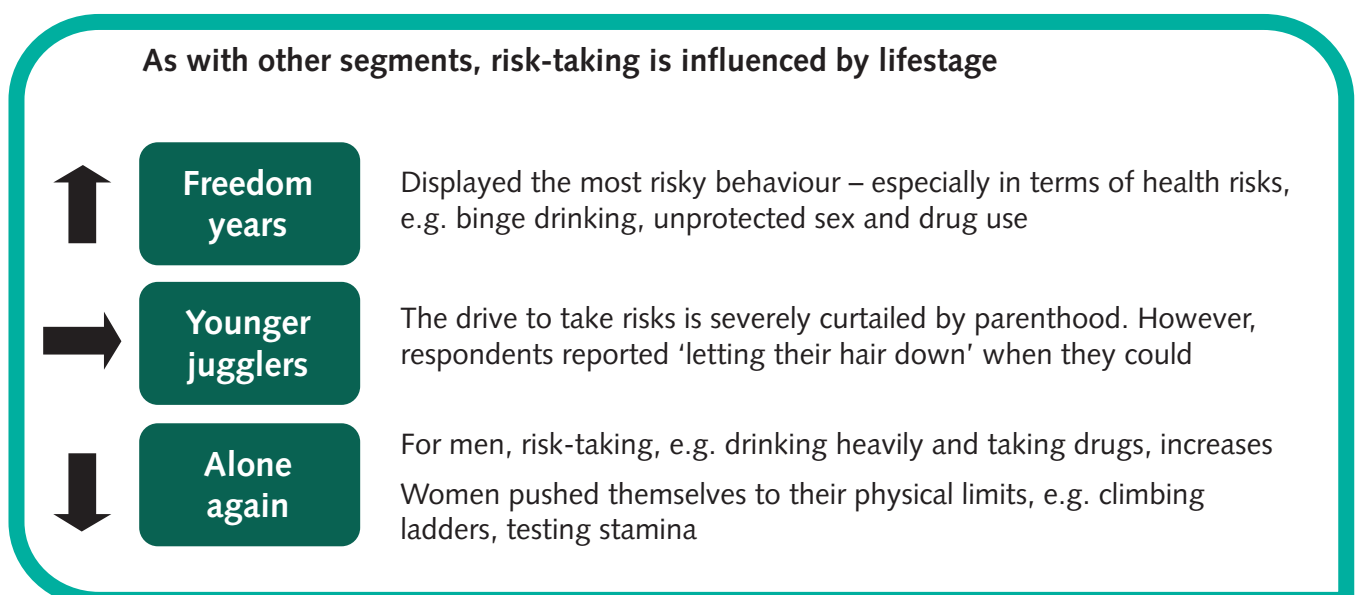
*"You have to do it step-by-step so you can deal with it in your own way. You have to take it however you feel comfortable."*

(Female, Freedom years, IMD 1–3, Croydon)

*"I know I'm feeling better when I put make-up on for the first time."*

(Female, Freedom years, IMD 1–3, Croydon)

**Figure 8.5: Hedonistic Immortals: risk-taking and lifestage**





HIs admitted that they typically needed the support of friends and family to 'help them through' difficult stages of life:

*"I do rely on family for support."*

(Female, Younger juggler, IMD 1–3, Croydon)

*"Meet your friends and have a drink or a nose-bag and chill out. Everyone's got a mate who can give you a new, better perspective on the problem."*

(Male, Freedom years, IMD 4–6, Slough)

*"You need someone to tell you to pull yourself together."*

(Male, Alone again, IMD 4–6, Lewisham)

*"I'm quite close to a friend at work and sometimes I feel like I look forward to going into work just so we can have a laugh, instead of sitting home alone."*

(Female, Younger juggler, IMD 4–6, Nottingham)

Seeing a lot of friends messed  
up on drugs

Or worried about them

Wouldn't do ever do loads

Seeing a lot of friends messed  
up on drugs

Worried about them.

Wouldn't ever do loads

(Male, Freedom years, IMD 1–3, Leeds)

Family deaths

psychological / emotional

More caring  
Think of others more

Family deaths

Psychological / emotional

More caring  
Think of others more

(Male, Younger juggler, IMD 1–3, Leeds)

Split

Fear.  
(Money, living alone).

Got me back  
slowly  
Now enjoy life

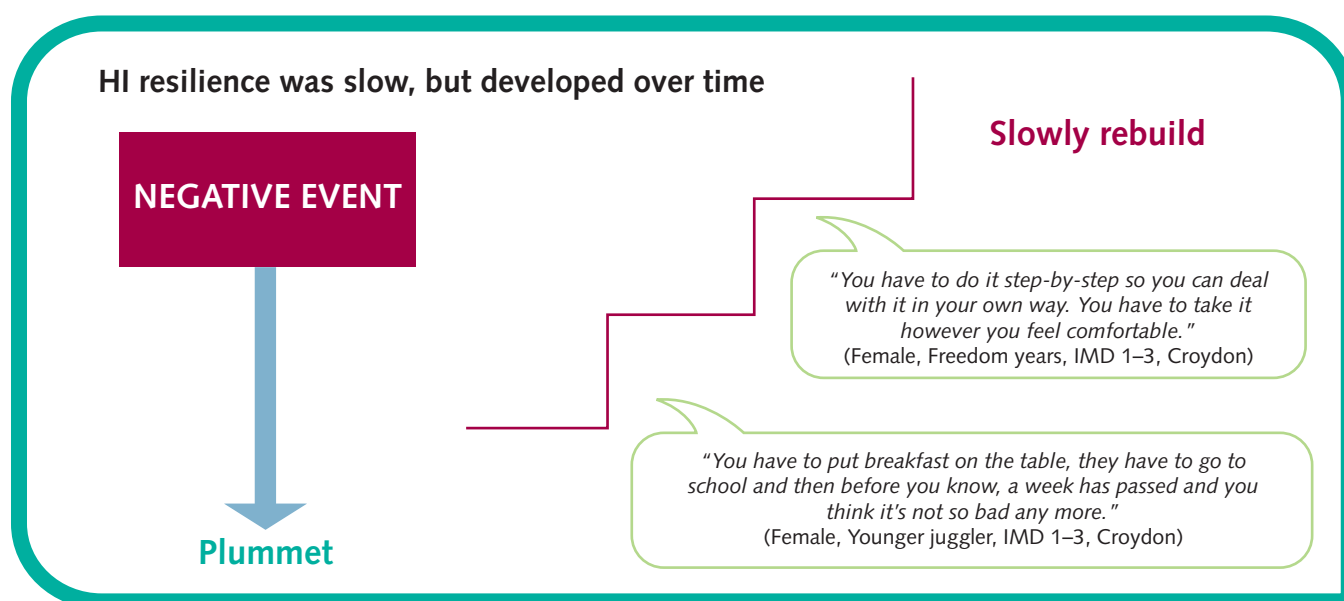
Split

Fear.  
(Money, living alone).

Got me back  
slowly  
Now enjoy life

(Female, Alone again, IMD 4–6, Brighton)

Figure 8.6: Hedonistic Immortals: resilience



*"We all like a good joke about the wife, but I couldn't do without her."*  
(Male, Younger juggler, IMD 1–3, Leeds)

Recovery seemed a slower process than was evident in other segments, but respondents all believed that they had learned or become stronger people as a consequence of tough times:

*"I started to learn about who I was."*  
(Female, Freedom years, IMD 1–3, Croydon)

*"Live happy!"*  
(Female, Freedom years, IMD 1–3, Croydon)

*"I grew up!"*  
(Male, Freedom years, IMD 4–6, Slough)

*"It did make me realise what you've got that's valuable to you."*  
(Female, Younger juggler, IMD 1–3, Croydon)

## 8.4 Interventions

HIs admitted to biasing their diaries towards more healthy behaviours and adopting more healthy behaviours than usual while undertaking the diary exercise. Some admitted

they were actually untruthful about their health behaviours, but a majority genuinely modified their behaviour:

*"Normally I buy fruit and vegetables but I usually end up throwing them away because I never get round to eating them. But this week I made more of an effort to eat more of the fresh stuff."*  
(Male, Alone again, IMD 4–6, Lewisham)

*"I packed up smoking and decided to cycle home from work rather than have a fag."*  
(Male, Younger juggler, IMD 4–6, Nottingham)

*"A big decision for me was to have cereal and fruit in the morning for breakfast because it was the healthier option."*  
(Male, Younger juggler, IMD 4–6, Nottingham)

*"I've started the Special K diet. I've been so controlled and not even let myself have a bigger bowl!"*  
(Female, Freedom years, IMD 1–3, Croydon)

The changes made by respondents typically related to aspects of their lifestyles that they were aware should be changed. Most saw the

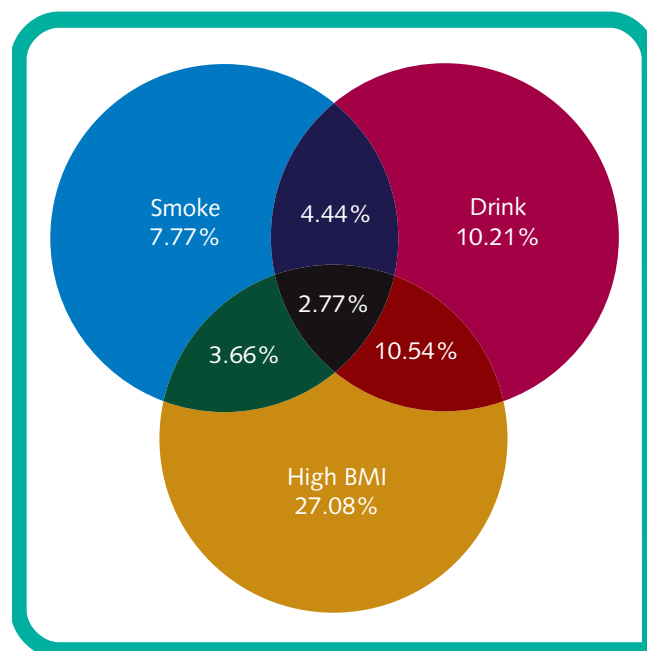
diary exercise as an opportunity to make these changes.

The HI view of 'health' was clearly incomplete. Most saw the following elements as constituting health:

- **Fitness.** Male HIs tended to focus on this issue, although their definition of regular exercise was often questionable. For example, if a respondent worked in a manual job, then they typically counted this as regular exercise:  
*"You can be healthy and be unfit, but if you're fit you're likely to be healthy."*  
(Male, Freedom years, IMD 4–6, Slough)
- **Diet.** This was the consistent focus for female HIs:  
*"I instantly thought it was about what you eat. I never thought to put things about activity down in the diary."*  
(Female, Younger juggler, IMD 4–6, Nottingham)
- **Avoiding damage.** There was a genuine belief that avoiding damage (for example, through not smoking, not drinking to excess or taking drugs) equates to good health.
- **Cosmetic factors.** Choice of positive behaviours was often influenced by vanity, rather than direct health considerations. This means that if respondents feel that they look good, they are unlikely to see health changes as necessary.

Linked poor health behaviour was very common among HIs. The extent of overlapping behaviour is substantiated by the quantitative analysis, illustrated in figure 8.7.

**Figure 8.7: Hedonistic Immortals: overlapping behaviours**



Source: Research Report No. 1

The same proportion of HIs as Unconfident Fatalists (UFs) smoke, drink and have a high body mass index (BMI), although both segments are eclipsed by Live for Todays (LfTs) at 4.32%.

HIs were very open about the extent of their risky health behaviours. For many, this is the identity that they wish to present to the world:

*"I'm not supposed to smoke weed because I'm asthmatic. But I don't see that as risk because it's helping me with my sickness."*  
(Male, Alone again, IMD 4–6, Lewisham)

*"Drinking without getting drunk is boring."*  
(Male, Freedom years, IMD 4–6, Slough)

*"...when you're in the moment and the condoms are in your jacket on the other side of the room."*  
(Male, Freedom years, IMD 4–6, Slough)

*"Smoking is not going to come into the equation...I enjoy it too much."*  
(Male, Alone again, IMD 4–6, Lewisham)

Reliance on fast food was particularly noticeable among this attitudinal segment:

Number 4 decision: GRABBED A TAKE-AWAY  
+ 2 CANS OF BEER

Why did I make this decision?  
TOO TIRED TO COOK

Number 4 decision: Grabbed a take-away  
and 2 cans of beer

Why did I make this decision?  
Too tired to cook

(Male, Alone again, IMD 4–6, Lewisham)

Number 1 decision: What shall I have for dinner? shall  
I make something or order out - order out.

Why did I make this decision? I was really tired and  
didn't have enough energy to make anything.

Number 1 decision: What shall I have for dinner? Shall  
I make something or order out... order out

Why did I make this decision? I was really tired and  
didn't have enough energy to make anything.

(Female, Freedom years, IMD 1–3, Croydon)

Number 4 decision: Had chips, battered sausage  
& curry sauce before going to bed.

Why did I make this decision?  
Because I was hungry and was  
walking past a take away, and they  
don't serve salad there. lol

Number 4 decision: Had chips, battered sausage  
and curry sauce before going to bed.

Why did I make this decision?  
Because I was hungry and was  
walking past a take away, and they  
don't serve salad there. LOL

(Male, Freedom years, IMD 4–6, Slough)

### 8.4.1 Views about overall health

HIs were very receptive to the idea of learning from their diary exercise. Many realised they were making more poor choices than they had expected, and were keen to consider changes:

*"I made the link between being busy and not eating properly...being busy and not taking care of myself."*

(Female, Younger juggler, IMD 1–3, Lewisham)

*"There's all this stuff that I know that I don't do."*

(Female, Alone again, IMD 4–6, Brighton)

*"I need to find some way of not panicking about my life and feeling better. Maybe it will be to walk more and set aside a Sunday afternoon to do things as a family."*

(Female, Younger juggler, IMD 4–6, Nottingham)

*"The diary made me realise I react to events ...rather than being proactive. If I get up earlier, I can actually eat breakfast."*

(Male, Alone again, IMD 4–6, Lewisham)

Many were already aware of their health shortcomings and saw the insights delivered by the diary exercise as an opportunity for change.

*Since being recruited for this research to fill in this diary its made me a bit more health conscious*

*Since being recruited for this research to fill on this diary it has made me a bit more health conscious*

Number 1 decision: *Made an appointment to see the Nurse to go on Quit Smoking programme*

Number 1 decision: *Made an appointment to see the nurse to go on quit smoking programme*

(Female, Alone again, IMD 4–6, Brighton)

Number 1 decision: *I decided to walk instead of taking the bus.*

Why did I make this decision? *I think with the group. Coming up I was more conscious of health.*

Number 1 decision: *I decided to walk instead of taking the bus.*

Why did I make this decision? *I think with the group coming up I was more conscious of health.*

(Male, Alone again, IMD 4–6, Lewisham)



### 8.4.2 Intervention approaches

HIs were evidently not in touch with the reality of their individual health situations: many seemed to be deluding themselves that they were healthier than they really were. The findings suggest that the key for intervention is to provide HIs with a personal 'wake-up' call, empowering them to recognise and acknowledge their own specific health issues.

Once HIs are engaged with the idea of making changes, they typically need to see immediate, tangible lifestyle benefits (e.g. feel better, become more active, look better, have fun) in order to maintain their motivation and enthusiasm:

*"Something where you can actually have a bit of fun with it and you don't feel like you're doing a workout."*

(Female, Freedom years, IMD 1–3, Croydon)

Messages must be couched in appropriate HI language – so, 'wellness', rather than 'health'. For this segment, 'wellness' is seen as the best route to living life to the full.

A health check could encourage HIs to think about the ways in which improving their health might increase the potential for enjoying themselves. Although few were overtly concerned about their health, peace of mind was seen as valuable. A wellness check away from a formal medical setting was certainly appealing and resonated with their focus on 'life' rather than 'health'. Some Freedom years respondents needed convincing about this, however, as they saw this approach as more relevant to older people.

To increase motivation, the service would need to formally and regularly track progress in order to make the results more tangible and imply a 'one-to-one tailored wellness journey'.

Vitality does not represent an appropriate approach for HIs. They believed the service was aimed at people with problems (so, 'not me'). Many were uneasy with the idea of a formal intervention and Vitality was perceived as too 'governmental'. However, some Younger jugglers felt the service might be of interest if it offered psychological support in relation to issues such as time and stress management – a requirement typical of this lifestage:

*"Someone to look after the kids occasionally to give me a bit of time to think about myself and plan better."*

(Female, Younger juggler, IMD 1–3, Croydon)

*"Time management...especially for working mums."*

(Female, Younger juggler, IMD 1–3, Croydon)

Single issue interventions were simply rejected – support for a specific 'problem' was not appealing. Although many felt that they needed to make changes, most wanted to retain control over how to make the changes:

*"There's no point in me going to see someone for advice about losing weight because I know what I should be doing."*

(Female, Younger juggler, IMD 4–6, Nottingham)

Environmental factors seemed unlikely to have an impact on HI health behaviour. The environment does affect HIs' overall levels of positivity, but the offer of additional facilities did not appear to motivate change:

*"I think it's the right thing to do but I think people's lifestyles don't allow them to do it."*

(Female, Younger juggler, IMD 1–3, Croydon)

For HIs, the ideal intervention would be a health-check journey, including:

- a 'wake-up' call for potential change;



- results tracking so that HIs can see tangible progress and stay motivated; and
- services tailored to the individual, who must be allowed to set his/her own goals.

The selling point will need to be a reason that HIs understand and identify with. For example:

- 'You will enjoy life more.'
- 'You will look better.'
- 'It's not hard to do – it's fun!'

## 8.5 Hedonistic Immortals: immersion depth analysis

### 8.5.1 Resilience

Virtually all the respondents cited a major life challenge or series of challenges (death of a family member, separation, family strife) as a key driver or drivers for personal resilience. There was a strong focus on emotional responses to challenge, including rebellion, independence and 'picking yourself up':

*"I don't worry about anything now. There's bigger problems in the world. Live and let die: if it happens, it happens."*

(Male, Freedom years, IMD 1–3, Leeds)

Across the HI sample, respondents believed that they had recovered from difficult life situations and emerged stronger and more positive in outlook.

All could identify people whom they see as lacking resilience – often family members or ex-partners. There is evidently a strong impetus among HIs to avoid repeating personal mistakes or mirroring the perceived negativity of others. HIs typically saw themselves as beacons of resilience, growing from a low base to outstrip many people they know.

It was also clear, however, that HIs are significantly challenged by stress and negative life events. The quality and intensity of their resilience seem to vary, and respondents spoke about 'feeling down' and 'losing confidence' when tested by problematic life situations.

It seems that the upbeat, determined aspects of the HI personality can be eroded over time. While respondents in the Freedom years lifestage were typically very confident and Younger jugglers were often transformed by the experience of family life, some Alone again respondents were evidently struggling to maintain a positive outlook.

Equally, it was clear that work delivers a significant boost in terms of resilience for HIs in segments IMD 1–3, while those in IMD categories 4–6 typically relied upon a settled family life to deliver the support they needed. Independence was a consistently stronger theme among those from IMD categories 1–3.

Overall, HIs saw resilience as a core aspect of their character and a product of challenges successfully overcome in the past. On probing, however, it became clear that the nature of HI resilience is much less consistent than respondents initially indicated. This segment is consistently tested by stress and problems, and seems to rely heavily on external structures such as work and family to support what may be a relatively fragile level of resilience.

### 8.5.2 Risk-taking behaviour

These respondents typically believed that risk enhances quality of life, and most embraced risk as a normal part of 'living life to the full'. Virtually all the sample equated risk with 'having fun' and saw behaviours such as binge drinking, smoking and drug use as acceptable elements in a fully lived life:

*"I am an 'all or nothing' person. I've taken a lot of financial risks in the past: loans for example. Now I have lots of store cards – I'm paying for clothes that I haven't even got in my wardrobe now!"*

(Female, Younger juggler, IMD 1–3, Croydon)

Acceptance of risk clearly went beyond the arena of health behaviour, with respondents reporting that they had taken significant risks with their financial affairs, taken part in extreme sports and chosen careers (police officer, for example) which involve considerable risk on an ongoing basis.

The respondent quoted above described herself as an 'all or nothing' person and this description might, it seems, apply to many in the HI segment.

### 8.5.3 Motivation

Motivation was relatively consistent across HI lifestage segments:

- Vanity: 'looking good/feeling good about myself' is especially important for Freedom years and Younger jugglers.
- Reward is important, often in the form of food, alcohol, social activity and/or exercise.
- Convenience: HIs go for what is interesting but also easy/simple to achieve.

However, HIs struggle with major motivational barriers:

- Boredom: HIs are quickly and easily bored.
- Gratification: HIs can be distracted by an opportunity to 'have fun now'.
- Effort: 'Can't be bothered' was a consistent theme in relation to unfulfilled plans or aspirations.

- Fixation/tunnel vision: HIs tend to become powerfully over-focused on, for example, food and alcohol. Equally, obsessions with exercise and dieting seemed common.
- Reliance on others: HIs were often wholly driven by the support offered by others, and behaviour typically changed quickly once that support was withdrawn.
- Excess: HIs tend to indulge wholeheartedly in behaviours they enjoy, and so are often, for example, binge eaters and drinkers.
- Lack of persistence/patience: behaviour which does not produce instant results is often quickly abandoned.

Overall, this is a segment which finds it difficult to maintain attention on any aspect of lifestyle without considerable support from other people. Enthusiasm for change and innovation is always evident, but this energy rarely seems to last: respondents indicated many examples of plans that had not been realised and intentions that had been abandoned. In order to maintain motivation it is necessary for HIs to address their relatively short attention span and their inclination to revert to behaviours which deliver immediate satisfaction:

*"I feel I deserve to indulge in something. Because I don't see the benefits of exercising immediately, I lose interest."*

(Male, Freedom years, IMD 1–3, Leeds)

### 8.5.4 Norms/social influences

Many in the sample appeared to have emerged from problematic family situations, with single-parent households and dysfunctional parents or siblings common elements.

Although HIs typically rely heavily on their friends for support and entertainment, it was common for friends to be identified as bad

influences in terms of health and behaviour. Equally, however, where positive behaviours were reported, these were often dependent upon the support of a trusted friend.

Respondents were often irritated by the suggestion that they might be influenced by others, and most assumed a level of independent choice and action that was not confirmed by actual reported behaviour.

It was evident that HIs can be quickly destabilised and shifted from their stated purpose by immediate social pressures or opportunities. The behaviour of peers and immediate family clearly had a strong influence on the inclinations of respondents, many of whom eventually admitted that they were 'easily led'. Overall, day-to-day influences are typically much more important than longer-term personal strategies or goals:

*"I admit that I am influenced by friends. They say, 'Go on, have another drink.' I've never been able to say no. But I can also be influenced positively – so after the gym they'd say, 'You're not going to the chippy tonight.'"*  
(Female, Younger juggler, IMD 4–6, Nottingham)

### 8.5.5 Segment movement

All respondents identified strongly with the HI segment description. Some clearly believed that they had been born as HIs, while others felt that they had matured into HIs from either the LfT segment or, in one case, the UF segment:

*"This is definitely me. I'd rather indulge right now and I'll worry about the future in the future. I can sort it in the future. I can change it whenever I want to."*  
(Male, Freedom years, IMD 1–3, Leeds)

It was felt that independence and 'growing up' had been the factors that had changed respondents from another Healthy Foundations (HF) segment into HI. Respondents believed that life events such as starting work, education, family or relationships have produced a great change – typically from a 'wild' lifestyle into something more controlled and mature.

Some believed that they had rebelled against a more rational upbringing – perhaps as a Balanced Compensator (BC) or Health-conscious Realist (HCR) – to become independent and an HI, often via a period as an LfT.

Younger respondents could see little in the future except more HI-style fun and excitement. Those in the Alone again segment, however, did acknowledge that there was some potential to move to a less positive segment such as UF if circumstances were not helpful.

### 8.5.6 Attitudes towards other segments

Most of the respondents believed that their friends tended to be from the more composed HF segments, such as BC or HCR.

HIs were generally critical of UFs, although some of the older respondents noted some UF tendencies in their own behaviour and outlook. UFs were the segment that HIs seem least likely to want to spend time with.

The LfT perspective was familiar to many HI respondents, but most saw this as a 'young person's' segment and likely to represent unsuitable territory for the person moving forward in their development and lifestyle. Equally, most believed that they did look ahead and plan much more than would be possible for an LfT.

HCRs were seen as the ultimate goal in terms of being 'sorted': the positive aspects of the segment appealed, but the attitudes towards risk made this seem unattainable to most respondents. Women were more inclined than men to target HCR as a goal. Equally, those in IMD categories 4–6 tended to believe that it would be necessary to be financially better off to achieve either BC or HCR status.

Given the difficulties imagined in relation to becoming an HCR, some felt that it would be better to aspire to BC. That segment seemed attractive to most in the sample, but many were concerned that critical variables, such as thinking that healthy lifestyle would be easy, feeling good about themselves and avoiding risk, could represent unrealistic aspirations.

### 8.5.7 Interventions: environmental factors

Free access to exercise classes and facilities was welcomed across the HI sample. It was generally seen as an option which would help respondents to maintain healthy behaviours and realise their aspirations to increase their levels of exercise.

These respondents were generally interested in undertaking more exercise, but were also easily dissuaded by factors of convenience and cost. Many from IMD categories 4–6 felt that they had the motivation, but not the money, to spend more time at the gym or swimming pool.

Mass condom distribution was also positively received. It was believed that this was a sensible approach for younger people in particular, although some noted that condoms are already available free from health and family planning clinics.

The idea of measuring BMI and providing healthy food vouchers to those who improve their BMI received a generally positive reaction. Most felt that the process would be positively motivating and likely to be helpful in maintaining a healthy eating regimen.

Banning junk food advertising and using 'alcohol kills' stickers were dismissed as unlikely to have any real impact. Respondents felt that the supermarkets would continue to promote junk food and that those who wish to drink would disregard warning labels.

### 8.5.8 Interventions: health checks

The idea of health checks was well received across the HI sample, and a variety of venues such as the gym, GP practice or community mobile centre (but definitely not a hospital) were all believed to offer suitable opportunities for a check-up. The essential aspect of this service, however, was that it should be convenient and easy to access.

Most wanted a health-check service that would be moderately regular (not more frequent than every two to three months) and tailored to the individual. All wanted the tone of the checks to be informal and for there to be an opportunity for a chat around the findings. Such a 'human' approach would, it was felt, be extremely motivating and helpful.

Younger HIs from IMD categories 1–3 were especially keen on charts and targets as part of the health-check process. There was clearly a significantly competitive element to the concept, which these respondents found highly motivating.

Overall, HIs embraced the idea of health checks while putting in place a number of caveats in order to avoid being too closely tied to the process and to ensure that convenience



would be a primary factor in structuring the concept. All were conscious that it might not take much to 'put them off' the process.

#### 8.5.9 Interventions: single and linked approaches

There was a mixed response to the idea of linked approaches. Virtually all respondents saw the Vitality service as 'not for them' – seeing it as extreme and only suitable for those who needed a major programme of interventions and significant support. HIs evidently wanted to protect their independence and ability to 'pick and choose' their level of involvement in health-related activities.

Most could see the value in tackling linked issues such as eating and exercise, but all were concerned that mixing too many challenges would make the endeavour overwhelming. Equally, it was obvious that some HIs feared losing control over the process and preferred to do things 'in their own way'.

Also, there was a need for HIs to feel that any approach would be tailored to their individual circumstances. Many believed that a holistic approach would be too broad-brush to be of real value.

#### 8.5.10 Interventions: enforced changes

There was strong support for the ideas of enforcing a zero drink-drive limit and charging for alcohol-related accident and emergency (A&E) admissions. These were seen as unacceptable and irresponsible behaviours which ought to be penalised.

Overall, HIs were more extreme than other segments in terms of approving of a hard-line approach to many of the interventions being examined. Many supported ideas such as keeping alcohol under the counter, 'alcohol

kills' stickers and banning junk food advertising – even though some admitted that these were unlikely to be successful. A majority were comfortable with the idea of the government taking a stronger line with those who deliberately take risks with their health.

As individuals who often take a conscious decision to indulge in bad behaviour, these respondents were very aware that it takes more than minor social barriers to alter choices.

Spraying the smell of oranges in retail environments was seen as a charming idea, but marginal in terms of producing worthwhile behavioural change.

Interestingly, however, many were equivocal about the idea of compulsory health programmes. Most believed that they would be annoyed if forced to personally take part in a health programme, especially if it was ineffective.

Overall, although their initial instinct was to support enforced change approaches, HIs became less enthusiastic when considering their own potential involvement in such schemes. Perceived control is clearly important to HIs.

#### 8.5.11 Interventions: national state interventions

There was strong support for the idea of standardising food and drink labelling. This was seen as an initiative which would provide people with better and more consistently available information in order to make choices affecting health. HIs, however, typically believed that they already knew what was, and what was not, good for them. This initiative would, it was felt, be for others who needed more support.

Funding local outreach projects received a mixed response, although several respondents supported the idea in principle. It was obvious, however, that few HIs believed this to be an initiative aimed at themselves. Again, most felt that they knew what they needed.

#### 8.5.12 Interventions: research as an intervention

All respondents agreed that participation in the research had made them think about their health and behaviour in a new way. Few had ever taken the time to really assess what they did on a day-to-day basis. A majority had made changes to their lifestyles and taken practical steps to address issues highlighted by the research process.

The diary exercise had made virtually all think deeply about their choices and behaviour, with most realising how poorly they ate and identifying a variety of problem areas with food and alcohol.

The group sessions had also made many more aware of their own attitudes and habits through hearing them echoed by others. Although many were not generally inclined to get involved in group sessions, the experience had evidently been beneficial, with a number actually changing behaviour in the weeks following the groups.

Most admitted that their personal perceptions of their health had been changed by participation in the groups, with some being encouraged to hear that others were 'worse than me'.

Interestingly, however, many respondents believed that they would not have undertaken the diary exercise or attended the group session without a financial incentive. Some had not completed health diaries provided by doctors in the past.

#### 8.5.13 Interventions: sources of advice/support/information

These respondents were strongly wedded to two ideas:

- that any service should be local in nature and character: convenience is a key driver for HIs; and
- that a trusted brand such as the NHS should be the gatekeeper and conduit to local services: HIs liked to be able to be confident in those promoting important personal services.

HIs typically wanted these local services to be branded in such a way that they would seem more informal and potentially 'fun'. For most, a service had to sound as though it could be accessed 'on your own terms'.

It was obviously important that the service should not be seen to be about failure and ill-health. Although some wanted their GPs to introduce the service, it was believed that GP involvement should cease at that point.



## 8.6 Hedonistic Immortals: summary of focus group and immersion depth findings

This segment demonstrates a number of **consistent characteristics**:

- **health is not a core concern**: pleasure is the priority;
- there is a **focus on the 'here and now'**: a short-term outlook;
- there is a **disinclination to plan or consider consequences**;
- they **embrace risk and feel in control of their health**;
- they are **uninterested in a healthy lifestyle per se** – 'life' is more important than 'health'.

This is a segment which **can show resilience**, but often requires support to do so. The growth of resilience is typically slow and based upon strong support networks among family and friends. These respondents are, however, easily distracted and influenced by the social group that surrounds them at any one time. Respondents typically believed that they were stronger and more resilient than in the past, but actual behaviour contradicts this view.

**Influences upon health behaviours are many and varied**, but proximity is key: HIs can be enticed into bad behaviour relatively easily. The HI view of health is relatively compartmentalised, with exercise, diet, avoiding damage and cosmetic factors as the driving considerations. Overlapping bad behaviours seemed common.

**HIs embraced the HI segment description and philosophy**, few really believing that they would ever wish to change to another segment. Most believed that they had either 'always' been HIs or emerged from the LfT segment (when they were younger and wilder). None could really imagine developing into duller, more rational segments such as BC or HCR.

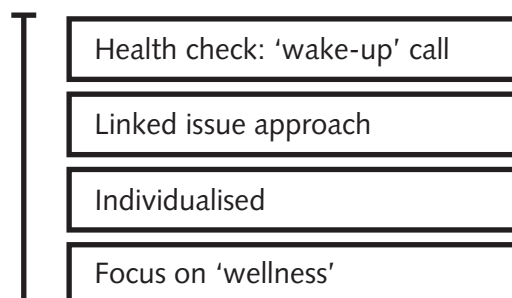
In relation to **interventions**:

- this segment is **fundamentally delusional** in relation to its health status and clearly needs a 'wake-up' call in order to initiate change;
- the segment is strongly affected by factors such as quality of environment and convenient, easy access to facilities: they **like instant results**;
- they typically **support prescriptive state interventions**, but reject compulsion in relation to their own choices;
- they typically **want tailored, personalised approaches**, with clear goals and targets to achieve;
- they **reject any approach which focuses on 'problems'**, preferring an upbeat presentation;
- **wellness is an appealing idea** and the notion of health checks was welcomed, provided that these are conveniently delivered, personalised and 'fun' in nature;
- a **linked approach to health interventions** was positively received, but **tailoring of approaches was most important**; some respondents were concerned that tackling too much would inevitably lead to failure;

- **enforced changes** which punish obviously irresponsible behaviours (drink driving, for example) were supported, but respondents rejected compulsion in relation to themselves;
- **national state interventions**, such as standardised food labelling, were supported, but typically 'not for me';
- support, health advice and information should be presented through a **trusted brand (NHS)**, and should be **local in delivery and 'fun' in character**;
- the **research exercise** had changed behaviour and stimulated consideration of health issues – but none would have undertaken it **without a financial incentive!**

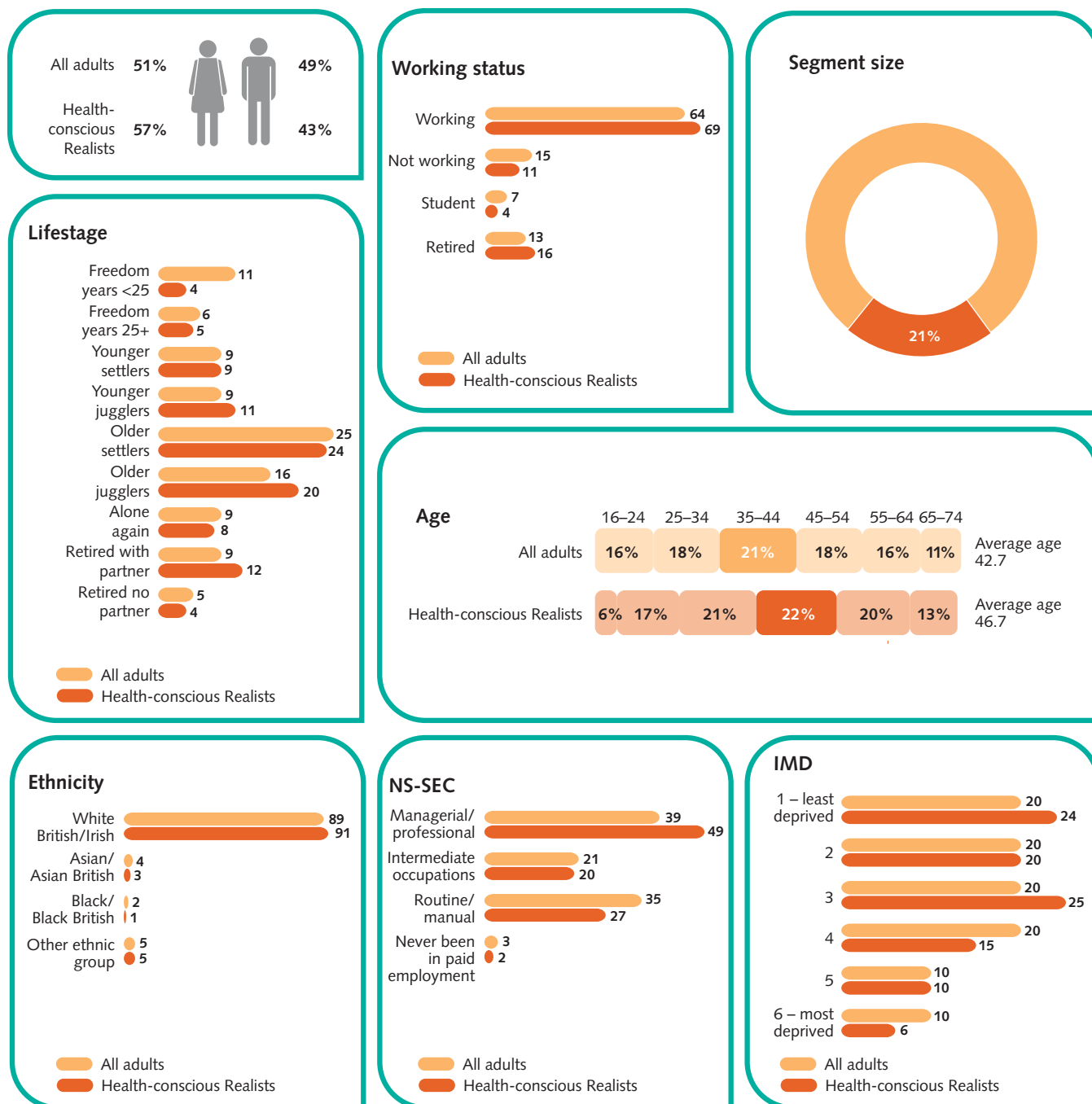
**Figure 8.8: Hedonistic Immortals: lifestages and motivations**

Freedom years	Younger jugglers	Alone agains
Resilience + Short-termism ++ Fatalism + Risk-taking +++ Motivation + Self-esteem + Control + Stress – Peer pressure +	Resilience + Short-termism + Fatalism + Risk-taking + Motivation + Self-esteem + Control + Stress + Peer pressure +	Resilience + Short-termism + Fatalism + Risk-taking ++ Motivation + Self-esteem + Control + Stress – Peer pressure +



# 9 Health-conscious Realists

Figure 9.1: Health-conscious Realists: demographics/lifestage



Base: All respondents (4,928/wtd 4,928/ess 2,496)/Health-conscious Realists (unwtd 936/wtd 1,045/ess 547)

Health-conscious Realists (HCRs) represent 21% of the overall sample from the quantitative work. They are the oldest segment with a female bias and the majority live in the least deprived areas.

## 9.1 Verification

The verification exercise confirmed the findings of the quantitative study. HCRs typically felt good about themselves. They demonstrated high levels of self-esteem and were evidently 'comfortable' with themselves:

*"...and I think that's a nice feeling to have."*  
(Female, Older settler, IMD 1–2, Bristol)

*"I am now in a good place within my life and where I am. I do feel like I can manage whatever life throws at me."*

(Female, Younger juggler, IMD 3–6, Nottingham)

These high levels of self-esteem were clearly associated with factors such as control and exercise of choice:

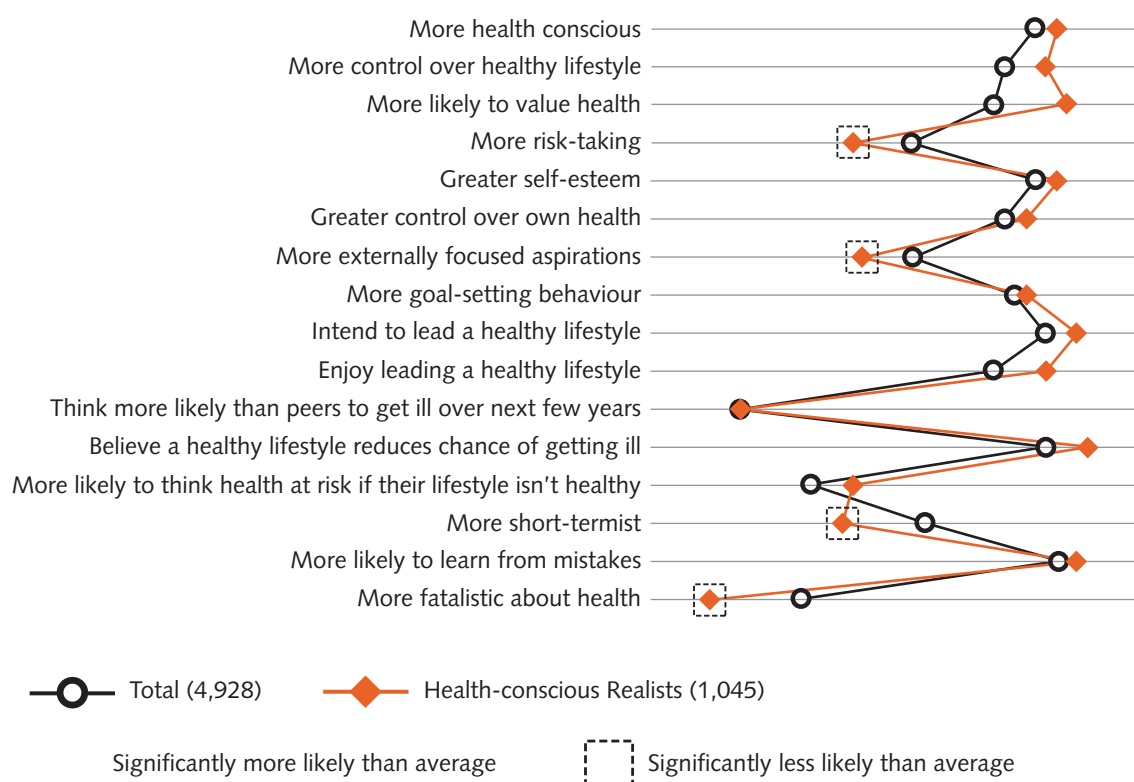
*"I'm in control of my health, therefore I feel good about myself."*

(Female, Younger juggler, IMD 3–6, St Albans)

*"We're all able to do what we want. We have the freedom to make choices."*

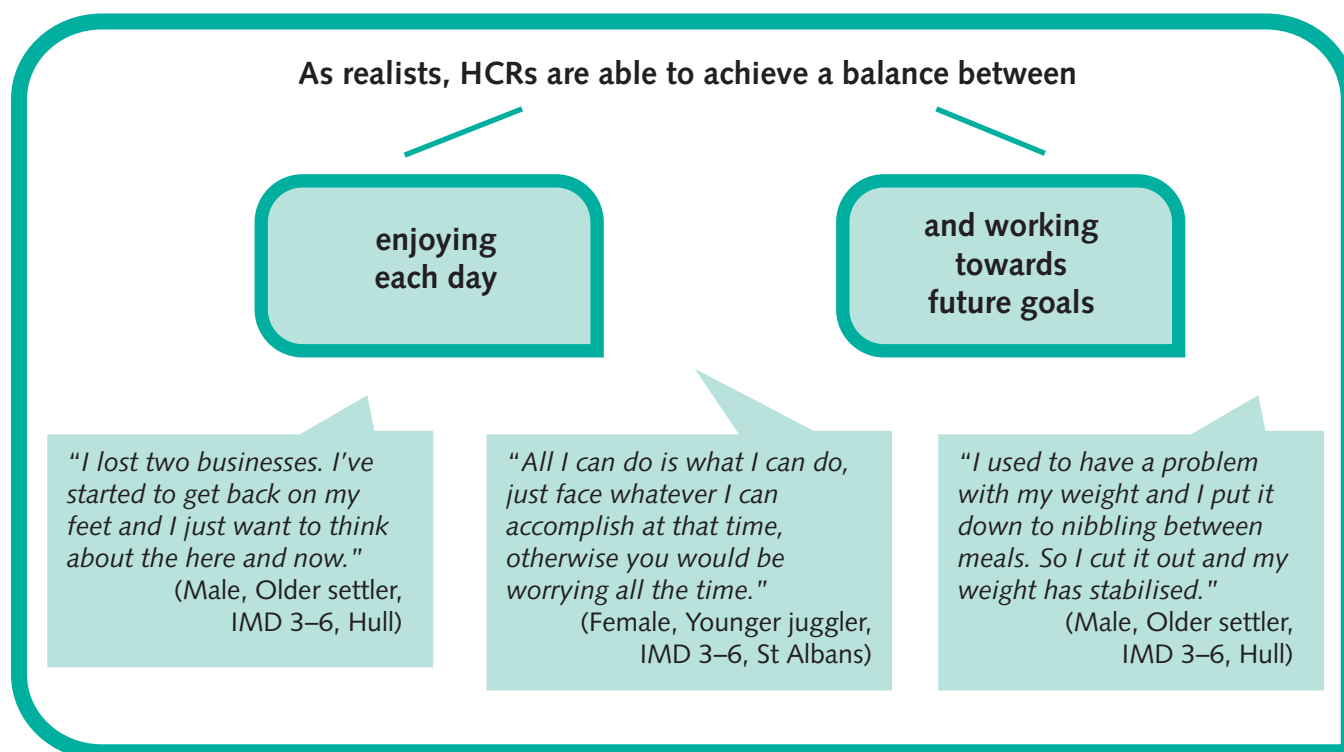
(Male, Alone again, IMD 3–6, Sutton Coldfield)

Figure 9.2: Health-conscious Realists: motivations



Base: All respondents (unwtd 4,928/wtd 4,928/ess 2,496)/Health-conscious Realists (unwtd 936/wtd 1,045/ess 547)

**Figure 9.3: Health-conscious Realists: planning and goal setting**



*"I can do what I want to do."*

(Female, Alone again, IMD 3–6, Bristol)

HCRs typically believed that they were in control of their health and were generally disciplined about exercising this control:

*"I try to have a healthy diet, get a lot of exercise – I think that it's up to me to take care of myself. I'm accountable."*

(Female, Younger juggler, IMD 3–6, St Albans)

*"It's your choice what you put in your body."*

(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

*"Health is do you eat four rounds of white bread or do you have two rounds of brown with a banana? You make that choice."*

(Male, Younger juggler, IMD 3–6, Manchester)

Respondents felt that they generally focused on the 'here and now', but probing revealed that most also had self-improvement goals.

As realists, HCRs are able (as illustrated in figure 9.3) to achieve a balance between:

- enjoying each day:

*"I lost two businesses. I've started to get back on my feet and I just want to think about the here and now."*

(Male, Older settler, IMD 3–6, Hull)

*"All I can do is what I can do, just face whatever I can accomplish at that time, otherwise you would be worrying all the time."*

(Female, Younger juggler, IMD 3–6, St Albans)

- and working towards future goals:

*"I used to have a problem with my weight and I put it down to nibbling between meals. So I cut it out and my weight has stabilised."*

(Female, Older settler, IMD 1–2, Bristol)

Respondents saw health as the means to achieving a full and rewarding life – typically agreeing with the statement 'If you don't have your health, you don't have anything':

*"Money is nothing compared to our health."*  
(Male, Older settler, IMD 3–6, Hull)

*"You can't do nothing without your health."*  
(Female, Alone again, IMD 3–6, Bristol)

*"If you can't do the sort of things you want to, no matter how much money you have, if you haven't got your health you still can't do it."*  
(Female, Older settler, IMD 1–2, Bristol)

Most saw a healthy lifestyle as enjoyable, although men from IMD 1–2 found it more difficult to achieve because of the strain of juggling their career alongside a healthy lifestyle:

*"You've got to find the time – that's not easy."*  
(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

The process **and** the results of living a healthy lifestyle were generally seen as positive and enjoyable. Respondents preferred to eat well and exercise regularly. Admittedly, it was not always seen as easy, but respondents tried to rise to the challenge:

*"I walk everywhere and go to the gym three times a week. It's non stop and I love it."*  
(Female, Younger juggler, IMD 3–6, Nottingham)

HCRs like to look good – however, most were keen to emphasise that this was more to do with feeling good about themselves and positive self-esteem than impressing other people:

*"I think people look at it the wrong way. You need to get in shape and create an image you're happy with."*  
(Male, Younger juggler, IMD 3–6, Manchester)

*"As you get older, you don't care so much. You're 'you'. You care what people think of you but not necessarily for your image."*  
(Female, Older settler, IMD 1–2, Bristol)

*"It's not that I don't like to look nice, but I don't think that it's that important how I look to other people."*  
(Female, Younger juggler, IMD 3–6, Nottingham)

*"It's important to take care of yourself as much as you can, but I don't care if anyone else likes my hair."*  
(Female, Older settler, IMD 3–6, Manchester)

Respondents did not agree with the statement 'I believe what happens with my health is decided by fate'. Most felt that their health was controlled by their own decisions:

*"What's fate got to do with it? It's down to me."*  
(Male, Older settler, IMD 3–6, Manchester)

*"You can to a certain extent look after yourself, physically, mentally and emotionally, and then make choices which are either beneficial or detrimental to your health."*  
(Female, Younger juggler, IMD 3–6, Nottingham)

*"I think you can help it; if you get massively overweight you're not helping yourself, are you?"*  
(Female, Older settler, IMD 1–2, Bristol)

Respondents were so deeply committed to this belief that they were disparaging about those who used fate as an excuse for poor health:

*"They say 'that may happen so what's the point in not smoking and eating sensibly'... whereas most people think it's in their hands."*  
(Female, Older settler, IMD 1–2, Bristol)

Respondents clearly derived little pleasure from taking risks because this would mean losing



control, which was not seen as agreeable. In addition, it seemed that HCRs had no need to achieve escape through unhealthy choices because most were content with the way they were living their lives:

*"Why be risky? To take risks you've got to be a certain type of person and I'm not that person. I like to be in control."*

(Female, Older settler, IMD 3–6, Manchester)

*"I feel better when I'm being healthy. There's not a place in my life for unhealthy food and living any more."*

(Female, Younger juggler, IMD 3–6, Nottingham)

Although respondents achieved limited pleasure from taking risks, they did enjoy challenging themselves:

*"I went to a water park and I had to go on everything...normally I don't go through tubes at top speed in water!"*

(Female, Older settler, IMD 3–6, Bristol)

*"It's about competing with yourself and challenging yourself to improve things...for yourself."*

(Male, Older settler, IMD 3–6, Hull)

Although inherently disciplined, respondents were not completely inflexible in relation to health – respondents believed that a largely healthy lifestyle justified the occasional indulgence:

*"You've got to give yourself a treat."*

(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

*"I believe what my grandmother told me: everything in moderation, but a little bit of what you fancy does you good."*

(Male, Alone again, IMD 3–6, Sutton Coldfield)

## 9.2 Environment and IMD

Unsurprisingly, IMD category 1–2 respondents were comfortable in their relatively affluent environments:

*"There's gyms here, swimming pools, tennis club, cricket club, good shopping."*

(Female, Older settler, IMD 1–2, Bristol)

It was clear that money made healthy living easier, facilitating access to healthy choices. Conversely, however, the pressure to make money was seen as both stressful and time-consuming:

*"You want to be in a position to give your kids a good start in life, so that they can get a start in the housing market."*

(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

*"My father retired when he was 65 and when he was 65 he looked 65, but when he was 67 he looked 85 because he had nothing to replace work with. I want a good balance between golf, grandchildren and work."*

(Male, Alone again, IMD 3–6, Sutton Coldfield)

Respondents from IMD categories 5–6 tended to focus upon the positive aspects of their community. Pleasant outdoor areas were appreciated by all – and respondents reported enjoying walking and taking advantage of their surroundings. Facilities and infrastructure – such as local sport teams, transport and facilities – are clearly important in terms of helping HCRs to maintain their healthy lifestyles. As with Balanced Compensators, this segment is sufficiently motivated to seize all available opportunities to make positive choices.

There were obvious differences between the health behaviours of men living in IMD categories 1–2 and 5–6. Younger jugglers and Older settlers living in IMD 1–2 were putting themselves under pressure to maintain their lifestyles, resulting in higher levels of stress. However, these respondents were better able to make positive health choices than those from IMD 5–6, whose environments were less helpful in terms of providing support or opportunities for healthier choices. Alone again men living in IMD 5–6 (typically ex-manual workers suffering health problems) were consistently exhibiting a number of poor health choices, including heavy drinking. Alone again men from IMD 5–6 have emerged from this research as a group in particular need of support, across all five Healthy Foundations attitudinal segments.

## 9.3 Key drivers

### 9.3.1 Aspiration

HCRs were realistic about achieving their life goals. Respondents typically focused on one single, achievable goal:

*"I would like to pass my driving test because buses are awful...I've got some money saved so it'll probably be after Christmas."*

(Female, Alone again, IMD 3–6, Bristol)

*"I saved up completely and I'm decorating the lot."*

(Female, Older settler, IMD 3–6, Manchester)

Respondents were also realistic about how they intended to achieve their goals. Most did not expect immediate results and maintained motivation by progressing gradually:

*"I thought I'd go to the gym and start running. It nearly killed me, but I think I could build up towards running the 5k."*

(Male, Alone again, IMD 3–6, Hull)

*"I try to take little steps towards my goals and I know that it's going to take time to get what I want."*

(Female, Younger juggler, IMD 3–6, St Albans)

### 9.3.2 Resilience

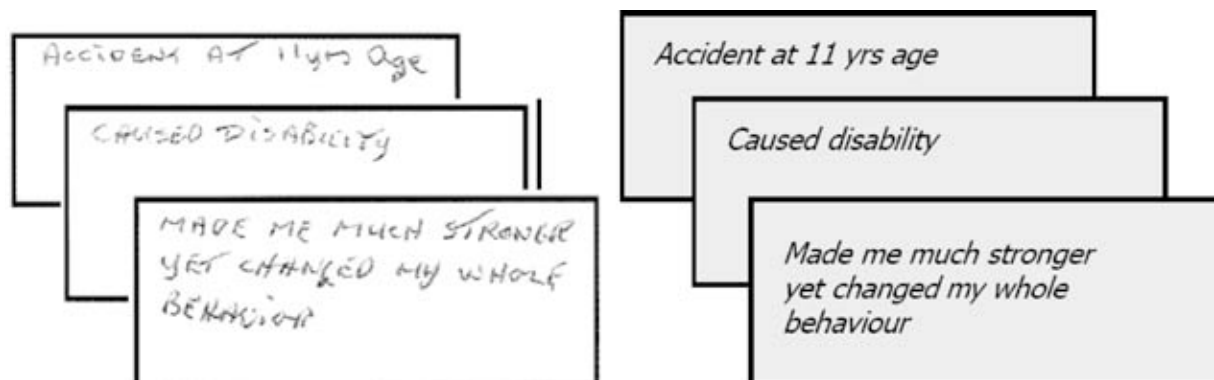
HCRs are typically resilient because they feel they have no other choice, as a majority had experienced traumatic life events. For HCRs, resilience is associated with masculine traits, such as control, strength, 'being tough' and rationality. When faced with a traumatic event, respondents reported making a clear decision to take control and turn the outcomes into a positive personal experience.

HCR men from IMD 5–6 had experienced significant life traumas, but demonstrated high levels of resilience.

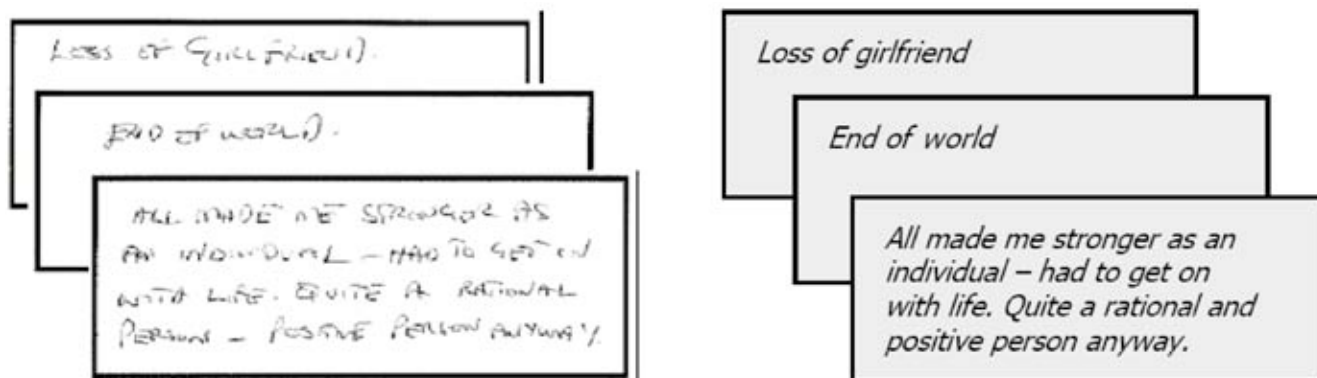
HCR men from IMD 1–2 were more likely to experience stress (rather than trauma) from trying to maintain lifestyles, but were fighting to remain resilient.

Women from IMD 1–6 had also experienced traumas and were demonstrating high levels of resilience.

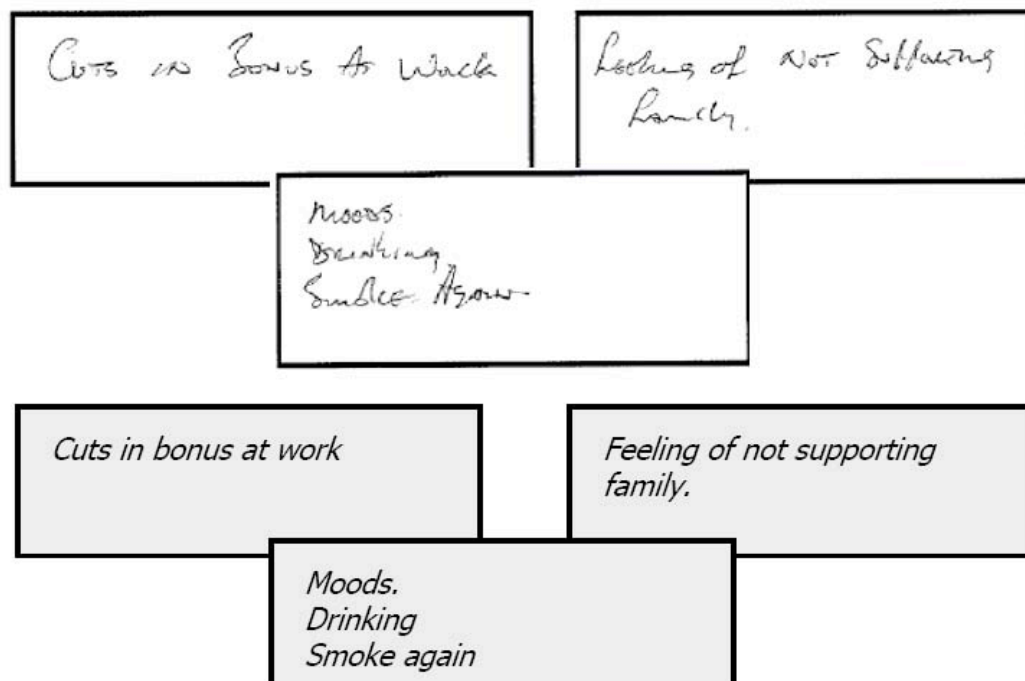
Even HCRs (both male and female), however, occasionally find it hard to cope: there was evidence of depression, but also of recovery.



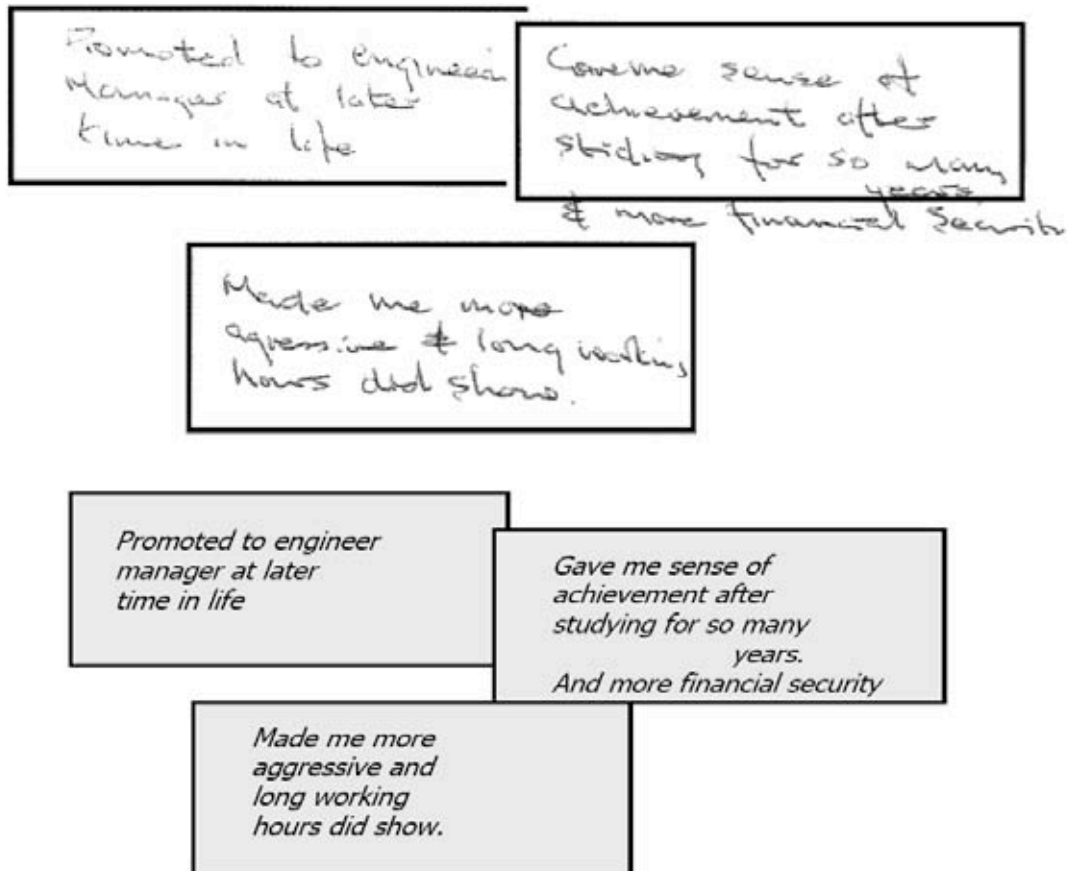
(Male, Older settler, IMD 3–6, Hull)



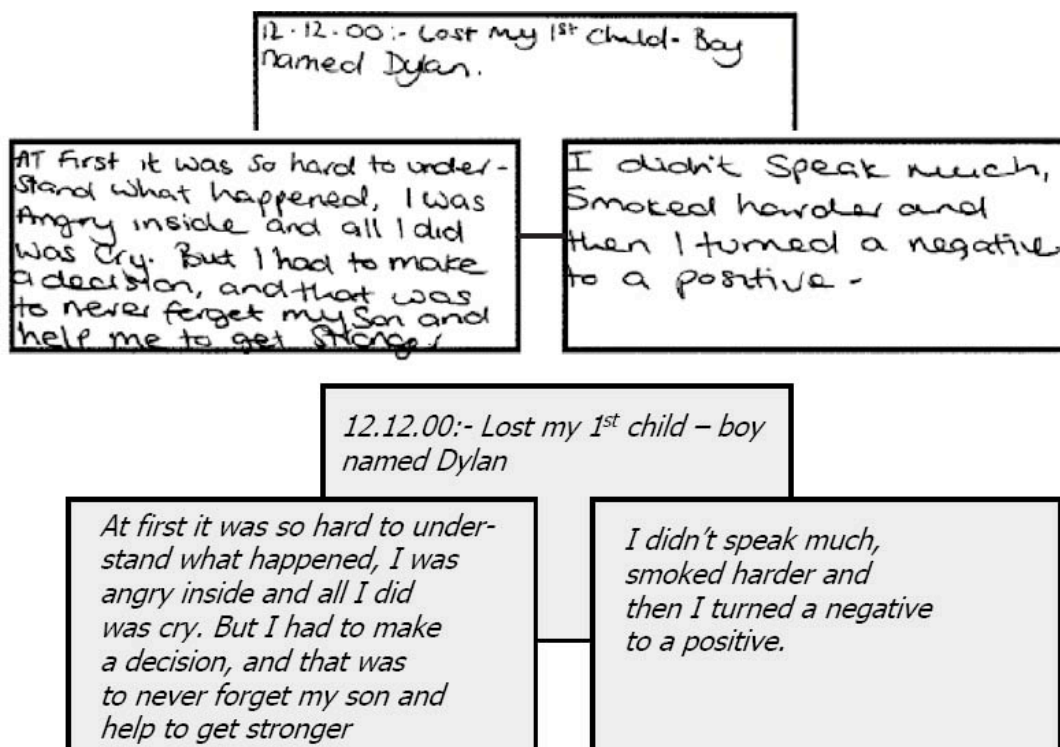
(Male, Alone again, IMD 3–6, Hull)



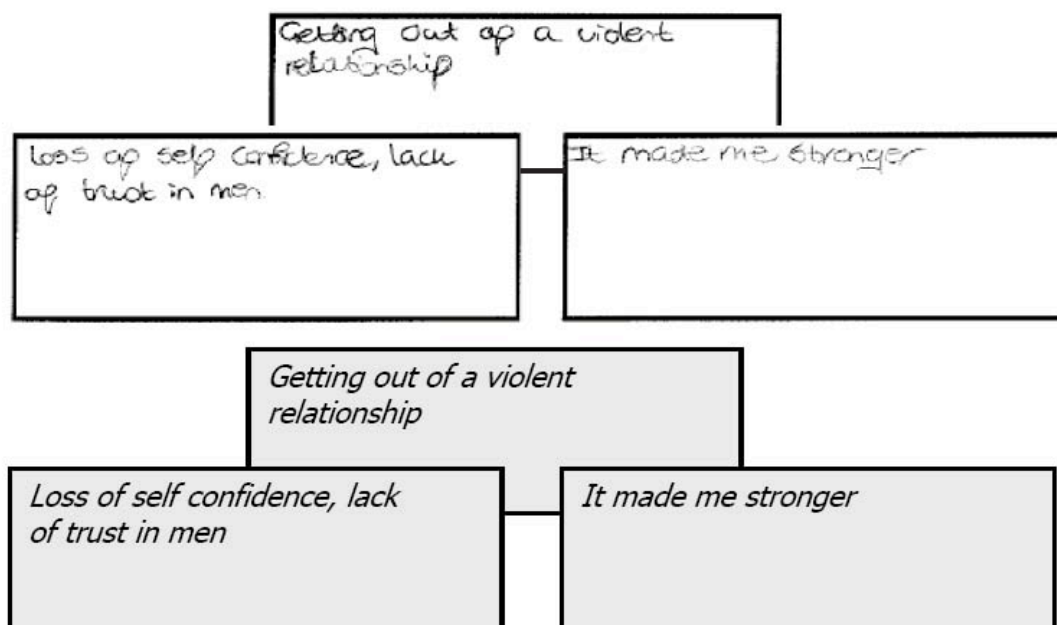
(Male, Younger juggler, IMD 1–2, Sutton Coldfield)



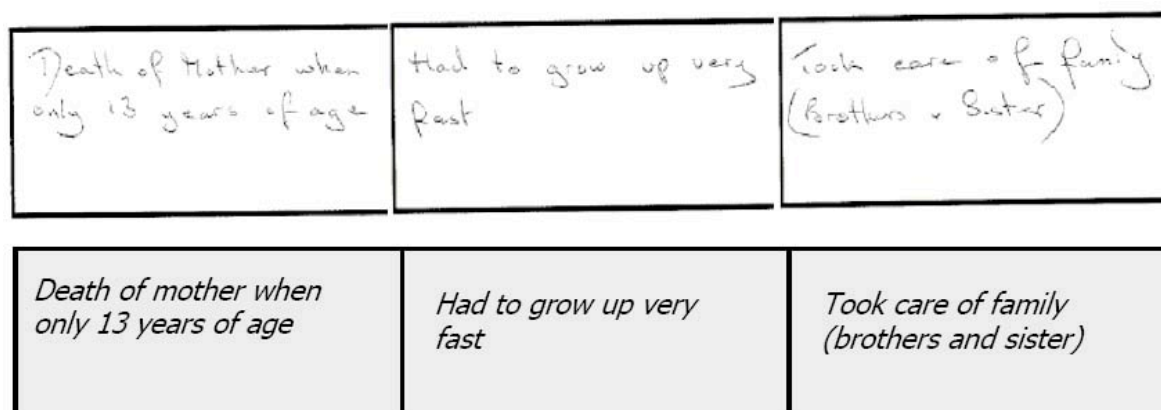
(Male, Older settler, IMD 3–6, Hull)



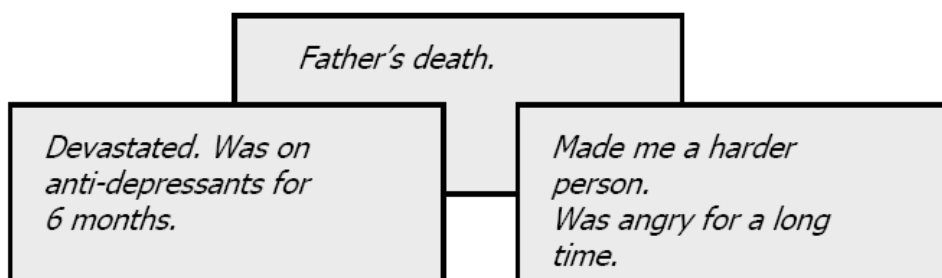
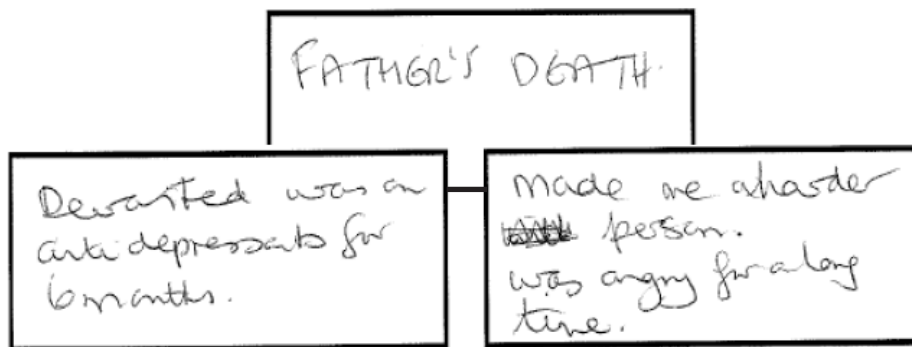
(Female, Younger juggler, IMD 3–6, St Albans)



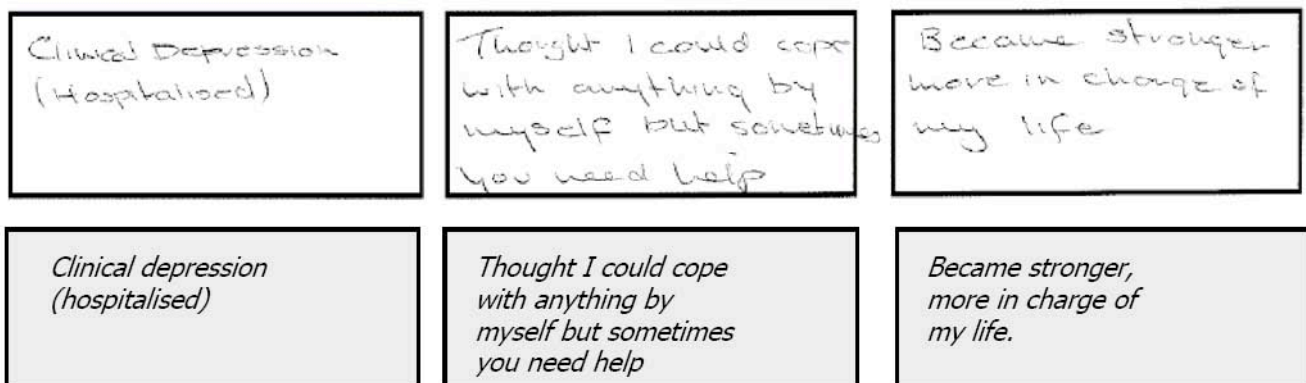
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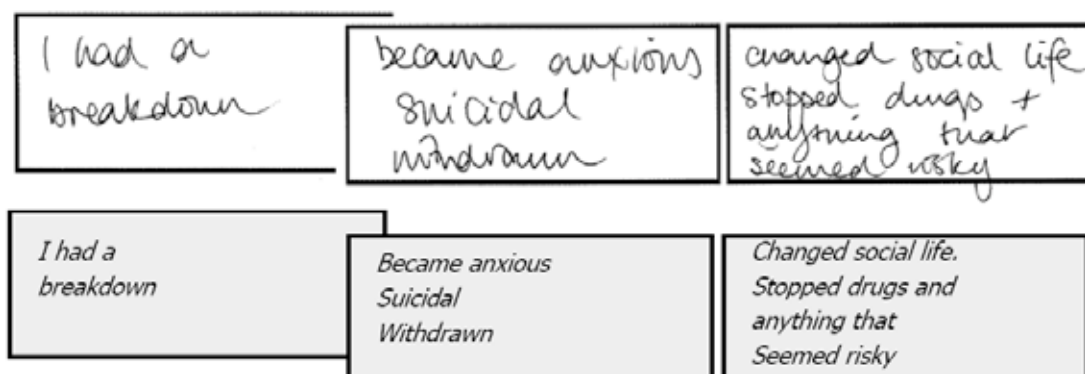
(Female, Alone again, IMD 3–6, Bristol)



(Female, Older settler, IMD 1–2, Bristol)



(Female, Older settler, IMD 1–2, Bristol)



(Female, Younger juggler, IMD 3–6, St Albans)



The HCR recipe for resilience (also illustrated in figure 9.4) comprises:

- acceptance of challenging times:

*"Shit happens and you have to deal with it."*  
(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

*"These are the cards I've been dealt, so I'll play them and see what happens."*  
(Male, Younger juggler, IMD 3–6, Manchester)

- taking control by making tough decisions:

*"You get to a point where enough is enough, my mum had [an abusive relationship] for 18 years and she lived with it day in day out, but you decide one way or another in the end."*  
(Female, Younger juggler, IMD 3–6, Nottingham)

*"...it was like I was on a cliff edge, and if I didn't choose the right path, and allowed the emotions to overwhelm me, I would go mad."*  
(Female, Younger juggler, IMD 3–6, St Albans)

- independence:

*"It made me become a lot stronger and a lot more in charge of my life: not doing what everybody wanted me to do if it wasn't right for me and being strong enough to say no."*  
(Female, Older settler, IMD 1–2, Bristol)

*"I wouldn't let anyone take me for a ride again! They wouldn't get away with it, I've been through too much."*  
(Male, Alone again, IMD 3–6, Hull)

- leadership – especially of the family:

*"You've got to put the face on and look at it rationally, no one will respect you if you let it all go."*  
(Male, Older settler, IMD 3–6, Hull)

*"Night time, you cry yourself to sleep and wake up with red eyes, a snotty nose and a headache. You go in the bathroom and you sort yourself out. And that's how you go on, day after day."*  
(Female, Older settler, IMD 3–6, Manchester)

Respondents were mostly able to talk about life events in unemotional terms. They typically focused on the need to be strong – and survive. Unlike other segments, they also accepted that tough times are a natural aspect of life and personal development:

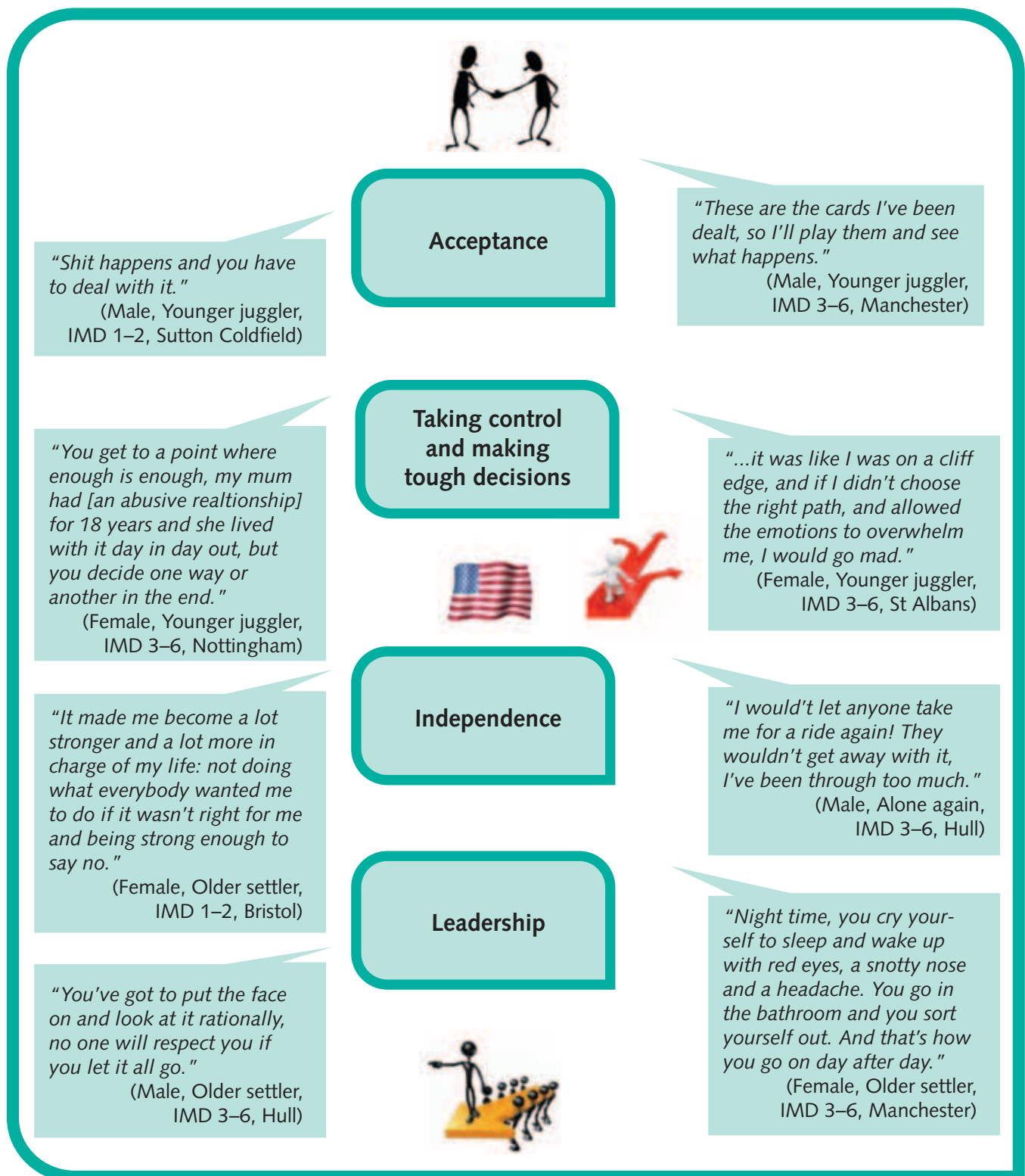
*"The hard things you go through in life just make you stronger, you can cope with it and can even get used to experiencing hard times."*  
(Male, Alone again, IMD 3–6, Hull)

*"...hopefully the next knock you get in life, won't take you so long to get over."*  
(Male, Older settler, IMD 3–6, Hull)

*"It's almost as though you've added something else to your personality or one part of your personality has come out a bit more."*  
(Female, Older settler, IMD 1–2, Bristol)

*"Life is about learning from your mistakes, and your trials and your errors."*  
(Female, Younger juggler, IMD 3–6, St Albans)

Figure 9.4: Health-conscious Realists: recipe for resilience



## 9.4 Interventions

HCRs consistently demonstrated positive health choices:

- regular exercise was a fundamental component of the HCR lifestyle:

Why did I make this decision?  
*cleaned myself for the exercise rather than take to car wash*

Why did I make this decision?  
*Cleaned [the car] myself for the exercise rather than take to car wash*

(Female, Alone again, IMD 3–6, Bristol)

Why did I make this decision?  
*I always try to walk if dry on a lunchtime as I hope it's strengthening my bone density.*

Why did I make this decision?  
*I always try to walk if dry on a lunchtime as I hope it's strengthening my bone density.*

(Female, Older settler, IMD 3–6, Bristol)

Number 2 decision: *Raked up dead leaves instead of using leaf vacuum.*

Why did I make this decision?  
*Could not be bothered to get out vacuum & extension leads required.*

Number 2 decision: *Raked up dead leaves instead of using leaf vacuum.*  
Why did I make this decision?  
*Could not be bothered to get out vacuum and extension leads required*

(Male, Older settler, IMD 3–6, Hull)

- healthy eating is also integral to the HCR lifestyle:

Number 2 decision: I'm drinking cranberry juice  
all day today  
 Why did I make this decision?  
It's full of antioxidants  
to flush your body clean of crap

Number 2 decision: I'm drinking cranberry juice  
all day today  
 Why did I make this decision?  
It's full of antioxidants  
to flush your body clean of crap

(Male, Younger juggler, IMD 3–6, Manchester)

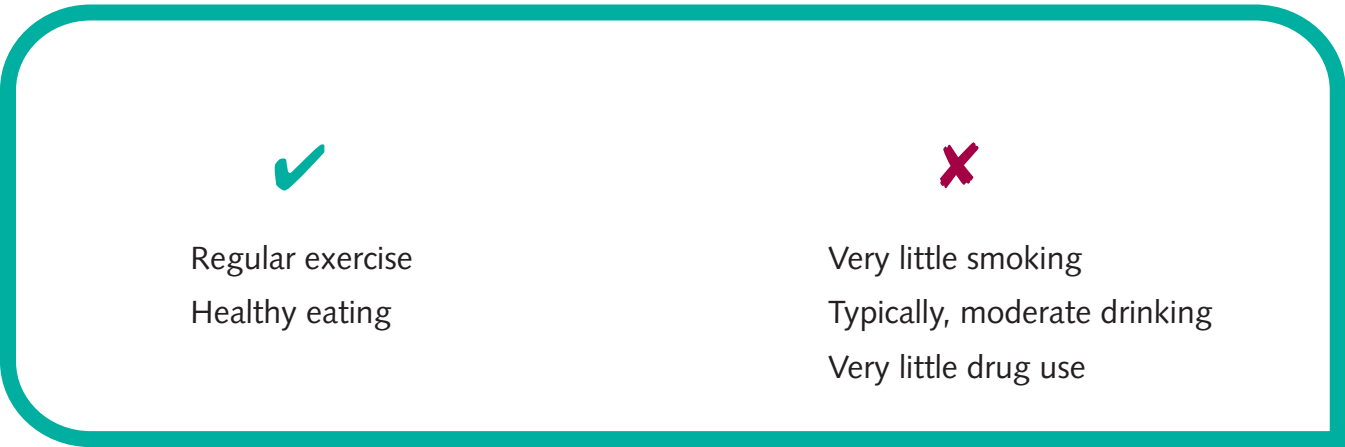
Number 1 decision: had a healthy Breakfast  
 Why did I make this decision?  
need as much energy as possible as  
going for a ride on my mountain bike.

Number 1 decision: Had a healthy breakfast  
 Why did I make this decision?  
Need as much energy as possible as  
going for a ride on my mountain bike.

(Female, Older settler, IMD 1–2, Sutton Coldfield)

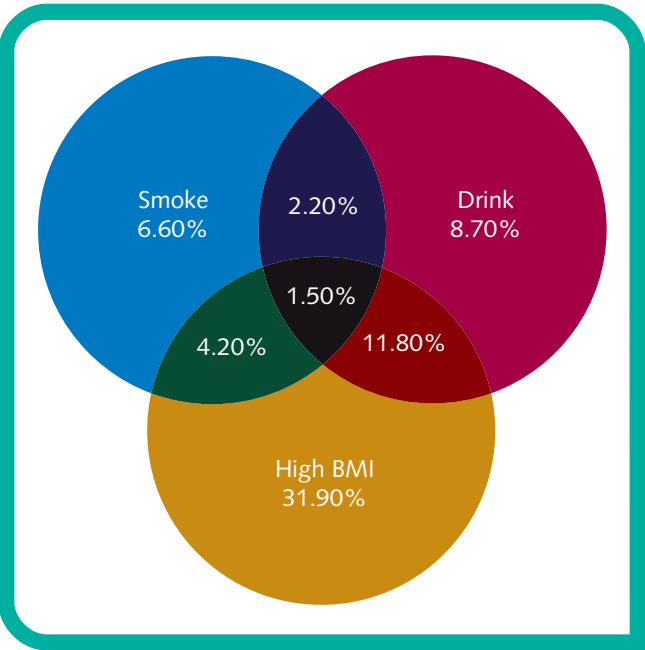
In addition, respondents consciously avoided damaging their health (see figure 9.5).

**Figure 9.5: Health-conscious Realists: Consistently made positive health choices**



Poor health choices were limited and overlapping behaviours even less common, as illustrated in figure 9.6.

**Figure 9.6: Health-conscious Realists: overlapping behaviours**



Source: Research Report No.1

A minority of respondents reported some heavy drinking – and, in particular, Alone again males from IMD categories 3–6 were inclined to turn to alcohol during difficult times.

Smoking was a very rare behaviour among HCRs, but there was a small minority who were still smokers.

There was only a single reference to drug use across the whole segment and this was recounted as a past experience.



(Male, Alone again, IMD 3–6, Hull)

Number 3 decision: Watched X-Factor, smoked too much again.

Why did I make this decision?  
Do this every Saturday evening. Always smoke too much when sitting watching T.V. It relaxes me.

Number 3 decision: Watched x-factor, smoked too much again

Why did I make this decision?  
Do this every Saturday evening. Always smoke too much when sitting watching T.V. It relaxes me.

(Female, Younger juggler, IMD 3–6, St Albans)

Number 2 decision: WISH I COULD STOP SMOKING

Why did I make this decision?  
BAD CHEST, AND LOST PEOPLE THROUGH CANCER

Number 2 decision: Wish I could stop smoking  
Why did I make this decision? Bad chest and lost people through cancer

(Male, Older settler, IMD 3–6, Hull)



A majority of HCRs were happy with their health, and found the diary exercise a rather repetitive chore.

However, the diary exercise did make many focus upon their daily health decisions. As a consequence, some (relatively minor) adjustments to behaviour were being considered:

*[Went to different exercise class with weighted hula hoops]: "The first time I did it I kept up with the regulars and I was so amazed that I achieved that, so I have kept going with it – I love it."*

(Female, Younger juggler, IMD 3–6, St Albans)

To help you change your behaviour, what support (if any) would be helpful?

*I don't need to change my behaviour  
I am quite content as I am*

**To help you change your behaviour, what support (if any) would be helpful?**

*I don't need to change my behaviour  
I am quite content as I am.*

(Female, Younger juggler, IMD 3–6, St Albans)

*I enjoy my life I think my  
behavior is fine!*

*I don't need to change my behaviour, I think my  
behaviour is fine!*

(Female, Alone again, IMD 3–6, Bristol)

To help you change your behaviour, what support (if any) would be helpful?

*None really – I am quite happy as I am*

**To help you change your behaviour, what support (if any) would be helpful?**  
*None really – I am quite happy as I am.*

(Male, Older settler, IMD 3–6, Hull)

*"Doing the diary focused my mind more on the thought that water is probably better for you than Red Bull – so that's what I drank."*

(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

*"I have made the decision to return to swimming as many days out of 7 as I can make it...swimming is good for me and I have just been on holiday for a week (was swimming every day but not my usual dedicated lengths)."*

(Female, Older settler, IMD 1–2, Bristol)

Most HCRs felt that they could improve their health, particularly in terms of losing weight, increasing exercise and improving eating. Weight loss was a consistent issue for HCRs (both male and female).

The minority concerned with that behaviour admitted that they needed to stop smoking and cut down drinking (particularly Alone again men, IMD categories 1–2).

Typically, HCRs were able to set personal goals and keep themselves motivated.

*"I had a minor operation on my shoulder and since then I've been having physio...I set myself a goal."*

(Female, Older settler, IMD 1–2, Bristol)

HCRs are clearly happy to take responsibility for their own health. Respondents seemed willing to review their health regularly and make appropriate adjustments as necessary. Additionally, all preferred to exercise control – to make their own decisions and create their own health plans. If opportunities are offered to make healthy choices, HCRs seem likely to seize them.

Communications which are supporting interventions must avoid patronising HCRs, who believe that they possess adequate knowledge to help themselves. Maintaining positive self-esteem is important, so interventions should be thematically upbeat and offer continued encouragement to maintain interest.

A health check might encourage HCRs to review their health on a more regular basis. HCRs would, however, need to be alerted to

To help you change your behaviour, what support (if any) would be helpful?  
*Botox (lol) no, someone to show me or help me by telling me how I can lose this weight and have a strong will power for myself and my family to stay healthy and active without it costing so much.*

**To help you change your behaviour, what support (if any) would be helpful?**

*Botox (LOL). No, someone to show me or help me by telling me how I can lose this weight and have a strong will power for myself and my family to stay healthy and active without it costing so much.*

(Female, Younger juggler, IMD 3–6, St Albans)

Number 3 decision: Attended weight watchers  
for weigh-in.

Why did I make this decision?

Am at goal weight but need to  
keep a constant check.

Number 3 decision: Attended weight watchers  
for weigh-in.

Why did I make this decision?

Am at goal weight but need to  
Keep a constant check.

(Female, Alone again, IMD 3–6, Bristol)

I can make goals and achieve  
them.

I can make goals and achieve  
them.

(Female, Younger juggler, IMD 3–6, St Albans)

DISCUSSED PARTICIPATING IN  
PARIS 2010 MARATHON WITH  
MATES – NEED A TARGET  
TO LOSE WEIGHT + GET FIT

Discussed participating in Paris  
2010 marathon with  
mates – need a target  
to lose weight and get fit

(Female, Older settler, IMD 1–2, Sutton Coldfield)

this somehow and it must be positioned as a service positively focused on maintaining 'wellness'. The type of information provided (e.g. blood pressure checks) could:

- give healthier HCRs an objective basis for decision-making; and
- provide less healthy HCRs with the motivational and ongoing monitoring mechanisms to make changes.

In principle, a 'holistic' approach to health was supported as potentially more effective than individual interventions. However, the Vitality programme clearly did not appeal to HCRs. They believed the service was aimed at people with health 'problems' and did not represent them. Moreover, HCRs did not believe that their lifestyles require this level of scrutiny.

For HCRs, therefore, the ideal approach is facilitation, in terms of building upon existing positive attitudes and behaviours, rather than

intervention. Direct intervention is not an appropriate approach for HCRs. They typically need services to be made available which will enable them to continue to make the healthy choices they want to make (and extend these where possible).

A health-check service could motivate HCRs to improve health behaviour and support them in maintaining positive health behaviours.

Overall, positive options should be offered within a community framework in order to allow HCRs to choose appropriately in terms of services and relevant infrastructure.

## 9.5 Health-conscious Realists: immersion depth analysis

### 9.5.1 Resilience

Respondents typically believed that they were resilient by nature and specific key life events have developed this instinct into actual behaviour and attitudes. A majority cited one (typically traumatic) life event – ranging from the birth of a child and marital breakdown, through personal illness and the death of loved ones – as the basis for a significant resilient response which had continued to the present day:

*“Getting married and having kids have made me who I am today. Until I had kids, what the hell me and my wife used to do with our time is absolutely shocking.”*

(Male, Younger juggler, IMD 1–2, Sutton Coldfield)

Most expressed a strong desire to prove themselves, demonstrate persistence and ‘get on with it’. Responsibility seemed to motivate this segment and drive an even more powerfully resilient reaction to ongoing challenges:

*“My wife leaving made me who I am now... I want to make sure I can look after my four boys.”*

(Male, Younger juggler, IMD 3–6, Manchester)

Although there have evidently been many chaotic and traumatic moments in their lives, HCRs typically show a stoic face to the world. This segment, in fact, demonstrates maximum resilience when faced with a challenge. Equally, most believe that there is ‘no going back’ to earlier attitudes and responses.

### 9.5.2 Norms/social influences

A majority of the respondents claimed that they had few direct influences upon their attitudes and behaviour. Among those in IMD categories 3–6, in fact, it was believed that a considerable amount of time was spent struggling against the potentially negative influence of friends and social groups. HCRs typically felt that they were independent and proactive in relation to health behaviours – even where harmful behaviours were concerned.

In the main, HCRs seem to have emerged from traditional and rather strict backgrounds, in which parents were powerful and sometimes eccentric in terms of their own behaviour. Fathers were evidently significant, powerful figures – typically strict and espousing a clear set of values. Where fathers were not strong role models, then uncles or grandfathers seem to have acted as substitutes. Not all respondents felt positively about their home life, but even those who expressed a desire to be different to their parents acknowledged that they had inherited a distinct perspective and value set:



*"I looked up to my uncle and grandfather. He was my model. I'd love to be half the person he was...he was just happy all the time, he was never down in the dumps about anything."*

(Male, Younger juggler, IMD 3–6, Nottingham)

Overall, HCRs from all segments believe that they are independent and strongly self-motivated individuals who reference a few respected figures from their past, but largely please themselves in terms of their health choices.

### 9.5.3 Segment movement

There was general agreement with the segment description (especially the attitude towards risk and strong element of control), although some were less sure that they really believed that maintaining a healthy lifestyle was easy. Equally, others clearly questioned whether they always felt good about themselves.

Although most respondents believed that the essential elements of an HCR outlook were 'in their blood', it was clear that life events – either positive (acquiring a family) or negative (breakdown) – had brought this potential to full realisation. Some had clearly been more reckless in the past, but believed that they had 'woken up' and now rejected many of the risks that they used to accept:

*"I think I've been like this from a very young age – I was into sports in youth and was conscious of health because of my sister's influence. I think I'm influencing my own family now."*

(Male, Older settler, IMD 3–6, Hull)

In the main there was strong belief across the sample segment that there is 'no going back' from being an HCR. Some were even actively

promoting the HCR perspective to friends and family. None believed that they would change in the near future and, in fact, it was seen as virtually impossible to retreat from the risk-averse, controlled, pragmatic posture of the HCR.

### 9.5.4 Attitudes towards other segments

HCRs typically identified aspects of themselves in each of the other segments, although all pointed out fundamental differences that would prevent them being categorised other than as HCR (for example, lack of interest in risk, lack of interest in looking good, not fatalistic).

There was least sympathy for Unconfident Fatalists (UFs), who were typically seen as negative, lazy and self-destructive. Although one older Alone again respondent felt that he occasionally strayed into this territory, this was recognised as being a consequence of self-pity and indulgence.

Live for Today's (LFTs) were seen as 'delusional' and the respondents – while admitting that 'living now' can occasionally be a good thing – rejected what was seen as an absurd attitude towards behaviour and possible impact on health. LFTs' perceived lack of control over their lives was both puzzling and irritating to HCRs.

Many HCRs were quite attracted by the Hedonistic Immortal (HI) segment, envying its apparently unaffected, relaxed hedonism and lack of responsibility. Few, however, could agree with the idea that they did not value, or think about, their health.

Balanced Compensators (BCs) seemed strange to HCRs, who typically found it hard to understand the short-termism involved in taking risks that are consciously recognised.

Equally, HCRs rejected the BC focus on looking good.

In the main, HCRs seemed to feel comfortable with most of the other segments, although some clearly found UFs rather testing and frustrating. In the main, respondents felt that their friends were 'people like myself'.

### 9.5.5 Interventions: environmental factors

Free access to exercise classes and facilities was welcomed across the HCR sample. It was generally seen as an active option to both the respondents themselves and others to maintain healthy behaviours. These respondents were generally positive about undertaking more exercise but also wanted services to be convenient in terms of access.

The idea of measuring body mass index (BMI) and providing healthy food vouchers to those who improve their BMI received a generally positive reaction, although a few respondents were unhappy with the 'nanny state' aspects of the scheme.

### 9.5.6 Interventions: health checks

There was a very positive response to the idea of health checks. All the respondents felt that they would take advantage of such a service. The idea of getting an 'all-round' health check in a single, relatively short session was very appealing. Respondents in IMD categories 3–6 believed that it was important that such checks were free.

HCRs were also very keen to see that such checks would include follow-up advice and support to address any issues identified during the session. It was felt that the service should be upbeat in tone and promote positive change.

Equally, there was consensus that these checks should be carried out by qualified people in a relatively formal health-related setting (a branch of Boots, for example). Men in particular believed that they would not be inclined to take part in a check carried out, for example, in a mobile unit in a town centre. Privacy and a one-to-one setting was seen as important.

Overall, HCRs were extremely interested in a health-check proposition. This is a segment that takes its health seriously and would welcome an opportunity to be assessed and discuss options for change with knowledgeable health staff.

### 9.5.7 Interventions: GP and mainstream services

Most respondents visited their GP a number of times each year, to renew medication or have routine checks (blood pressure, cholesterol). None were visiting secondary care or other clinics on a regular basis.

A majority felt that they had a functional relationship with their GP, with most seeing a variety of different GPs at their practice and bemoaning the lack of continuity in care. One Alone again respondent from IMD categories 3–6 lived a considerable distance from his GP and could not access services easily. Only one or two respondents felt that they had a good relationship with their GP and expressed satisfaction.

Overall, HCRs' view of primary care was largely critical, with no sense that the system was built to provide an ongoing relationship between patient and healthcare professional.



### 9.5.8 Interventions: enforced changes

There was strong support for the ideas of enforcing a zero drink-drive limit and charging for alcohol-related A&E admissions. These were seen as unacceptable and irresponsible behaviours which ought to be penalised.

Overall, HCRs were similar to HIs, in that they were more extreme than other segments in terms of approving of a hard-line approach to many of the interventions being examined. Many supported ideas such as selling alcohol under the counter, 'alcohol kills' stickers and banning junk food advertising – even though some admitted that these were unlikely to be successful. A majority were comfortable with the idea of the government taking a stronger line with those who deliberately took risks with their health.

These respondents took very few risks with their health, but recognised that it will take more than minor social barriers to alter choices. For some, spraying the smell of oranges in retail environments was seen as 'bizarre'.

Again, many were equivocal about the idea of compulsory health programmes and saw mandatory recording of BMI as potentially intrusive.

Overall, HCRs were inclined to support enforced-change approaches, especially since most believed that they would be unlikely to be personally affected by many of the suggested changes.

### 9.5.9 Interventions: national state interventions

There was strong support for the idea of standardising food/drink labelling. This was seen as an initiative that would provide people with better and more consistently available information in order to make choices about

health. HCRs, like HIs, typically believed that they already knew what was, and what was not, good for them. This initiative would, it was felt, be for others who need more support.

Funding local outreach projects received a relatively positive response, although some believed that it was the NHS's role to provide help for those in need. It was obvious, however, that few HCRs believed this was an initiative aimed at themselves. Most felt that they knew what they needed.

### 9.5.10 Interventions: sources of advice/support/information

A majority of HCRs were relatively comfortable with the idea of government intervention in relation to health matters. Although many were uncomfortable with the idea of a 'nanny state', most felt that the government (in the form of the Department of Health (DH)) was the natural agency to think strategically about the health of the nation.

There was a belief that DH should be engaging in a more open conversation with the public about health matters and 'letting the people know what they are considering for the future'.

Most, however, did not believe that services should be delivered locally by government-branded services, unless the NHS was involved. Equally, some felt that local councils would also be appropriate sponsors of interventions.

The NHS was broadly trusted to monitor the quality of any interventions or services, although most believed that this was not its primary function and any activity in this area should not interfere with mainstream NHS healthcare business.

There was also felt to be a role for charities to offer help to specific groups, while respondents

believed that local sports facilities should be involved in providing exercise opportunities linked to health initiatives.

## 9.6 Health-conscious Realists: summary of focus group and immersion depth findings

This segment demonstrates a number of **consistent characteristics**:

- they feel **good about themselves**: typically independent and self-motivated;
- they are **comfortable with control** and exercising choice;
- they **feel in control** and are not fatalistic;
- they are **realistic, disciplined and goal-driven**;
- they believe that **health is the foundation of a good life**;
- they believe that a **healthy life is enjoyable and easy to achieve**;
- feeling good about themselves is more important than looking good to others;
- they are **uninterested in risk-taking**, although they **enjoy challenges**.

This is a **strongly resilient segment**, which believes that its resilience is a necessity in life. Most believe that their own resilience has been generated by important (and often traumatic) life events. HCRs typically feel that 'tough times' drive personal development and challenges require a stoic response.

**Influences are relatively few**, since this segment sees itself as in control of its health choices. Most seem to have emerged from close and relatively strict family backgrounds, often with a strong father figure in evidence.

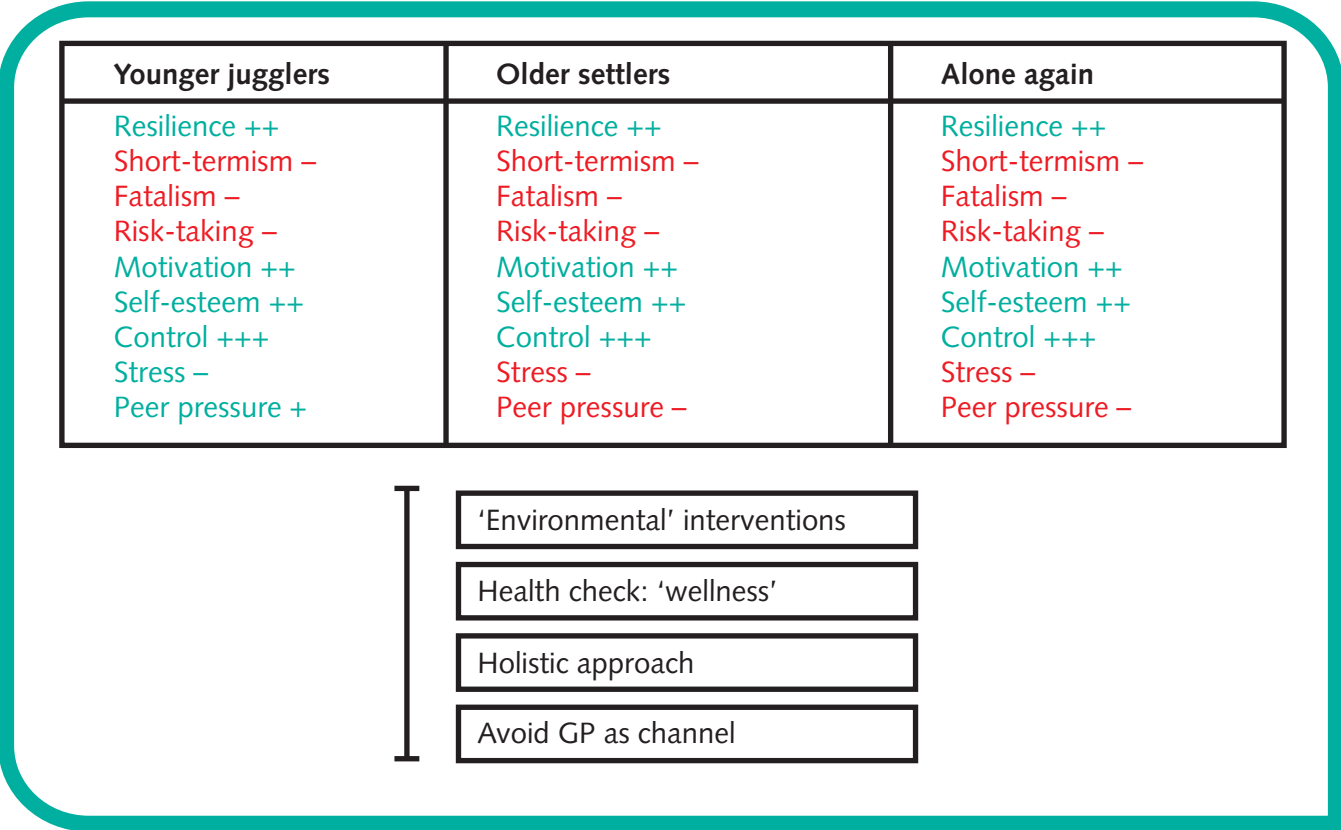
Most believe that they have **'always' been HCRs**. For many respondents, the HCR lifestyle and philosophy is seen as a one-way street and most feel that 'once an HCR, always an HCR'.

In relation to **interventions**:

- this segment strongly supports **free access to facilities**, but **rejects prescriptive or 'nanny-state' interventions**;
- the **notion of health checks is consistently welcomed** as relevant – but these must be serious in nature, private (one-to-one) sessions conducted by professionals;
- HCRs are consistently **critical of primary care quality** and the lack of a relationship with their GP;
- **enforced changes** that punish obviously irresponsible behaviours (drink-driving, for example) are supported, but respondents typically believe that these 'will not affect me';
- **national state interventions**, such as standardised food labelling, are also supported, because they might help HCRs to make better-informed choices;
- **government involvement in presenting health advice and information is seen as acceptable**: but local services should be branded locally, even if they are sponsored by the NHS, for example.

This a **broadly 'hands-off' segment**, which sees itself as capable of making any changes necessary to increase the quality of its health – it can be **assisted, but not instructed**.

Figure 9.7: Health-concious Realists: lifestages and motivations



# 10 Comparative Analysis

Qualitatively, it appeared that some segments were more closely connected than others. Respondents from some segments seemed to have 'graduated' from other segments and often expressed aspirations about the segment they would like to move to in the future. Consequently, these linked segments might be viewed, in some ways, as a 'scale' of motivational change or development. This section of the report outlines the relationships between each of the Healthy Foundations (HF) segments. These may be important if interventions are intended to work across a number of segments.

## 10.1 Segment links: Balanced Compensators and Health-conscious Realists

Freedom years Balanced Compensators (BCs) felt they had always been in the BC segment, while older BCs believed that they had probably 'graduated' from Live for Today (LFT) or Hedonist Immortal (HI) status to BC over time, with increased responsibility and maturity. However, although their attitudes might be seen as positive and healthy, respondents in other segments clearly did not consistently aspire to becoming BCs. Moving to the BC segment was often perceived as unrealistic, either because it would be too challenging or because the BC inclination towards risk was unattractive. For BCs, the most commonly

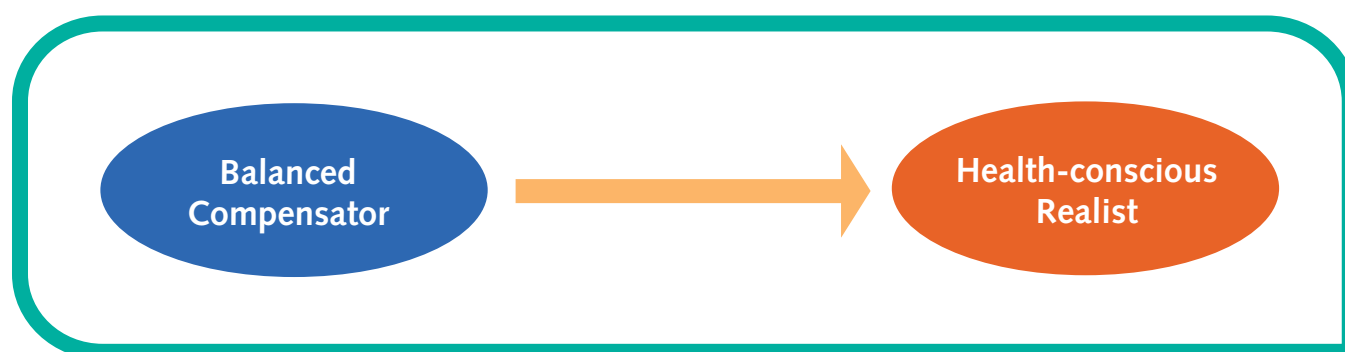
assumed future shift would be to Health-conscious Realist (HCR) status, driven by age and increasing aversion to risk.

BCs were, in fact, the only segment that believed they would eventually 'graduate' to HCR in the future as their responsibilities increased. LFTs and UFs rejected HCR status because the segment was viewed as dull and 'fanatical' about health (which was in itself considered unhealthy). HIs were attracted by the positive aspects of the HCR attitude, but overall believed that the HCR lifestyle would be unachievable. In fact, the reported route to HCR status indicates that this assumption may be well founded: HCRs generally felt they had always possessed the potential to be HCRs, but in most cases it seems that a significant life event had triggered the attitude.

Interestingly, HCRs reciprocated by rejecting LFT and UF status, feeling little sympathy for the seemingly negative and self-destructive attitudes typical of these segments. HIs' apparently 'carefree' attitudes towards life had some appeal for HCRs, but BCs were seen as odd because they took risks when the potential consequences are known. It was clear that, in general, HCRs had little interest in changing segments.

The research indicates that interventions for BCs and HCRs could potentially overlap in many areas. The main similarity between BCs and HCRs in relation to interventions is that both segments would be most receptive to 'assistance' rather than 'instruction' about their health. Both segments wish to maintain

**Figure 10.1: Balanced Compensators and Health-conscious Realists: movement between segments**



personal control over health choices. In this sense, interventions focused on environmental factors and provision of facilities could benefit both segments equally, since both will proactively seek out available resources.

Health checks could also simultaneously target both segments. Messaging could focus on maintaining wellness, and although the service could be delivered by health professionals, both segments may be more comfortable in a non-clinical environment.

Branding, however, would have to be carefully considered if BCs and HCRs were to be targeted together. While BCs reject government branding, HCRs are more open to this idea. However, leading with local service branding might solve this problem.

## 10.2 Live for Todays, Unconfident Fatalists and Hedonistic Immortals

LfT was seen by many respondents as a primarily 'youth-focused' segment, and many respondents from other segments felt they had probably been LfTs at some time in the past. LfTs themselves recognised the attitude as a youthful one, with one Freedom years respondent labelling it a 'teenage view'. Older LfTs considered that their segment traits developed during their teenage years, when

they began to make decisions which were independent of their parents.

Although few LfTs expected to change segments in the future, most viewed HI and BC status positively and some appeared to aspire to these segments (both of which were also perceived as having attractive 'youthful' qualities). Some LfT respondents felt they had previously been in the UF segment (or at least shared a number of UF characteristics) and perceived their current LfT lifestyle as more positive and healthy. Equally, UFs felt that if they were to change segments, they were most likely to 'graduate' to LfT.

UFs were the only segment that regularly disputed their attitudinal identity. Those from IMD categories 1–5 often felt they identified more strongly with LfTs or HIs – those segments for which fatalism was still evident (BC was viewed as desirable but unachievable). Also unique to UFs was the identification of a 'core' group within the attitudinal segment – made up of respondents from IMD category 6.

BCs were sympathetic towards UFs and typically believed that appropriate support could help them to move out of the UF segment – a clear indication that mentoring approaches might be possible. Conversely, HCRs were intolerant of UFs because they

perceived the attitude as a consequence of laziness and negativity. Other segments were also disapproving, even though some respondents (especially LfTs and HIs) indicated that they might have been UFs during past 'hard times' or that they had the potential to 'regress' to UF status.

Few HIs expected to change segments, but older HIs acknowledged a potential to slip into UF attitudes when faced with negative situations. HIs believed either that they had always been HIs or that they had 'graduated' to HI, generally from LfT status. All other segments viewed the HI attitude positively – indeed, some LfTs, BCs and UFs positively aspired to their upbeat attitude.

LfTs, UFs and HIs have very different needs, which have been outlined in previous chapters. However, there are a number of areas of overlap between these segments. Developing interventions that address all three segments would mean that, even if individuals

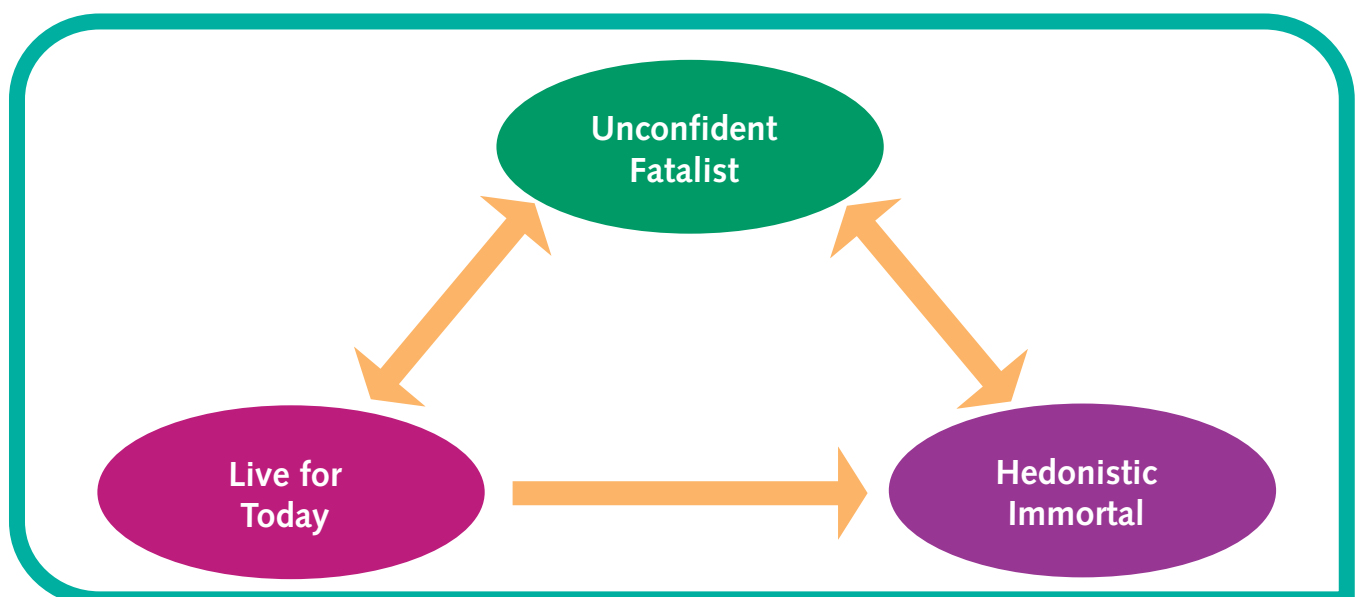
shifted segments, services would continue to reach them.

LfTs and UFs are in similar need of a 'starting point' to engage them with health issues and services. Equally, both UFs and HIs will require a 'wake-up' call in order to initiate engagement with services.

Each segment requires this initial contact for different reasons:

- UFs require a trigger for motivation. Currently, most UFs believe that only the shock of illness can deliver this trigger.
- LfTs are generally unlikely to engage with services, and are unclear themselves what could initiate an active interest in their own health.
- HIs are delusional about their health, so they require a 'wake-up' call to illuminate the reality of their health status.

**Figure 10.2: Live for Todays, Hedonistic Immortals and Unconfident Fatalists: movement between segments**





All segments responded positively to the idea of a health check – an intervention that has the potential to provide the starting point required by all segments. For LfTs, such a service might provide knowledge that could inspire change. A health-check service could also potentially alert UFs and HIs to the reality of their health status in such a way that illness could be prevented.

All three segments have high levels of trust in the NHS brand, and would prefer services to be delivered by local NHS providers. Further, all support the idea of a linked approach to interventions – and so, once engaged, these segments could be more easily directed towards other service areas and opportunities. For example, both LfTs and UFs expressed interest in learning more about time management, stress management and mental health interventions.

UFs and HIs place great importance on personalised, tailored services with clear goals and targets. LfTs also require a clear structure in order to maintain engagement. A service that addresses personal issues for the individual, with ongoing support and monitoring, seems likely to maintain momentum and interest among individuals from all three segments. It would, however, be important for such a service to proceed in 'small steps', so as not to excessively challenge or intimidate these relatively 'fragile' segments.

Because all segments have different needs, each would require different messaging approaches:

- UFs are private and timid in character, and likely to quickly withdraw from services. Therefore, messages need to be sensitively framed. The trust of GPs (and high levels of

pre-existing illness) that is typical within the segment suggests that GPs or local NHS services would be the ideal channels for reaching UFs.

- LfTs are the segment least likely to engage with a service. Stress and a lack of structure are critical drivers for change for this segment, so messages that focus on these areas would be beneficial.
- HIs require upbeat messaging, with a focus on wellness. A key ingredient for engaging this segment will be a sense of 'fun', and care should be taken that messages are not too serious in content.

### 10.3 Index of Multiple Deprivation

Overall, IMD had most impact among the least motivated segments – LfTs and UFs. IMD 1–5 UF (and female IMD 6 UF) respondents showed similar evidence of poor health choices. However, IMD 6 Alone again men made the most damaging health choices.

LfTs all identified strongly with area, but those in IMD categories 4–6 were more reliant on social networks and as a result were often influenced towards poor health choices by their peers.

HIs were equally resilient across IMDs and diet and exercise issues were also consistent.

The most motivated attitudinal segments – BC and HCR – appeared to be even more resilient in deprived areas. BCs displayed negligible differences in attitudes and health choices across IMDs. In fact, those from IMD categories 4–6 seemed more resilient, possibly because they encounter more challenges against which to test the quality of their resilience. This was also true of the HCR segment, where those in IMD categories 3–6

appeared to have encountered greater traumas and consequently developed higher levels of resilience. Those in less deprived areas, in fact, seemed to struggle to maintain a healthy lifestyle primarily because of the stresses of maintaining their financial position.

IMD alone was rarely found to dictate health choices: the index was most influential when coupled with lifestage. For example:

- HCR male Younger jugglers and Older settlers in IMD categories 1–2 made more positive choices than Alone again men in IMD categories 3–6, who were eating poorly and drinking heavily.
- HI Freedom years and Alone again respondents reported more heavy smoking and drinking in IMD categories 3–6. Interestingly, Freedom years in IMD categories 3–6 actually seemed to incorporate unhealthy behaviours into their identity.
- Responses to environment among HIs in IMD categories 4–6 depended on lifestage: Freedom years and Alone agains wanted to leave, whereas Younger jugglers were content to stay in their area.
- Alone again men from IMD categories 4–6 have emerged as a group in particular need of support, across all attitudinal segments.

As a result, it appears that IMD alone is not a strong enough factor to use when targeting services.

## 10.4 Lifestage

Lifestage was an important factor – at times, even more influential than attitudinal segment, because the specific concerns of lifestage can take precedence over those of the attitudinal segment.

Lifestage had the potential to enhance or suppress segment traits. Younger jugglers across all segments reported an unwillingness to take risks because they felt obliged to protect themselves for the sake of their children. For UFs and some LfTs, having children helped with motivation to stay positive and structured. BC Younger jugglers made concessions in terms of their personal aspirations in order to prioritise the needs of their families.

Younger jugglers across attitudinal segments had an interest in improved time management and help with prioritising health: the stress of managing children and work is often a barrier to healthy choices across attitudinal segments (with the exception of HCRs). Therefore, interventions offering stress and time management might help Younger jugglers in all segments to spend more time on issues linked to their own health.

Younger juggler respondents from all segments valued positive environments and family-friendly facilities (for example, where parents and children are able to swim together). Services would need to be locally based and aimed at family units, since both mothers and fathers would be interested in engaging with this type of service.

Except for BCs, Alone again males were disadvantaged in all segments. Health behaviours were worse among Alone again men – compared with their female counterparts – because they did not typically have the motivation or support provided by a partner and children. HCR Alone agains were less resilient and made unhealthy choices, while HI Alone again men had significantly increased risk-taking behaviours, such as drinking heavily and taking drugs. Alone agains should be targeted across attitudinal segments, but especially in deprived areas.

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# Appendix 1: Pre-pilot Focus Group Topic Guide (July 2009)

## Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health (DH) to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering future consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life, which can be a positive as well as a potentially negative attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all the above.
- **Gender** and concepts of masculinity/femininity.

## Part B: Understanding our audience

### 1. Descriptive verification of the segment (20 min)

**Projective 1: Hand out qualities sheet. Ask respondents to look over the sheet and highlight with a pen which ones they identify with. Use two different colours – one to show statements agreed with and a different colour for statements strongly agreed with.**

Ask each of the respondents:

- Which statements did you strongly agree with? Why?
- Can you give examples of how these statements fit into your life?
- How about statements you simply 'agreed' with? Why did you agree? Why did you only 'agree' with these? Are there times when it doesn't apply? When, why?

Collectively:

- What statements were not agreed with? Why?

*I'd like to start off by learning a bit about this area.*

- What's it like living around here?

*Probe: what are the **good things** about living around here? Examples of social assets such as neighbourliness, social networks, trust, shared values, citizenship, participation? What impact do these have upon you?*

*Probe: what are the **not-so-good things** about living around here? Examples? What impact (in detail) do these have upon you?*

*Follow up spontaneous comments, then probe (if necessary): community safety,*

*schools, green spaces, leisure facilities, transport, health services.*

- How happy are you living here?
- Is your future here?

*Probe: are you content to bring up your family here?*

*Probe: would you want to spend your retirement here?*

- **What do you think people visiting here for the first time would say about this area? How would you be 'badged'?**

### 2. Aspiration

*Now I'd like to get to know you a bit better. Let's think back to when you were growing up.*

- What kinds of things did you want to achieve when you were growing up? Follow up spontaneous comments, then probe (if necessary):

**Money:** *what did you hope for, on a scale from 'becoming wealthy with financial security' to 'having enough to get by on'?*

**Relationships:** *what kind of loving/nurturing family and relationship(s) did you hope for (if any)?*

**Self-fulfilment:** *what did you hope to achieve in terms of education, personal development, e.g. thrill-seeking, travel?*

**Work:** *what did you hope for, on a scale from career success and enjoying your work to working to pay the bills?*

**Health and well-being:** *did you have any hopes for your health, e.g. staying fit and well, level of fitness, body shape, feeling good about yourself?*

**Social mobility:** *where do you hope to be in your life compared with your family and peers?*

- Overall, what motivated you when you were growing up?
- What motivates you now?

*Probe: power, pleasure, fulfilling your potential?*

- Have your goals for the future changed over time? If so, how have they changed? Why have these goals become important to you?

⇒ **In particular, how (if at all) have any hopes you had for your health changed over time? Why? Do you have different goals now? If so, why?**

### 3. Key life events

*I'd like to have a think about how the things that happen to us may influence what we hope to get out of life.*

- What are the significant things that have happened to you? Why was that? (See *Stimulus D*)

**Projective 2: Ask each respondent to complete the life events mapping exercise.**

- Write significant events on card (both positive and negative).
  - Map their effects on you as a person – both **positive and negative**.
  - Now map their effects on the way you live your life (if any).
- ⇒ **Looking back at our map, have life events (good or bad) influenced your health at all, i.e. encouraged you to do more healthy or less healthy things?**

### 4. Resilience

- Have you had to make a difficult decision that changed your life significantly?
- How did that feel? What was sacrificed? Was it worth it?
- When times have been tough, what have you learned from the experience?

SIGNIFICANT EVENT	HOW I FELT	HOW IT MADE ME BEHAVE
<div></div>	<div></div>	<div></div>
<div></div>	<div></div>	<div></div>
<div></div>	<div></div>	<div></div>



**Projective 3: Moderator, pick an anecdote relevant to the group (e.g. moving away from a deprived area, challenging bullying at school or work, dealing with relationship problems). If someone wanted to remove themselves from these circumstances:**

- What qualities would they need to have? What decisions would they have to make? How would family/friends feel about someone making big changes in their life?
  - Would perceptions of gender (i.e. what 'being a man' or 'being a woman' is about) influence someone's response to hard times?
- ⇒ **At tough times, have you gained skills that have helped you later on in life? If so, what? How have these helped you?**

## Part C: Introducing health

### 5. Overview

*I'd like to begin by discussing how you feel about health.*

- What do 'good health' and 'poor health' mean to you?  
*Probe: what do 'good health' and 'poor health' look like?*
- Do you do anything because you feel that it is good for you?
- If so, what? When did you start doing these things?
- Why do you see that behaviour as good for you?  
*Probe: is this your opinion or is it influenced by someone else's? If so, whose?*
- What encouraged you to start doing these things?

- Have you kept doing these things for a while? If so, what has encouraged you to keep doing these things?

*Ask the questions above in terms of behaviour that may be perceived as not so good for you.*

- ⇒ **Do you think about what you do now affecting your health later on in life? If so, when and why? If not, why not?**

### 6. Short-termism

- Generally speaking, how much do you think about the future?
- What plans do you have?

*Probe both short-term and long-term plans.*

**Moderator – note goals (which might include saving, living somewhere different, working more/less, travel, improving skills).** For each goal, ask:

- How do you plan to achieve your goals?
- How far in advance did you start to plan?
- Would you consider these to be short-term or long-term goals?

- What does it mean to 'live for today'?

**Projective 4: Tell me about a day in the life of Mr/Mrs 'Live for Today' – add to the drawing to illustrate the way he/she goes about life from breakfast through to evening.**

- If Mr/Mrs 'Live for Today' continues to live in this way, when will his/her health be affected? (in months, years, much later in life?) In what ways?

- Let's think about some of the things we have said we do that we do not feel are so good for us. Do you feel that it is worthwhile to make changes now which may affect your health in the future? Why/why not? If not, what changes would it be worthwhile considering?

➔ **What would encourage you to consider your future health?**

## 7. Risk-taking behaviour

- What would you describe as 'risky behaviour'? Please give examples of risky behaviour. (**Moderator list risks – at least three.**)

*Now we'd like to explore your views about a variety of behaviours that could be perceived as 'risk-taking'.*

**Moderator – return to list of risks. For each risk, explore:**

- To what extent would you say that XX is risky?  
*Probe: What could happen that might be risky?*
- To what extent is XX 'normal'?
- What do you think motivates people to XX?
- What or who has shaped your views about XX?
- Do you XX yourself? If so, what, how, when?

*Probe: What or who influences your decision to XX?*

- If not, why not?

*Probe: who/what are the key influences upon your decision not to XX?*

- Generally speaking, do you consider yourself a risk-taker? Why/why not?

- What kind of risks do you take?

*Probe any type of risk: financial, physical, social (such as fights with family and friends), sporting, sexual, others?*

- What really gives you 'a buzz'? What benefits do you get from taking these risks?  
*Probe: enjoyment?*

- Do you feel that you take any risks with your health? If not, why not?

- If so:

*Probe: in what ways and in what situations? Why do you see that particular behaviour as risky – and what are the specific risks involved?*

- ➔ **Overall, do you feel that you are any more or less likely than other people of your age to become ill in the future? Why do you say that?**

## Part D: Factors influencing specific health choices

*I'd now like to move on to looking at some of the choices we have made this week which may influence our health.*

**Projective 5: Ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion, focus on decisions involving several behaviours, particularly:**

- smoking and/or drinking and/or poor diet choices
- drinking and risky sexual behaviour
- smoking, drinking and drug taking.

⇒ **Why did you make these choices? Listen for spontaneous reasons, then probe influence of the ideas outlined below.**

## 8. Self-esteem

- How were you feeling about yourself when you made these decisions?

⇒ **Is this typical?**

*Probe: how do you generally feel about yourself when you make decisions which may be good or bad for your health?*

## 9. Social influences

- Does anyone else influence your 'healthier' decisions? If so, whom?

*Probe: friends, family, colleagues, people in the community?*

- Who, if anyone, would you say are your role models? Why?
- Is there anything else that has influenced your behaviour in a positive way (e.g. smoking ban)?
- Does anyone else influence your 'less healthy' decisions? If so, whom?

*Probe: friends, family, colleagues, people in the community?*

- Who, if anyone, would you say is a 'bad influence' on you? Why?

⇒ **Is this typical? If so, in what ways do the people around you influence decisions that may be good or bad for your health?**

*Probe: smoking, drinking and other risk-taking behaviour among family/friends.*

## 10. Control

- Did you feel in control of what was going on in your life when you made these decisions?
- If not, why not? What was making you feel less in control?
- Generally speaking, do you feel in control of your life?
- Are there certain situations when you feel less in control than others? If so, what type of situations? When do these occur and why?

⇒ **How does feeling more in or out of control influence decisions which may be good or bad for your health?**

## 11. Finances

- Did money worries influence your decisions? If so, how?

*Probe: impacts of employment, unemployment, debt, limited income.*

- Do you have debt? If so, how does it affect your decisions?

⇒ **More generally, what impact do money worries have on decisions that may be good or bad for your health?**

## 12. Stress

- How were you feeling generally when you made these decisions?
- Is this typical?

*Probe: do you feel stressed at times? If so, when?*

⇒ **How do your stress levels influence decisions that may be good or bad for your health?**

By the end of this section of the discussion, ensure that:

- all respondents have contributed
- a range of health behaviours have been discussed
- decisions involving more than one health behaviour have been fully explored.

## Part E: Overall personal health

Respondents to rate their health choices for each day on a scale of more to less 'healthy'.

MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							
SUNDAY							

### 13. Views about overall health

Let's have a think about what our health looks like.

- What have you found out about your health?

*Probe: any surprises?*

- Can you see any links between different habits?

*Probe: between smoking and/or drinking and/or poor diet choices, between drinking and risky sexual behaviour, between smoking, drinking and drug taking?*

→ Overall, how do you feel about your diet, your level of physical activity, your drinking habits and your smoking patterns?

### 14. Cultural norms

- How would you describe 'normal' health behaviour for your peers (age, area)?

*Probe: areas like exercise, diet, drink, smoking, drugs, unprotected sex, etc.?*

- How do you think other people would describe your age group?
- Do you see yourself as fitting in with these 'norms'?

*Probe: do you share similar patterns or do you resist these tendencies (if needed, use the example of binge drinking in Britain to prompt)?*

#### ➡ **How does this make you feel about yourself?**

*Probe: thoughts and feelings about their place in society/age group.*

### 15. Making changes

- Would you like to make any changes to improve your health?
- If yes, what would you like to achieve?  
**(Moderator note)**
- In what ways do you feel you could and in what ways to you feel you couldn't make positive changes to your health? Why do you feel this way?

### 16. Fatalism

**Projective 5: Some people hold the view that if a person is meant to become ill, it doesn't matter what a doctor tells them to do, they will become ill.**

- To what extent (if at all) do you sympathise with this view?
- Are you fatalistic about your health? If so, in what ways?
- Why do you feel this way?
- Are you fatalistic about anything in your life? If so, what?

*Probe: pensions, relationships, career/prospects, health, abilities.*

- Why do you feel this way about these things?

#### ➡ **What would encourage you to feel that you had more power to influence your health in a positive way?**

### 17. Support to make changes

*I'd like to discuss each of the changes we have decided we would like to make. We're going to be discussing the help and support we might need to make these changes. Please answer from a personal perspective, i.e. what would help me make these changes – not what you feel might work for other people or people in general.*

**Moderator: return to list of desired changes.**

- What would making these changes involve?
- What would encourage you to make this change?

*Probe: peers/friends/family changing behaviour, social norms: 'what everyone is doing', safety concerns, cosmetic concerns, achieving specific personal ambitions/goals?*

- What difficulties would need to be addressed in order to make this change possible for you?

*Probe: lack of perceived need, in a comfort zone, 'do the same as all my friends/family', lack of ongoing encouragement/support, no sense of control?*

### 18. Sources of support/advice/information

- Are you the type of person who prefers to make changes by yourself – despite what everybody else is doing? If so, what type of support (if any) do you need?



- Do you need support from those around you to make positive changes to your health? If so, who are the key people you need to support you to make this change? How do you need them to support you?
- Would you like any support/advice/information from outside of your friends and family to help you make these changes?

⇒ **To what extent do you need support to make changes to your health? If so, what support do you need – and from whom?**

*Probe: other like-minded people in the community, community-based health professionals, voluntary groups?*

## 19. Environment

- Are there any changes that need to be made to your environment to support you in making changes?
- In which places do changes need to be made?

*Probe: home, work, community?*  
What changes need to be made?

⇒ **How would your surroundings need to change to support you in making changes?**

## Section F: Potential interventions (service delivery)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

## 20. Focus on specific issues

- Would a service focusing on specific issues be motivating for you (e.g. diet, exercise, smoking, physical activity)?

- If so, which specific issues would be motivating and why?

*Explain government recommendations: to eat five portions of fruit and veg a day, to do 30 minutes of activity a day, to drink only 2–3 units per day (women) and 3–4 units per day (men), to quit smoking.*

- Why do you think these goals have been recommended?
- Do you typically achieve any of these recommendations?
- If so, what or who helps you achieve these goals?

⇒ **If not, does achieving any of these goals motivate you? Why/why not? If so, what are the barriers that you would need to overcome? What kind of service would you need to overcome these barriers?**

## 21. Focus on linked behaviour

- Would a service focusing on linked behaviour be motivating for you?
- Does thinking about one type of behaviour make you think about other aspects of health – for example, would a message about healthy diet also make you think about taking more exercise – or would a message about smoking make you think about other risky behaviour such as drug taking or unprotected sex?

*Probe: why do you say that?*

- Share Vitality project example (Stimulus A)
- Would this type of service appeal? Would you consider using it? Why/why not?
- If so, where should such a service be delivered, e.g. GP surgery, Sure Start classes, supermarkets?



➡ **What issues would it be helpful to link together?**

## 22. Focus on 'wellness'

- Would a focus on 'wellness' be motivating for you?
- Share GO Wellness service example (Stimulus B).
- Would this type of service appeal? Would you consider using it? Why/why not?
- If so, where should such a service be delivered, e.g. GP surgery, Sure Start classes, supermarkets?
- If so, what messages about 'wellness' would be motivating?

*Probe the idea of achieving the most from your life, for you and your family.*

➡ **Would it be more or less motivating to focus on your health as a whole (rather than specific behaviours)?**

## 23. Focus on the factors influencing unhealthy behaviour

- Would a focus on the factors influencing less healthy behaviour be motivating for you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus C) or Bristol transport example (Stimulus D).
- Would this type of support appeal? Why/why not?

➡ **Would it be more or less motivating to focus on the specific needs of you and your family (FNP) or your environment (Bristol) to encourage you to make changes to your lifestyle?**

## 24. Creating the ideal service

Using the examples already discussed as inspiration, respondents to create their own service to suit the changes to their lifestyles which they would like to make. The service should be relevant to their age group and locality.

***Moderator: ensure that respondents have covered each of the factors on the intervention mixing desk when designing their ideal service.***

### • Direct or indirect support

- How should this support/advice/information be delivered?

*Probe: direct, i.e. face-to-face, telephone or indirect, i.e. self-help from written materials, websites?*

### • Location

- Where should support/advice/information be delivered?

*Probe: at home, at work, in the community?*

### • Timing

- When should support/advice/information be delivered?
- Are there particular times when you would need encouragement? If so, when?

### • Tone

- In what tone should support/advice/information be offered to you?
- What type of approach is likely to motivate you?

*Probe: positive, encouraging vs. challenging, forceful?*

# Appendix 2: Balanced Compensators Focus Group Topic Guide (August 2009)

## Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health (DH) to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through the Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life that can be a positive, as well as a potentially negative, attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all of the above.
- **Gender:** and concepts of masculinity/femininity.

## Part B: Verification of the segment (20 min)

**Projective 1: hand out Stimulus A – attitudinal statements sheet. Ask respondents to look over the sheet and highlight with a pen which ones resonate. Use two different colours – one to show statements agreed with and a different colour for statements strongly agreed with.**

- What statements did you strongly agree with? Why?
- How about statements you simply 'agreed' with?
- Are there times when this doesn't apply? If so, when and why?
- What statements did you not agree with? Why?

## Part C: Immersion – lives (30 min)

### 1. Image

*I'd like to start off by learning a bit about this area.*

- What's it like living around here?

*Probe: what are the **good things** about living around here?*

*Probe: what are the **not-so-good things** about living around here?*

- Is your future here?
- What do you think people visiting here for the first time would say about this area?

### 2. Aspiration

*Now I'd like to get to know you a bit better.*

- Do you have goals for yourself? If so, what are they? Do you have any plans about how you will achieve your goals? If so, what are they? What, ideally, would like to achieve in the next ten years?
- *Tease out the nature of these goals/aspirations – develop skills learning; get rich and acquire possessions, feel financially secure; have a good time; look good and be respected by others; acquire professional status; have kids, etc.*

### 3. Key life events/resilience

*I'd like to have a think about how things that happen may influence us.*

**Projective 2: chart (Stimulus B) supported by examples of significant life events (Stimulus C). Ask respondents to write significant events on card (both positive and negative). NB: these events might be personal or events that have happened to people they know, e.g. friends/family.**

- When times have been tough, what do we learn from the experience?
- What qualities do we all need to get through the tough times?
- What makes them stronger/what makes them weaker:
  - my personality – it's the way I am. Please describe
  - people
  - events
  - time-poor/time-rich
  - lack of motivation
  - self-control
  - haven't thought about it – it's habitual (possibly an addiction – or will be) – can't break this behaviour – have they tried to change (this may be picked up under Section 6)?

#### 4. Risk-taking behaviour

- What would you describe as 'risky behaviour'? *Please give examples of 'risky behaviour' (Moderator list risks – at least three.)*
- Would you take any of these risks? If so, why? If not, why not?
- Generally speaking, do you consider yourself a risk-taker? Why/why not?
- What really gives you 'a buzz'?
- Do you feel that you take any risks with your health? If not, why not?

#### Part D: Immersion – health (30 min)

*I'd now like to move on to looking at our diary of health choices...*

**Projective 3: Ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion, focus on decisions involving several behaviours, particularly: smoking and/or drinking and/or poor diet choices, drinking and risky sexual behaviour or smoking, drinking and drug taking.**

#### 5. Factors influencing health choices

- **Self-esteem:** how were you feeling about yourself when you made these decisions?
- **Social influences:** did anyone else influence this particular decision? If so, how and why?
- **Control:** did you feel in control of what was going on in your life when you made these decisions?
- **Finances:** did money worries influence your decisions? If so, how?

*By the end of this section of the discussion, ensure that:*

- *all respondents have contributed*
- *a range of health behaviours have been discussed*
- *decisions involving more than one health behaviour have been fully explored.*

*We need to include some discussion about fatalism generally and as applied to health.*

*We also need to include some discussion about short-termism (living for today) as applied generally to their lives and as applied specifically to their health.*

#### 6. Views about overall health

*Having completed the diary exercise, what did you learn about yourself?*

- What, if anything, have you found out about your health?
- How would you describe 'normal' health behaviour for your peers?
- Do you see yourself as fitting in with these 'norms'?
- Would you like to make any changes to improve your health? If so, what? How would you go about making these changes?

<p><b>Break for 15 min</b></p>
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## Part E: Interventions – service delivery (30 min)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

### 7. Approach

- **Single issues:** would a service focusing on specific issues be motivating for you (e.g. diet, exercise, smoking, physical activity)?
- If so, which specific issues would be motivating and why?
- **Linked behaviour:** would a service focusing on linked behaviour be motivating for you? If so, which behaviours would you link?
- Share Vitality project example (Stimulus D).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Wellness:** would a focus on 'wellness' be motivating for you?
- Share GO Wellness service example (Stimulus E).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Contextual factors:** would a focus on the factors influencing less healthy behaviour be motivating for you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus F) or Bristol transport example (Stimulus G).
- Would this type of support appeal? Why/why not?

### 8. Creating the ideal service

***Projective 3: using the examples already discussed as inspiration, respondents to decide how they would adapt services to support the changes to their lifestyles they would like to make. The service should be relevant to their age group and locality. Moderator: ensure that respondents have covered each of the following factors when adapting services:***

- **Direct or indirect support:** how should this support/advice/information be delivered?
- **Location:** where should support/advice/information be delivered?
- **Timing:** when should support/advice/information be delivered?
- **Tone:** what type of approach is likely to motivate you?

*Probe: positive, encouraging vs. challenging, forceful?*



# Appendix 3: Live for Todays Focus Group Topic Guide (August 2009)

## Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health (DH) to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through the Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life that can be a positive, as well as a potentially negative, attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all the above.
- **Gender:** and concepts of masculinity/femininity.

## Part B: Verification of the segment (20 min)

**Projective 1: Hand out Stimulus A – attitudinal statements sheet. Ask respondents to look over the sheet and highlight with a pen which ones resonate. Use two different colours – one to show statements agreed with and a different colour for statements strongly agreed with.**

**Moderator note – when discussing short-termism and fatalism in particular,**



**remember to discuss in relation to health and generally.**

- What statements did you strongly agree with? Why?
- What does this statement mean to you?
- Please give examples of how each works in your day-to-day life.
- How about statements you simply 'agreed' with?
- What does this statement mean to you?
- Are there times when this doesn't apply? If so, when and why?
- What statements did you not agree with? Why?

## Part C: Immersion – lives (30 min)

### 1. Image

*I'd like to start off by learning a bit about this area.*

- What's it like living around here?  
*Probe: what are the **good things** about living around here?*  
*Probe: what are the **not-so-good things** about living around here?*
- Is your future here?
- What do you think people visiting here for the first time would say about this area?

### 2. Short-termism

*Now I'd like to get to know you a bit better. We've talked a little about living for today – let's explore that a little more.*

- Generally speaking, how much do you think about the future?

- What plans do you have?

*Probe both short-term and long-term plans.*

**Moderator – note goals (which might include saving, living somewhere different, working more/less, travel, improving skills).**

How do you plan to achieve your goals?

How far in advance did you start to plan?

Would you consider these to be short-term or long-term goals?

*Let's think about some of the things we do that we do not feel are so good for us – moderator list responses.*

- Do you feel that it is worthwhile to make changes now that may affect your health in the future? Why/why not?
- If not, what changes would it be worthwhile considering?

### 3. Key life events/resilience

*I'd like to have a think about how things that happen may influence us.*

**Projective 3: chart (Stimulus B) supported by examples of significant life events (Stimulus C). Ask respondents to write significant events on card (both positive and negative). NB: these events might be personal or events that have happened to people they know, e.g. friends/family.**

- When times have been tough, what do we learn from the experience?
- What qualities do we all need to get through the tough times?
- What qualities do us girls/us blokes need to get through?

- What makes you stronger/what makes you weaker?

*Probe: my personality – it's the way I am (please describe), people, events, time-poor/time-rich, lack of motivation, self-control, haven't thought about it, it's habitual (possibly an addiction – or will be), can't break this behaviour, being a man/being a woman.*

#### 4. Fatalism

**Projective 4: Some people hold the view that if a person is meant to become ill, it doesn't matter what a doctor tells them to do, they will become ill.**

- To what extent (if at all) do you sympathise with this view?
- Are you fatalistic about your health?
- If so, in what ways? Why do you feel this way?
- What would encourage you to feel that you had more power to influence your health in a positive way?
- Are you fatalistic about anything in your life? If so, what?

*Probe: pensions, relationships, career/prospects, health, abilities.*

- Why do you feel this way about these things?

#### Part D: Immersion – health (30 min)

*I'd now like to move onto looking at our diary of health choices...*

**Projective 4: ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion,**

***focus on decisions involving several behaviours, particularly: smoking and/or drinking and/or poor diet choices, drinking and risky sexual behaviour or smoking, drinking and drug taking.***

#### 5. Factors influencing health choices

- **Self-esteem:** how were you feeling about yourself when you made these decisions?
- **Social influences:** did anyone else influence this particular decision? If so, how and why?
- **Control:** did you feel in control of what was going on in your life when you made these decisions?
- **Finances:** did money worries influence your decisions? If so, how?

*By the end of this section of the discussion, ensure that:*

- *all respondents have contributed*
- *a range of health behaviours have been discussed*
- *decisions involving more than one health behaviour have been fully explored.*

#### 6. Views about overall health

*Having completed the diary exercise, what did you learn about yourself?*

- What, if anything, have you found out about your health?
- How would you describe 'normal' health behaviour for your friends/family/age group/society?
- What do girls your age/blokes your age normally do?

- Do you see yourself as fitting in, in comparison with your friends/family/age group/society?
- Have you tried to change?
- Would you like to make any changes to improve your health? If so, what? How would you go about making these changes?

**Break for 15 min**

## Part E: Interventions – service delivery (30 min)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

### 7. Approach

- **Single issues:** would a service focusing on specific issues be of interest to you (e.g. diet, exercise, smoking, physical activity, drinking/drugs, sexual health)?
- If so, which specific issues would be relevant and why?
- **Linked behaviour:** Ask respondents to write down their own linked behaviours – ‘when two or more health decisions come together’ – once written, ask respondents to explain the behaviours.
- Why are these behaviours linked?
- Would a service focusing on linked behaviour be relevant to you?
- Share Vitality project example (Stimulus D).
- Would this type of service appeal? Would you consider using it? Why/why not?

- **Wellness:** would a focus on ‘wellness’ be motivating?
- Share GO Wellness service example (Stimulus E).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Contextual factors:** would a focus on the factors influencing less healthy behaviour be helpful to you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus F) or Bristol transport example (Stimulus G)
- Would this type of support appeal? Why/why not?

### 8. Creating the ideal service

**Projective 5: using the examples already discussed as inspiration (Vitality, GO Wellness, FNP and Bristol transport), ask respondents to decide how they would adapt an existing service to support the changes to their lifestyles they would like to make. The service should be relevant to their age group and locality.**

**Moderator: ensure that respondents have covered each of the following factors when adapting services:**

- whether direct or indirect support is preferred
- where services should be delivered (i.e. location)
- when services should be delivered (i.e. timing)
- how services should deliver their support/assistance (i.e. tone – *positive, encouraging vs. challenging, forceful*).

# Appendix 4: Unconfident Fatalists

## Focus Group Topic Guide

### (September 2009)

#### Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through the Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life, which can be a positive, as well as a potentially negative, attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all the above.
- **Gender:** and concepts of masculinity/femininity.

#### Part B: Verification of the segment (20 min)

**Projective 1: hand out Stimulus A – attitudinal statements sheet. Ask respondents to look over the sheet and highlight with a pen which ones resonate. Use two different colours – one to show statements agreed with and a different colour for statements strongly agreed with.**

**Moderator note – when discussing short-termism and fatalism in particular, remember to discuss in relation to health and generally.**

- What statements did you strongly agree with? Why?
- What does this statement mean to you?
- Please give examples of how each works in your day-to-day life.
- How about statements you simply 'agreed' with?
- What does this statement mean to you?
- Are there times when this doesn't apply? If so, when and why?
- What statements did you not agree with? Why?

## Part C: Immersion – lives (30 min)

### 1. Fatalism

**Projective 2: some people hold the view that if a person is meant to become ill, it doesn't matter what a doctor tells them to do, they will become ill.**

To what extent (if at all) do you sympathise with this view?

- Are you fatalistic about your health?
- If so, in what ways? Why do you feel this way?
- What would encourage you to feel that you had more power to influence your health in a positive way?
- Are you fatalistic about anything in your life? If so, what?

*Probe: pensions, relationships, career/prospects, health, abilities.*

- Why do you feel this way about these things?

### 2. Image

*I'd like to start off by learning a bit about this area.*

- What's it like living around here?

*Probe: what are the **good things** about living around here? Probe: what are the **not-so-good things** about living around here?*

- Is your future here?
- What do you think people visiting here for the first time would say about this area?

### 3. Key life events/resilience

*I'd like to have a think about how things that happen may influence us.*

**Projective 3: chart (Stimulus B) supported by examples of significant life events (Stimulus C). Ask respondents to write significant events on card (both positive and negative). NB: these events might be personal or events that have happened to people they know, e.g. friends/family.**

- When times have been tough, what do we learn from the experience?
- What qualities do we all need to get through the tough times?
- What qualities do us girls/us blokes need to get through?
- What makes you stronger/what makes you weaker?

*Probe: my personality – it's the way I am (please describe), people, events, time-poor/time-rich, lack of motivation, self-control, haven't thought about it,*



*it's habitual (possibly an addiction – or will be), can't break this behaviour, being a man/being a woman.*

#### 4. Aspiration

*Now I'd like to get to know you a bit better. Let's think back to when you were growing up*

- What kinds of things did you want to achieve when you were growing up? Follow up spontaneous comments, then probe (if necessary):

**Money:** *what did you hope for on a scale from becoming wealthy with financial security, to having enough to get by on?*

**Relationships:** *what kind of loving/nurturing family and relationship(s) did you hope for (if any)?*

**Self-fulfilment:** *what did you hope to achieve in terms of education, personal development, e.g. thrill-seeking, travel?*

**Work:** *what did you hope for on a scale from career success and enjoying your work, to working to pay the bills?*

**Social mobility:** *where do you hope to be in your life compared with your family and peers?*

**Health and well-being:** *did you have any hopes for your health, e.g. staying fit and well, level of fitness, body shape, feeling good about yourself?*

- Overall, what motivated you when you were growing up?
- What motivates you now?

*Probe: power, pleasure, fulfilling your potential?*

- Have your goals for the future changed over time? If so, how have they changed? Why have these goals become important to you?
- In particular, how (if at all) have any hopes you had for your health changed over time? Why? Do you have different goals now? If so, why?

#### Part D: Immersion – health (30 min)

*I'd now like to move onto looking at our diary of health choices ...*

**Projective 4: ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion, focus on decisions involving several behaviours, particularly: smoking and/or drinking and/or poor diet choices, drinking and risky sexual behaviour or smoking, drinking and drug taking.**

#### 5. Factors influencing health choices

- **Self-esteem:** how were you feeling about yourself when you made these decisions?
- **Social influences:** did anyone else influence this particular decision? If so, how and why?
- **Control:** did you feel in control of what was going on in your life when you made these decisions?
- **Finances:** did money worries influence your decisions? If so, how?
- **Stress:** How do your stress levels influence decisions that may be good or bad for your health?

*By the end of this section of the discussion, ensure that:*

- *all respondents have contributed*



- *a range of health behaviours have been discussed*
- *decisions involving more than one health behaviour have been fully explored.*

## 6. Views about overall health

*Having completed the diary exercise, what did you learn about yourself?*

- What, if anything, have you found out about your health?
- How would you describe 'normal' health behaviour for your friends/family/age group/society?
- What do girls your age/blokes your age normally do?
- Do you see yourself as fitting in, in comparison with your friends/family/age group/society?
- Have you tried to change?
- Would you like to make any changes to improve your health? If so, what? How would you go about making these changes?

**Break for 15 min**

## Part E: Interventions – service delivery (30 min)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

## 7. Approach

- **Single issues:** would a service focusing on specific issues be of interest to you (e.g. diet, exercise, smoking, physical activity, drinking/drugs, sexual health)?
- If so, which specific issues would be relevant and why?
- **Linked behaviour:** *Ask respondents to write down their own linked behaviours – 'when two or more health decisions come together' – once written, ask respondents to explain the behaviours.*
- Why are these behaviours linked?
- Would a service focusing on linked behaviour be relevant to you?
- Share Vitality project example (Stimulus D).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Wellness:** would a focus on 'wellness' be motivating?
- Share GO Wellness service example (Stimulus E).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Contextual factors:** would a focus on the factors influencing less healthy behaviour be helpful to you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus F) or Bristol transport example (Stimulus G).
- Would this type of support appeal? Why/why not?

## 8. Creating the ideal service

***Projective 5: using the examples already discussed as inspiration (Vitality, GO Wellness, FNP and Bristol transport), ask respondents to decide how they would adapt an existing service to support the changes to their lifestyles they would like to make. The service should be relevant to their age group and locality.***

***Moderator: ensure that respondents have covered each of the following factors when adapting services:***

- whether direct or indirect support is preferred
- where services should be delivered (i.e. location)
- when services should be delivered (i.e. timing)
- how services should deliver their support/ assistance (i.e. tone – *positive, encouraging* vs. *challenging, forceful*).

# Appendix 5: Hedonistic Immortals

## Focus Group Topic Guide

### (October 2009)

#### Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through the Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life, which can be a positive, as well as a potentially negative, attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all the above.
- **Gender:** and concepts of masculinity/femininity.

#### Part B: Verification of the segment (20 min)

**Projective 1: hand out Stimulus A – attitudinal statements sheet. Ask respondents to look over the sheet and highlight with a pen which ones resonate. Use two different colours – one to show statements agreed with and a different colour for statements strongly agreed with.**

**Moderator note – when discussing short-termism and fatalism in particular, remember to discuss in relation to health and generally.**

- What statements did you strongly agree with? Why?
- What does this statement mean to you?
- Please give examples of how each works in your day-to-day life.
- How about statements you simply 'agreed' with?
- What does this statement mean to you?
- Are there times when this doesn't apply? If so, when and why?
- What statements did you not agree with? Why?

## Part C: Immersion – lives (30 min)

### 1. Risk-taking behaviour

*Now I'd like to get to know you a bit better. We've talked a little about risk-taking – let's explore that a little more.*

- What would you describe as 'risky behaviour'? *Please give examples of 'risky behaviour' (Moderator lists risks – at least three.)*
- Would you take any of these risks? If so, why? If not, why not?
- Generally speaking, do you consider yourself a risk-taker? Why/why not?
- What really gives you 'a buzz'?
- Do you feel that you take any risks with your health? If not, why not?

### 2. Short-termism

- Generally speaking, how much do you think about the future?
- What plans do you have? *Probe both short-term and long-term plans. Moderator – note goals (which might include saving, living somewhere different, working more/less, travel, improving skills).*
- How do you plan to achieve your goals?
- How far in advance did you start to plan?
- Would you consider these to be short-term or long-term goals?

*Let's think about some of the things we do that we do not feel are so good for us – moderator lists responses.*

- Do you feel that it is worthwhile to make changes now that may affect your health in the future? Why/why not?
- If not, what changes would it be worthwhile considering?

### 3. Image

*Now I'd like to learn a bit about this area.*

- What's it like living around here?

*Probe: what are the **good things** about living around here?*

*Probe: what are the **not-so-good things** about living around here?*

- Is your future here?
- What do you think people visiting here for the first time would say about this area?

#### 4. Key life events/resilience

*I'd like to have a think about how things that happen may influence us.*

**Projective 1: chart (Stimulus B) supported by examples of significant life events (Stimulus C). Ask respondents to write significant events on card (both positive and negative). NB: these events might be personal or events that have happened to people they know, e.g. friends/family.**

- When times have been tough, what do we learn from the experience?
- What qualities do we all need to get through the tough times?
- What qualities do us girls/us blokes need to get through?
- What makes you stronger/what makes you weaker:

*Probe: my personality – it's the way I am (please describe), people, events, time-poor/time-rich, lack of motivation, self-control, haven't thought about it, it's habitual (possibly an addiction – or will be), can't break this behaviour, being a man/being a woman.*

#### Part D: Immersion – Health (30 min)

*I'd now like to move onto looking at our diary of health choices...*

**Projective 2: ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion, focus on decisions involving several behaviours, particularly: smoking and/or drinking and/or poor diet choices, drinking and risky sexual behaviour or smoking, drinking and drug taking.**

#### 5. Factors influencing health choices

- **Self-esteem:** how were you feeling about yourself when you made these decisions?
- **Social influences:** did anyone else influence this particular decision? If so, how and why?
- **Control:** did you feel in control of what was going on in your life when you made these decisions?
- **Finances:** did money worries influence your decisions? If so, how?
- **Stress:** How do your stress levels influence decisions that may be good or bad for your health?

*By the end of this section of the discussion, ensure that:*

- *all respondents have contributed*
- *a range of health behaviours have been discussed*
- *decisions involving more than one health behaviour have been fully explored.*

#### 6. Views about overall health

*Having completed the diary exercise, what did you learn about yourself?*

- What, if anything, have you found out about your health?
- How would you describe 'normal' health behaviour for your friends/family/age group/society?
- What do girls your age/blokes your age normally do?
- Do you see yourself as fitting in, in comparison with your friends/family/age group/society?
- Have you tried to change?

- Would you like to make any changes to improve your health? If so, what? How would you go about making these changes?

Break for 15 min

## Part E: Interventions – service delivery (30 min)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

### 7. Approach

- **Single issues:** would a service focusing on specific issues be of interest to you (e.g. diet, exercise, smoking, physical activity, drinking/drugs, sexual health)?
- If so, which specific issues would be relevant and why?
- **Linked behaviour:** Ask respondents to write down their own linked behaviours – 'when two or more health decisions come together' – once written, ask respondents to explain the behaviours.
- Why are these behaviours linked?
- Would a service focusing on linked behaviour be relevant to you?
- Share Vitality project example (Stimulus D).
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Wellness:** would a focus on 'wellness' be motivating?
- Share GO Wellness service example (Stimulus E).

- Would this type of service appeal? Would you consider using it? Why/why not?
- **Contextual factors:** would a focus on the factors influencing less healthy behaviour be helpful to you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus F) or Bristol transport example (Stimulus G)
- Would this type of support appeal? Why/why not?

### 8. Creating the ideal service

**Projective 3: using the examples already discussed as inspiration (Vitality, GO Wellness, FNP and Bristol transport), ask respondents to decide how they would adapt an existing service to support the changes to their lifestyles they would like to make. The service should be relevant to their age group and locality.**

**Moderator: ensure that respondents have covered each of the following factors when adapting services:**

- whether direct or indirect support is preferred
- where services should be delivered (i.e. location)
- when services should be delivered (i.e. timing)
- how services should deliver their support/assistance (i.e. tone – positive, encouraging vs. challenging, forceful).



# Appendix 6: Health-conscious Realists Focus Group Topic Guide (November 2009)

## Part A: Introductions (10 min)

- **Introduce self, RWL** (independent market research agency).
- **Introduce research:** we have been commissioned by the Department of Health to explore people's attitudes towards their health. The aim is to understand how different groups of people think about their health so that DH can have a better understanding of people's needs.
- **Confidentiality and full anonymity** guaranteed through the Data Protection Act, Freedom of Information Act and Market Research Society Code of Conduct.
- **Respondents to introduce themselves:** name, age, employment, family, interests.

**Note to moderators:** throughout the discussion, make sure you probe for insight into key issues such as:

- **Resilience:** 'standing apart' – the ability to initiate and maintain positive behaviour in an environment where other people doing different things.
- **Short-termism:** 'living in the now' and not considering consequences.
- **Fatalism:** 'what will be, will be...' – feeling powerless and that the individual can't make a difference, maybe drawing comfort from this view.

- **Risk-taking:** 'ah, what the hell...' – comfort with taking chances in life which can be a positive, as well as a potentially negative attitude.
- **Norms:** cultural influences of family, friends, societal, other.
- **Social influences:** smoking, drinking, risk-taking behaviour in the household, in the workplace, in the community.
- **Image:** how they/their neighbourhood may be viewed by society.
- **Aspirations:** internal and external.
- **Key life events:** both positive and negative.
- **Financial pressure:** the effects of poverty and debt on all the above.
- **Gender:** and concepts of masculinity/femininity.

## Part B: Verification of the segment (20 min)

**Projective 1: hand out Stimulus A – attitudinal statements sheet. Ask respondents to look over the sheet and highlight with a pen which ones resonate. Use two different colours – one to show statements agreed with, and a different colour for statements strongly agreed with.**

**Moderator note – when discussing short-termism and fatalism in particular, remember to discuss both in relation to health and generally.**

- What statements did you strongly agree with? Why?
- What does this statement mean to you?
- Please give examples of how each works in your day-to-day life.
- How about statements you simply 'agreed' with?
- What does this statement mean to you?
- Are there times when this doesn't apply? If so, when and why?
- What statements did you not agree with? Why?

## Part C: Immersion – lives (30 min)

### 1. Risk-taking behaviour

*Now I'd like to get to know you a bit better. We've talked a little about risk-taking – let's explore that a little more.*

- What would you describe as 'risky behaviour'? Please give examples of 'risky behaviour'.

**(Moderator lists risks – at least three)**

- Would you take any of these risks? If so, why? If not, why not?
- Generally speaking, do you consider yourself a risk-taker? Why/why not?
- What really gives you 'a buzz'?
- Do you feel that you take any risks with your health? If not, why not?

### 2. Short-termism

- Generally speaking, how much do you think about the future?
- What plans do you have? *Probe both short-term and long-term plans.*

**Moderator – note goals (which might include saving, living somewhere different, working more/less, travel, improving skills).**

- How do you plan to achieve your goals?
- How far in advance did you start to plan?
- Would you consider these to be a short-term or long-term goals?

*Let's think about some of the things we do that we do not feel are so good for us – moderator lists responses.*

- Do you feel that it is worthwhile to make changes now that may affect your health in the future? Why/why not?
- If not, what changes would it be worthwhile considering?

### 3. Image

*Now I'd like to learn a bit about this area.*

- What's it like living around here?

*Probe: what are the **good things** about living around here?*

*Probe: what are the **not-so-good things** about living around here?*

- Is your future here?
- What do you think people visiting here for the first time would say about this area?

#### 4. Key life events/resilience

*I'd like to have a think about how things that happen may influence us.*

**Projective 2: chart (Stimulus B) supported by examples of significant life events (Stimulus C). Ask respondents to write significant events on card (both positive and negative). NB: these events might be personal or events that have happened to people they know, e.g. friends/family.**

- When times have been tough, what do we learn from the experience?
- What qualities do we all need to get through the tough times?
- What qualities do us girls/us blokes need to get through?
- What makes you stronger/what makes you weaker:

*Probe: my personality – it's the way I am (please describe), people, events, time poor/time rich, lack of motivation, self-control, haven't thought about it, it's habitual (possibly an addiction – or will be), can't break this behaviour, being a man/being a woman.*

#### Part D: Immersion – health (30 min)

*I'd now like to move onto looking at our diary of health choices...*

**Projective 3: ask each respondent to choose a decision (based on the diary exercise) that they made in the past week which may affect their health. During the discussion, focus on decisions involving several behaviours, particularly: smoking and/or drinking and/or poor diet choices, drinking and risky sexual behaviour or smoking, drinking and drug taking.**

#### 5. Factors influencing health choices

- **Self-esteem:** how were you feeling about yourself when you made these decisions?
- **Social influences:** did anyone else influence this particular decision? If so, how and why?
- **Control:** did you feel in control of what was going on in your life when you made these decisions?
- **Finances:** did money worries influence your decisions? If so, how?
- **Stress:** How do your stress levels influence decisions that may be good or bad for your health?

*By the end of this section of the discussion, ensure that:*

- *all respondents have contributed;*
- *a range of health behaviours have been discussed; and*
- *decisions involving more than one health behaviour have been fully explored.*

#### 6. Views about overall health

*Having completed the diary exercise, what did you learn about yourself?*

- What, if anything, have you found out about your health?
- How would you describe 'normal' health behaviour for your friends/family/age group/society?
- What do girls your age/blokes your age normally do?
- Do you see yourself as fitting in, in comparison with your friends/family/age group/society?
- Have you tried to change?

- Would you like to make any changes to improve your health? If so, what? How would you go about making these changes?

Break for 15 min

## Part E: Interventions – service delivery (30 min)

*Different people are likely to have different preferences in terms of how they go about making changes in their lives. I'd like to discuss a number of different ideas to find out which type of approach to delivering services you'd find most relevant and motivating.*

### 7. Approach

- **Single issues:** would a service focusing on specific issues be of interest to you (e.g. diet, exercise, smoking, physical activity, drinking/drugs, sexual health)?
- If so, which specific issues would be relevant and why?
- **Linked behaviour:** Ask respondents to write down their own linked behaviours – 'when two or more health decisions come together' – once written, ask respondents to explain the behaviours.
- Why are these behaviours linked?
- Would a service focusing on linked behaviour be relevant to you?
- Share Vitality project example (Stimulus D)
- Would this type of service appeal? Would you consider using it? Why/why not?
- **Wellness:** would a focus on 'wellness' be motivating?
- Share GO Wellness service example (Stimulus E)

- Would this type of service appeal? Would you consider using it? Why/why not?
- **Contextual factors:** would a focus on the factors influencing less healthy behaviour be helpful to you?
- For example, parenting: share Family Nurse Partnership example (FNP, Stimulus F) or Bristol transport example (Stimulus G)
- Would this type of support appeal? Why/why not?

### 8. Creating the ideal service

**Projective 4: using the examples already discussed as inspiration (Vitality, GO Wellness, FNP and Bristol transport), ask respondents to decide how they would adapt an existing service to support the changes to their lifestyles they would like to make. The service should be relevant to their age group and locality.**

**Moderator: ensure that respondents have covered each of the following factors when adapting services:**

- whether direct or indirect support is preferred
- where services should be delivered (i.e. location)
- when services should be delivered (i.e. timing)
- how services should deliver their support/assistance (i.e. tone – positive, encouraging vs. challenging, forceful).

## Appendix 7: Balanced Compensators Verification Exercise

I like to look good.

I don't feel in control of my health.

I feel good about myself.

I get a lot of pleasure from taking risks.

I believe what happens with my health is decided by fate.

I am not that motivated by material wealth and possessions.

I think a healthy lifestyle is generally easy and enjoyable.

I believe I am more likely than other people of the same age to become ill.

I like to live for today.

## Appendix 8: Live for Today's Verification Exercise

I like to live for today.

The main thing that affects my health is what I personally do.

I generally focus on the here and now rather than worry about the future.

I feel in control of my health.

I don't think I am any more likely than anyone else to become ill in the future.

I think a healthy lifestyle is generally easy and enjoyable.

I get a lot of pleasure from taking risks.

I feel good about myself.

I believe what happens with my health is decided by fate.



## Appendix 9: Unconfident Fatalists Verification Exercise

I generally focus on the here and now rather than worry about the future.

I feel in control of my health.

Nothing is more important than good health.

I think I am more likely than people of my age to become ill in the future.

I think a healthy lifestyle is generally easy.

I think a healthy lifestyle would be enjoyable.

I get a lot of pleasure from taking risks.

I feel good about myself.

I believe what happens with my health is decided by fate.

# Appendix 10: Hedonistic Immortals Verification Exercise

I feel good about myself.

I generally focus on the here and now rather than worry about the future.

I feel in control of my health.

Nothing is more important than good health.

I am no more likely than other people of my age to become ill in the future.

I think a healthy lifestyle is generally easy.

I think a healthy lifestyle would be enjoyable.

I get a lot of pleasure from taking risks.

I believe what happens with my health is decided by fate.

# Appendix 11: Health-conscious Realists Verification Exercise

I feel good about myself.

I generally focus on the here and now rather than worry about the future.

I feel in control of my health.

I get a lot of pleasure from taking risks.

If you don't have your health, you don't have anything.

I believe what happens with my health is decided by fate.

I am no more or less likely than other people of my age to become ill in the future.

It is important to have an image that others find appealing.

I think a healthy lifestyle would be easy and enjoyable.

# Appendix 12: Key Life Events Stimulus

HOW IT MADE ME BEHAVE			
HOW I FELT			
SIGNIFICANT EVENT			

# APPENDIX 13: The Allocation Questionnaires

## 13.1 The 19-item questionnaire and allocation algorithm

Note: The numbers next to the answers (e.g. '1' next to 'Disagree strongly' at Q1) indicate the coding for input into the questionnaire. They should not be shown on cards or printed questionnaires.

Q1 I am going to read out some things that other people have said. Please tell me how much you agree or disagree with each one.

### SHOW CARD 1

1 = Disagree strongly

2 = Disagree

3 = Disagree slightly

4 = Neither agree nor disagree

5 = Agree slightly

6 = Agree

7 = Agree strongly

Don't know

- I feel good about myself
- I get a lot of pleasure from taking risks
- I generally focus on the here and now rather than worry about the future
- I learn from my mistakes

Q2 I am going to read out some things that other people have said they would like to have or do over the course of their lives. Could you tell me how important each one is to you personally. Please take your answer from this card.

### ROTATE ORDER OF PRESENTATION

### SHOW CARD 2

- To have money, wealth and possessions
- To have an image that others find appealing

7 = Very important

6

5

4

3

2

1 = Not at all important 1

Don't know

**Q3** How much do you agree or disagree with these things?

ROTATE ORDER OF PRESENTATION

SHOW CARD 3

1 = Disagree strongly

2 = Disagree

3 = Disagree slightly

4 = Neither agree nor disagree

5 = Agree slightly

6 = Agree

7 = Agree strongly

Don't know

- Following a healthy lifestyle is an effective way to reduce my chances of becoming ill
- If you don't have your health, you don't have anything
- There is nothing more important than good health
- I'm very involved in my health
- I am in control of my own health
- The main thing which affects my health is what I personally do
- If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway
- I **intend to** lead a healthy lifestyle over the next 12 months

**Q4** For you, would leading a healthy lifestyle be...

SHOW CARD 4

1 = Extremely difficult

2

3

4

5

6

7 = Extremely easy

Don't know

**Q5** How much control do you believe you have over whether or not you lead a healthy lifestyle over the following year?

SHOW CARD 5

1 = No control

2

3

4

5

6

7 = Complete control

Don't know



Q6 For you, would leading a healthy lifestyle be...

SHOW CARD 6

1 = Not enjoyable

2

3

4

5

6

7 = Enjoyable

Don't know

Q7 And still thinking about your own lifestyle at the moment, which of the statements on this card best describes your view?

SHOW CARD 7

If I don't lead a healthy lifestyle, my health could be at risk...

5 = In the next 12 months

4 = In the next few years

3 = In the next 10–20 years

2 = Much later in my life

1 = Not at all

Don't know

Prefer not to answer

Q8 Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years?

SHOW CARD 8

5 = I am much more likely to get seriously ill than other people of my age

4 = I am a little more likely

3 = No more or less likely

2 = I am a little less likely

1 = I am much less likely to get seriously ill than other people of my age

Not applicable/Already have a serious illness

Don't know

## The 19-item allocation model (88% accuracy)

1. Code responses to each question as described in the grid below.
2. Use the grid below to obtain a score for each segment. For each respondent and each segment (i.e. each column) in turn, multiply each response code by the respective coefficient. Add all these products together. Then add the constant to this number to obtain a score for each respondent for each segment.
3. The respondent is then allocated to the segment which has the **highest** score  
(Cluster 1 = Hedonistic Immortals; Cluster 2 = Live for Today's; Cluster 3 = Unconfident Fatalists; Cluster 4 = Health-conscious Realists; Cluster 5 = Balanced Compensators).

An allocation spreadsheet has been developed and is available from the Department of Health website. Feed the responses to each of the questions into the spreadsheet and the segment allocation is calculated for you.

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q1) I feel good about myself 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	3.0054	2.9373	2.1103	2.9960	2.8211
(Q1) I get a lot of pleasure from taking risks 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	0.9756	0.7416	0.6647	0.4300	0.7260
(Q1) I generally focus on the here and now rather than worry about the future 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	0.3880	0.8898	0.6723	0.0462	0.4494

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q1) I learn from my mistakes 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	6.9780	6.7493	4.8281	6.7917	7.1311
(Q2) Could you tell me how important the following is to you personally: to have money, wealth and possessions 1 = Not at all important 2 3 4 5 6 7 = Very important	1.3387	1.5221	1.6213	1.1826	1.7175
(Q2) Could you tell me how important the following is to you personally: to have an image that others find appealing 1 = Not at all important 2 3 4 5 6 7 = Very important	0.5705	0.4362	0.3680	0.1444	0.6200
(Q3) Following a healthy lifestyle is an effective way to reduce my chances of becoming ill 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	3.9102	3.3240	3.3488	3.7575	3.7178

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q3) If you don't have your health, you don't have anything 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	-0.0053	1.3511	1.3329	1.6369	1.5452
(Q3) There is nothing more important than good health 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	-0.2029	0.9837	1.1286	1.1017	1.0732
(Q3) I'm very involved in my health 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	0.4232	0.2637	0.6409	0.5659	0.7349
(Q3) I am in control of my own health 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	1.2251	1.0090	0.3294	0.9939	0.9553

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q3) The main thing which affects my health is what I personally do 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	2.0940	2.0776	1.6065	2.1340	2.1522
(Q3) If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	0.1762	1.1370	0.6954	0.0507	0.5696
(Q3) <b>I intend to</b> lead a healthy lifestyle over the next 12 months 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	4.3811	3.6399	4.0125	4.3116	4.3971
(Q4) For you, would leading a healthy lifestyle be... 1 = Extremely difficult 2 3 4 5 6 7 = Extremely easy	1.2142	0.9830	0.6126	1.2246	1.0701

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q5) How much control do you believe you have over whether or not you lead a healthy lifestyle over the following year? 1 = No control 2 3 4 5 6 7 = Complete control	2.6680	2.5149	2.2773	2.7067	2.7283
(Q6) For you, would leading a healthy lifestyle be... 1 = Not enjoyable 2 3 4 5 6 7 = Enjoyable	0.8041	0.3567	0.8252	1.0223	1.0085
(Q7) If I don't lead a healthy lifestyle, my health could be at risk... 5 = In the next 12 months 4 = In the next few years 3 = In the next 10–20 years 2 = Much later in my life 1 = Not at all	1.9662	1.4627	3.0454	2.4288	0.7983
(Q8) Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years? 5 = I am much more likely to get seriously ill than other people of my age 4 = I am a little more likely 3 = No more or less likely 2 = I am a little less likely 1 = I am much less likely to get seriously ill than other people of my age	5.6337	5.3904	6.5177	5.4566	3.2765
Constant	–97.6558	–95.9594	–86.4225	–105.0422	–104.4905



## 13.2 The 6-item questionnaire and allocation algorithm

Note: The numbers next to the answers (e.g. '1' next to 'Disagree strongly' at Q1) indicate the coding for input into the questionnaire. They should not be shown on cards or printed questionnaires.

**Q1** I am going to read out some things that people have said. Please could you tell me how much you agree or disagree with each one.

### SHOW CARD 1

1 = Disagree strongly

2 = Disagree

3 = Disagree slightly

4 = Neither agree nor disagree

5 = Agree slightly

6 = Agree

7 = Agree strongly

Don't know

- I learn from my mistakes – THIS ALWAYS COMES FIRST, OTHER THREE ROTATE
- If you don't have your health you don't have anything
- There is nothing more important than good health
- If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway

**Q2** People think differently about their health and how it might change in the future, and the next question is about that subject. Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years?

### SHOW CARD 2

5 = I am much more likely to get seriously ill than other people of my age

4 = I am a little more likely

3 = No more or less likely

2 = I am a little less likely

1 = I am much less likely to get seriously ill than other people of my age

Not applicable/Already have a serious illness

Don't know

Q3 And still thinking about your own lifestyle at the moment, which of the statements on this card best describes your view? If I don't lead a healthy lifestyle, my health could be at risk...

SHOW CARD 3

5 = In the next 12 months

4 = In the next few years

3 = In the next 10–20 years

2 = Much later in my life

1 = Not at all

Don't know

Prefer not to answer

## The 6-item allocation model (67% accuracy)

1. Code responses to each question as described in the grid below.
2. Use the grid below to obtain a score for each segment. For each respondent and each segment (i.e. each column) in turn, multiply each response code by the respective coefficient. Add all these products together. Then add the constant to this number to obtain a score for each respondent for each segment.
3. The respondent is then allocated to the segment which has the **highest** score.

An allocation spreadsheet has been developed and is available from the Department of Health website. Feed the responses to each of the questions into the spreadsheet and the segment allocation is calculated for you.

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q1) I learn from my mistakes 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	8.0975	8.0163	6.5261	8.0475	8.3603
(Q1) If you don't have your health, you don't have anything 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	1.2754	2.5556	2.3325	2.7361	2.7461
(Q1) There is nothing more important than good health 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	2.1545	3.1711	3.2080	3.3574	3.5057

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
(Q1) If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway 1 = Disagree strongly 2 = Disagree 3 = Disagree slightly 4 = Neither agree nor disagree 5 = Agree slightly 6 = Agree 7 = Agree strongly	1.0131	1.8549	1.4578	0.9104	1.3904
(Q2) Compared with other people, how likely do you think it is that you will get seriously ill over the next few years? 5 = I am much more likely to get seriously ill than other people 4 = I am a little more likely 3 = No more or less likely 2 = I am a little less likely 1 = I am much less likely to get seriously ill than other people	7.2353	7.2275	5.8584	7.3693	9.3918
(Q3) If I don't lead a healthy lifestyle, my health could be at risk... 5 = In the next 12 months 4 = In the next few years 3 = In the next 10–20 years 2 = Much later in my life 1 = Not at all	5.6543	6.3751	4.9042	5.3105	6.8069
Constant	–51.8623	–66.2656	–48.3473	–63.1987	–79.1493

# Appendix 14: The Short Recruitment Questionnaire

QA. Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years? (Q1)	
I am much less likely to get seriously ill than other people	Balanced Compensators
I am a little less likely	Go to QB
No more or less likely	Go to QD
I am a little more likely	Go to QH
I am much more likely	Unconfident Fatalists

QD. Agreement with – If you don't have your health, you don't have anything (Q3)	
Disagree strongly	Hedonistic Immortals
Disagree	
Disagree slightly	
Neither agree nor disagree	Go to QE
Agree slightly	Go to QF
Agree	
Agree strongly	Go to QG

QB. Agreement with – If you don't have your health, you don't have anything (Q3)	
Disagree strongly	Hedonistic Immortals
Disagree	
Disagree slightly	
Neither agree nor disagree	
Agree slightly	
Agree	Go to QC
Agree strongly	

Q5. Agreement with – If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway (Q3)	
Disagree strongly	Hedonistic Immortals
Disagree	
Disagree slightly	
Neither agree nor disagree	Live for Todays
Agree slightly	
Agree	
Agree strongly	

QC. If I don't lead a healthy lifestyle, my health could be at risk (Q2)	
In the next 12 months	Health-conscious Realists
In the next few years	
In the next 10–20 years	Balanced Compensators
Much later in my life	
Not at all	

Q6. Agreement with – If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway (Q3)	
Disagree strongly	Health-conscious Realists
Disagree	
Disagree slightly	
Neither agree nor disagree	Live for Todays
Agree slightly	
Agree	
Agree strongly	

QG. Agreement with – If a person is meant to get ill, it doesn't matter what a doctor tells them to do, they will get ill anyway (Q3)	
Disagree strongly	Health-conscious Realists
Disagree	
Disagree slightly	
Neither agree nor disagree	
Agree slightly	Live for Today's
Agree	
Agree strongly	

QH. Agreement with – If you don't have your health, you don't have anything (Q3)	
Disagree strongly	Unconfident Fatalists
Disagree	
Disagree slightly	
Neither agree nor disagree	
Agree slightly	Go to QI
Agree	
Agree strongly	

QI. If I don't lead a healthy lifestyle, my health could be at risk (Q2)	
In the next 12 months	Unconfident Fatalists
In the next few years	
In the next 10–20 years	Live for Today's
Much later in my life	
Not at all	



## Appendix 15: Vitality Leaflet



**VITALITY**  
*Your Health & Well-being Service*  
[LOVEVITALITY.ORG](http://www.LOVEVITALITY.ORG)

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### It's Crunch Time!

Feel healthier, fitter and happier with **FREE** support from Vitality!

**With our help you can:**

- Get fit
- Eat well
- Lose weight
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- **FEEL GREAT!**

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Created by your local NHS

### We life!

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- Stop smoking
- Get fit
- **Feel great!**

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**Tainted**



Smoking is totally one-sided. You love it. It doesn't love you. What a killer.

Love to stop smoking?

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Funded by your local NHS



**We love life!**



It's easy to:

- Eat well!
- Lose weight!
- Get fit!
- Feel great!

FREE advice and support, courses, programmes, group activities and much more...

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# Appendix 16: GO Men's Health Check Service

The GO Men's Health Check encourages men to take better care of their health and to make more use of available health services. It was developed to offer a variety of activities to men, from health screening to participation in men-only health groups.

The service provides a one-stop health check done immediately, either at a doctor's surgery or pharmacist.

Men attending can receive a free 20–25-minute check-up that includes:

- blood pressure measurement
- finger pin-prick sample of blood taken to check cholesterol and blood glucose levels
- BMI and waist measurement
- personal and lifestyle advice on smoking, alcohol, diet and exercise, with the aim of giving men and their families greater control over their lives and health.

The results are then analysed and explained to the man in question immediately. With his consent, results are sent to his doctor who can then refer him to other services that may be of benefit.

Research shows that men who have attended a health check are very likely to attend a follow-up and would recommend it to other men. Research with doctors also shows that they are happy with the health check service and that it benefits people who would otherwise not come to see them.



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