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The social context of change in tobacco consumption following the introduction of 'smokefree' England legislation: A qualitative, longitudinal study

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ABSTRACT

Legislation implemented in England on 1st July 2007 to prohibit smoking in enclosed public places aimed primarily to limit exposure to second-hand smoke, thereby reducing smoking-related morbidity and mortality. We conducted a qualitative study between April 2007 and December 2008 in six contrasting localities in two metropolitan areas in the north and south of England, which examined the impact of the legislation on individuals, families and communities. Using a multi-level longitudinal case study design, we collected data at community and individual levels, from three months prior to the legislation to a year after its enactment through a range of methods, including semi-structured interviews with panel informants and observations in locality settings. Drawing on theoretical understandings of the relationship between structure, agency and practice, this paper examines the social and cultural contexts of change in tobacco consumption. Observations in a variety of community settings identified reduced smoking in public places post-legislation. More than half of panel informants reported decreased consumption at one year post-legislation; a minority had quit, maintained or increased their smoking levels. The dominant pattern of reduced consumption was attributed primarily to constraints imposed by the legislation. This suggests that the law may have provided an impetus for some smokers to cut down or quit. Smoking behaviour was, however, strongly influenced by the social networks in which smokers were embedded, indicating that, while individuals had the power to act, any changes they made were largely shaped by social structural factors. Our findings support the need for a comprehensive tobacco control strategy that takes account of the complex array of contextual factors that constrain and enable smoking.

Background

Legislation prohibiting smoking in enclosed public places in England came into force on 1st July 2007 ('smokefree England' (Department of Health, 2008)). Its main aim was to reduce exposure to second-hand smoke, which has been shown to be detrimental to health (Department of Health, 2008; Tobacco Task Group, 2005). As part of a comprehensive approach to tobacco control in other countries, laws that restrict smoking in public places have enhanced opportunities for quitting and promoted reductions in consumption (Albers, Siegel, Cheng, Biener, & Rigotti, 2007; Chapman et al., 1999; Elton & Campbell, 2008; Gallus et al., 2006; Ministry of Health, 2006). In Scotland, where legislation was implemented in 2006, a comprehensive evaluation strategy was developed to assess its impact (Haw et al., 2006) and several major studies were undertaken, including a qualitative longitudinal investigation using a case study approach which explored change in four contrasting communities (Martin, Ritchie, & Amos, 2008; Ritchie, Amos, & Martin, 2010).

Building on the experience of the Scottish community study, the Evaluation of Smokefree England (ESME) study (Platt et al., 2009) was designed to include a greater number and range of communities in the north and south of the country and to include sub-groups, such as ethnic minorities and young people, which are likely to be particularly affected by smoking legislation (Wiltshire, Amos, Haw, & McNeill, 2005; Wiltshire, Bancroft, Parry, & Amos, 2003).

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Introduction

Social theorists working in the field of public health have pointed to the need to develop a sociologically meaningful definition of context that brings together notions of 'space' (a three-dimensional physical environment in which objects and events occur) and 'place' (space invested with human meaning and significance) (Christensen & Prout, 2003; Frohlich, Corin, & Potvin, 2001). Cummins, Curtis, Diez-Roux, and Macintyre (2007) argue for the need to understand the relationship between place and health in order to be able to deliver policy interventions that are sensitive to context. Furthermore, in order to understand the impact of context on disease, it has been argued that it is important to examine the relationship between structure, agency and practice (Cockerham, 2005; Frohlich et al., 2001; Frohlich, Potvin, Chabot, & Corin, 2002). Frohlich et al. define social structure as "the factors involving individuals' relationships to each other and the attendant power relations" (Frohlich et al., 2002, p. 1403). Structure is constituted by the rules and resources that govern social life (Giddens, 1984), including positions occupied within society's socio-economic structures, e.g. social class, ethnicity, gender, education and family. Agency is defined as human action involving the exercise of power (Giddens, 1984), while social practice is the reflexive human activity that makes and transforms the world (Frohlich et al., 2002). The debate about whether human behaviour is primarily determined by social structure or individual agency has a long history in sociology. Theorists such as Giddens have focused on structure and agency as complementary forces. Structure plays an important role in constructing choices for people as well as imposing constraints on their practices. Structure is not possible without action because action produces structure. Individuals 'act out' the structure in their practices and these practices feed into the larger system, which, in turn, recreates the conditions that make structure possible (Frohlich et al., 2002).

Based on this theoretical framework, Frohlich et al. (2002) developed a "heuristic tool" which they called "collective lifestyles." They reject the biomedical conceptualisation of health-related behaviours as discrete and individualistic; rather, they are treated as "generated practices – practices that both reinforce and emerge from the context" (Frohlich et al., 2001, p. 785). Thus, cigarette smoking is conceptualised as a social practice and collective lifestyle behaviour because it is a "shared way of relating and acting in a given environment" (Frohlich et al., 2001, p. 791; see also Poland et al., 2006).

Drawing on theoretical understandings of the relationship between structure, agency and practice, this paper examines the social and cultural contexts of change in tobacco consumption following the implementation of smokefree England legislation. The data presented here are derived from interviews with panel informants and observations in public places both before and after the legislation and constitute a subset of the data collected for this study.

Methods

Research design

We conducted a longitudinal qualitative study between April 2007 and December 2008, covering both the pre- and post-legislation phases of smokefree England. The views, attitudes and experiences of individuals, families, key target groups and communities were explored using a multi-level longitudinal case study approach (Woodfield, Molloy, & Bacon, 2003). We collected data through a range of qualitative methods, including repeat interviews with panel informants and key stakeholders, observations in community venues, and focus groups with sampled community populations. The principal method was repeated interviews with a purposively selected panel of adults who were regular smokers or recent ex-smokers, comprising mixed age groups, both genders, and with a significant ethnic minority representation. This provided the opportunity to explore micro-level changes over time and develop a detailed picture as to how individuals' attitudes, beliefs and behaviours responded differentially to a changing context. Observations in community venues provided information about what was happening in a range of public settings in relation to the smokefree England legislation (Petticrew et al., 2007).

Locality selection

The two case study areas, both large metropolitan conurbations (in the north and south of England), and the six localities (three in each area) were purposively selected (using Census ward statistics) to ensure variation in respect of urbanity/semi-rurality, ethnicity, SES and smoking prevalence. The localities were of comparable population size (apart from locality 6, which had a considerably smaller population but had the appropriate socio-economic profile) and formed discrete 'communities' where people live and socialise. Neither areas nor localities have been named in order to protect the identity of study participants. There was marked variation between and within localities in respect of their history, socio-economic composition and demographic characteristics.

The localities

South. Locality 1: a lively, vibrant, inner city environment, with markets, restaurants, bars and boutiques popular with locals and tourists. The area is densely built-up with a significant Bangladeshi population, many of whom live in crowded conditions on council estates. *Locality 2*: an ethnically and socio-economically mixed inner city locality, with large houses for the more affluent in close proximity to housing estates. Several small shops, ethnic cafes, public houses, bookmakers and a university campus line the main thoroughfare. *Locality 3*: a socio-economically advantaged outer city locality, part of one of the least ethnically diverse boroughs in the city. Tree-lined streets are crossed by two main thoroughfares lined with many small specialist shops, cafes and restaurants, some of which were smokefree prior to the legislation.

North. Locality 4: close to the city centre, with considerable ethnic diversity, including Pakistani, Bangladeshi and Czech communities. Part of the locality is currently subject to regeneration efforts and many parts of the locality appear run-down. *Locality 5*: an inner city locality of two halves. One part has a feeling of faded grandeur: the main street is lined with bookmakers, amusement arcades, a range of shops and many small cafes and pubs. The other part is populated largely by students: pleasant cafes, charity shops, banks, restaurants and other small businesses line the main thoroughfare. *Locality 6*: a small attractive market town close to a major city with a full range of amenities, including an attractive park, leisure centre and library and many cafes, restaurants and shops. Popular with tourists, anti-social behaviour is actively discouraged.

Panel recruitment and interview content

Panels of respondents were recruited by a professional research agency using a tight specification. For each locality, a recruitment grid was developed and informants were defined, in the first instance, in terms of their current smoking status (smokes daily or has quit smoking within last 12 months), age and gender. Panel members were recruited using door-step and direct recruitment methods in selected public places. The panel was intended to