

Evaluation Report

Evaluation of the adoption and implementation of the Christchurch City Council smokefree social housing policy



An evaluation report prepared for
Smokefree ABC Team, CDHB /Smokefree Canterbury
by the Information Team,
Community and Public Health, CDHB
April 2016

Canterbury
District Health Board
Te Poari Hauora o Waitaha

Community and Public Health

Main Office

310 Manchester Street

Christchurch

New Zealand

PO Box 1475

Christchurch 8140

New Zealand

Phone: +64 3 364 1777

Fax: +64 3 379 6125

www.cph.co.nz

The information contained in this document may be derived from a number of sources. Although the CDHB has taken reasonable steps to ensure that the information is accurate, it accepts no liability or responsibility for any acts or omissions, done or omitted in reliance in whole or in part, on the information. Further, the contents of the document should be considered in relation to the time of its publication, as new evidence may have become available since publication. The Canterbury District Health Board accepts no responsibility for the manner in which this information is subsequently used.

© Canterbury District Health Board, 2016

Front page Te Pae Mahutonga graphics courtesy of Healthy Christchurch.

Contents

Executive Summary	1
Background	1
Methods	1
Results	2
Discussion	2
Conclusion	3
Recommendations	3
Background	4
Public health impact of smoking	4
Population-level approaches to tobacco control	4
Policy instruments, and the evolution of the Health in all Policies (HiAP) approach	5
The Joint Work Plan	6
Smokefree multi-unit housing environments	6
Third-hand smoke	7
Evidence for the impact of smokefree social housing policies on smoking behaviour	8
Social housing in Christchurch	8
Programme aim	9
Methods	11
Evaluation Aim	11
Process evaluation objectives	12
Quantitative/Qualitative methodology	13
Results	15
Objective 1: Rationale	16
Objective 2: Partnership	20
Objective 3: Operational detail	26
Objective 4: Refurbishment and maintenance issues	29
Objective 5: Population demographics	32
Objective 6: Prevalence of smoking	34
Objective 7: Characteristics of the housing stock	37
Objective 8: Views of key stakeholders	41
Objective 9: Unintended consequences	57
Objective 10: Modifications to the policy/implementation	58
Objective 11: Equity	59
Discussion	62
Conclusion	72
Recommendations	73
References	76
Appendix	79
Survey and interview questions	79

Executive Summary

Background

Tobacco smoking continues to be a major public health problem in New Zealand. In spite of dramatic declines in tobacco use among New Zealanders in recent years, people of lower socioeconomic status continue to have higher smoking prevalence than those in more socioeconomically advantaged groups. Tobacco eradication measures need to focus more intensely on socioeconomically deprived populations to overcome the contextual inducements to initiate smoking and the barriers to successful cessation. Overall, the promotion of smokefree environments in New Zealand plays a key role in tobacco control, as these environments change social norms regarding the acceptability of smoking. Smokefree environment policies have been consistently associated with reductions in smoking, reductions in second-hand smoke exposure and the related adverse health outcomes. New Zealand's goal is to reduce the prevalence of smoking and the availability of tobacco products to minimum levels by 2025.

Applying novel smokefree policies in new contexts is seen as a valuable strategy for reducing disparities in smoking-related outcomes in disadvantaged populations (including Māori). Increasingly, improving population health has become a shared goal across many sectors (and progressively, using a Health in All policies approach). The Health in all Policies (HiAP) approach is derived from the Ottawa Charter for Health Promotion (1986) and is a further innovation on earlier joined-up approaches to public policy. Partnerships are central to the HiAP approach, along with a focus on win–win outcomes or so called co-benefits or mutual gains. The ultimate goal of HiAP is to achieve health gains (in this case via the provision of smokefree environments and stop-smoking support, providing benefits for both smokers and non-smokers) while also enhancing the non-health interests and intentions of the various sectors or agencies involved (the project partners).

The Christchurch City Council (CCC) maintains a large portfolio of social housing and has been an early adopter of a smokefree housing policy established by means of the HiAP (partnership) approach. The CCC's smokefree social housing policy is a partial smoking ban that restricts tenants to smoking outside of their units (smoking on patios and balconies and in common garden areas is permitted). The policy implementation specifically includes the offer of smoking stop-smoking support or nicotine management to tenants who smoke. Implementation is ongoing on a contract-by-contract basis (i.e. all *new* tenants sign a contract that includes the no-smoking rule, or alternatively, the no-smoking rule may be triggered by redecoration or refurbishment).

Despite a growing body of international evidence, the effects of implementing a smokefree housing policy in a New Zealand social housing context have not previously been studied. This process evaluation presents findings on the merit, worth, importance and implementation of this smokefree policy— to inform the future refinement of the programme and to inform the development and implementation of similar partnership-based (HiAP) initiatives.

Methods

The evaluation used mixed methods to assess and describe the consultative/collaborative approach employed by the Christchurch City Council, Community and Public Health (CPH, a division of CDHB), and Smokefree Canterbury members/partners in the development and implementation of the policy and the benefits of working collaboratively (the partnership). The evaluation assessed the extent to which the

programme has been/is being implemented and the extent to which the policy is achieving the goal of providing healthier environments for existing and future CCC social housing tenants. The evaluation utilised on-line surveys, a pen-and-paper survey, semi-structured qualitative interviews, document review, database reviews, a website review, and observational site visits to collect data. Data collection was undertaken with consideration given to potential ethical, privacy, confidentiality and equity issues and in accordance with the CDHB's commitment to the Treaty of Waitangi. Data were analysed using a range of quantitative and qualitative data analysis techniques.

Results

The findings of this evaluation suggest that the implementation of a (soft regulatory prospective roll-out) smokefree policy in the Christchurch City Council's portfolio of subsidised multi-unit housing complexes was generally accepted and complied with by tenants. Survey and interview results also indicated that the scope of the policy (as implemented) was "about right" and that policy implementation had progressed smoothly. Overall, 87% of the 788 tenants (non-smokers and smokers) who responded to the tenants' survey indicated that they supported the policy. A smoking prevalence of 24% was self-reported by respondents and this equates to a prevalence approximately ten percentage points above the New Zealand general population. In the 25-49 years age range, 37% of respondents self-reported that they were current smokers. Interview and survey results indicated high levels of support for the policy from Tenancy Advisors. Tenancy Advisors reported that they had been adequately trained in providing stop-smoking support (cessation support) and that they were generally comfortable with providing support, however, the results indicated that the real-world delivery of smoking cessation interventions is likely inconsistent.

The Council's smokefree policy is deemed relatively 'soft' and non-coercive in comparison with similar policies internationally (and this appropriately reflects the sensitivity of the tenant population). The policy is likely to result in reduced third-hand smoke damage to units and may potentially increase cessation-related behaviours among smokers over the long term. In addition, long-term sustained implementation of the policy should result in reduced operating costs for the housing provider (including fire damage and insurance costs). These benefits will likely accrue slowly, which is not unexpected given the incremental implementation of the no-smoking rule. Continued effort will be required over years, and the effect size may be modest until a critical mass of no-smoking contracts has accrued.

Discussion

This smokefree initiative blends people, place and policy to achieve both health and non-health outcomes, and the partnership process is an example of the HiAP approach in action in a community context. The HiAP approach used in this project explicitly focused on win-win outcomes via a partnership between three key stakeholders: the Christchurch City Council, Community and Public Health (a division of the CDHB) and Smokefree Canterbury. This partnership is discussed in detail in the body of this report. Key features of the partnership included strong senior-level commitment, clear purpose, trust and a complementary mix of skills and knowledge. Grounded in the HiAP framework, the project resulted in significant relationship-building and institutional capacity-building across the partners (not just the non-health partner). The project also resulted in the implementation of the systems, procedures and practical tasks necessary to operationalise the no-smoking rule. These operational tasks are also discussed in detail within the report with respect to the particular characteristics of this sensitive and vulnerable tenant population and the characteristics of the built environment. There is considerable potential to target a difficult-to-reach population with stop-smoking support in conjunction with this policy.

Conclusion

This evaluation project has assessed the process of developing and implementing a no-smoking rule in a social housing context. The findings support the establishment of smokefree policies in subsidised social housing in New Zealand, as a useful and viable strategy to reduce the tobacco burden among low socioeconomic status populations. However, for smoking to be eliminated entirely (or to reach the $\leq 5\%$ level), then at least moderate levels of resources need to be devoted to staff training and the systematic delivery of stop-smoking support, follow-up, and perhaps enforcement.

Smokefree policies in subsidised housing are unlikely to worsen socioeconomic disparities¹. The CCC's no-smoking policy only prohibits the act of smoking indoors, not the occupation of units by people who smoke, and as such is unlikely to displace or otherwise adversely affect residents who continue to smoke. Further, international research suggests that such policies can help motivate smoking cessation and reduce cigarette consumption. The current no-smoking rule was considered appropriate and reasonable ("about right") by managers, Tenancy Advisors and tenants (with regard to restrictiveness and coercion, fairness and enforcement actions). This evaluation has confirmed the utility of the smokefree policy.

Recommendations

A number of opportunities exist for the further refinement of the human resources and systems that underpin this programme, and further co-benefits may be possible. Detailed recommendations are provided at the end of the report and these recommendations cover the key areas of administrative and operational systems, future refinement of the policy parameters, and the strengthening and further development of the partnerships (CCC – CDHB – Smokefree Canterbury). A range of recommendations are also made relating to the ongoing systematic and sustainable 'embedding' of the policy and the provision of culturally appropriate stop-smoking support to all tenants who smoke, including an emphasis on the needs of Māori.

¹ However, ethnicity-based disparities could not be rigorously investigated in this evaluation.

Background

Public health impact of smoking

Tobacco smoking continues to be a major public health problem in New Zealand. In addition to causing around 5000 deaths each year (Ministry of Health, 2013), it is a leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health (Ministry of Health, 2014b). In addition, second-hand smoke causes premature death and disease in children and in adults who do not smoke. The scientific evidence indicates that there is no risk-free level of exposure to second-hand smoke. Recent evidence also implicates the role of third-hand smoke (THS) in contributing to health problems (Community & Public Health, 2016; Ferrante et al., 2013). Third-hand smoke results from nicotine and other substances left behind on surfaces after exposure to smoke, which continue to emit toxins (discussed below).²

Stopping smoking confers immediate health benefits on anyone who smokes (Ministry of Health, 2014b). In spite of dramatic declines in tobacco use among New Zealanders in recent years (from ≈24% in 2003 to ≈15% in 2013) (Ministry of Health, 2004, 2014a), people of lower socioeconomic status (SES) continue to have high smoking prevalence (for example, in 2013, the smoking prevalence in areas of high socioeconomic deprivation was over 30% compared to ≈12% in areas with the lowest levels of deprivation)³. Ivory et al. (2015) argue that to be truly effective, tobacco eradication measures need to focus more intensely on deprived areas to overcome the contextual inducements to initiate smoking and the barriers to successful cessation. Overall, the promotion of smokefree environments in New Zealand plays a key role in tobacco control, as these environments change social norms regarding the acceptability of smoking. Smokefree policies have been consistently associated with reductions in smoking behaviour, reductions in second-hand smoke (SHS) exposure and the related adverse health outcomes⁴ (Hoffman & Tan, 2015).

Population-level approaches to tobacco control

Many countries have achieved substantial declines in smoking and tobacco-related disease through the implementation of comprehensive tobacco control programs. Tobacco control efforts have evolved over time as evidence has grown to support the use of different approaches (Levy, Hyland, Higbee, Remer, & Compton, 2007). The population-based approaches most commonly used include increased taxes, public education through mass media campaigns and health warnings, tobacco marketing restrictions and packaging requirements, youth access restrictions, and the introduction of smokefree indoor and outdoor environments (Koh, Joossens, & Connolly, 2007).

Internationally, there seems to be a growing interest in setting tobacco endgame goals; planning towards achieving close-to-zero prevalence of tobacco use within a specific timeframe (Malone, McDaniel, & Smith, 2014). More recently, some experts have called for a tobacco-free world by 2040, stating that this goal is socially desirable, technically feasible, and could become politically practical (Beaglehole, Bonita, Yach, Mackay, & Reddy, 2015). Thomson et al. (2012) suggest that a prevalence level of 15% (or less) adult tobacco use provides a situation or context where smoking is sufficiently 'non-normal' for governments to plan for an end to tobacco use. California, Canada, Sweden, Australia and New Zealand have all made

² THS consists of pollutants that remain on surfaces and in dust after tobacco has been smoked, are re-emitted into the gas-phase, or react with other compounds in the environment to form secondary pollutants (Ferrante et al. 2013).

³ <http://www.health.govt.nz/system/files/documents/publications/annual-update-key-results-nzhs-2013-14-dec14.pdf>

⁴ Smokefree policies and tobacco taxation may be the two most important interventions.

world-leading progress in the reduction of smoking prevalence. There is now clear evidence for the effectiveness of increasing tobacco prices, and moderate evidence for smoking bans in public places and anti-tobacco mass media campaigns (Wilson et al., 2012). Levy et al. (2007) estimate that about 60% of the effect of policies on prevalence is attributable to price (US data), with clean air laws and media also playing important roles. Further, Finland has moved beyond aspirational goals, being the first country in the world to set the endgame objective by law (Tobacco Control Act of 2010)⁵ New Zealand's goal is to reduce the prevalence of smoking and the availability of tobacco products to minimum levels by 2025⁶ (which is often interpreted as reaching a smoking prevalence of below 5%). Such aspirations require strong and visionary political leadership (Thomson et al., 2012) and rely on hard-won fundamental shifts in social norms (Koh et al., 2007). To this end, priority populations (including those who are most disadvantaged) need support to make the 2025 goal a reality and to ensure that such populations are not increasingly marginalised.

Policy instruments, and the evolution of the Health in all Policies (HiAP) approach

Despite the effectiveness of current tobacco control measures in New Zealand, reducing the large inequalities in smoking prevalence between Māori and non-Māori will probably require the implementation of still more intense and/or entirely novel tobacco endgame strategies (van der Deen, Ikeda, Cobiac, Wilson, & Blakely, 2014). Applying novel smokefree policies in new contexts is seen as a potentially valuable strategy. Policies are intended to influence the real world by guiding the decisions that are made, and the evolution of policy instruments in the domain of health has now progressed through three broad and overlapping stages. Firstly, in 1978, the Alma-Ata Declaration on Primary Health Care (WHO, 1978) called for 'intersectoral action' or for the health sector to look beyond its role of acute medical care and consider how to deal with the actual causes of people's ill health (the social determinants of health). Moving beyond Alma-Ata, the next major development was the Ottawa Charter for Health Promotion, which called for the development of healthy public policy, not just health policy; considering a range of approaches across all policy environments, to bring about improvements in health and wellbeing (WHO, 1986). Health in all Policies (HiAP) is a further innovation on these earlier joined-up approaches to public policy, taking as a starting point the crucial role that health plays in the economic life of a society. Health has become a major economic (sustainability) and social driving force, and improving population health has therefore become a shared goal across many sectors. HiAP is concerned with the health impacts of policy across all sectors, and provides a lever for governments to address the key determinants of health through a systematic approach (Kickbusch, 2008).

HiAP has been defined as "*an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity*" (WHO, 2013). Central to the HiAP approach is the focus on win-win outcomes (also referred to as mutual gains and co-benefits). The ultimate goal of HiAP is to achieve health gains while also enhancing the non-health interests and intentions of the various sectors or agencies involved (i.e. non-health sectors can still invest full attention in their own agendas, and achieve both health and non-health benefits for populations) (Kickbusch, 2008). Capacity building (institutional capacity) is a key process for implementing a HiAP approach and is contingent on the presence of appropriate and/or adequate human, information, financial or infrastructural resources (often there is also the need for an 'institutional warm-up period'). Additional resources may also be required to

⁵Tobacco-Free Finland the Goal by law: In 2040, no more than 2 percent of the Finnish population will use tobacco products. www.stm.fi/en/welfare/substance_abuse/tobacco

⁶ Which includes the sub-goals of increased quit attempts and increased access to support.

deal with any challenges that emerge in the course of implementing the policy. Actors (e.g. experts, managers, and staff) actually need the capacity to carry out the day-to-day activities related to policy implementation. Successful policy implementation requires both feasibility, and buy-in (to be viewed as legitimate, and to gain acceptance) from all of the project partners (Freiler et al., 2013).

Smokefree Canterbury

Smokefree Canterbury have been working within the CCC processes to raise smoking issues and to develop interventions for more than 15 years (for example progressive adoption of smokefree recreation spaces) and Community and Public Health/CDHB, as a member, has worked particularly closely alongside the Cancer Society to progress relationships and interventions.

The Joint Work Plan

The Joint Work Plan between the Christchurch City Council (CCC) and the Canterbury District Health Board (CDHB), which dates from early 2013, was/is the next step in building on this connection to develop a closer collaborative relationship. Many operational and policy development relationships were already in existence, however, are now more formally recognised through the Joint Work Plan and reported on via the CCC-CDHB Senior Managers quarterly meeting. It is acknowledged that each organisation has different and changing priority areas of work and this Joint Work Plan is intended to be flexible enough to adapt to changing and emerging priorities while also outlining areas where the two organisations may commit to working together in the future. The Joint Work Plan Objectives are –

- Develop collaborative relationships at management and operational levels that support greater understanding of each other's roles and responsibilities.
- Realise opportunities to enhance ways of working together and improve work effectiveness.
- Deepen understanding by both parties of the influence of social, economic, environmental, and cultural factors upon health and wellbeing.

Source: Christchurch City Council and Canterbury District Health Board Joint Work Plan Agreement March 2014, CCC and CDHB internal document.

Smokefree multi-unit housing environments

Internationally, the implementation of smokefree housing policies has tended to evolve in countries with high population densities, where a significant proportion of the population reside in multi-unit housing (for example, the US, where ≈25% of the entire US population reside in multi-unit housing, either government subsidised or free market) (Lemp, 2010). Although smokefree housing policies are becoming widespread in many jurisdictions, 'health' per se is rarely the initial impetus for housing-complex managers to consider implementing a no-smoking rule (most often the impetus is 'cost or complaint'). For example, a recent review of 21 smokefree initiatives in multi-unit housing in California found that increased costs for maintenance⁷ (including fire insurance) was the most commonly cited motivation for moving towards smokefree properties (Lemp, 2010; Ong, Diamant, Zhou, Park, & Kaplan, 2012). However, responding to complaints about second-hand smoke ingress and the health hazards of exposure to second-hand smoke ranked closely in second place in the Californian studies (also, complaints about smoking far outweighed any complaints about actions to prohibit or limit where smoking was allowed). The relatively few published

⁷ The average cost, including materials and labour, of turning over a unit that was lived in by a smoker was estimated to be at least double the cost of a unit lived in by a non-smoker.

studies to date have shown no-smoking policies in subsidised multi-unit housing to be acceptable by both non-smokers and current smokers⁸ (Ballor, Henson, & MacGuire, 2013) and to reduce cigarette smoking and increase quit rates (for example, Pizacani et al. 2012).

Third-hand smoke

Responding to the health hazards of exposure to second-hand smoke has been a major driver of smokefree environmental policies generally.

However, increasingly, third-hand smoke (THS) is also being recognised as a potential public health issue (Community & Public Health, 2016; Ferrante et al., 2013), although the clinical significance and full public health implications of THS have yet to be quantified (Destailats, Singer, Lee, & Gundel, 2006; Matt, Quintana, Zakarian, et al., 2011; Singer BC, 2002; Singer, Hodgson, & Nazaroff, 2003; Singer, Revzan, Hotchi, Hodgson, & Brown, 2004; Sleiman et al., 2010; Thomas et al., 2013). Sleiman et al. (2010) reported the

formation of nicotine-derived carcinogens on indoor surfaces via laboratory and environmental studies, leading to concerns about potential THS hazards. Matt et al. (2011) presented findings that indicate THS accumulates in smokers' homes and persists when smokers move out even after homes remain vacant for two months and are cleaned and prepared for new residents (the toxins being trapped in carpets, upholstery, curtains, pillows, mattresses, and similar materials months after the last smoking has taken place). Thomas et al. (2013) have extended these earlier studies by further analysing surface dust samples from both the homes of smokers and non-smokers, finding tobacco-specific lung carcinogens to be present on surfaces in most homes occupied by smokers. Indoor surfaces can represent a hidden reservoir of toxins that can be re-emitted long after the cessation of active smoking (Ferrante et al., 2013). **Figure 1** shows an example of a housing unit where remediation would undoubtedly be required before it could reasonably be inhabited again. Remediation may involve utilising recognised procedures and technologies to restore internal surfaces to a clean and acceptable standard⁹. No national standard has yet been developed for the remediation of smoke-damaged rental housing.



Figure 1: An example of THS damage

Because of the impact of both second-hand smoke and third-hand smoke, the only way for multiunit housing tenants to avoid absorbing tobacco smoke from neighbours is to live in a smokefree complex and increasingly (in other countries at least) there is great demand for such dwellings (Koster, Brink, & Clemmensen, 2013). Taken together, the laboratory and real-world studies indicate the presence of potentially clinically significant toxins from THS¹⁰ (Matt, Quintana, Destailats, et al., 2011, p.1219).

⁸ Although support for smokefree buildings may be stronger among non-smokers than current smokers.

⁹ Although such standards have not been quantified to date. Remediation could involve any or all of the following procedures: high efficiency particulate air (HEPA) vacuuming; washing of the walls and floors to remove the majority of contamination; cleaning heating, ventilation and air conditioning systems and kitchen or bathroom exhausts; encapsulating walls and ceilings (using oil-based paint, oil-based polyurethane or epoxies); and replacing wall linings and carpets.

¹⁰ Includes inhalation exposure to compounds re-emitted into the air from indoor surfaces (Becquemin et al., 2010).

Although the presence and persistence of THS has been demonstrated, the dose-response relationship (i.e. the actual harm to health for a given exposure to THS) has not yet been quantified. However, results suggest that non-smokers living in homes previously occupied by smokers (without proper cleaning/remediation) are exposed to at least some level of THS and careful consideration should be given to housing sensitive populations (e.g. children, the elderly) (Matt, Quintana, Destailats, et al., 2011)^{11&12}.

Because of the lack of hard evidence on clinical health outcomes, the formation of public policies in response to potential THS health risks (specifically) is in the early stages (Matt, Quintana, Destailats, et al., 2011). However, numerous voluntary private policies have emerged with some major international hotels and car rental companies having adopted complete or partial smoking bans to protect non-smokers from the effects of lingering tobacco smoke. Over time, these policies have grown out of complaints and concerns about unpleasant odour, respiratory symptoms, and eye irritation among hotel guests and customers of rental car companies (Matt et al., 2008). From these examples, it appears that consumer preferences may be at least as important as hard evidence. Given the scientific evidence discussed above, and consumer preferences and expectations, social housing providers may increasingly face challenges around the safety and acceptability of housing units previously occupied by people who smoke.

Evidence for the impact of smokefree social housing policies on smoking behaviour

There is a growing body of international evidence indicating that implementing comprehensive smokefree policies in multi-unit housing complexes is associated with positive changes in cessation-related behaviours and reduced second-hand smoke exposure among social housing tenants (for example see Pizacani, Maher, Rohde, Drach, & Stark, 2012). However, the effects of implementing a smokefree housing policy in a New Zealand social housing context have not been studied. Unlike most other countries, much of New Zealand's subsidised housing has been developed in the form of detached single-family houses (similar to private housing) or more recently in duplex or small block configuration.¹³ This approach to social housing differs radically from the large high-rise clustered developments (superblocks) that are common in other more densely populated countries. In the main, the control of SHS (or dealing with complaints relating to SHS incursions) has been a major driver of smokefree policy implementation in jurisdictions outside of New Zealand. In housing that is detached or semi-detached, SHS incursions are less likely and these contextual factors probably explain the relative lag in the implementation of social housing policies in New Zealand. Individual-level and structural-level differences in these contextual factors may modify the impacts of no-smoking policies across the operational and health domains, possibly leading to different (health) outcomes.

Social housing in Christchurch

The Christchurch City Council was the first local authority in New Zealand to provide social housing, starting in the early 1920s. The purpose of social housing is to meet the housing requirements of those who cannot participate in the private housing market, due to both lack of means and unaffordability¹⁴. Today a wide

¹¹ Human exposure to THS pollutants has not yet been thoroughly studied and the magnitude of the potential health effects of THS relevant to different exposure pathways and profiles has not been fully quantified.

¹² Køster et al. (2013) emphasise that the only way for multiunit housing tenants to totally avoid absorbing tobacco smoke from neighbours is to live in a smokefree complex.

¹³ With some higher density medium-rise building developments, more recently, particularly in Auckland.

¹⁴ Social housing makes up approximately 5% of the total New Zealand housing market and is provided through three main bodies – central government, local government and community based organisations.

range of people are eligible for the Council's social housing service. They include the elderly, disabled persons, sickness or unemployment beneficiaries and people on very low incomes. In general, all of these people have met financial hardship criteria and they are also some of Christchurch's most vulnerable residents¹⁵. Prior to the Canterbury earthquakes in 2010/11, there were 117 complexes and more than 2,640 units throughout Christchurch and Banks Peninsula (reduced to approximately 2,216 units post-earthquakes). The CCC has the second largest portfolio of social housing in New Zealand¹⁶, after Housing New Zealand. While the no-smoking policy was in part introduced as a cost saving measure (a reduction in smoking-attributable damage to internal surfaces and potentially reduced insurance costs), the CCC also recognises the potential health and wellbeing benefits that smokefree environments might offer to CCC social housing tenants¹⁷. The Council invited Smokefree Canterbury to provide guidance for the implementation of the policy. This involvement included opportunities for staff to be trained to engage with tenants about the policy and to offer support to quit or manage their smoking if applicable. Cessation services were also invited to provide support and Aukati Kai Paipa¹⁸ (AKP) is an active partner.

Programme aim

The aim of the programme is to reduce the Council's operating costs for social housing (by modifying where people smoke), to provide healthier environments for existing and future CCC social housing tenants, and to encourage increased smokefree behaviours and increased wellbeing amongst the tenant population. The overall long-term goal is that the programme will result in reduced smoking prevalence in this disadvantaged population and a reduction of exposure to second-hand smoke (SHS) and third-hand smoke (THS) for all smoking and non-smoking residents and visitors. The programme implementation commenced at the beginning of January 2014.

Specific programme (intervention) objectives¹⁹

(1) Cost²⁰: To reduce ongoing operating costs by eliminating smoking-attributable damage to internal surfaces, damage caused directly by burns/fire, and potentially a reduction in insurance premiums for smokefree facilities.

(2) Health (cessation²¹): To create an environment/context that favourably influences and shapes existing and future CCC social housing tenants' (and visitors') smoking behaviours²² (cessation and/or other harm

¹⁵ <http://www.ccc.govt.nz/services/social-housing/social-housing-history/>

¹⁶ The Christchurch City Council is in the process of changing the way social housing is provided, with the formation of a standalone company as a Community Housing Provider.

¹⁷ The CCC would also like to use this project to demonstrate to other CCC teams how partnerships with other organisations can better serve their community.

¹⁸ Aukati Kai Paipa is a free face-to-face stop smoking service that is available in various locations around New Zealand and is based on a Māori framework.

¹⁹ The programme objectives as drawn from the project evaluation plan (CPH & CCC, 2014).

²⁰ Typically, the process of cleaning and refurbishing a housing unit previously occupied by a smoker(s) is significantly more involved, and hence more costly, than in the case of a non-smoking unit. The average difference in refurbishment cost has not yet been quantified due to incomplete data collection, however, significant savings are a realistic expectation (for example, cleaning versus repainting interior walls is one obvious opportunity for reduced expenditure). Savings would be expected to be ongoing.

²¹ Continuous abstinence represents the 'gold standard' of smoking cessation outcomes as it is universally accepted that stopping smoking confers immediate health benefits. However, there are a range of individual-level pre-cursor, preparatory or enabling outcomes that might also be considered as important, including changes in knowledge, attitudes and cessation-related behaviours (e.g. setting quit dates, seeking help, using nicotine replacement therapy).

²² Effectiveness studies of smoking cessation interventions do not need to directly measure changes in individual-level health status as the links between smoking and many disease states have already been well established and validated.

reduction behaviours). The environment/context should exert a favourable influence on tenants' health outcomes via multiple pathways including: environmental modification, social learning/modelling/changing social norms, reduced smoking cues, and the provision of individual level stop-smoking support and interventions.

(3) Health (harm reduction): To create an environment/context that favourably influences and shapes existing and future CCC social housing tenants' (and visitors') smoking behaviours (reduction^{23,24}). The environment/context should also exert a favourable influence on tenants' and visitors' health outcomes via reduced environmental (passive) exposures to second-hand and/or third-hand smoke.

Special notes

— The planning stages and the data collection for this evaluation were undertaken in 2014-15, prior to the CCC's Housing Unit transitioning to a 'Community Housing Provider' (CHP) model (during 2016). Therefore, the CHP as a legal entity is not specifically discussed in this evaluation and the application of the smokefree policy in a CHP context has not been specifically analysed here. However, in principle, applicability to community housing provider models can reasonably be assumed (with or without adaptations as necessary).

— Further, during the evaluation period, the 'pending' transfer to the new CHP model may have influenced the extent to which some system, training and operational tasks were (or were not) embedded into business-as-usual. Anecdotally, the transitional stage caused a level of uncertainty, generally — this may have influenced policy implementation in ways that were not captured by this evaluation.

²³ Interventions may also include nicotine maintenance as a strategy to provide tobacco users concerned about their health with a new option: to substitute, in place of conventional combustible cigarettes, the long-term use of another, potentially less dangerous nicotine-delivery product that can still satisfy the user's nicotine addiction.

²⁴ Harm reduction via a reduction in consumption is also an important and valid concept in public health (alongside cessation/abstinence behaviours).

Methods

Evaluation Aim

An overarching aim of this process evaluation is to assess and report the extent to which the CCC smokefree social housing policy is being implemented and the extent to which it is/has the potential to achieve the goals of reducing operating costs and providing healthier environments for existing and future CCC social housing tenants. This report primarily describes ‘processes’. However, a number of process-related ‘outcome’ measures (such as tenant acceptance and compliance) are used to inform the analysis and discussion around implementation (but tenant-centred smoking outcomes are not specifically included in this report at this time). A secondary aim is to describe the collaborative methods employed by the CCC and CDHB staff in the development and implementation of the policy and to demonstrate the benefits of working collaboratively to other CCC teams and other interested groups. **Figure 2** illustrates the basic evaluation structure employed in this report.

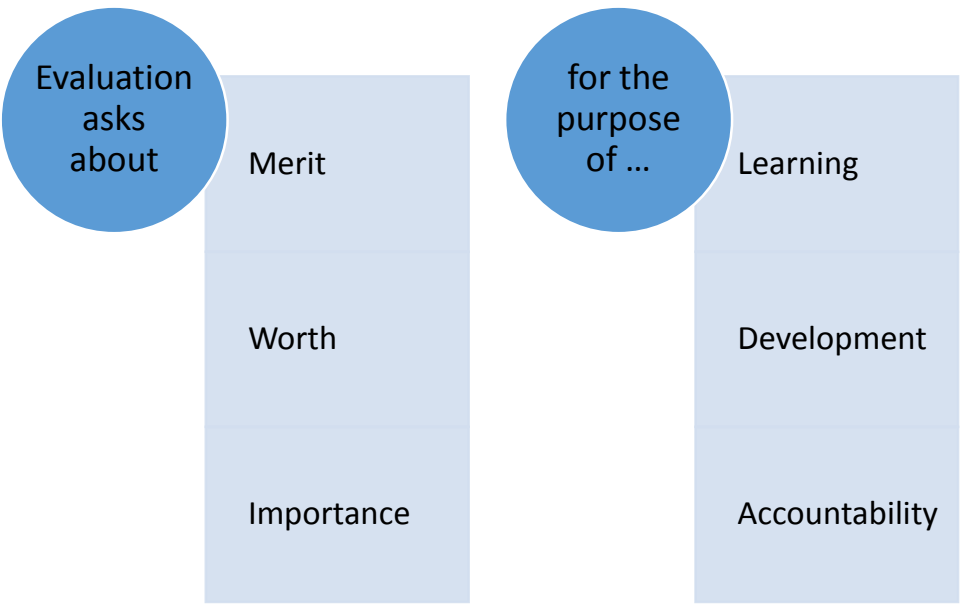


Figure 2: The systematic determination of the quality, value and importance of a programme
Adapted from McKegg (2006).

Process evaluation objectives

To assess and report the process of policy formation and implementation (including the collaborative processes involving CCC and CDHB staff).

Outcome evaluation (not included in this report)

Note: an outcome evaluation is not included in this report, however, four broad objectives are outlined below to indicate the possible scope for future outcome evaluation²⁵.

- To assess and report the extent to which implementation and enforcement has led to compliance.
- To assess and report relevant economic outcomes including: maintenance, insurance and other costs of smoking versus non-smoking units (renovation of units where smoking is permitted and smoking-attributable fires).
- To assess and report the extent to which the policy/environmental change has influenced behaviour (i.e. is there evidence that the policy actually provides a healthier environment?)²⁶.
- To assess and report if the changes have equitable impact on all tenants/potential tenants/disadvantaged populations.

Data collection

Ten main data sources were used in the preparation of this report (**Box 1**). The survey questions for the qualitative interviews and the on-line surveys can be found in **Appendix 1**. Some sections of this report present findings from multiple data sources and these are identified and explained within each relevant section (e.g. some findings are supported by qualitative and quantitative data and/or from multiple interviewees and/or other sources). In some instances, these data sources are cross-referenced in the text to provide clarity.

Box 1: Data sources used for the evaluation

1. On-line survey of CCC Tenancy Advisors.
2. Pen-and-paper survey of tenants (the Tenants' Satisfaction Questionnaire administered by the Housing Unit, Operations Group).
3. Qualitative interviews with tenants.
4. Qualitative interviews with CCC Tenancy Advisors.
5. Qualitative interviews with CCC Housing Unit managers.
6. Qualitative interviews with Smokefree Canterbury participating partners.
7. Document review (CCC documents).
8. Database review (Review of tenant profile database).
9. Site visits (observation).
10. Website review (CCC social housing web pages and other web searchable PDF documents available in the public domain).

²⁵ At a time that allows for sufficiently complete implementation and institutional capacity building to have occurred: following distribution of this process evaluation report and implementation of any of the recommendations provided, including enhanced data collection (perhaps 1-2 years in the future).

²⁶ The policy goes beyond environment in that it uses environmental change partly to drive behavioural change for smokers. Environment, alone, is also relevant to non-smokers.

Stakeholders interviewed

Key stakeholders interviewed included CCC tenants, CCC staff, Community and Public Health staff, Smokefree Canterbury partners, and Health Promotion Agency staff (concept/methods only), with numbers of interviews and interviewees' roles as follows:

- six social housing tenants (smokers and non-smokers),
- CCC Social housing Smokefree project manager²⁷ (as at March 2015),
- CDHB Smokefree project manager (for social housing),
- three CCC Tenancy Advisors,
- Aukati Kai Paipa practitioner, and
- CDHB/Cancer Society health promoter.

Quantitative/Qualitative methodology

Both quantitative and qualitative data analysis methods were used in the preparation of this report, to enrich understanding of the operational and social processes under study, and specifically to provide a more comprehensive analysis of the interrelated processes of policy implementation (Creswell & Plano Clark, 2011). All interviews²⁸ were completed by the two analysts and all were audio recorded. All interviews were transcribed by an independent transcriber who was otherwise uninvolved with the research project. Thematic analysis was used whereby interview comments were analysed and summarised by examining, 'themes' (meaning) or patterns within the data. Responses were identified, coded, categorised described and summarised (Daly, Kellehear, & Gliksman, 1997). The findings from the thematic analysis were integrated with other quantitative data and presented in the report where applicable.

Other considerations relating to the evaluation methodology

Ethical Considerations

This programme was reviewed against the Health and Disability Ethics Committee (HDEC) flow-chart²⁹ and did not need to undergo HDEC review for these reasons: (1) the study did not involve human participants recruited in their capacity as: consumers of health and disability support services, or relatives/caregivers of such consumers, or volunteers in clinical trials (i.e. 'patients') and (2) the study is categorised within the list of exemptions as a "minimal risk observational study".

Privacy/Confidentiality

All data have been either aggregated (reported at the study population level not the individual subject level) or have been anonymised.

Burdens minimised

Participants were not interviewed more than necessary; only data necessary for the purposes of the evaluation were collected. The burden on participants was minimised by adding questions to existing questionnaires (where possible) rather than creating new separate questionnaires.

²⁷ Two different CCC housing unit managers have been involved in the policy implementation: 'CCC project manager 1' prior to March 2015 and 'CCC project manager 2', March 2015 – current.

²⁸ Except one brief interview which took place with the CPH/Cancer Society health promoter.

²⁹ <https://ethics.health.govt.nz/system/files/documents/pages/HDEC%20scope%20summary.pdf>

Equity/Treaty of Waitangi

The target/study population– low-income tenants living in Christchurch City Council social housing units with an indoor smokefree housing policy. The programme/evaluation has the potential to reduce smoking-related health inequalities in this disadvantaged population (including Māori)³⁰.

³⁰ The precision of the ethnicity data for the social housing population is not known, therefore whether Māori are under or over represented is not clear.

Results

The results in this section are presented below under each evaluation objective (listed as a numbered section heading). A brief outline of these objectives is provided here in **Box 2**. In most cases, each section of results has been informed by more than one source of data. Typically, quantitative and qualitative findings have been blended to describe the findings and themes as they relate to each evaluation objective.

Box 2: The evaluation objectives

1. To describe the Council's rationale for implementing a smokefree policy and the process by which the policy/protocol was developed.
2. To describe the nature of the relationship between the CDHB and the CCC (the partnership) as it relates to the development and implementation of the CCC smokefree social housing policy.
3. To describe the operational detail of the policy, including contract variations/new contracts; to describe the processes for managing non-compliance and complaints.
4. To describe the relevant refurbishment and maintenance issues and how the policy is intended to impact on these outcomes (cost, time, insurance, other).
5. To describe the population demographics.
6. To document the prevalence of smoking.
7. To describe the characteristics of the housing stock.
8. To document the views of key stakeholders; to describe the level of consultation the CCC engaged in; to measure and report tenants' acceptance of the policy.
9. To identify any unintended consequences.
10. To identify modifications that may be needed.
11. To describe any potential or actual equity issues.

Objective 1: Rationale

To describe the Council's rationale for implementing a smokefree policy and the process by which the policy/protocol was developed (data sources 4, 5 & 6).

The Christchurch City Council had two main reasons for implementing the Smokefree policy:

- to reduce maintenance costs, and
- to improve tenants' health and wellbeing.

The CCC worked in partnership with Smokefree Canterbury (including the Cancer Society and the CDHB) to adopt and implement the policy.

Timeline

The CCC formally adopted the smokefree policy in late January 2014, but prior to this, consultation had occurred over a number of years. Key developments are outlined briefly below.

- The CCC had a long-term relationship with Smokefree Canterbury, for example, having worked together to introduce smokefree parks and playgrounds, stadia (Lancaster Park), swimming pools, and some events.
- Pre-earthquakes (i.e. prior to September 2010), the CCC engaged in talks with Smokefree Canterbury regarding developing further a smokefree 'footprint' for the CCC buildings³¹.
- In September 2010, the earthquakes halted those discussions.
- In April 2013, a CCC tenant complained to the Cancer Society about second-hand smoke from a neighbouring tenant.
- This complaint triggered a renewed discussion between the Cancer Society and the CCC about adopting a smokefree policy.
- Throughout 2013, the Cancer Society continued advocating with the CCC for a smokefree policy, phoning the CCC monthly to check on progress.
- In 2013, the CCC Housing Unit carried out background research to support the policy proposal. They:
 - submitted a legal request to the CCC's legal team (the legal team found that there were no legal barriers to implementing the policy),
 - the Council considered third-hand smoke issues,
 - considered the potential scope of the policy, and
 - looked at similar policies, particularly the associated cost savings (based on the higher average cost of redecorating a unit vacated by a smoker vs non-smoker).
- The CCC's Housing Unit submitted a report to (the precursor of) the Community Housing and Economic Development Committee, proposing that a smokefree policy be adopted.
- In early 2014, the CCC worked with the CDHB and Cancer Society to consider how to deliver stop-smoking support to tenants.
- The CDHB/Cancer Society helped the CCC to develop specific aspects of the policy³².
- At a meeting of Christchurch City Councillors, on 30/01/14, the CCC endorsed the policy.
- On 31/01/14, the first CCC tenant signed a contract that included the new smokefree clause.
- The CDHB co-ordinated training for the CCC's Housing Unit staff (including smoking cessation training, and guidance on policy, process and implementation).

³¹ Not only social housing but all Council owned buildings.

³² In the main providing guidance and technical knowledge and skills, rather than writing policy documents.

Success factors for adoption of the policy

The Cancer Society and Community and Public Health (under the Smokefree Canterbury umbrella) worked hard to advocate with the Council for a smokefree policy. The Cancer Society believed that success factors for getting the policy adopted included:

- effective information sharing (that is, being able to answer the CCC's questions),
- good rapport,
- existing receptiveness to the idea (that is, not having to 'sell' the policy),
- 'buy-in' from mid-management³³,
- encouraging the CCC to take ownership of the policy, and
- encouraging the CCC to consider sustainability of the policy.

Scope

In considering the scope of the smokefree policy (that is, how 'hard' or 'soft' it would be), the CCC believed it was important to consider the vulnerability of tenants, particularly in light of the earthquakes, and the need for any policy change to be gradual. Although the CCC originally considered a harder policy, that is, "across the entire housing portfolio", it re-considered this scope to restrict the new policy to new tenancies and the "repair and rebuild programme" (CCC project manager 2). Further considerations included "human rights", with the CCC believing that it would be too harsh "not to let [tenants] smoke outside the unit" (CCC project manager 1); however, this consideration was balanced with the potential efficacy of the policy (that is, the policy needed to be strong enough to make a difference in terms of reducing smoking-related damage).

Dual focus

Originally, the primary rationale for the policy was cost-saving, that is, reducing the cost of maintenance and re-decorating of smoke-damaged units. It was apparent that the rationale for the policy had shifted over time, developing more of an emphasis on how the policy may help improve tenants' health and wellbeing³⁴. It was perceived that this shift became "60% in favour of maintenance and 40% towards [tenants' wellbeing]" (Tenancy Advisor 3). This dual focus had become very evident to the CDHB, upon the first project meeting with the Housing Unit:

"They were very clear that they wanted to support the tenants [to quit smoking] as well as gain compliance, so that was the senior management in the Housing Team." (CDHB project manager).

The shift towards a health focus arose as the CCC realised that helping tenants to quit smoking aligned with their responsibility to maintain the "health and safety of the tenants" (CCC project manager 1) and with their model of sustainable tenancies. As such,

"more and more ways were considered to see how we can help tenants, keep them in their tenancies, give them a healthy environment" (CCC project manager 1).

Health and safety considerations included reducing any potential toxic impact of third-hand smoke.

³³ 'Key players' amongst mid-management consisted of a core group of supportive managers. This support was perceived by the Cancer Society as "essential" to the adoption of the policy.

³⁴ Arguably, in part, because there was an election and a change in Council members and (pro smokefree) leadership.

Social landlord

The CCC sees itself as a 'social landlord'³⁵. This means:

- committing to 'sustainable tenancies' (focused on problem-solving and upholding stable tenancies),
- aiming to empower tenants to 'lead better lives' (following a community development model), and
- employing staff who genuinely care about tenants' wellbeing.

The shared team ethos of caring for tenants' wellbeing is important to successfully empowering tenants – the "same goal" (CCC project manager 1) was shared across both Tenancy Advisors and management. Individual Tenancy Advisors spoke of being motivated to implement the smokefree policy because it achieved the goal of empowerment:

"we find a lot of tenants that struggle financially so...we know that's a big problem for a lot of them that drink and smoke...a lot of their income's going on those things and if we can reduce that, then they can better their lives...the drive for us [is]...tenants that don't manage their money very well, and if we can stop them smoking and give them a bit more money then hopefully they can live a better life... move onwards and upwards...it's just to empower them..." (Tenancy Advisor 1).

Empowering tenants was viewed as mutually beneficial for the CCC, with the CCC project manager believing that the policy would have "knock-on effects" (CCC project manager 1) by reducing anti-social behaviour and rent arrears:

"because if a tenant feels valued then they want to contribute more...so it's a symbiotic relationship to an extent" (CCC project manager 1).

Innovative Council

Both the CCC project manager and a Tenancy Advisor suggested that the Christchurch City Council desired to be at the "forefront" (Tenancy Advisor 1) of what was happening nationally. The CCC's Housing Unit had supportive management and experienced staff "leading the way on some of the issues. We have people on the [housing] team who are from different housing organisations...we've got some from the UK, we've got great management in place, [one Tenancy Advisor] comes from Housing NZ and has always had the community focus in place as have I" (CCC project manager 1). The project manager [1] felt that the Council was "probably unique" in adopting this particular style of smokefree policy – one that includes a focus on health and stop-smoking support:

"this approach is probably one that not every council does adopt, not for the sake of trying, but possibly they don't have the opportunities to do so" (CCC project manager 1).

This sense of proactive leadership in terms of Smokefree Aotearoa 2025 was identified by one Tenancy Advisor, who stated that "it's better to be at the front of the queue doing it now rather than waiting for everybody else to do it" (Tenancy Advisor 1). S/he believed that the wider smokefree legislative environment had set a precedent: "we've seen it happen in pubs and cafes" (Tenancy Advisor 1).

³⁵ With a particular emphasis on the social responsibility aspects of tenancy management.

Champions

Within the CCC and its Housing Unit, individual champions had helped to put smokefree on the agenda and to drive the policy forward. According to one Tenancy Advisor, “[CCC project manager 1] has been the biggest driver...and I think everybody has just sort of got on board and seen the benefits of it” (Tenancy Advisor 1).

Section summary

The rationale for the Council’s smokefree social housing policy emerged over time, with the Council becoming increasingly aware of maintenance costs caused by smoking and of the benefits of introducing a smokefree policy. The Council was aware that such a policy also needed to include a focus on health, with support for tenants to quit smoking. The Council worked in partnership with Smokefree Canterbury (including the Cancer Society and the CDHB) to adopt and implement the policy. This background process took place over 2013 and the policy was adopted in late January 2014. The CCC Housing Unit supported the smokefree policy from the point of view of being able to empower its tenants to lead better lives.

Objective 2: Partnership

To describe the nature of the relationship between the CDHB and the CCC as it relates to the development and implementation of the CCC smokefree housing policy. What qualities and attributes were important? (data sources 4, 5 & 6).

In January 2014, the Christchurch City Council and the Canterbury District Health Board partnered together to implement the CCC's smokefree social housing policy, with its dual focus on compliance with the smokefree rule and supporting tenants to quit smoking. The partnership arose from a longer-term relationship with Smokefree Canterbury (as described under 'Rationale'). This relationship was critical for getting the policy adopted. In early 2014, the smokefree project managers from the CCC and the CDHB began working closely together in order to implement the policy correctly and fully, specifically focusing on smoking cessation.

Mutual need

Both organisations (the CCC and the CDHB) demonstrated a clear need for the partnership. From the CCC's perspective, the partnership was needed to facilitate best practice implementation of the smokefree policy:

"[it was] critical for providing knowledge and expertise for implementing the smokefree policy according to best practice" (CCC project manager 1).

The CCC lacked "the in-house experience" since the smokefree policy was "completely new to us", therefore, it made "sense to ... form a relationship to be sure that it was adopted, hopefully correctly and fully" (CCC project manager 1).

From the CDHB's perspective, the partnership was key to reaching a disadvantaged (and less accessible) community with stop-smoking support. The partnership also furthered existing relationships with a "strategic partner" for establishing smokefree public areas (CDHB project manager).

Clear roles

Each organisation was clear about its specific role in the partnership.

Overall, the CCC had an operational role in the partnership, integrating smokefree as business-as-usual within the Housing Unit. The CCC was committed to "putting [the] policy into practice...so that [it] becomes part and parcel of the tenancy agreement" (CCC project manager 1). This included following the correct processes, standardising procedures, ensuring that Tenancy Advisors were trained in offering stop-smoking support, facilitating Aukati Kai Paipa's access to the tenant community, and referring to other specialist stop smoking services. The CCC project manager also had a role within the wider Joint Working Strategy group, to "develop and promote the policy...Council-wide" (CCC project manager 1).

The CDHB's role included offering solutions to make the smokefree policy sustainable practice, by putting good systems in place and providing the CCC with access to smokefree resources (including cessation services and other Smokefree Canterbury partners). The CDHB aimed to integrate "smoking care as usual care" (CDHB project manager). The role included facilitating training for CCC staff (building their confidence in addressing smoking issues and offering/delivering stop smoking support and nicotine management), facilitating the delivery of AKP services to CCC tenants and co-ordinating evaluation of the policy. The CDHB also saw its role as helping the CCC to improve its systems to support the policy.

Shared purpose

Having the two organisations share a common goal had allowed the CCC to adopt and implement the policy more successfully. This shared goal allowed the CCC to take “big steps” with the policy:

“We’ve all got the same goal and without the support...from you guys [evaluators] and [Cancer Society manager] and [the] health promoter and [CDHB project manager], we wouldn’t be where we are now. We would certainly still be [heading] in the right direction but I think because of that we’re able to make big steps as we’ve already seen” (CCC project manager 1).

The shared goal also provided the impetus to keep working together: “I think all of us are ... resolved to saying, ‘this is important ... we need to keep working together’, and people have put their money where their mouth is. And that’s really encouraging” (CCC project manager 1). The goals of the partnership fit well with the CCC’s commitment to a community development model, specifically focusing on empowering tenants to lead better lives. Likewise, the CDHB sought to improve the health of a vulnerable, and relatively less accessible, population by helping tenants to quit smoking and to live in a smoke free environment. The CDHB project manager believed that the partnership was enhanced by sharing an “outcomes” focus (with the outcome of reducing the amount of indoor smoking). Because the Council was committed to pursuing compliance, incorporating the dual focus of smoking cessation was made more feasible.

Trust and rapport

The two project managers had worked to build “trust” (CDHB project manager). They had a good rapport, partly based on the personality fit, which was perceived as “enormously” helpful (ibid): “I get on well with [CCC project manager 1], that’s just how it is ... if you don’t have people with [similar] views...they don’t facilitate the way”. This was reinforced by the CCC project manager, who suggested that

“unless you’ve got that...click...where you don’t have to worry too much about the thing you’ve just said, if it’s received right or anything like that...so you can be relaxed with the approach that we take and yet we’re all on the same page...let’s be relaxed about things. You get me, I get you” (CCC project manager 1).

The trust was also built on “respect [for] what each other can offer” (CDHB project manager) and a compatible, “relatively informal” working style (CCC project manager 1). Rapport was also enabled by the CCC project manager’s passionate commitment to the project and therefore being “completely engaged” (ibid). Over time, the rapport had developed into “working cohesively and becoming as one” because “we want that one thing” (CCC project manager 1). Overall, it was important that staff working in partnership across different organisations shared positive esteem, as experienced by the CCC and the CDHB:

“everybody that I’ve been involved with on this project has been great and has been...approachable and honest and genuine...it is important that you have that” (CCC project manager 1).

Senior-level commitment

Obtaining senior-level commitment was often a starting point for working in partnership – the CDHB project manager would usually “start with someone in the organisation who’s got a link to senior management who can facilitate that to happen...usually always [it]...will require someone at a senior level to give the authority for any other activity to happen” (CDHB project manager).

It was very important that the project had “political will” (CDHB project manager). ‘Political will’ for this project was enabled partly by the smokefree culture having become “more or less supported within the Council” (ibid). Furthermore, at the first meeting of the Joint Working Strategy group, the CCC project manager had advocated that “the first thing we should be thinking about is getting Council to adopt it” (CCC project manager 1). Prior to this, there had “not officially [been] Council buy-in” (ibid) for the policy.

Key characteristics of working in partnership, therefore, were having a mutual need, clear roles, a shared purpose, trust and rapport and senior-level commitment. Additionally, further enablers to working in partnership were identified (listed in **Box 3**).

Benefits

The partnership had provided the CCC with skills and expertise it would not otherwise have had. Specifically, the CCC had gained access to resources and its housing staff had been trained as Quit Card providers. The partnership had made the task of accessing resources much more efficient. It meant that “we didn’t have to... go ‘round looking for resources, and ... spending time and wasted energy...because it was there” (CCC project manager 1).

Box 3: Enablers of partnership-working

- Including **other partners** as necessary (e.g. Smokefree Canterbury).
- Identifying **champions** who are passionate about the project and who make things “easy” (CDHB project manager). Ideally this is someone who is in a senior position.
- Agreeing on the **rationale**: e.g. “the Housing Unit itself has now got more confidence and belief in that what we’re doing is the right thing and for the right reason... [there has been a] switch from being an economic [rationale to] getting support out there to the community” (CDHB project manager).
- Having a **formal agreement** to work together (e.g. the Joint Work Plan).
- Having **systems** which enable the organisation to take ownership of developing the policy: e.g. the CCC had “systems you can somehow embed that work into, that means it becomes a necessary piece of work. It means that people have to respond to it” (CDHB project manager).
- Having a **key link person**. e.g. “somebody in that organisation that I can connect with who can make things happen” (CDHB project manager).
- Being **accessible and responsive**. Both project managers praised how each other had responded to requests e.g. “I talked about training, and probably within a couple of weeks...he’s been really good at doing that” (CDHB project manager); “everybody that’s been involved with this really has...been so open and easy to get in touch with” (CCC project manager 1); “if she’s not got the answer she’ll get back to me as quick as possible”.
- Being **flexible**, e.g. the CDHB project manager discussed being flexible around time-frames; the CCC project manager appreciated flexibility in understanding that “we want to do [things] but perhaps for reasons out of our control we can’t ... do certain things....so maybe then we can look at something else...” (CCC project manager 1).
- **Communicating clearly** and sharing information: e.g. “we have our own ways of working internally and you guys ... have your ways ... but the two don’t necessarily know how each other kind of operates... being able to ask questions of each other, to get an idea of how it fits in with each other’s work” (CCC project manager 1).
- Focusing on **solutions**. e.g. the suggestion of training Tenancy Advisors as Quit Card providers was a solution to the team being unsure “how to ... actually raise the point properly” of quitting smoking. The CCC project manager felt that this solution “exemplifies how easy it is actually working on this project because we don’t really come across many stumbling blocks that we can’t resolve”.
- Identifying **practical supports**: such as the proximity of partnering organisations (e.g. “at least it’s only around the corner there even if we meet up for a coffee...so locality I think does play a key part”(CCC project manager); the availability of meeting rooms.
- Keeping sight of the **bigger picture** e.g. Smokefree Aotearoa 2025: “It’s not just about housing but about the bigger picture” (CDHB project manager).

This partnership (amongst others) was particularly beneficial in enabling the CCC to “sustain tenancies holistically”:

“there’s been huge benefits of working collaboratively with agencies that are... specialists in that area...of course the smokefree project again is a no-brainer, working with people that have got the expertise, and also the resources” (CCC project manager 1)

As well as working with the CDHB to implement the smokefree policy, the CCC partnered with other organisations to seek better outcomes for tenants: “We strive to develop relationships where we can anyway, because I think there’s a lot to be gained from a two-pronged approach to anything” (CCC project manager 1). Encouraging tenants to quit smoking gave them “opportunities...saving money, living a healthier life, better wellbeing, better choices” (Tenancy Advisor 1).

The CCC therefore viewed the current partnership as a “model” for working with other organisations, and acknowledged continuing to learn from this project: “we’re still ironing out the kinks ‘cos it is still new. I know we’re a year down the line but there’s been such a huge progression within that year and I think a lot of that is because we’re working more efficiently together” (CCC project manager 1). The CCC project manager suggested transposing this knowledge:

“we’ve got to this point, so I think that model could be transposed in other ways ... So if somebody’s coming up with an initial concept of, ‘well I’d like to see this get off the ground, how do we go about it?’...So we can say ‘well actually I’ve had ... experience in that’, if we adopt what we’ve already worked to ... tailor it to that approach, I think it could be a huge benefit” (CCC project manager 1).

From the CDHB’s perspective, the partnership had benefited the CDHB by progressing smokefree policy development: the fact that the CCC had implemented its smokefree social housing policy was a win. This (project) partnership had strengthened existing partnership relationships. The CCC had come on board as a smokefree “champion”, therefore the Joint Working Strategy group was “functioning more successfully than I think it might have otherwise” (CDHB project manager). A further long-term benefit of the partnership was the potential for the CCC to show leadership through the Joint Work Plan:

“Because of our Joint Work Plan³⁶ strategy now...there’s huge potential now for the Council to be a leader actually in the community with smokefree, leading towards Smokefree 2025, and I think we’ve got some momentum bubbling for that to happen” (CDHB project manager).

The partnership had also enabled the CDHB to gain better access to the community for its Aukati Kai Paipa stop smoking team, allowing the team to proactively reach clients.

³⁶Many operational and policy development relationships currently exist and are formally recognised through a Joint Work Plan, as described on page 6 .

Expectations

Overall, the CCC project manager had very high praise for the CDHB:

“I can’t applaud them enough, I really can’t”
(CCC project manager 1).

It was “hugely important” that the CDHB was accessible and responsive. Because of this, the implementation had gone “very well”, it’s been “really good” (CCC project manager 1).

The CDHB project manager was “thrilled” with the way the CCC had engaged with the policy. She felt that the CCC had “done well” so far in terms of implementation and was impressed that the CCC “certainly mean business” in terms of compliance. She believed that, overall, implementing the policy was a ‘work-in-progress’, with “quite a bit of room to work on” embedding stop-smoking support as business-as-usual, and “encouraging nicotine replacement therapy” (CDHB project manager). Her ongoing priority was “enabling staff to feel comfortable” with providing stop-smoking support. The CCC had continued to “step up” in terms of stop-smoking support, particularly in facilitating Aukati Kai Paipa access to community lounges, “but we’ve still got work to do” (CDHB project manager). In some ways, expectations of progress (including time-frames) were tempered by recognising the role of “working alongside...in a support and encouraging and facilitating role”, meaning that the CDHB sometimes needed to take a ‘back seat’ (CDHB project manager). Both project managers commented that they would have liked to have been involved in the project earlier in the process (i.e., alongside other CCC and CDHB staff, during the early policy drafting and implementation planning stages). The reality was that they had each “picked up something that was already in progress” (i.e., at the implementation stage) (CDHB project manager). However, this is a likely scenario in many instances of partnership-working.

Project managers (and other staff) identified challenges to working in partnership (**Box 4**). An overall challenge for both partners was ensuring the sustainability of the smokefree policy. The CDHB project manager was “careful” that initiatives were not reliant on individual staff (including herself): “I’m quite careful or resistant to doing things that might look good on paper...but actually when you leave they’re gone – or when that person leaves it’s gone...I think we’re at the time where it has to be sustainable practice and that’s where the Council can make that happen” (CDHB project manager). Similarly, the CCC believed it was necessary to keep the policy in “view all the time” (Tenancy Advisor 1) in order to ensure its sustainability, aided by regular contact with the CDHB:

Box 4: Challenges to partnership-working

- Potentially, overcoming **barriers** to approaching those who possess **expertise** e.g. “sometimes you feel ‘well I don’t want to approach that person because that guy’s a CEO’...and so you may be a little bit reluctant to make an approach” (CCC project manager 1).
- Negotiating “**boundaries**”, including time-frames. Respect for the other organisation’s boundaries meant knowing that “you can’t call the shots” and “know[ing] your place” (CDHB project manager). This also meant needing to be “patient” while waiting for things to happen.
- Needing a **formal structure** or systems to support project initiatives and to make sure those systems are sustainable. E.g. “At the moment, for example, all the information that the Housing Officers have is not all together in one programme. They have to go here, there and everywhere to get all the relevant bits of information” (CDHB project manager).
- **Managing risk**. E.g. the “risk” (CDHB project manager) posed by the transfer of the Council’s housing stock to the new housing entity: “There will probably be a whole new range of training required with different providers...I’m hoping that we can get enough embedded in the time period before that happens, that it just continues to evolve appropriately but I’ve also learnt that..we can’t control that” (CDHB project manager).
- Accommodating **personal attitudes**. E.g. CCC staff who are themselves smokers: “somebody’s own personal attitude to smoking...that varies, and that’s always the greatest challenge to really accommodate that and address it” (CDHB project manager).
- Keeping the smokefree issue on the housing **agenda**, amidst the changing political environment: “things have got to be kept in perspective and kept in the forefront if we want to make it work” (Tenancy Advisor 1).

“it...could just drift out of view and it needs to be in the view all the time. So I think if we keep regular contact with you guys [evaluators] and training, regular training, updates, what’s going on, how it’s working, where we can go, I think that helps.” (Tenancy Advisor 1).

The CCC had “committed to Smokefree 2025” and therefore had “that date...to work to”, with staff efforts required “long-term” (CCC project manager 1). The CCC project manager believed that with Councillors’ support for the policy, efforts could be sustained over the long-term:

“ten years I think working on this in whatever capacity, because the Council’s stated we are behind this, we promote this and so we’re doing our thing towards that” (CCC project manager 1).

“we can’t do without the partnerships that we’ve already established now...we still need to continue in that vein and the Joint Working Party is one example of that” (CCC project manager 1).

The partnership was necessary because dealing with the overall large scope of the problem of tenant smoking was “huge. The implications arising from it are massive” (CCC project manager 1).

Section summary

Overall, from the CDHB project manager’s perspective, the partnership between the CDHB (Community and Public Health) and the CCC is the key to reaching a disadvantaged community with stop-smoking support. The partnership is enabled by the long-term relationship established with Smokefree Canterbury. Overall, from the CCC project manager’s perspective, the partnership provides knowledge and expertise for implementing the smokefree policy according to best practice. Key enablers and challenges for working in partnership were identified by project managers (Boxes 3 and 4).

Objective 3: Operational detail

To describe the operational detail of the policy, including contract variations/new contracts (i.e. the process of implementation at an individual contractual level and the roll-out across the CCC housing stock overall). To describe the processes for managing non-compliance and complaints) (data sources 4-7).

The CCC's smokefree social housing policy is a partial smoking ban that restricts tenants to smoking outside of their units (smoking on patios and balconies and in common garden areas is permitted as long as all windows and doors are closed). The policy implementation is ongoing by way of a prospective roll-out, on a contract-by-contract basis. Specifically, all *new* tenants sign a contract that includes the no-smoking rule, or tenants who move units or complexes sign new contracts (this includes temporarily vacating a unit for redecorating or refurbishment or repairs); or tenants may voluntarily sign a contract variation that enacts the new rule³⁷.

Since the adoption of the smokefree policy in January 2014, the CCC's housing stock has been progressively transitioning to smokefree status via new contract sign-ups and refurbishment-triggered contract variations. As at March 2016, 821 of a total of 2301 (35.6%) individual housing units were designated smokefree (this includes 715 new tenants and 106 tenants who have signed a contract variation voluntarily). The prospective roll-out always meant that the goal of all Council units becoming smokefree was long-term, but achievable: "it is going to be a fair bit of time, that all Council units will be smokefree by natural attrition and tenants leaving or moving on or being evicted or dying ... You can imagine that's going to be a fairly lengthy process but...at least you can say it's a finite period" (CCC project manager 1).

Sign-up

Signing a new contract takes the form of an extended interview between the Tenancy Advisor and the tenant, covering all the terms and conditions of the tenancy agreement, not only those pertaining to the smokefree policy. Tenants have the opportunity to ask questions. They understand that if they choose not to sign the contract with its updated smoking clause, they will not get the unit.

Signing a contract variation (when triggered by Council's works programme) is entirely voluntary, but once signed, it is enforceable like any other contract. All tenants (except one) had chosen to sign the variation (when given the opportunity): "you are not forced into signing that variation because your current tenancy agreement is really still valid. Having said that, the vast majority of tenants sign it. After all, we could give you basically a random unit, if you think about it, so we want it looked after, so usually we get the buy-in" (CCC project manager 1). In the past, contract variations would have been triggered regularly through the Council's works programme, however, currently there is limited resourcing for programmed maintenance.

Non-compliance

The process for managing non-compliance is the same process used in other instances of tenant breaches under (Section 56 of) the Residential Tenancies Act (1986). Self-resolution is seen as the first step in dealing with any issues that come up in a tenancy. The CCC was committed to "tenant sustainability", aiming for "tenants to remain in the units at the end of the day. And to be happy and comfortable and safe". Therefore there was no "knee-jerk reaction" (such as eviction) to non-compliance (CCC project manager 1).

³⁷ At the time of initial implementation, this 'voluntarily' option was simply a 'theoretically possible option', it was not actively implemented—however, over time, some Tenancy Advisors reported that they began to encourage tenants to voluntarily sign an addendum to their existing contract—when not otherwise required/requested to do so.

Formal enforcement included issuing a written breach notice, giving the tenant 14 days to rectify the breach of contract. The few breach notices that had been served for smoking were “very much a drop in the ocean with all the other breaches that we serve”. The breach notice was “a big slap on the wrist. Trying to make it in an official format as possible for you to take notice” (CCC project manager 1). Failing this, the Tenancy Tribunal could make a ruling on an issue that cannot be resolved and issue an order that is legally binding on the parties involved in the dispute. At the time of interviews, this process had not been tested with regard to any breaches of the no-smoking rule (no breaches had been considered sufficiently problematic to warrant escalation to the Tenancy Tribunal) – and it was very unlikely that any smoking breach would be escalated to the Tenancy Tribunal. In reality, the focus after a breach notice would be on offering support and looking for ways to work together; however, in the event of continuous breaches, the CCC had “little recourse” (CCC project manager 1).

Currently, there was no system in place for offering further solutions to address continuous breaches. This was partly due to the perception that the workload for Tenancy Advisors of implementing the new policy was already high enough. The problem of tackling continuous breaches would be dealt with if and when they became a regular pattern – it was a “watch-this-space kind of thing” (CCC project manager 1). It was likely that charging tenants for damages would be an effective tool (discussed further in ‘Key Stakeholders: Tenancy Advisors’ section).

Stop-smoking support

In addition to the regulatory function of the policy, the policy also endorses a support function, in that tenants who identify as current-smokers receive an offer of smoking stop-smoking support (and help in accessing this support and/or nicotine addiction management support). All Housing Unit staff have been specifically trained to implement the policy. Training included an initial session to provide background information on the policy, its rationale, smoking (and second- and third-hand smoke); and also covered ‘brief interventions’ to quit, referral agencies, medications and the government goal of Smokefree Aotearoa 2025. Following the initial training, all staff were offered the opportunity to be trained as Quit Card providers. (At the time of interviews, all except one Tenancy Advisor had taken this opportunity – although some time had elapsed since this training). There was the potential to offer further training as demand arose but there was not a structured programme in place for refresher training³⁸. Tenancy Advisors were also able to email the CDHB staff with questions and were able to access resources, including stickers and pamphlets, from websites. Stop-smoking support was also targeted at tenant community lounges, via “literature”, posters and visits from the Aukati Kai Paipa practitioner. Overall, the CCC project manager believed that the process of supporting tenants to quit smoking was “a matter of...filtering that message through to tenants... it’s work in progress” (CCC project manager 1).

At the time of interviews, there was still opportunity for quit-smoking conversations between CCC staff and tenants to happen more routinely. It was probably not “the first thought in the Tenancy Advisor’s head” (CCC project manager 1) to offer such support and a “top-up [to Quit Card training]...might be in order”. It may also be helpful to highlight statistics: “once we get the stats published that we get for certain things including breach notices...once that starts being highlighted more...as I see the number increasing, that would be enough to warrant focusing on that particular area” (ibid).

³⁸ See also, ‘Special notes’ p.10.

There was currently not a formal system for referral if tenants chose to accept the offer of stop-smoking support. Tenancy Advisors were encouraged to offer support directly and to refer tenants to the Smokefree Canterbury website and Quitline. The CCC project manager was “aware of the availability of [AKP practitioner] and the team, and...we do have the literature and we do have the pamphlets we can give out, and we do have the Quit Cards. So although there’s the resource there, whether it’s tapped into fully or acknowledged completely, I don’t know, there’s no process per se” (CCC project manager 1). The CCC project manager felt that the team needed to know its limits in terms of helping tenants to quit smoking: “I think we’ve got to realise what our obligations are and I think that’s really just putting them in touch with somebody”. To a certain extent, offering stop-smoking support to tenants would be “because people feel passionate about it, and that’s kind of what we’ve tried to instil in them” (CCC project manager).

Section summary

The no-smoking policy applies to all new tenants who have rented a CCC unit since 31st January 2014 and states that tenants must not smoke inside their unit. Additionally, tenants who have their unit refurbished may voluntarily sign a no-smoking contract. If tenants breach the policy by smoking inside, they are encouraged to resolve the issue; if they fail to do so, they may be issued a 14-day breach notice as a warning. Breaches of the smokefree rule are treated in the same way as any other tenancy matter. Potentially, if not addressed, the matter could be escalated to the Tenancy Tribunal (although at this stage, this was very unlikely). The policy was accompanied by support for tenants to quit smoking (and/or manage nicotine addiction) and all Tenancy Advisors had been trained to deliver this, although at the time of interviews, there was potential to develop this further.

Objective 4: Refurbishment and maintenance issues

To describe the relevant refurbishment and maintenance issues and how the policy is intended to impact on these outcomes (cost, time, insurance, other) (data sources 4, 5, 6 & 9).

A key driver for the smokefree social housing policy was the increased cost of maintaining units damaged by cigarette smoke. It was difficult to quantify this cost, however, one Tenancy Advisor estimated the cost of cleaning and repairing a smoke-damaged unit at approximately \$1000, none of which was re-claimed from the tenant. All of the Tenancy Advisors spoken to described “yellow” walls in units that had been occupied by smokers for many years. Tenancy Advisors were also unanimous in their conviction that the new smokefree policy would result in reduced maintenance costs, albeit over the longer-term. **Figure 3** below illustrates yellow walls (with light patches, e.g. at left of picture) from a unit in which a tenant smoker had lived from 2007-2015, even though the tenant had stopped smoking during the tenancy.



Figure 3: Third-hand smoke damage ‘yellow walls’

Tenancy Advisors described extensive damage to units caused by indoor smoking. The yellowing of originally white walls was subtle at first, but became more obvious over four to five years:

“you really see the change, it’s only after about four or five years that you think, that wall wasn’t that colour. But because it’s changed gradually you don’t really notice it yourself. Like anything, you don’t notice things growing, it’s just you think that’s slightly changed colour, and then once it has turned that yellow...it will take four or five years before that really happens.” (Tenancy Advisor 1).

Tenancy Advisors also described the impact of third-hand smoke on new tenants, who moved into units previously occupied by smokers. The third-hand smoke was not removed by the Council's conventional approach to cleaning – or even repeated attempts at cleaning:

“we actually had one [where] the tenant had been a heavy smoker and because of funding we just can't afford to do the redecs, and...it was cleaned...three or four times, and there is still evidence of the cigarette and it's still kind of leached out and that sort of thing...So once it's in there it's really hard to get rid of.” (Tenancy Advisor 3).

In this case, despite extensive cleaning after the smoking tenant had moved out, the cigarette smoke damage continued to cause concern to the new tenant. The new tenant was not happy living in the smoke-affected unit and was ultimately moved to a newer, cleaner unit.

Another Tenancy Advisor described a case in which the new non-smoking tenant had not complained about being moved into a smoke-damaged unit, but the Tenancy Advisor had taken it upon him/herself to “push quite hard” for repainting. As a result of the Tenancy Advisor's persistence, the Council's process was changed so that units vacated by smokers were cleaned twice. However, the Tenancy Advisor believed that even cleaning twice was insufficient, and had advocated for repainting smoke-damaged units.

Impact of the smokefree policy on maintenance issues

All Tenancy Advisors interviewed agreed that the smokefree policy would have a significant positive impact by reducing maintenance costs caused by smoking. They felt that this impact would be apparent in the short-term in the form of less damage to carpet from cigarette burns and in the medium term (four to five years) in the form of reduced nicotine-staining in units:

“The nicotine stains when people leave [who] have been there five, ten, fifteen years, they're very noticeable. With this [policy], that's the thing we will notice but we won't see that for a few years yet.” (Tenancy Advisor 1).

In addition to reduced maintenance costs the policy would reduce fire risk. Tenancy Advisors had had past experience of cigarette smoking leading to fires:

“And it has happened a couple of times over the last ten years that I've seen where somebody's been smoking, then they fell asleep. They've got out both times that I've remembered. It was still fairly hair-raising” (Tenancy Advisor 1).

Tenancy Advisors believed that the effectiveness of the policy in reducing future maintenance costs would further be aided by the policy giving the Council the authority to charge the tenant for damages, a tool which they had not previously possessed. Compliance – and therefore effectiveness – of the policy would be facilitated by tenant awareness about liability for damage, which meant that:

“you'd hope that the goal for...future damage for the Council in terms of cost would be zero because if there is any damage it's going to be the tenant that is going to be paying for it” (Tenancy Advisor 2).

It was expected that awareness of liability for damage would be increased by ‘word of mouth’ among tenants.

One Tenancy Advisor noted that it is difficult for individual Advisors to determine which contract tenants are on, identifying a need for more systematic recording of contract status (discussed further in ‘Key Stakeholders: Tenancy Advisors’ section). This operational issue could be addressed in order for the CCC to obtain maximum benefit from the policy.

Section summary

The damage to CCC units caused by smoking was very apparent, and included burns to carpets and other surfaces and yellowing of walls. Additionally, third-hand smoke tended to 'leach out' even after cleaning. It was difficult for Tenancy Advisors to quantify this damage, but cleaning and repair costs were estimated at around \$1000 per smoke-damaged unit. Tenancy Advisors believed the impact of the policy on reducing maintenance costs would be substantial, although it may take four to five years for this cost-saving to become apparent. Some improvements were expected to be observed sooner, such as less damage to carpets and improved fire safety. Tenancy Advisors anticipated that the new ability to charge tenants on new contracts for damage caused by smoking would boost compliance.

Objective 5: Population demographics

To describe the population demographics (data source 8).

The demographic characteristics of the CCC social housing portfolio were sourced from the 2014 CCC Housing Unit's administrative data set (Orme, 2014). Overall, there are more male tenants than female tenants (57% vs 43% respectively) and the median age is ~65yrs. Tenants are mostly single people living alone³⁹. The reliability of the ethnicity data for the resident population is unclear. As reported in the administrative dataset, the combined categories 'New Zealander'; 'New Zealand European'; and 'Other' account for 95% of the tenant population with ~5% of tenants identifying as 'Māori'. The 2014 data show that the response category 'unknown' (n=849) is almost as large as the leading category 'New Zealander' (n=911), which makes the data difficult to interpret. All tenants' income is in the \$10,000 - \$20,000 per annum range (the 'financial hardship' criterion for qualifying for CCC housing determines the upper limit). Of those tenants receiving a benefit⁴⁰, 38% receive the invalid's benefit; 36% superannuation; 13% sickness; and 8% the unemployment benefit. No other demographic or health data are routinely collected⁴¹. In addition to the quantitative data collected via the administrative dataset, Tenancy Advisors and the CCC Project Manager described the nature of the population they worked with. While it was not possible to access data regarding the number and age of tenants in units, Tenancy Advisors estimated that, while the Council did accommodate some couples and small families, the "vast majority" (up to 75%) of the units were occupied by single tenants. Although only comprising a small proportion of the total housing population, individuals from couples and small families are particularly vulnerable to second-hand smoke from family members who smoke inside their units.

A disadvantaged population

The CCC social housing population differs from the general population in that, as noted above, a key eligibility criterion is financial hardship. Because of the well-established link between income and health,⁴² tenants are at greater risk of poor health status.⁴³ Indeed, this is borne out by the CCC data (described above) which shows that approximately half of all tenants are on either a sickness or invalid's benefit⁴⁴. This connection is also reflected in Tenancy Advisor perceptions of the tenant population experiencing more health problems than the general population and comprising many who could be considered "vulnerable". In addition, the Canterbury earthquakes of 2010-11 had triggered or exacerbated poor physical or mental health for some.

One Tenancy Advisor cautioned that "a small change for us [the Council] is a big change for our clientele" (Tenancy Advisor 1). The Tenancy Advisor felt that a smokefree policy which was too restrictive could potentially harm tenants' wellbeing, by depriving them of something (smoking) that was the focus of their day:

³⁹ Exact data not provided (but most of the CCC housing stock is of 'studio' or 'one bedroom' configuration).

⁴⁰ Data not available but most people in the \$10 000 - \$20 000 PA income range might be assumed to be beneficiaries.

⁴¹ With the exception of smoking status (implemented for this, and subsequent outcome, evaluation(s) of the project).

⁴² In all countries, socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and lesser access to high quality health services than their more privileged counterparts. See, for example, Ministry of Health and University of Otago. 2006. Decades of Disparity III: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981–1999. Wellington. Ministry of Health.

⁴³ Currently, the CCC does not formally record health information for individual tenants – although a high proportion of health issues amongst the tenant population is consistently reported by Tenancy Advisors and Housing managers.

⁴⁴ Invalid's Benefit was replaced by Supported Living Payment on 15 July 2013

“...we’ve got a lot of people that depend on their smokes and they get up and that’s their whole day, and if you say to them you can’t smoke here or you can’t do that, it could set them back...” (Tenancy Advisor 1).

On the other hand, the same Tenancy Advisor viewed the smokefree policy as potentially “empower[ing]” a population with little disposable income, by encouraging them to quit smoking and therefore putting money back in their pocket to spend on things beneficial to their wellbeing:

“...if we can stop them smoking and give them a bit more money then hopefully they can live a better life and enjoy the home they’re given, and maybe even move onwards and upwards” (Tenancy Advisor 1).

Section summary

Quantitative and qualitative data portray the CCC tenant population as low-income (earning under \$20,000 p.a.), mostly receiving income from Work and Income (WINZ) benefits and as suffering disproportionately from poor health. Because of this tenant vulnerability, a carefully staged approach to policy implementation is needed.

Objective 6: Prevalence of smoking

To document the prevalence of smoking (data source 2).

The Tenant Satisfaction Questionnaire⁴⁵

The CCC regularly surveys social housing tenants to obtain their views and feedback regarding their housing experience. The aim of the survey is to assist the CCC to improve how it manages social housing. Tenants are asked questions across the following broad categories: demographics, satisfaction with service, satisfaction with the condition of the housing unit, a rating of value-for-money, satisfaction with communication and with the Tenancy Advisors, wellbeing and health, interaction with neighbours, safety and “best aspects” of the council’s housing service together with “aspects that need the most improvement”. The pen-and-paper Tenant Satisfaction Questionnaire is individually delivered to every CCC Housing Unit (≈2200) on alternate years or a random sample of 600 units on the other years (Dec 2014 was a full survey year). The information provided by individual tenants remains confidential (non-identifiable) to the survey administrators.⁴⁶

Three new questions were added to the 2014 Tenant Satisfaction Questionnaire specifically to inform this evaluation. These questions were written in plain language and were necessarily brief and therefore could only cover the topics of prevalence, behaviour and attitudes in a very limited way. To estimate the point-prevalence of smoking in the tenant population, the New Zealand Census smoking status question was used verbatim. To gauge where tenants usually smoked while at home (regardless of whether or not they occupied a ‘smoking’ or ‘no-smoking’ unit), the following multi-choice question was used: *“If you smoke where do you smoke now when you are at home? (please tick ALL that are true for you)”*. Finally, to gauge tenants’ attitudes and acceptance of the policy, tenants were asked *“What do you think about this “No Smoking” Policy? (please tick ONE option)”*.⁴⁷

Response rate

The three smoking-related questions were answered by 788 of approximately 2200 CCC social housing tenants, giving a response rate of ≈36%. This response rate was similar (slightly lower) than the overall response rate to the full survey (≈40%). The survey administrators reported that this response rate was “typical”. The administration/collection of the survey was incentivised by a 1:200 chance of winning a \$50 supermarket voucher and the provision of a freepost return envelope)⁴⁸. The following section summarises the Tenant Satisfaction Questionnaire data.

Self-reported smoking status (point prevalence)

Tenants were asked the current New Zealand Census smoking status question and 788 tenants responded to this question. Overall, a smoking prevalence of 24% was self-reported by tenants (**Figure 4**), and this equates to a prevalence approximately 10 percentage points above the New Zealand general population, based on 2013 census data⁴⁹.

⁴⁵ This data may be subject to certain reporting biases (selective revealing or suppression of information by tenants), see the discussion section for comments on the reliability and validity of this data.

⁴⁶ Therefore most individual dwelling-level analyses are not possible as most data is reported at the level of the housing complex or aggregated over the entire housing population.

⁴⁷ The responses to this latter question have been included in ‘Section 8: Key Stakeholder Views’

⁴⁸ Other researchers of social housing no-smoking policies have generated final response rates of over 80% by employing systematic follow-up and higher value incentives.

⁴⁹ While it might be argued that smoking prevalence in the CCC social housing population could be expected to be falling in parallel with that of the New Zealand general population, Baker et al. (2012) reported a notably stable

Do you smoke cigarettes regularly?

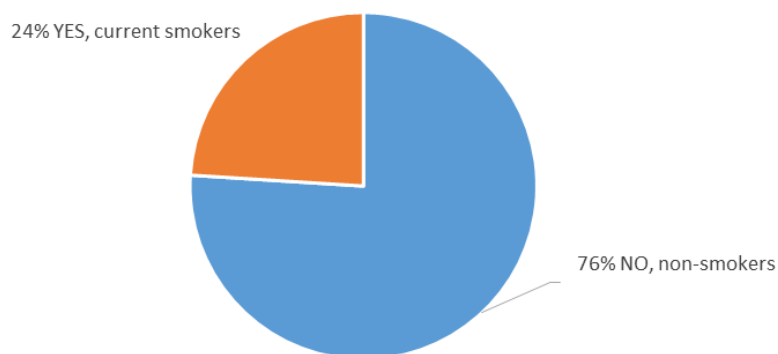


Figure 4: Self-reported smoking status (n=788)

Note that in the 25-49 years age range (not shown separately), 37% of tenants self-reported that they were current smokers (less than 20% for New Zealand overall). Overall, nearly half (48%) of non-smokers self-reported that they had smoked previously (ex-smokers).

Figure 5 shows smoking prevalence by ethnicity. Of the 55 respondents who identified their ethnicity as Māori, 17 (31%) self-reported that they were current smokers. Of the 650 respondents who identified their ethnicity as New Zealand European, 159 (24%) self-reported that they were current smokers. Note that according to CCC administrative data, a total of only 67 CCC residents were Māori as at September 2014, and this equates to between 3-5% of all CCC social housing tenants (the estimate is not precise due to missing data). Given the small absolute numbers and relatively poor data quality, the estimate of smoking prevalence among Māori CCC tenants should be viewed with low confidence.

Self-reported smoking status by ethnicity

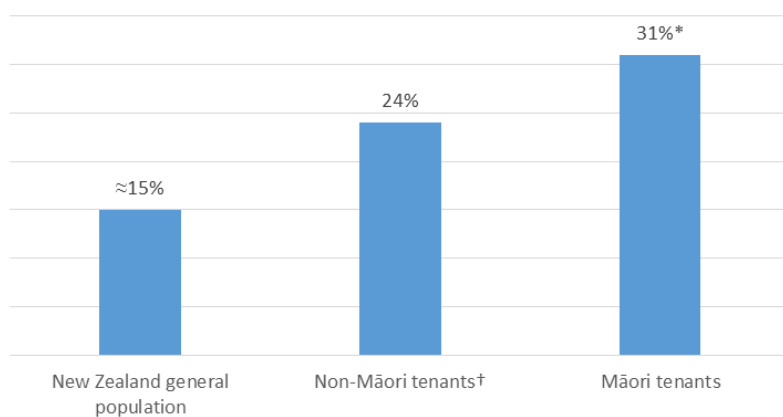


Figure 5: Percentage of tenants who self-reported as current smokers, by ethnicity, with the New Zealand population prevalence as a reference value⁵⁰.

* This value of 31% should be viewed with low confidence due to missing data and low absolute counts. The equivalent percentage for all Māori 15 years and older living in New Zealand is approximately 40%.

[†] Predominantly 'New Zealander' and 'New Zealand European'.

prevalence in another social housing population (Housing New Zealand) over a seven year period, 2004-2010 (average smoking prevalence 32.3%).

⁵⁰ http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/tobacco-smoking.aspx

Where residents currently smoke

Tenants were asked to respond to the question “*If you smoke where do you smoke now when you’re at home?*” The following response options were provided: in my unit; outside on my porch, patio or balcony; outside in my parking lot or other common area; other. The aim of this question was to broadly capture the number of current smokers who self-reported smoking in their units (this included current smokers on new contracts as well as current smokers on old contracts, who may or may not have had their own voluntary no-smoking rules). Unfortunately, responses to this question could not be individually matched to contract status at the time of the survey as it was found that the administrative and survey data sets could not be matched at the level of the individual tenant. Therefore it was not possible to determine self-reported compliance with the no-smoking policy (i.e. to answer the question: of those residents who smoke *and* who occupy a unit on a new contract, what percentage smoke inside?). Of self-reported current smokers, ≈20% indicated that they smoked inside their units, ≈70% indicated that they smoked on their balcony or patio, and the balance indicated that they smoked at other outside locations⁵¹. This data may be subject to certain reporting biases (selective revealing or suppression of information by tenants), and given the relatively low response rate to the survey, it is not exactly clear how many tenants smoke inside (the absolute number)⁵².

Tenancy Advisors’ estimates of smoking prevalence

Prior to this evaluation, the prevalence of smoking amongst tenants had not been recorded. The Tenant Satisfaction Questionnaire was a first attempt to record prevalence. The result from the Tenant Satisfaction Questionnaire – 24% prevalence – was much lower than expected, based on previous anecdotal reports of an overall high smoking prevalence amongst the tenant population. In addition, Tenancy Advisors were asked to estimate the prevalence of smoking among tenants. Tenancy Advisor estimates of smoking prevalence were higher than the prevalence recorded by the Tenant Satisfaction Questionnaire, ranging from 40-60%. Of note, it was also observed that the reliability of smoking status recorded at sign-up may be reduced by tenants being reluctant to identify as a smoker, in case this affected their chances of obtaining a tenancy.

Section summary

Prior to this evaluation, smoking prevalence amongst the CCC tenant population had not been recorded. In the December 2014 Tenant Satisfaction Questionnaire, delivered to all 2200 tenants (with an overall response rate of ~40%), three new questions asked about: smoking prevalence; where residents usually smoked; and attitudes towards the smokefree policy. The overall self-reported smoking prevalence was 24%. This figure was lower than estimates provided by Tenancy Advisors, who estimated that between 40-60% of the tenant population were smokers. While the Tenancy Advisor estimates are inevitably subjective, the suggestion is that the true smoking prevalence is higher than 24% indicated by the survey. The Tenant Satisfaction Questionnaire data recorded the prevalence of smoking as slightly higher amongst Māori (31%), although this data is viewed as unreliable due to the low numbers of tenants recording their ethnicity as Māori (3-5%). Of all current smokers, 20% indicated that they currently smoke inside, although it was not possible to determine self-reported compliance (due to not being able to link data to contract status).

⁵¹ These data may be subject to certain reporting biases (selective revealing or suppression of information by tenants), see the discussion section for comments on the reliability and validity of these data.

⁵² Notwithstanding the limitations of the data, subsequent survey results might reasonably be expected to show a decline in indoor smoking.

Objective 7: Characteristics of the housing stock

To describe the characteristics of the housing stock (data sources 4-9).

As previously described, certain characteristics of building concept, design and lay-out may plausibly influence the design and implementation of no-smoking policies and any resultant smoking-related cost savings and improvement in health outcomes. The characteristics of the housing portfolio are described below to inform the discussion of 'fit' (suitability/acceptance) with regard to the housing context and tenant population, and the specific policy parameters as implemented.

Perhaps the most notable feature of these homes or clusters of homes is their relatively low population density format (small building footprints on relatively large sections)⁵³. The 1970s and 1980s were particularly high-growth years and many formulaic housing complexes were built whereby typically 2-6 unit single-level 'blocks' were replicated and set out around a cul-de-sac or lane or crescent (e.g. **Figure 6** and **Figure 7** below). After a 1996 CCC review of housing needs, a formal decision was made to build more flexible accommodation options to meet the community's needs (e.g. units with more bedrooms or facilities for people with physical disabilities).^{54 55} **Figures 7-11** below show examples of typical housing unit styles and street lay-outs in Christchurch city. Almost all of the CCC's housing stock is comprised of these (or similar) low-rise complexes (rather than the detached individual dwellings that are typical of private residential dwellings and rental properties, or the 'state houses' available through the Housing New Zealand Corporation). These low-rise, low-density complexes differ radically from the high-rise buildings typical of social housing in other countries.

CCC housing complexes tend to be located in the less affluent neighbourhoods across Christchurch City and the surrounding suburbs (including Banks Peninsula). Units are usually single story, but two- and three-level complexes are not uncommon in some areas. The housing units are constructed of various common materials (including timber-framed with brick or fibre cement exterior cladding, concrete block, or pre-cast concrete panel construction) and are generally of lower specification than privately owned residences. **Figure 6** and **Figure 9** show different ends of the spectrum, from low-density single-level blocks of four units located in the suburbs, to inner city, higher density three-level blocks arranged into a complex of 7 blocks/118 units (built 1963-1975). Some modern complexes are included in the portfolio including **Figure 8** and **Figure 10**. Most, but not all, units have an outdoor balcony or patio (these may be covered or uncovered) or units may have a porch or some other form of covered entrance. Some blocks of multi-storey units have common stairwells and/or foyers but may have no covered outdoor patio or other area. Few, if any, complexes employ common or ducted heating and/or ventilation systems.

⁵³ Blocks of units within a complex are often separated by large grassed, un-fenced common areas, and these common areas may blend into the access footpaths and the roadway(s).

⁵⁴ <http://www.ccc.govt.nz/services/social-housing/social-housing-history/>

⁵⁵ Today, a wide range of people are eligible for the Council's social housing service including the elderly, disabled persons, sickness or unemployment beneficiaries and people on very low incomes.

Examples from the CCC social housing portfolio



Figure 6: A typical CCC housing complex (A)

Nine buildings each comprising four residential units.



Figure 7: A typical CCC housing complex (b)

A social housing complex consisting of seven separate building blocks built in 1980. The site has a total of 32 residential units and a residents' lounge.



Figure 8: A CCC housing complex in Western Christchurch

A CCC housing complex in the western Christchurch within the suburb of Hornby. The building is a 2-storey structure, consisting of a communal block and multi-unit residential block (constructed in 2001).



Figure 9: Central city housing

A central city multi-unit housing complex: 118 units in 7 similarly-constructed residential buildings (built 1963-1975).



Figure 10: A rebuilt housing complex post Christchurch earthquakes

Staff descriptions of housing stock

Qualitative data gathered from the CCC project manager and the three Tenancy Advisors further illustrate characteristics of the CCC housing stock of particular relevance to policy design and/or implementation.

Limited individual space

Tenants lived in close proximity to each other, with one Tenancy Advisor describing the close living conditions as being “on top of or next to each other” (Tenancy Advisor 2). Although the complexes (in terms of number of units) were relatively small by international standards, with (typically) large spaces between them, the spaces between were usually open grass without landscaping. The lack of fencing and separation between units meant a lack of defined individual space outside for tenants. In the CCC project manager’s eyes, this created the problem of tenants having “nowhere to hide”, for example, in terms of how smoking impacts on others:

“...if you go to one side of the building it [smoking] may be affecting somebody else there mightn’t even be much space to move around in the periphery of the block. And so that becomes an issue in itself” (CCC project manager).

These comments highlight that the physical nature of social housing contributes to second-hand smoke issues. Because of the close living situation, there is a potential issue of ‘smoke waft’ within shared outdoor spaces.

Communal spaces

Communal lounges were relatively rare and were usually only provided in larger complexes (i.e., those of 50 or more units). These shared lounges were used for a variety of purposes, including tenant meetings, First Aid training and other activities. Communal lounges were smokefree by Council policy.

While it was observed that complexes provide “open, free space” outside, giving tenants the opportunity to mix, there were few landscaped outdoor areas, such as seating or barbeque areas, and, as noted above, no designated outdoor smoking areas:

“... generally all the complexes have a lot of open, free space which is communal and you might find that ... neighbours can congregate there ‘cos they’ll be out washing their clothes and things like that, so you do have those sort of shared spaces.” (Tenancy Advisor 2).

Section summary

Although the CCC social housing stock is generally low-density (small building footprints on relatively large sections), the designs still tend to create close living conditions, due to the lack of individual separated (outdoor) space (as compared to many private homes in New Zealand). Most complexes have shared open space outside but these spaces typically lack visual separation by landscaping or other features, and there are no designated outdoor areas for smoking. Indoor communal spaces are smokefree but are relatively uncommon as they are found only within the larger complexes (i.e. ≈50+ units). The potential for the close living situation and shared outdoor space to contribute to smoke waft may be an issue for the Council to consider in its ongoing implementation of the policy.

Objective 8: Views of key stakeholders

To document the views of key stakeholders (residents, tenancy managers, Smokefree ABC team) towards the policy and to describe the level of consultation the CCC engaged in to inform their decision. To measure and report tenants' acceptance of the policy (data sources 1-6: key stakeholders of the smokefree policy include the tenants, Tenancy Advisors and the CDHB's Aukati Kai Paipa team, as well as the two project managers from the CCC and the CDHB).

Tenants

The success of the smokefree policy is contingent upon the views of the tenants themselves towards the policy. To this end, the evaluation attempted to capture the views of tenants (through both qualitative and quantitative methods) as key stakeholders of the smokefree policy. A set of interviews was conducted with tenants as the final component of this process evaluation. As recruiting and interviewing individual tenants in their homes is significantly resource-intensive, only a small number of interviews were conducted to explore awareness of the policy, support (or otherwise) for the policy, and/or to flag any other major issues related to policy implementation. A convenience sample of six tenants was selected from a list of volunteer interviewees via the CCC database (three non-smokers and three current smokers). These tenant interviews were intended to provide a brief non-exhaustive overview of initial policy implementation only, from the tenants' perspective (process evaluation), rather than an in-depth qualitative study of the impact of the smokefree policy on tenants' smoking behaviours (outcome evaluation).

Of the three smokers, two were actively trying to quit. Only two of the six interviewees were on new contracts, and therefore legally obliged to comply with the smokefree rule; the others were all long-term tenants who did not expect that they would trigger the new contract in the near future (although one voluntarily abstained from smoking indoors) – as they were not expecting to move units and their units were unlikely to be redecorated (note that there are some long-term tenants who are unlikely to sign a new contract within their lifetime). One of the tenants shared the unit with his/her partner who was present at the interview.

Tenants who were interviewed accepted the policy in a matter-of-fact way. Smokers accepted it as 'about right' (Tenant Five) and as the 'new normal':

"Same as in places like pubs you can't smoke, 'cos you know you used to but now we can't smoke in there" (Tenant's partner).

"It's normal yeah" (Tenant 1).

The non-smokers interviewed also accepted the policy, stating that it was "fair enough" (Tenant Two), "it doesn't worry me" (Tenant Three) and "that's all there is to it" (Tenant Four). They supported the policy from a property maintenance perspective, being sympathetic to the negative impact of smoking on the living environment and the accompanying financial burden for the Council. The Council was therefore viewed as a responsible landlord for imposing the smokefree rule.

Amongst smokers, acceptance of the policy was also linked to the quality of the indoor living environment. Tenants believed that complying with the policy was a 'fair exchange' for good-quality accommodation; conversely, one tenant viewed it as unreasonable to avoid smoking inside when "basic" maintenance work was needed, believing that coming under the smokefree policy would be a fair exchange if "the place was done up". On the other hand, another tenant's previous unit was "damp" and "mouldy" and s/he was therefore motivated to accept the smokefree policy in exchange for a newer, warmer unit.

Tenants interviewed perceived general acceptance of the policy amongst others throughout the complexes (although they acknowledged the potential for some rebellion from long-term smokers). They felt the current scope of the policy was about right and were cautious about extending it to include outdoor areas, although also recognised that the Council needs to “get tough” at some stage.

Tenant interviews highlighted the importance of the wider social and legislative environment in promoting acceptance of the new CCC smokefree policy. The Smokefree Environments Amendment Act 2003, described by one tenant as “banning smoking in the boozers”, had prepared people for what to expect. The same tenant believed that it was a logical progression to extend similar legislation to Council housing.

Tenants on new contracts had become aware of the smokefree policy when they signed the contract. Others on old contracts learned of the policy through various channels, primarily word-of-mouth but also through the media (including talk-back radio). Those on old contracts noted that they preferred direct, personal communication from their Tenancy Advisor for such matters but acknowledged the constraints of limited resources:

“So no it wasn’t my Tenancy Advisor ...it all just came through the normal channels. There was some mail... I heard things about it, people talked about it. No-one actually came round here personally and said, well we’re bringing this rule in, which probably would have been quite good... I know the Council is strapped...but I think this is a reflection of that” (Tenant 3).

The small number of tenant interviews was insufficient to elicit comments on all aspects of compliance, however, one clear theme was that smoking outside was weather-dependent⁵⁶. Partial compliance occurred due to a lack of shelter in poor weather (wet, cold or windy conditions):

“I smoke inside sometimes....sometimes I have a smoke out there [on] a nice day – a really sunny day I smoke out there – but raining days inside” (Tenant 1).

Despite good intentions, the smoker had concluded:

*“... bugger this smoking [outside]...you get b***** soaked and you get colds”* (Tenant 1).

Compliance varied amongst different housing sites, with the availability of and access to sheltered outdoor areas making it more or less easy to comply (this also depended on the self-motivation of the individual). Some tenants were self-motivated to voluntarily make their own unit smokefree. Tenants (both smokers and non-smokers) also reported being able to extend the policy to visitors without any issues. Tenants themselves observed compliance amongst others, noting that the number of tenants smoking outside had possibly increased since the introduction of the policy.

Interviewees had variable understanding about how the policy was to be enforced. It was perceived that enforcement had not become routine, although tenants believed that it was certainly possible for Tenancy Advisors to incorporate follow-up of the policy into business-as-usual:

⁵⁶ The active promotion of nicotine management strategies (by Tenancy Advisors) could possibly alleviate this apparent barrier to compliance.

"I think they probably check it every time they check something else...like they come in to check the smoke alarms and they come...for other reasons...and they would probably just notice if somebody was smoking inside" (Tenant 5).

However, it was apparent (at the time of interview) that not all of those on new contracts had been followed up to check on compliance. There was some uncertainty about consequences, including the possibility of potential eviction for breaching the policy: "I don't know what would happen. They might evict us" (Tenant 5).

Tenants interviewed perceived that the smokefree policy was a sensitive issue, and that its implementation needed to be managed carefully. They reported that the Council had so far implemented the policy smoothly and successfully and that the Council's quiet, staged approach was appropriate for this population. In one sense, the Council "can't do any more", they have "done their bit" (Tenant Three). However, there was a tension implicit in the need for sensitivity alongside the impetus for a change toward healthier environments:

"they've got to be careful how they do it...[but] the longer they leave it, the more people are going to die...they've been nice now for too long. They've got to start acting" (Tenant 4).

Tenant interviews therefore highlighted that an ongoing issue for implementation is the need for sensitivity in how the Council communicates information regarding the policy. Further suggestions for implementation were providing wet-weather smoking areas in all complexes (and designated outdoor smoking areas in general, to minimise smoke waft), and receptacles for cigarette butts, both of which may aid compliance.

A strong theme that emerged from the tenant interviews was that of the resources required for a full and successful implementation of the policy. The implementation of the policy has a dual aspect – that is, setting the smokefree rule in conjunction with providing smoking stop-smoking support. Whilst the initial implementation had been smooth, it was clear that considerable resources (in the form of input from Tenancy Advisors) would be required to adequately follow up on compliance and to provide stop-smoking support. Tenant interviews suggested that at sign-up, Tenancy Advisors were not routinely offering stop-smoking support, supporting the quantitative findings. Tenants suggested that more effective communication (including more personal contact between Tenancy Advisors and tenants) would aid compliance and enable cessation.

Tenants were motivated to quit smoking and shared stories of how difficult it was to do so, including in terms of background circumstances and social environments that had enabled smoking, such as intergenerational smoking. Tenants highlighted barriers and enablers to quitting success. The former included that some perceived smoking both as an activity, "something to pass the time", and a reliever of stress. Tenants cautioned that the smokefree policy had the potential to exacerbate interpersonal conflict, with it being "pretty easy...in complexes like this for there to be strife" (Tenant 2).

Enablers to quitting included existing social support systems (such as support provided by work colleagues), specific motivators and social norms. Quitting attempts were enabled by acquaintances also trying to quit: "my boss... wanted to give up smoking. I said I'll go with you" (Tenant One). Other attempts were inspired by financial and health imperatives to quit, including those triggered by experiences of observing family

members suffer from smoking-related ill-health. A powerful theme was the strength of social norms in shaping smoking behaviour. One tenant had moved from a complex where:

“Anybody smoking inside so ... may as well...smok[e] inside” (Tenant 1).

In general, although derived from a small number of tenant interviews, these findings indicate that the smokefree policy creates a barrier/disincentive to smoking, making it harder for tenants to smoke: they either have to knowingly break the rule by smoking inside or they must go outside to smoke. Although decisions to quit were not directly attributed by interviewees to the policy, there was evidence that a new smokefree environment enabled quitting.

Tenant Satisfaction Questionnaire

The quantitative data source for this evaluation was the CCC’s Tenant Satisfaction Questionnaire⁵⁷ (December 2014), to which a new question was added, asking tenants to respond to what they thought about the “no smoking” policy.

Tenant support for the no-smoking policy

Tenants were asked to respond to the question “What do you think about this “No Smoking” Policy?” by selecting one of the following options: “It’s a good idea”, “It’s O.K.”, “It’s a bad idea” or “Don’t know, I haven’t heard of this policy”.

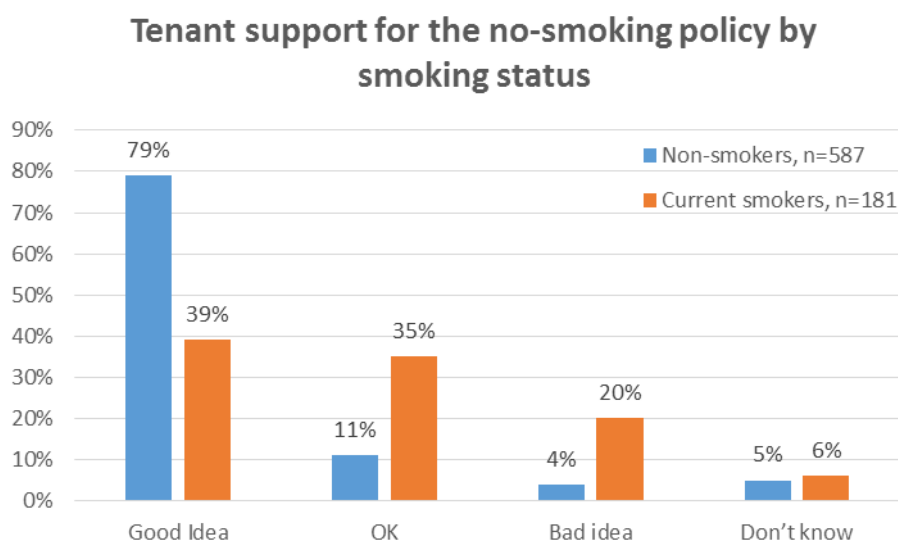


Figure 11: Participant responses to the Tenant Satisfaction Questionnaire question “What do you think about this “No Smoking” Policy?” represented by self-reported smoking status.

Figure 11 shows that respondents identifying as non-smokers were more inclined to support the no-smoking policy than respondents identifying as current smokers. In total, 90% of non-smokers indicated that they supported the policy (either “good idea” or “OK”) with only 4% thinking the policy was a bad idea (5% didn’t know). Although support for the policy by respondents identifying as current smokers was less strong, 74% (n=133) of current smokers reported that they thought the policy was at least “OK” and 20% (n=37) of current smokers thought the policy was a bad idea (6% didn’t know). Overall, respondents indicated clear support for the no-smoking policy with 87% of respondents (529 non-smokers and 133

⁵⁷ n= 768 respondents

current smokers) reporting that the policy was “a good idea” or “OK” versus the 8% of respondents who indicated a lack of support for the policy (combined data not shown on **Figure 11** for clarity). Seven respondents provided qualitative comments. One respondent favoured the policy from a safety perspective:

“I totally support the “NO SMOKING” Policy because it’s not only good for health of the tenant but ... If you are not so careful you will start a fire.”

Tenant concerns

Six of those who provided comments either opposed the policy or indicated negative consequences, such as smoking waft, inequity, stigma, security and social issues. One important finding was the sense of discrimination felt by one tenant, who believed s/he was being doubly stigmatised as a person needing social housing and by being forced to smoke outside:

“No smoking policy, I believe [is] discriminatory. I can't use a legal product in my own home! ... The council has a legal obligation to house the mentally ill, I don't have the same rights and protections as others.”

Qualitative responses also drew attention to the practical difficulties raised by tenants smoking outside. These included the social dynamics between tenants, with one respondent suggesting that smoking outside contributed to “verbal abuse” and “fights”. Another respondent stated that smoking outside “just does not work”. Two respondents described second-hand smoke issues, with one requesting a designated smoking area:

“Also the smoking rules aren't that effective. Neighbours smoke outside their doors but as our complexes are joined that smoke comes straight into my place and I have had cancer so I worry about that. Would it be possible to have a designated smoking area away from the flats?”

Section summary

Overall, 87% of the 788 tenants (non-smokers and smokers) responding to the survey supported the policy (agreeing that it was either a “good idea” or “OK”). Amongst the six tenants interviewed, there was a high level of support for the policy and of the need for the policy and for stop-smoking support. Tenants believed that the smokefree rule was a fair exchange for an improved standard of living. There was a matter-of-fact acceptance towards the policy, summed up as “you’re not allowed to smoke and that’s all there is to it”. This was perhaps a reflection of the wider smokefree legislative environment preparing the way for other smokefree policies and of related changing social norms, which have made smoking inside less acceptable. Tenants felt that the scope of the policy was currently “about right” and were cautious about extending it to include grounds or outdoor areas. They felt that the policy had been implemented smoothly, although follow-up was needed to check on compliance. Tenants felt they would like more communication with their Tenancy Advisors but acknowledged that Council resources were limited. Modifications to the implementation of the policy to support compliance could be considered, including designated, covered outdoor smoking areas and receptacles for disposing of cigarette butts.

Tenancy Advisors

Tenancy Advisors are responsible for practically implementing the smokefree policy. This includes informing new applicants/tenants of the policy and its implications (i.e. where they can smoke, what they need to do to be compliant) and the consequences of non-compliance. At tenant 'sign-up', Tenancy Advisors inform applicants of the clauses in their tenancy agreement (including the no-smoking rule) before signing the contract. Tenancy Advisors are also required to ask and document the tenant's smoking status and this in turn provides an opportunity to provide (and record) any smoking stop-smoking support given (the ABCs)⁵⁸. This section summarises the findings from an on-line Tenancy Advisors' survey as well as in-depth face-to-face interviews with three Tenancy Advisors. The findings presented below cover the following themes: stop-smoking support; systems and protocols; 'fair exchange'; communication; soft policy; enforcement; compliance; social norms; business-as-usual; resources; and investment and return.

Tenancy Advisors' Survey

The Tenancy Advisors' Survey was made available for Housing Unit staff to complete online between 1st July and 8th July 2015 (using the SurveyMonkey platform). The survey was compulsory and was promoted to the Tenancy Advisors via a link sent by email by the Housing Unit manager, with participants being assured of anonymity. The expected response rate of 100% (6/6) was achieved⁵⁹. Tenancy Advisors were asked a number of questions covering their beliefs and attitudes towards the new policy, their experience to date with educating applicants/tenants, their experiences with providing stop-smoking support, and their views and experiences with enforcing the policy (note that each Tenancy Advisor is responsible for approximately 350-400 tenants, therefore a single Tenancy Advisor's behaviours and attitudes could potentially influence a large number of individuals).

In the main, Tenancy Advisors reported that they thought the policy was a "good" or "great" idea (2/6 and 4/6, respectively) and most of the following results are in keeping with this support for the policy. Most Tenancy Advisors (5/6) reported that they had been fully trained to implement the policy and to provide smoking stop-smoking support to tenants (with all Tenancy Advisors reporting having completed at least one training session and/or training from peers).

Tenancy Advisors reported being either "very comfortable" (3/6) or "reasonably comfortable" (3/6) with providing stop-smoking support, however, the Tenancy Advisors' results indicated that the real-world *delivery* of the ABCs is likely inconsistent. **Figure 12** shows an apparent decline in stop-smoking support activities by Tenancy Advisors that is associated with the degree of difficulty or resource intensiveness of the intervention (i.e. either A, B or C). 'Ask' rates were reported to be high, with all Tenancy Advisors explaining the policy 100% of the time or "almost always" and most Tenancy Advisors (5/6) reporting that they then ask tenants their smoking status. Most Tenancy Advisors (4/6) reported that they also record tenants' smoking status in the contract notes. Most Tenancy Advisors (5/6) reported that they provide tenants with brief advice to quit smoking and most (4/6) reported that they record that brief advice to quit

⁵⁸ Providing the cessation ABCs (Ask, Brief advice, Cessation support) is the evidence based framework used for providing support to current smokers in New Zealand (Ministry of Health, 2014b) and Tenancy Advisors are trained in this model.

⁵⁹ Note that for the Tenancy Advisors' Survey, the sample size is small (6) and the results are therefore presented as counts (number of Tenancy Advisors). Representing these results as percentages does not communicate any greater meaning.

has been given⁶⁰. However, stop-smoking support activities appear to be provided less consistently. Half of the Tenancy Advisors reported that they referred willing tenants to the 0800 Quitline service for telephone counselling. The same three Tenancy Advisors also reported that they personally provide face-to-face smoking stop-smoking support (i.e. a brief counselling session) to tenants who ask for help. However, only one Tenancy Advisor reported that s/he proactively follows up with tenants to renew cessation advice and support (e.g. once a year).

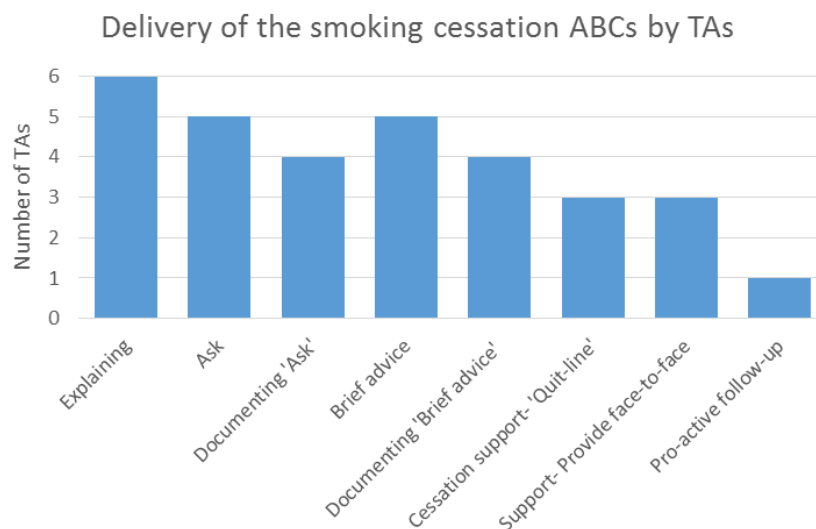


Figure 12: The apparent decline in stop-smoking activities by Tenancy Advisors (TAs) with the increasing complexity and resource intensity of the activities.

While most Tenancy Advisors reported providing at least some stop-smoking support at the time of sign-up, uptake by tenants was reported to be low. Most Tenancy Advisors (5/6) reported that mostly, *“tenants listen and are generally receptive, but do not accept the offer there and then”*. One Tenancy Advisor commented that the sign-up process can create “information overload, particularly for vulnerable tenants” and other Tenancy Advisors reported similarly that the ‘sign-up’ interview might not be the best time to offer stop-smoking support.

The Tenancy Advisors’ views and actions with regard to policy enforcement⁶¹ and compliance were also briefly explored in two questions in the Tenancy Advisor Survey. Most Tenancy Advisors concurred that the policy did not include clearly defined enforcement actions. One Tenancy Advisor indicated that the policy was ‘very difficult’ to enforce and two Tenancy Advisors considered it ‘difficult’. Two Tenancy Advisors gave a ‘neutral’ response, and one Tenancy Advisor indicated that the policy was ‘easy’ to enforce. One Tenancy Advisor commented that s/he considered it “Extremely unlikely that we would obtain possession of a unit if a tenant continues to smoke in the unit”. This comment reflects the view that smoking in a unit would not be considered by the Tenancy Tribunal as a sufficiently serious breach of a tenancy agreement to warrant eviction. Another Tenancy Advisor reported that “The tenant will be charged at the end of their tenancy for

⁶⁰ However, an audit of the relevant documentation (by the evaluators) identified far fewer completed ‘sign-up’ forms than new contracts struck, and a proportion of these forms was incorrect/incomplete.

⁶¹ Enforcement refers to any actions required to address ‘breaches’ of the tenancy agreement, rather than the actions needed to implement the policy as part of day-to-day work or normal process.

the damage to the property”⁶². Despite there being limitations with respect to immediately implementable enforcement actions, most Tenancy Advisors (5/6) reported that they considered the policy was having ‘some’ or ‘a big’ impact on the quality of the indoor environment. No formal complaints (from either current smokers or non-smokers) were reported by Tenancy Advisors. One Tenancy Advisor commented that “There has generally been a great deal of compliance with new tenancies. I expect there to be issues of non-compliance as time goes on but will be interesting to see”.

Finally, Tenancy Advisors were asked to rate the impact that the no-smoking policy has had in terms of their normal day-to-day work. Most Tenancy Advisors (4/6) indicated that implementing the policy extends their work and provides an opportunity to make a real contribution to the health and wellbeing of all tenants, or that it fits within and it goes ‘hand-in-hand’ with the other supports that are routinely provided. Two Tenancy Advisors indicated that the new policy does not really make a lot of difference to their work. No Tenancy Advisors indicated that they did not see it as being part of their role.

Tenancy Advisor interviews

Tenancy Advisors provided an overview of how the policy was working operationally. Overall, Tenancy Advisors felt that the implementation of the policy had “gone really well” (Tenancy Advisor 2) – which concurred with tenant views. They were aware that the overall process of becoming a smokefree housing provider was a very gradual one. There were only about 200 new contracts per year out of a total of 2000 tenants, with an average tenancy of “about two years” (Tenancy Advisor 1) and about 50% of the units “keep turning over”. Advisors estimated that it may be 10 years before the CCC reached 80-90% of the tenants with the smokefree policy. In the meantime, gentle reinforcement of the policy consisted of including the policy in the tenancy agreement, applying no-smoking stickers to doors and windows, “reminding people of what’s going on” and charging for damages (Tenancy Advisor 1). Tenancy Advisors believed that the soft approach was appropriate and potentially effective. However, the policy needed to be kept at the forefront (of Council direction) – aided by the partnership with the CDHB to “keep us motivated” (Tenancy Advisor 1).

As suggested by the Tenancy Advisor Survey, Tenancy Advisors stated they felt confident providing stop-smoking support. They had been formally trained as Quit Card providers at the Community and Public Health (CPH) office. Ongoing training included team discussions and problem-solving, and a few visits from the CDHB Smokefree team to answer questions and provide brochures. Tenancy Advisors felt their team was “really good at ... communicating” (Tenancy Advisor 3) to resolve specific issues. It had also been helpful to be “more informed” (Tenancy Advisor 1) about the government’s Smokefree 2025 priorities. One Tenancy Advisor had become more confident over time, learning new communication skills appropriate to the situation and becoming more persistent in tailoring the message to the individual:

“when you started before it was like ‘no’ and it’s like ‘o.k’. That was the end of it. But now you...just sort of try and carry on a little bit further and see if they’re receptive or not...you ask the question, ‘do you smoke?’...you get a vibe of whether they’re willing to talk about it or not, and some people just aren’t...it depends on the ‘no’ that you get, whether you can actually still carry on with it...you just go with it and see what happens”
(Tenancy Advisor 3).

⁶² No comments were made here on the practicalities of charging this low-income group for damages (however, see later sections).

However, this increased confidence appeared to be an exception, with another Tenancy Advisor suggesting that skills had diminished over time – “it’s been so long since we did it” (Tenancy Advisor 2), consequently suggesting regular six-monthly re-training.

‘Reactive’ approach to stop-smoking support

A general theme was that Tenancy Advisors were more reactive than proactive in offering support, except for one Tenancy Advisor who proactively initiated conversations with all smoking tenants whom s/he visited. As per the Tenancy Advisor Survey, Tenancy Advisors suggested that in practice, providing stop-smoking support was more likely to entail ‘asking’ and providing ‘brief advice’ to quit (generally at sign-up) than offering specific stop-smoking support activities. In keeping with the survey findings, uptake by tenants had been low. One Tenancy Advisor noted that the support offered needed to be non-forceful, with the offer of “‘we’ve got the facilities to help you, if you want it, it’s there” (Tenancy Advisor 1).

As indicated by the Tenancy Advisor Survey, the sign-up procedure was perceived as information-heavy and as not necessarily the ideal time for offering stop-smoking support. However, in general, the sign-up sheet and the wording in the tenancy agreement worked well and together the documents were comprehensive. Tenancy Advisors made some specific suggestions about how to improve this procedure. One was to move the no-smoking clause from the middle to the end of the interview, which “might allow for a bit more conversation...and to expand on it a bit more” (Tenancy Advisor 2). Another suggestion was to “get a little bit more out of them” (Tenancy Advisor 1) rather than just “do you smoke?” (for example, more information about where/when/how often tenants smoked) – although, as noted, the interview was already information-dense.

Lack of systems and protocols

The lack of formal (written) protocols and systems in place to support the policy appeared to be problematic. For example, all Tenancy Advisors interviewed were aware that the policy entitled them to charge tenants for smoking-related damage. This was discussed with tenants at sign-up, but there was no written protocol to support this. In addition, there were no systems for identifying which tenants were on old or new contracts or for recording breaches. ‘Smokefree’ stickers were applied inconsistently to units for those on new contracts, and it was suggested that these be applied retrospectively to all units that had been newly tenanted since the introduction of the policy. There also needed to be a better system for keeping track of tenants’ smoking status and of those who indicated that they wanted to quit, so that they could be followed up.

‘Fair exchange’

The policy had been received well by tenants, who were “open to the question” (Tenancy Advisor 2) of smokefree housing. This openness was perceived as critical to the success of the policy. Tenancy Advisors suggested that acceptance of the policy was expressed in a matter-of-fact way and that it was linked to a ‘fair exchange’: “we’re saying to them look we’re going to paint your unit and do this and this and this...you can’t smoke inside...I think they’re pretty happy with that” (Tenancy Advisor 2). On the other hand, it was difficult to enforce the policy for old, sub-standard housing (which was considered common): “it’s hard to say to a tenant that you’ve got to maintain this property when it’s not in great condition anyway” (Tenancy Advisor 1). Instead, providing brand-new units (for example, earthquake re-builds) gave the policy “more weight” and gave tenants “different expectations” (Tenancy Advisor 1). Prior to the current policy, one Tenancy Advisor had successfully negotiated a tenant’s decision to quit smoking in exchange for a redecorated unit. The tenant had quit, and the Tenancy Advisor had (eventually) successfully honoured the

earlier promise: it “took me probably 13 months but I got it done in the end” (Tenancy Advisor 3), with progress delayed due to limited funds.

Some older, long-term tenants were less willing to accept the policy and could “get a bit grumpy” (Tenancy Advisor 1) about needing to change longstanding habits. One Tenancy Advisor’s strategy was to provide advance notice of the policy, and then diplomatically respond to objections with:

“I’m not telling you you can’t do anything...I’m advising you that these things may change”
(Tenancy Advisor 1).

Consequently, this approach met with general acceptance – although acceptance was qualified by the comment that change was unlikely: “well you’ll be carrying me out in a box anyway ...” (Tenancy Advisor 1).

Careful and sensitive communication

Good communication skills were an integral part of implementing the policy. Tenancy Advisors needed to be diplomatic (as noted above), judicious (‘judging the tone of the no’, when offering stop-smoking support) and sensitive in discerning how best to advise of the policy. The theme of careful and sensitive communication being a pre-requisite for acceptance of the policy echoed what tenants themselves said. This careful approach appeared to have been successful, with Tenancy Advisors having had no complaints since policy implementation. The lack of complaints included those pertaining to second-hand smoke, although there had been a complaint pre-policy and it was likely to be a “future issue” (Tenancy Advisor 2) (current complaints concerned marijuana rather than tobacco).

Soft policy

The scope of the policy was viewed as appropriate for this population, for whom “small steps” were necessary – “you can’t just rush in” (Tenancy Advisor 1) — “Change is... big” and therefore:

“push it too far [and] it will just fall over” (Tenancy Advisor 1).

A soft policy was needed because a full smoking ban had the potential to “set [tenants] back” if smoking was removed entirely – it was “their whole day” (Tenancy Advisor 1). Currently, the soft scope of the policy was more practical to enforce than a “blanket ban for an entire complex” (Tenancy Advisor 2). Whilst one Tenancy Advisor wished to extend the policy to “all tenants, not just the new ones” (Tenancy Advisor 3), s/he also recognised that this would be difficult to enforce: “you couldn’t do it half-way through a tenancy”. The scope was also appropriate to the quality of the housing stock – with the potential to be “tougher” (Tenancy Advisor 1) for brand-new units (for example, complexes re-built since the earthquakes). At the moment, Tenancy Advisors felt it was too soon to make balconies and patios of individual units smokefree.

Enforcement unclear

As indicated by the Tenancy Advisors’ Survey, Tenancy Advisors were unclear about the precise methods of enforcing the policy, having had little need to do so at the time of interview. This lack of clarity could be attributed to the lack of written protocols or systems in place for dealing with breaches. To a large extent, it was up to individual Tenancy Advisors to invent their own system for responding to and recording breaches, although such methods were sometimes discussed at team meetings. For example, one Tenancy Advisor had initiated his/her own system for keeping track of relevant tenant details, incorporating smoking status and the start date of the tenancy into existing tenant visit records – s/he intended to pass this method on to the other Tenancy Advisors.

As mentioned above, it was difficult for Tenancy Advisors to enforce the policy when they did not know which of their tenants were on a new contract:

“it’s going to be hard because you’re not going to [know]... you’ll go and visit them but you don’t know whether [smokefree is] in their clause or not” (Tenancy Advisor 3).

The only official system for enforcement appeared to be issuing a written breach notice; however, the “reality” (Tenancy Advisor 1) was that the notice “doesn’t really hold much weight”. Tenancy Advisors stated that it was “very unlikely that we would terminate” (Tenancy Advisor 1) a tenancy for a breach of the smokefree policy, since as a “social landlord” they were committed to maintaining tenancies. A further reality for Tenancy Advisors was that despite their commitment to the policy and to tenants, they were limited by the availability of resources (that is, Tenancy Advisor time):

“we could breach someone, we could talk to them, we could remind them of the agreement...if we can keep on quite regularly, they would stay outside and smoke but unfortunately we don’t have that time” (Tenancy Advisor 1).

Since Tenancy Advisors were very limited in their ability to punish bad behaviour (such as non-compliance), an alternative strategy was the potential of positive reinforcement – in the form of rewards for good behaviour. These rewards could take the form of free rent (for a time) or “\$100-200” maintenance vouchers (Tenancy Advisor 1) for repairs or upgrades.

Evidence of compliance

At the time of interviews, there had only been one ‘official’ breach (amongst the three Tenancy Advisors interviewed) and tenants appeared to be complying. One Tenancy Advisor noted, for example, a tenant who had recently signed a new contract and who was observed smoking outside: “every time I go out there he’s always smoking outside with his door closed so it is working, it is working” (Tenancy Advisor 2). All three Tenancy Advisors had observed increased smoking outside since the implementation of the policy:

“change in the last 12 months... I have noticed there’s more and more people sitting outside and having that smoke rather than sitting inside the house smoking” (Tenancy Advisor 1).

Tenancy Advisors felt that non-compliance would be obvious, with evidence of smoking inside both visible and able to be smelled. However, they would not know until they did the annual inspections. There were reports of partial compliance, some of it weather-dependent – “a few” tenants had used “the excuse, ‘well it was really cold that day’” (Tenancy Advisor 1) and the Tenancy Advisor had speculated that this may increase with colder days. Another Tenancy Advisor felt that compliance was partial across his/her portfolio:

“a lot of tenants...have said ‘we’re smoking outside’ but...[there were] other ones where you’d walk into a room and it’s full of smoke” (Tenancy Advisor 3).

Note: although these smokers were not necessarily on new contracts – as noted, it was/is difficult to know who should be complying with the smokefree rule.

Social norms

An important factor in aiding compliance was the context of wider social norms – the fact that more people were smoking outside was “not just because of what we’re doing” (Tenancy Advisor 3), it was also due to knowledge circulating about government priorities (Tenancy Advisor 1). The impact of “trends” on the

tenant population was described by one Tenancy Advisor: “as soon as one group starts doing it, the rest will” (Tenancy Advisor 1). Similarly, word-of-mouth was an important tool for ensuring compliance:

“once that word gets out...that’s the one thing we do have in our favour. Word of mouth is huge” (Tenancy Advisor 1).

This meant that in future, when Tenancy Advisors charged tenants for damages caused by smoking, “word will get around” (Tenancy Advisor 1), thus acting as a deterrent to smoking inside.

Business-as-usual

As noted in the survey results, Tenancy Advisors were positive about how providing stop-smoking support fitted into their day-to-day work schedules. It was “no problem at all” (Tenancy Advisor 2), having “just become part of it now...part of that sign-up process”. Further opportunities for offering support were provided by annual inspections, and one Tenancy Advisor stated that this had become routine: “well I was doing the tenant visits, so I thought ‘well you may as well do the whole lot together’” (Tenancy Advisor 3). S/he took an opportunistic approach to providing support when visiting tenants, finding out “who smoked and who didn’t and what they thought of it and if they wanted to speak to CDHB” (Tenancy Advisor 3). Another Tenancy Advisor noted that conversations could be triggered by the condition of the unit: “if...it’s yellow...that’s when you’re going to have that conversation around offering them support” (Tenancy Advisor 2). Tenancy Advisors did express a differing sense of priority about the smokefree message. For one, it was seen as urgent, something that s/he would prioritise over other activities because “the other things can...wait, whereas giving up smoking probably shouldn’t wait” (Tenancy Advisor 3):

“even if I was flat-stick, if someone was to ask for help I’d give it, ‘cos I just think it’s beneficial to them” (Tenancy Advisor 3).

Another Tenancy Advisor felt that promoting smokefree was more “constant” (Tenancy Advisor 1) than other issues which could “escalate quite fast” and therefore required immediate attention (e.g. conflict with other tenants).

Limited resources

The theme of limited resources emerged strongly from both Tenancy Advisor and tenant interviews. Tenancy Advisors had heavy case-loads, of approximately 350-400 tenants each, and were expected to complete annual inspections for each tenant. They felt the pressure of being under-staffed:

“we’re really stretched at the moment with lack of staff...so everything is...a bit harder to get done” (Tenancy Advisor 3).

More resources were needed to follow up tenants. Tenancy Advisors regretted that current resources were insufficient to follow up tenants after sign-up (as had occurred in the past), suggesting that a welcome visit within the first six months (Tenancy Advisor 1) would be ideal. This lack of follow-up was explicitly attributed to “resources, it’s time and people” (ibid). It was particularly important in light of the new policy to follow up those who indicated they were either in the process of quitting smoking or who wished to quit, otherwise there was the risk of losing those who indicated they were interested. That was:

“the end of that conversation...they get lost...there’s a lack of follow-up” (Tenancy Advisor 2).

Tenancy Advisors explicitly stated that a full and proper implementation of the policy would be resource-intensive:

“If it was to be driven successfully and done properly, it could take quite a bit of time...to really push through, it would take a heck of a lot of time and that’s why we don’t do as much as we should because we just don’t have the resources. Simple as: if we had double the amount of staff, we’d be doing a lot more” (Tenancy Advisor 1).

Investment and return

Tenancy Advisors believed that the investment required to implement the policy was worth it in terms of the positive benefits for tenants. One Tenancy Advisor hoped that in future, tenants would be less likely to be placed in units that were contaminated by third-hand smoke, and that this would benefit their physical and mental health. Another felt that the negative impact of smoking on health required urgent attention and that the implementation of the policy, including support to quit, was therefore a high priority (discussed above). Another Tenancy Advisor strongly supported the policy because it potentially meant a better quality-of-life for tenants who quit, freeing up more of their money for them to spend on other things (discussed in Section 1: ‘Rationale’). The policy could have social benefits for tenants, in that they “get to meet the other neighbours as well” (Tenancy Advisor 1). All Tenancy Advisors agreed that the policy was likely to save the Council maintenance costs, albeit in the longer-term (discussed in Section 4: ‘Refurbishment and Maintenance issues’).

Section summary

Tenancy Advisors supported the smokefree policy (including its current scope) and believed it had been successfully implemented so far, with a positive response from tenants. They believed that tenant acceptance was partly due to a ‘fair exchange’, with tenants prepared to accept a smokefree policy in exchange for a better quality of housing. Tenant acceptance was also a reflection of changing social norms, predisposing people to smoking outdoors. Tenancy Advisors had been trained in how to support tenants to quit and felt comfortable doing so, but in practice, were more likely to ‘Ask’ about smoking status than to provide specific stop-smoking support (e.g. referral to Quitline or providing a brief counselling session). Stop-smoking support was therefore more reactive than proactive. Tenancy Advisors were unclear about specific enforcement actions, but stated that they would be unlikely to terminate a tenancy for breaching the smokefree rule. In particular, enforcement was difficult because of a lack of systems and protocols. Significantly, Tenancy Advisors might not know which of their tenants were on a new contract when they visited. Very few breach notices had been issued for smoking inside: overall compliance was perceived to be very good, with more tenants observed smoking outside since the policy had been implemented. Tenancy Advisors felt they were able to implement the policy as business-as-usual, and despite being frustrated by limited resources, saw it as worth the effort in terms of better wellbeing and improved lives for tenants.

Aukati Kai Paipa

Aukati Kai Paipa (AKP) is a quit-smoking programme originally set up for Māori, specifically targeting Māori, Pacific Island and pregnant women, but depending on capacity the programme may “work with everyone” (AKP practitioner). In mid-2014 (over a two-month period), an AKP practitioner from Community and Public Health, CDHB, visited over 20 CCC community lounges to deliver stop-smoking support to tenants. The purpose of these visits was for the practitioner to make herself available to tenants. Tenants who visited the lounges indicating that they would like support to quit, were then followed up with the standard AKP three-month service.

The process of visiting CCC community lounges was arranged initially by the CDHB project manager and facilitated by a CCC Activities Officer. The Activities Officer listed complexes that had community lounges or vacant units and targeted those with stop-smoking support. The Activities Officer delivered flyers to tenant letterboxes in advance of the visits and also advertised on the walls of community lounges. On the day, the AKP practitioner found it difficult trying to make contact with tenants:

“Sometimes nobody came, sometimes one or two came and ... just wanted to check me out and really didn’t want to do anything and a few times we got some people to sign up. Yeah, one place I was really busy which I thought was great, but I haven’t seen any of them since so it was quite difficult to make contact with a lot of them” (AKP practitioner).

The AKP practitioner was available to answer questions and to invite tenants to sign up for stop-smoking support, finding that “some of them did ask some really good questions about NRT and how to use it correctly” (AKP practitioner). She also found that another good opportunity for conversations about cessation was provided by community lunches and barbeques – an effective way of being able to “mix” with tenants: “it was a new idea and it worked quite well. Yes, so I could just mix with the people there, and it was quite informal and it was quite good”.

Partnership with the CCC was key to AKP’s access to the tenant community. The AKP practitioner was reliant on the CCC Activities Officer to introduce her to tenants in the complex to give her a ‘foot in the door’. Despite having this access enabled, the AKP practitioner often had a low uptake and sometimes felt uncomfortable due to a perception that tenants were reluctant to meet with them.

Since the first round of visiting all community lounges, there had been no follow-up. The AKP practitioner needed the same process to be initiated by the CCC (and was available if/when needed):

“we were going to do another round but it just hasn’t happened, hasn’t come about...it was suggested that I would do it again but I mean I can’t just get up and walk in there...somebody has to go in [with] the flyers” (ibid).

She was unsure of how to improve the system for a potential second round of visiting community lounges, but felt that it was important to be respectful of tenants’ own space: “without invading their personal [space], ... they’ll be getting an individual drop in all their letter boxes anyway, as well as in the community lounge. So apart from door knocking and annoying them...?”

From her visits to over 20 different community lounges, the AKP practitioner had a low response (she had worked with 16 tenants overall, one of whom completed the full three-month programme and quit). All of her AKP work with tenants had been coordinated by the CCC Activities Officer; she had had no direct referrals from Tenancy Advisors.

The AKP practitioner believed that the potential effectiveness of the work she had done with CCC tenants (as with other clients) was in 'planting the seed'. Although she sometimes had low success rates, she had found that clients may be successful later:

"a lot of the people that I work with that don't quite get there, I run into them in the street, and they say hey I've been quit, all because of you. ...and they [say], 'I went to my doctor and I knew that I had to do this, that I had to do this, I did it and I've quit.'"

She had identified a high need for stop-smoking support amongst CCC tenants, many of whom were long-term smokers who had tried unsuccessfully to quit in the past. She believed that many tenants very much wished to quit, but some were put off seeking help because of concerns about confidentiality:

"Some of them really, really want to stop smoking. But I don't think they wanted other people to know so they weren't coming to see me...the few that I did sign up, they were all very concerned that ... 'nobody's going to talk about it'. 'No it's [a] confidential, completely confidential service'...I think they didn't want people to know that they were trying to stop smoking and that they hadn't made it."

She had also identified that a key reason for smoking (and finding it difficult to quit) was loneliness:

"A lot of them smoke because they're so lonely. They've got nothing else and that was very consistent through the whole place because they're very lonely. One man that I went to... I couldn't even sit inside. We used to meet in the community lounge every time I visited him but I just couldn't [meet in his unit], I would just cough and cough, it was so thick with smoke."

For some tenants, therefore, the AKP practitioner perceived that quitting smoking (or complying with a smokefree rule) would be very difficult and a significant lifestyle change – and that the effort of changing was too much of a barrier: "some of them just don't want to change. They're not willing to do it 'cos they're just so lonely." Overall, the AKP practitioner believed that the CCC's smokefree policy was important, and that it may be difficult to fully implement, but that the CCC needs to "keep trying". She stated: "it will be difficult but it's got to happen and hopefully more people will take up our offer of free service." She believed that while it was important to respect the privacy of tenants' own homes, because they did not own the property "I don't think they're entitled to smoke in it". She thought the possible extension of the scope of the policy to include grounds was "feasible...as long as they back it up with cessation support". She felt that a staged approach/soft policy was appropriate:

"you can't just say, as from tomorrow no-one's smoking in or around the grounds or the buildings ... You have to phase it in."

Section summary

Overall, the AKP practitioner believed many tenants have a strong desire to quit; barriers to quitting include loneliness (smoking helps keep them occupied) and concern about the confidentiality of services (as tenants did not want others to know they were trying to quit). Her visits to complexes had been facilitated by a CCC Activities Officer. A further round of visits was possible, but had not yet been followed up. Overall, matching the delivery of services to the 'most willing' appears to be a task worthy of further work: including the establishment of a more systematic approach along with more innovative ways of reaching current smokers.

Project Managers

The views of both project managers have been discussed extensively elsewhere (e.g. see 'Rationale', 'Partnership' and 'Operational Detail' sections) therefore only a very brief summary of their views is provided here.

Christchurch City Council

Like the Tenancy Advisors, the CCC project manager felt that “on the whole it’s going really well” (CCC project manager 1) and that “it’s working”. New tenants clearly understood that the no-smoking rule was part of the Tenancy Agreement (if they chose not to sign, they did not get their unit) and there had been little resistance. Tenants on new contracts who smoked inside were being “challenged” by Tenancy Advisors and it was approached as a “standard tenancy matter”. It was evident that tenants “want to address their smoking habits and didn’t really know how to go about doing that” (CCC project manager 1) but with the visits from the Aukati Kai Paipa practitioner, some tenants had been able to get help. In addition to saving the Council money on maintenance, the smokefree policy was likely to have important “knock-on effects” such as reduced anti-social behaviour and rent arrears because when “a tenant feels valued then they want to contribute more”. The CCC project manager believed that:

“if we can help them modify their smoking habits or hopefully quit, then that person gets to live a healthier life ... if you’re feeling better about where you are and you’re healthier, you might look after your home better ... You might take a bit more pride, you might become involved with things, you know those unquantifiable effects that come from it the implications from it ... are quite wide-ranging.”

Canterbury District Health Board (Smokefree ABC Team, Community and Public Health)

The CDHB project manager felt that the implementation of the policy was a “work in progress”. This was partly about ensuring that good systems and structures were in place to support the policy and partly about consistency in offering stop-smoking support. She felt staff needed to become more confident in offering stop-smoking support although at least the “platform” of training was in place. She was committed to reaching a “very disadvantaged” group with stop-smoking support and ensuring that they did not become even further marginalised by remaining smokers in a smokefree society. She aimed to increase their access to support to increase their chances of quitting. Overall, she was “delighted” with the response of Council staff, including some “strong leadership”, but felt there was “lots of scope to do more”.

Objective 9: Unintended consequences

To identify any unintended consequences of policy implementation and to document the problem-solving processes employed to mitigate any negative effects. Including but not limited to involvement of cessation services: training of Tenancy Advisors, how this is working now, reliability of Tenancy Advisors offering support (data sources 1-5).

Few unintended consequences as a result of the policy emerged from interviews. The potential for second-hand smoke to become a problem was indicated by some comments in the Tenant Satisfaction Questionnaire and anticipated as a future effect by Tenancy Advisors (although Tenancy Advisors had received no specific complaints about second-hand smoke post-policy). Tenancy Advisors did feel that the problem of second-hand smoke would be difficult to act on:

“you’re kind of caught between a rock and a hard place you know. If you do approach the tenant to say ‘this is affecting somebody else’ ...do you run the risk of that person then saying ‘well I’ll have to go inside then’. So it’s really a sensitive subject to actually tackle. If you look at it purely from a responsibility point of view, there’s nothing for us to act on. And so the complaining tenant might be upset about that but you know there’s no course of action open to us ‘cos it’s not a breach” (Tenancy Advisor 1).

Other possible unintended consequences were the possibility of ill-health, due to smoking outside in inclement weather; a sense of discrimination from being forced to smoke outside; and exacerbation of social conflict, which was reported as being already common in housing complexes. The issue was raised in both tenant interviews and the Tenant Satisfaction Questionnaire, with tenants suggesting that having tenants congregate together outside to smoke “just does not work” and that “verbal abuse [and] fights” may result.

Objective 10: Modifications to the policy/implementation

To identify modifications that may be needed to improve the programme (including any compliance/enforcement related issues) (data sources 1-5).

Based on the survey results (Tenancy Advisors' and tenants') and the face-to-face interviews, several suggestions were put forward regarding future modifications to the policy (i.e. the policy parameters, refer to **Figure 13** below). Also, a number of suggestions were made regarding the implementation of the policy, with a focus on ensuring enhanced compliance. These ideas and suggestions are listed below and some of these items also appear in **Recommendations** (p.73). Note that the list below does not comprise a set of recommendations or endorse all/any items per se, here it simply reports the suggestions made by CCC staff and tenants. It was suggested that the first two points may enable compliance, and reduce potential unintended consequences. Currently, the policy may be difficult to comply with in poor weather, because doing so could potentially result in poorer health (from being exposed to wet/cold conditions). The Council may need to consider ways of at least reducing, but preferably eliminating, smoke waft (if this becomes problematic in the future). Practically, this might be achieved by providing designated smoking areas away from tenants' units.⁶³ Ideally, these areas would be sheltered from the wind and rain (some complexes may already have suitably sheltered outdoor areas). The remaining seven points directly or indirectly relate to improving the provision of stop-smoking support to all tenants who smoke.

The following list includes possible ideas for policy/implementation modifications.

- Provide designated sheltered outdoor smoking areas (as needed, on a case-by-case basis).
- Provide receptacles for disposing of cigarette butts.
- Ensure regular (e.g. six-monthly) refresher training of Tenancy Advisors in providing stop-smoking support.
- Develop clear, written protocols for enforcing the policy.
- Offer specific stop-smoking support (e.g. counselling conversations, referral to Quitline) routinely to all tenants.
- Follow up new tenants with a welcome visit (to check on compliance and offer support to quit).
- Review the 'sign-up' conversation, to consider the best placement of the no-smoking clause discussion.
- Ensure effective systems are in place to support the policy (e.g. identifying which of individual Tenancy Advisors' tenants are on old/new contracts; applying Smokefree stickers consistently; recording breaches consistently; Tenancy Advisors having ready access to records of tenants' smoking/quitting status).
- Improve the 'reach' of the policy/implementation via Tenancy Advisors communicating more directly with tenants on old contracts to encourage them to voluntarily sign new contracts and accept stop-smoking support.

See the **Discussion, Conclusion** and in particular the **Recommendations** sections below for more details on the above items.

⁶³ Although the Council may also wish to consider any potential negative social impact of tenants congregating together (see 'Unintended Consequences' section)

Objective 11: Equity

Describe any potential or actual equity issues with reference to the Treaty of Waitangi: e.g. does the policy give rise to any disparities in potential health benefits for residents? Does the policy reach the most disadvantaged and contribute to a reduction in health inequalities? (data sources 1-5).

This evaluation examined the ‘fairness’ of the smokefree policy on two levels. Firstly, the evaluation considered the fairness of imposing a non-smoking rule on tenants (i.e. whether smokefree policies in subsidised housing generally could worsen socioeconomic disparities by adversely affecting low-income people and displacing residents who refuse to comply) and secondly, whether or not the burdens and benefits of the policy are distributed evenly across all tenants (e.g. perhaps some current smokers receive smoking stop-smoking support and others do not).

The first question is informed, to a large degree, by law: the CCC’s no-smoking policy only prohibits the act of smoking indoors, it does not influence potential tenants’ eligibility for a tenancy and the policy is therefore consistent with the Council’s obligations as a landlord under the Residential Tenancies Act 1986. In addition, issues of fairness (generally) were informed by interviews with both Tenancy Advisors and tenants, with all of those interviewed believing that the policy was fair. Most believed that the policy was designed to ‘help’ tenants, that it did not disadvantage tenants in any way, and that any potential disadvantages were outweighed by the potential health benefits.

Tenants interviewed felt that the policy was ‘fair enough’: if people wanted to live on CCC property, they accepted that they did not smoke inside. Furthermore, it was fair in the sense that people had been given ‘ample warning’ of policy changes to come by the Smokefree Environments Act 2003. The only sense of unfairness was if tenants were expected to comply with a smokefree rule when their unit was already old and in poor condition, requiring maintenance. One tenant also acknowledged that a ‘one-size-fits-all’ approach to policy was not necessarily appropriate, stating that

“I do understand that associations and committees and whatever can make these rules to suit one or two people or hurriedly, and just overlook the fact that they’re standing pretty hard on some people’s feet” (Tenant 2).

Several tenants expressed negative opinions about the policy in the Tenant Satisfaction Questionnaire (December 2014). The strongest opinion was that the policy was “discriminatory”, by stigmatising those who had mental illnesses and lived in social housing and were forced to smoke outside. Another suggested the invasiveness of “Big Brother” surveillance-type policies restricting tenants’ privacy and freedom. Other comments highlighted that second-hand smoke caused by tenants smoking outside was potentially harmful to other tenants.

The potential for unfairness of the policy was explored in interviews with both Tenancy Advisors and tenants. All Tenancy Advisors anticipated that as the policy was rolled out to more and more tenants, tenants were likely to claim that the policy was ‘unfair’ if their neighbour was allowed to smoke inside but they were not (that is, due to those on ‘new’ and ‘old’ contracts living side by side). Tenants discussed the potential of those with physical disabilities or mobility issues being unfairly disadvantaged, by finding it difficult to move outside for a cigarette. During interviews it was observed that tenants had differential access to sheltered outdoor areas, yet all tenants on no-smoking contracts were expected to comply. The Aukati Kai Paipa practitioner acknowledged how difficult it would be for some long-term tenants to either quit smoking or comply with a smokefree policy, suggesting that they used smoking as a way of coping with

loneliness and filling in time. In these cases, it would be equitable to support tenants to address their loneliness in other ways if they were expected to stop smoking inside.

A further strong theme emerging from the interviews was that the soft scope of the policy was appropriate to the tenant population – and therefore potentially more equitable. Tenancy Advisors and CCC Project Managers spoke of how change was “huge” for tenants and that therefore any policy change needed to be gradual. Furthermore, the population was one in which “friction” was common, therefore the policy had the potential to exacerbate that friction – for example, from complaints about second-hand smoke or from neighbouring tenants experiencing the policy differentially (some on new contracts, some not). The CCC had considered tenants’ vulnerability, particularly post-earthquake, in recommending that policy change needed to be accompanied by support for tenants to quit smoking. The need for support was echoed by the Aukati Kai Paipa practitioner, who felt that extending the scope to include grounds was “feasible”, as long as stop-smoking support was provided.

Tenant interviews highlighted the relative disadvantage experienced by the tenant population, for example, in terms of tenants being more likely than the wider population to experience illnesses that prevent them from working, and which in some instances may predispose them to smoke; and background circumstances and social environments that had enabled smoking, such as intergenerational smoking. Tenants, in general, also have less access to those things that positively influence health and wellbeing, such as strong social networks, employment and good living conditions, than the wider population. In addition tenants may at times live amongst social tensions which exacerbate stress and can fuel addictions. Tenant stories depicted a clear need for stop-smoking support.

The policy had the potential to make living conditions and overall quality of life more reasonable and equitable for those who may have been exposed to various ‘unfair’ life circumstances (including intergenerational smoking and poverty). By providing an environment which enabled tenants to quit smoking, the policy empowered tenants to improve their lives by freeing up more of their money to spend on other things. It also reduced the impact on their living environment from both second-hand and third-hand smoke. Many tenants who smoked currently lived in units “thick with smoke” (AKP practitioner). Currently, some new tenants moved into smoke-damaged units – this was perceived as unfair by at least one Tenancy Advisor, but was likely to become less common over time as the policy resulted in less third-hand smoke damage to units.

In terms of whether the policy helps a hard-to-reach sector of the population (particularly long-term tenants) to quit smoking, most interviewees were uncertain about whether this was so. Because of the progressive roll-out of the policy (and reportedly, lack of money for programmed maintenance), many current tenants were unlikely to ever sign a new contract and may therefore live out their lives within CCC social housing without receiving support to quit. Indeed, one Tenancy Advisor believed that the policy should apply to all tenants, not just new ones (despite acknowledging that in practice, this would be difficult to implement). The degree of stop-smoking support that tenants (those on new contracts) were receiving was unclear, with data suggesting that providing specific cessation activities had not yet become ‘business-as-usual’ for most Tenancy Advisors.

Section summary

The Christchurch City Council’s smokefree social housing policy is equitable from the perspective of not denying smokers a place to live within social housing. However, drawbacks of the policy include the sense

of discrimination/stigma that may be experienced by some tenants from being required to smoke outside and the impact of second-hand smoke (from smoking outside) on neighbouring tenants. Overall, the policy is likely to improve equity for a disadvantaged and vulnerable population, by potentially improving access to stop-smoking support, and potentially also their health and quality of life. The gradual implementation of the policy was equitable as it avoided tenants being set back by the impact of significant change. Equity of the policy is enhanced by providing stop-smoking support alongside the smokefree rule; however, in practice, further work is needed to help support tenants to quit.

Discussion

This smokefree initiative blends people, place and policy and it is an example of the HiAP approach in action. The findings of this evaluation suggest that the implementation of a soft regulatory prospective roll-out of a smokefree policy in the Christchurch City Council's portfolio of subsidised multi-unit housing complexes was generally accepted and complied with by tenants. The Council's smokefree policy is deemed relatively 'soft' and non-coercive in comparison with similar policies internationally. It is likely to result in reduced third-hand smoke damage to units and may potentially increase cessation-related behaviours among smokers over the long-term. In addition, long-term sustained implementation of the policy should result in reduced operating costs for the housing provider (including fire damage and insurance costs). These benefits will likely accrue slowly, which is not unexpected given the incremental implementation of the no-smoking rule. Continued effort will be required over years, and the effect size (for many of the objective outcomes) may be modest until a critical-mass of no-smoking contracts has accrued. There is considerable potential to target a difficult-to-reach population with stop-smoking support in conjunction with this policy.

The rationale for the policy, as understood by managers and Tenancy Advisors

Managers and Tenancy Advisors have stated the following reasons for implementing the smokefree policy: a better environment for residents; improving residents' health; fewer conflicts between residents (a reduction in anti-social behaviour); lower maintenance costs; lower smoke-related damage to units; potentially lower fire and insurance costs; the opportunity to promote wellbeing; and the opportunity to initiate other conversations about health.

Barriers to implementation

Managers and Tenancy Advisors have also acknowledged the following potential barriers to implementation: enforcement issues; objections from existing residents; and increased staff time/lack of resources. A key barrier is the lack of resources needed for follow-up – in order to implement the policy well, more person-time is needed for visiting tenants soon after moving in, as a 'welcome visit' – this includes following up on those who indicated they wanted to quit smoking (but who declined the offer of support at sign-up). Some Housing Unit staff expressed a frustration about the limited resources, as they see that investing staff time in pro-active rather than reactive work can ultimately reduce staff workloads, improve service delivery, and improve tenant health and wellbeing.

Costs: operational/maintenance

Managers and Tenancy Advisors have stated that the smoking-related damage to units can be considerable and that refurbishment costs can run into the thousands of dollars. The managers and Tenancy Advisors were all very confident that the no-smoking policy would reduce these costs but that the time-frame could be quite long (in the range of 5-10 years). In part, this was thought to be because of the progressive roll-out of the policy and that only part of the population is transient (the remainder comprising long-term tenants, some of whom smoke). Managers and Tenancy Advisors recognised that there are still a lot of smoke-damaged units in the portfolio and that working through these would take time. However, there was general agreement that the ultimate goal should be to reduce smoking-attributable damage costs (to the Council) to zero by a combination of eliminating the damage and by implementing the policy of charging tenants for any damage, once new contracts are signed.

This short-to-medium-term focus on refurbishment costs perhaps underestimates the total (direct and indirect) cost savings that may be derived from smokefree social housing policies. Smoking-related cost savings in social housing contexts (including averted health care utilisation, morbidity, and mortality) suggest substantial societal benefits from the implementation of smokefree social housing policies (e.g., Ong et al., 2012). However, the estimation of these broad-picture costs was beyond the scope of this evaluation due to the unavailability of the necessary data (this level of data collection has not been undertaken by the CCC). However, with respect to operational costs, international evidence suggests that housing units governed by complete smokefree policies incur maintenance costs of approximately half that required to maintain smokers' units (over the service life of the housing complex).

Characteristics of the CCC's no-smoking policy (with reference to the international literature)

The policy development and implementation was contingent on a creative partnership between a public health organisation (Smokefree Canterbury/Community & Public Health/CDHB) and a community and statutory organisation (The Christchurch City Council), to help a disadvantaged group of people who smoke (CCC social housing tenants). The initiative serves to demonstrate that a creative partnership can extend the reach of the health system and provide an opportunity to address determinants of health that lie outside of the health care system. The CCC's no-smoking policy is relatively 'soft' but clearly regulatory as it seeks to limit the discretion of tenants and seeks to compel certain types of behaviour, specifically, not smoking inside (and it also provides for the option of nicotine management). Generally, the advantages (simple to implement) and limitations (difficult to regulate and punish) of soft policy approaches need to be considered together, particularly given the tendency for 'hard' coercive measures to undermine cooperation and community trust. The CCC's soft policy approach can also be considered consistent with the Housing Unit's primarily facilitative, supportive and promotional approach to tenant wellbeing. Managers and Tenancy Advisors commented on the degree to which the CCC's no-smoking policy is 'soft' vs 'hard'. The generally held view was that the high levels of intrusiveness, enforcement and coercion that hard policies entail would not be appropriate for this sensitive tenant population. Managers and Tenancy Advisors agreed that the soft policy option employed primarily facilitative and promotional approaches that were consistent with the Council's motivation to render assistance to non-compliant parties. Tenancy Advisors also recognised that the social climate in which the policy had been developed was important, as shifts in social norms can radically influence policy design, with regard to the likely acceptance of the proposed enforcement approaches. The environments that policies seek to influence or manipulate are typically complex adaptive systems (Milio, 1987), and Tenancy Advisors recognised that the effects of making a policy change are not always entirely predictable and that the policy and its implementation might need to be revised (firmed up) over time.

The type of policy used in a particular situation (the policy parameters) can have a significant impact on the outcomes achieved. **Figure 13** (below) illustrates a number of key considerations for smokefree policy design in social housing contexts, when employing a 'Health in All Policies' approach (drawn from this evaluation and the published literature). Overall, the CCC selected policy parameters at the lower end of the range available, after considering the relevant factors. However, this approach differs considerably from other possible approaches (e.g. one-point-in-time complex-wide implementation) that have been used in other jurisdictions (e.g. subsidised multi-unit high-rise housing complexes in the US) (Satterlund, Treiber, Kipke, & Cassady, 2013).

In all likelihood, 'one size doesn't fit all' and different approaches can probably be tailored successfully to different contexts. For example, Pizacani et al. (2012) describe a comprehensive no-smoking policy

implemented by a large property management company in metropolitan Portland, Oregon. The policy was implemented in subsidised high-rise multi-unit housing complexes at one-point-in-time, and banned smoking in apartments and in all indoor and outdoor communal areas within 25 feet (7.5m) of buildings (effectively prohibiting smoking on most properties).⁶⁴ Pizacani et al. (2012) found that the smokefree policy was associated with decreased cigarette consumption and significantly increased rates of smoking cessation. This example demonstrates that at least in *some* circumstances, implementing fairly stringent policies is feasible, and stringent policies can still result in good acceptance and compliance.

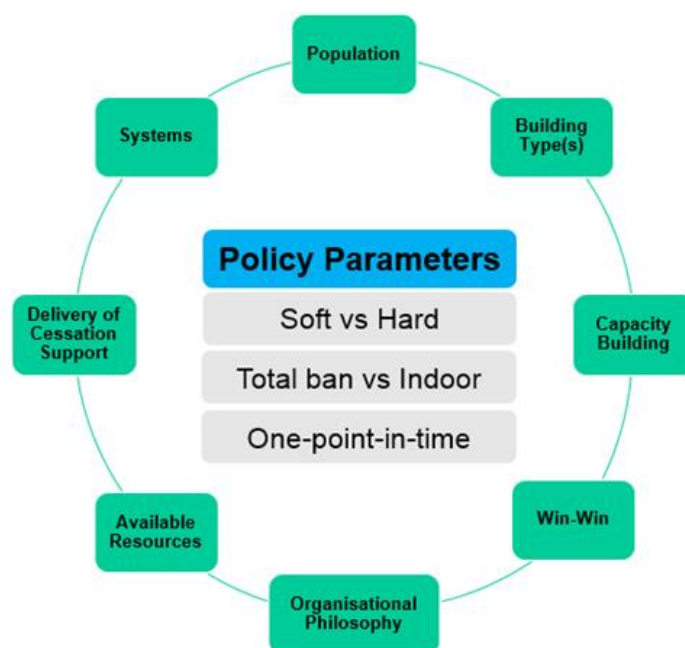


Figure 13: Key considerations for smokefree policy design

One noteworthy limitation of this approach is that strict enforcement actions including evictions may be inconsistent with some providers' broader goals of tenant retention (different providers may have different philosophies on the retention of vulnerable tenants). Increasingly, policy implementation relies on the cooperation of a number of actors and coercive measures tend to undermine cooperation and community trust. Therefore, soft instruments are not necessarily weak or less effective than hard instruments. (Levi-Faur, 2012). Smoking is an individual activity occurring within a social context (Frohlich, Potvin, Chabot, & Corin, 2002) and the normality of smoking or not-smoking within social settings is thought to be an important driver of compliance.

Section summary

The evidence gathered from Managers, Tenancy Advisors, and tenants (both non-smokers and current smokers) suggests that the policy parameters are a good fit with the population and context: respondents considered the policy to be "*about right*" (in terms of fairness and reasonableness). Further, the CCC's less stringent approach is fairly consistent with published reports of campaigns in other countries, when the focus has been on housing complexes serving priority and/or sensitive populations (Lemp, 2010; Satterlund et al., 2013). Overall, much policy theory now suggests a shift away from 'hard' policy instruments towards 'soft' ones and the CCC's policy aligns with this trend. However, some Tenancy Advisors and tenants suggested that the policy parameters could be modified or 'firmed-up' over time so that the policy continues to keep pace with changing social norms. For example, Tenancy Advisors suggested that the practice of charging tenants for smoking-attributable damage could be formally embedded in routine practice and applied more consistently, and that new/rebuilt complexes could be designated as completely smokefree (buildings and grounds)⁶⁵. Overall, the policy can be seen as being consistent with the HiAP approach, as it takes into account health implications (or more specifically seeks an opportunity to improve

⁶⁴ Tenants were notified of the policy in writing six months before the policy was implemented.

⁶⁵ While the CCC's no-smoking policy is clear in terms of where people may or may not smoke, it is less clear on the consequences for non-compliance. The practice of charging tenants for smoking-attributable damage does not appear to be explicitly documented as part of the no-smoking rules.

health) and seeks synergies (between organisations and across operational domains) in order to improve population health and health equity⁶⁶.

Prevalence of cigarette smoking: what is the size of the problem?

As reported in the **Results** above, the prevalence of smoking in the tenant population was reported to be 24% based on 788 responses to the smoking status question within the tenant satisfaction questionnaire (from approximately 2200 CCC social housing tenants, a response rate of ≈36%). This self-reported point prevalence of 24% is approximately 10 percentage points above that reported by the New Zealand general population (using the exact same census question). This 'gap' represents inequity. Without sustained and focused efforts it would seem unlikely that this equity gap between social housing populations and the general population will close, therefore the CCC's no-smoking rule can be seen to have merit, value and importance.

Further, while the 10 percentage point gap is significant, it is likely an underestimate for a number of reasons including an assumption that those who are more likely to respond may also be less likely to smoke⁶⁷. Specifically, the response rate can be considered low, considering that the survey was delivered to all tenants by the housing provider for the purpose of improving services and the reliability of self-reported smoking data has been widely questioned (in other studies). In particular, in the context of increased anti-tobacco legislation and more hostile social norms around smoking, some survey respondents are believed to feel uncomfortable admitting that they currently smoke. This bias is reported to be most apparent when data are collected through a survey method where the respondent can be easily identified (Grimm, 2010)⁶⁸ and/or when the reported smoking status is linked (or perceived to be linked) to a direct or possible negative consequence (i.e. the idea that smoking may impact negatively on the tenancy in some way) (Ferrence, Einarson, Selby, Soldin, & Koren, 2009). Heightened stigma surrounding the action of smoking may decrease the likelihood that individuals who engage in smoking identify with the label 'smoker' and recent research suggests that this social desirability bias can significantly distort estimates of smoking prevalence (Leas, Zablocki, Edland, & Al-Delaimy, 2015).

In addition to the Tenant Satisfaction Questionnaire results, Tenancy Advisors were asked to estimate the prevalence of smoking in the tenant population based on their observations and knowledge of their individual portfolios. Tenancy Advisors' estimates ranged from about '¼' to 'most'. Anecdotally at least, Tenancy Advisors reported that the prevalence of smoking in the tenant population was very high and this is consistent with other research in other subsidised social housing settings here in New Zealand and in other developed countries. In the US, for example, studies show that the prevalence of cigarette smoking by multi-unit housing tenants ranges (across studies) from 8% (Baezconde-Garbanati et al., 2011) to 48% (Hood, Ferketich, Klein, Wewers, & Pirie, 2013).

In New Zealand, Baker, Zhang and Howden-Chapman (2010) reported a prevalence of approximately 40% in a national social housing cohort (39.1% of 16,049 respondents in 2003) and 32.3% average over the years 2004-2008⁶⁹ (Baker, Zhang, & Howden-Chapman, 2012). **Figure 14** displays the trend-lines for the New

⁶⁶ The CCC's no-smoking policy can be categorised as follows: HiAP → tobacco control → regulatory → indoor [only] air environment → soft → prospective roll-out.

⁶⁷ These factors are considered in more detail below in the **Limitations** section.

⁶⁸ In the case of the Tenant Satisfaction Questionnaire, tenants are easily identified as each survey form is individually allocated including pre-printed name, address and a unique identifier number.

⁶⁹ Considerably above the ≈20% reported in the 2006 census.

Zealand general population, the Housing New Zealand study, and the CCC tenant satisfaction questionnaire data. The data suggest that the prevalence of smoking in social housing contexts may be approximately ten percentage points (at least) higher than that of the general population at any point in time. **Figure 14** also shows that the rate of decline towards New Zealand's Smokefree 2025 goal may be slower (or more resistant to change) than that in the general population. These findings are consistent with van der Deen's (2014) analysis and conclusions that the New Zealand Government's Smokefree 2025 goal would not be attained by any demographic group under current business-as-usual assumptions.

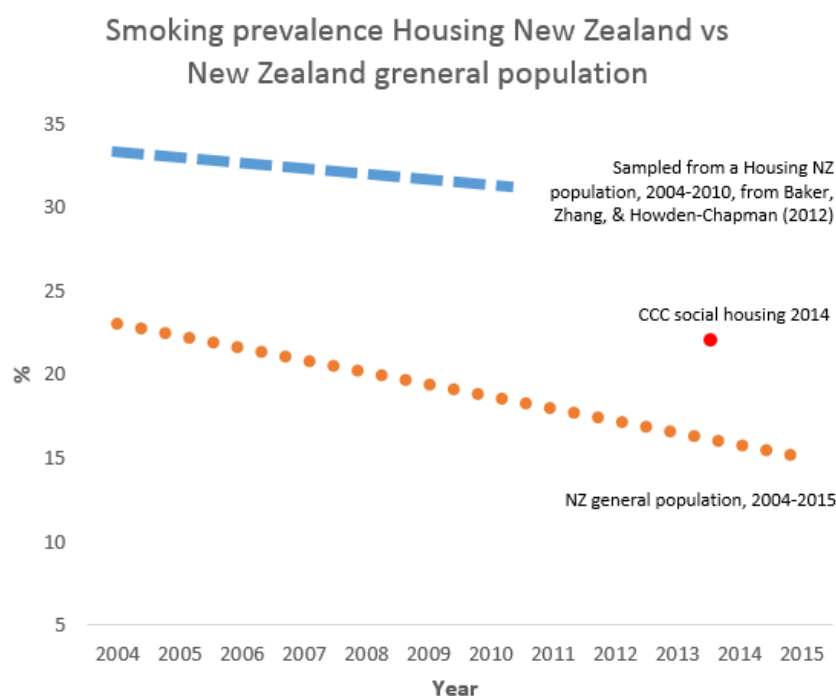


Figure 14: Smoking prevalence trends 2004-2015, HNZ vs the NZ general population

The orange dotted-line shows the trend in smoking prevalence in the New Zealand general population 2004-2015. The blue dashed-line shows Housing New Zealand data collected from May 2003 to December 2010 (≈77 000 tenants) (Baker, Zhang, & Howden-Chapman, 2012). The red-dot shows the point prevalence estimate of smoking from the CCC's 2014 Tenant Satisfaction Questionnaire.

Where residents currently smoke

Many people implement their own voluntary home smoking bans and smokefree homes are becoming more prevalent. Voluntary home smoking bans have been shown to help smokers stop smoking and to help prevent relapse back to smoking (Hyland et al., 2009). However, it was not possible to determine self-reported compliance with the no-smoking policy (i.e. what percentage of 'new-contract' tenants smoke inside anyway?) because responses to this question could not be individually matched to contract status. Further, it is likely that tenants who are current smokers may have under-reported smoking in their units, as they may have perceived the question to be linked to possible negative consequences (i.e. the potential for negative consequences to follow after admitting breaking a condition of their tenancy). Thus social desirability bias may have distorted the estimates of where people currently smoke (reported in the Tenant Satisfaction Questionnaire as ≈20% vs ≈70%, indoor/outdoor respectively⁷⁰). Both current smokers and non-smokers described their application of voluntary no-smoking rules (i.e. how these rules apply to themselves and to visitors who smoke). Generally, tenants who had implemented voluntary no-smoking

⁷⁰ The balance indicated that they smoked at other outside locations.

rules reported positive effects consistent with the literature (i.e. generally supportive of cessation, including increased control of visitors' smoking behaviours). Due to the limitations of the data, it remains difficult to accurately determine individual tenants' compliance with the no-smoking rule. Notwithstanding the limitations of the data, subsequent survey results might reasonably be expected to show a decline in indoor smoking⁷¹.

The main issue of concern as documented by this process evaluation, in relation to where residents smoke, is that of second-hand smoke. The issue was raised initially by the CDHB project manager who believed that smoking waft from tenants smoking outside in close proximity to their neighbours had the potential to cause friction. This theory was borne out by tenant data, with two comments in the tenant satisfaction questionnaire reflecting on the issue and one comment specifically requesting a designated outdoor area to address the problem.

Tenant support for the no-smoking policy

The data from the Tenant Satisfaction Questionnaire indicated a high level of acceptance of the smokefree policy and this can be viewed as confirming the appropriateness of the policy to the context. Among CCC social housing tenants, 90% of non-smokers indicated that they supported the policy (either that it was a "good idea" or "OK"). Support from current smokers was less emphatic, still, 74% of current smokers reported that they thought the policy was at least "OK" versus 20% of current smokers who thought the policy was a bad idea (6% didn't know). Overall, respondents indicated clear support for the no-smoking policy. Other studies have shown that the acceptability of comprehensive smokefree policies among low-income tenants in social housing is generally high (60-75%) although again, the support among current smokers is generally lower (Drach, Pizacani, Rohde, & Schubert, 2010; Hennrikus, Pentel, & Sandell, 2003). The data from the Tenant Satisfaction Questionnaire is therefore consistent with international findings. In addition, questions about second-hand smoke exposure were included in Tenant and Tenancy Advisor surveys (i.e. questions about second-hand smoke entering their homes from external sources such as their neighbours, namely second hand smoke incursions or drift). There were reports of this occurring but no evidence of this being problematic (i.e. very low levels of complaint -to date- and tenants describing the possibility more hypothetically than in reality).

Furthermore, qualitative data from the tenant interviews supports the findings of the Tenant Satisfaction Questionnaire. Tenants were matter-of-fact about the no-smoking policy, accepting the rule as 'just the way it is'. Tenants felt that as a condition of being offered a place to live the rule was "fair enough". They suggested: *"If you don't like it, don't live here"* (Tenant 2); *"You know as far as smoking goes, they've told you you're not allowed to smoke and that's all there is to it"* (Tenant 4); *"No you can't smoke inside ...that's all"* (Tenant 1). Similarly, tenants felt that the policy was reasonable in its scope, with one tenant smoker commenting that *"it's not much of a hardship"* (Tenant 5) to go outside to smoke. Tenants were generally not in favour of extending the scope of the policy to include outdoor areas at this stage.

Overall, the Tenant Satisfaction Questionnaire provided new information on tenant smoking behaviours and attitudes and expanded the range of topics included in the "YOUR WELLBEING" section of the questionnaire. However, the validity of the data is unclear (given the low response rate and the potential for reporting biases). Other researchers of social housing no-smoking policies have generated survey response rates of over 80% by employing systematic follow-up and higher value incentives (for example

⁷¹ I.e. the Council's objective is to reach zero percent of tenants smoking inside.

Pizacani et al., 2012). Improving the response rate to the Tenant Satisfaction Questionnaire would enhance its usefulness but the survey nevertheless provided a snapshot of smoking in this population. Perhaps most relevant to this process evaluation are the findings about tenants' attitudes and knowledge.

Tenancy Advisor attributes, attitudes, performance and observations

Cessation training and delivery

Heart Foundation Smoking Cessation Practitioner Training ('Quit card') was provided for all Tenancy Advisors. However, there is currently no systematic and documented approach to 'top-up' training or training for new staff. At the completion of this one day (5-6 hour) free training session, attendees were able (had some level of proficiency) to provide smokers with motivation and support to stop (or manage) their smoking (some pre-course reading was also required)⁷². Attendees then became registered quit-card providers, which allows the card holder to redeem subsidised NRT products at pharmacies⁷³. The New Zealand Guidelines for Helping People to Stop Smoking (Ministry of Health, 2014) are structured around the ABC pathway and emphasise the importance of making an offer of stop-smoking support and referring people who smoke to a stop-smoking service.

As reported in the results (above), most Tenancy Advisors reported that they felt comfortable with the idea of delivering the ABCs, however, in practice, the delivery of the ABCs was inconsistent (refer to **Figure 12**, p.47). Moving from simply asking tenants their smoking status to delivering the 'B & Cs' does become more difficult and requires increased resource intensiveness and skill, and this may be a barrier to implementation⁷⁴. Some Tenancy Advisors stated that they thought that the tenant sign-up survey process might not necessarily provide the right opportunity for implementing the ABCs (at least not the BCs). Tenancy Advisors stated that time pressures and the number of other important topics that need to be covered (tenancy matters) can create too great a burden for some tenants (and possibly Tenancy Advisors) and they might not be able or ready to cope with discussions of smoking cessation (limiting this discussion to the contracting time only). The delivery of stop-smoking support represents an important and requisite component of the programme as it is an explicit outcome of the Health in All Policies (HiAP) approach.

Tenant interviews revealed a need for support to quit from current smokers. Taken together, the evidence from Tenancy Advisors' interviews and the Tenancy Advisors' on-line survey indicates that there is currently an opportunity for re-training of Tenancy Advisors in providing Quit Support. The length of time passed since initial training, and the relative infrequency of providing support, means that stop-smoking support skills (as a trained Quit Card provider) most likely decline over time. There is also currently an opportunity for more training in the systematic recording of applicants' (tenants') smoking status at sign-up, recording breaches and complaints, and conducting follow-up visits to check both compliance and offer quit support.

⁷² A large portion of the training is Motivational Interviewing – the Heart foundation does offer updates and has done so more recently with the new guidelines. Until June 2014 the course was two days but this has been modified with the guideline changes. Registered Health Professionals and social workers can become quit card providers by completing online learning at <http://learnonline.health.nz/login/index.php>

⁷³ As of Jan 1st 2016, this is not possible as the Ministry of Health has restricted quit-card registration to health care professionals only.

⁷⁴ Evidence clearly shows that delivering the ABCs consistently and completely can be challenging in community settings (e.g. DePue et al., 2002).

Enforcement

Another area where training would seem important is enforcement. Available enforcement actions reported by Tenancy Advisors included discussions with tenants or verbal warnings, written breach notices, and charging tenants for smoking-related damages. Tenancy Advisors believed that the ability to charge for damages was a key enforcement tool and felt that 'word of mouth' would make this even more effective in ensuring compliance. Some Tenancy Advisors reported issuing verbal warnings to tenants and discussed the possibility of written warnings and charging for damages, but there was no evidence that these tools were being applied consistently across Tenancy Advisors' portfolios. Currently, there appears to be no written protocol or standardised approach to enforcement and training in these areas of tenancy management and it would appear to be necessary to ensure consistent use of the different enforcement tools.

Follow-Up

Currently, there appears to be no systematic approach to following up tenants (who smoke) after the tenancy sign-up process (i.e. over months and years post sign-up) therefore those who do not accept an offer for support 'on the spot' are likely to be lost to follow-up⁷⁵.

Implementation/administration

In addition to the Quit Card training, current and future staff also need to be proficient in certain aspects of implementation of the policy such as effectively recording applicants' smoking status at the sign-up interview (and how to accurately record the provision of brief advice and stop-smoking support, if given). Another aspect of implementation that could be strengthened is signage. Based on visits to ten sites (25th Feb 2014 and 5th Aug 2015), there was little evidence of a systematic approach to signage that identifies the smokefree units and clearly states the no-smoking rules. Generic 'No Smoking' signs were observed on the doors and windows of some units, however, these seemed to be rather randomly allocated and did not appear to correlate closely with the actual contract status of occupiers⁷⁶.

Section summary, Tenancy Advisors

The evidence is clear that increasing the provision of stop-smoking support and follow-up directly impacts quit rates and smoking-related health outcomes (Ministry of Health, 2014b). There is probably no upper boundary to what might be considered desirable with respect to the provision of support, other than the net resources available at any time (in this case largely human resources). As already discussed, the HiAP approach involves explicitly focusing on win-win outcomes or the co-benefits or efficiencies that may accrue as a result of delivering 'health' alongside the day-to-day business of an organisation. Capacity building (institutional capacity) has been identified as a key process of HiAP and such capacity building typically occurs within an 'institutional warm-up period' when synergies and efficiencies are developed (Kickbusch, 2008). As described above, a number of opportunities exist for the further refinement of the human resources and systems that underpin this programme and further co-benefits may be possible (for example, a reduction in anti-social behaviour and other tenant issues that divert CCC resources from proactively supporting the wellbeing of all tenants).

⁷⁵ Only one Tenancy Advisor reported that he/she systematically followed up tenants proactively.

⁷⁶ Based on observation, Tenancy Advisor, and tenant interviews.

Partnership in a HiAP context

The CCC project manager viewed the smokefree social housing partnership as a model for partnership working, using a HiAP approach⁷⁷. The CCC Housing Unit had previous experience of working in partnerships, having sought relationships with agencies such as the Mental Health Foundation, in order to seek better outcomes for its tenants. The CCC also had (has) an existing partnership agreement (involving a joint work plan) with the CDHB and this was seen to be a helpful enabler for this project. The CCC and CDHB have worked together over many years. Their Joint Work Plan is seen as an important step in building on and developing a closer collaborative relationship between the two organisations. Many operational and policy development relationships currently exist and they are formally recognised through this Work Plan and reported on via the CCC-CDHB Senior Managers meeting.

The smokefree social housing partnership was fully aligned with the purpose of the Joint Work Plan (as stated above) and had many benefits to both the CCC and the CDHB. The CCC benefited from the specific skills and expertise and knowledge of 'best practice' that the CDHB brought to the partnership. The CDHB benefited from being able to gain access to a disadvantaged population in order to provide targeted stop-smoking support (as well as strengthening the partnership with the CCC and further developing inter-relationships and ideas for possible future projects). The project managers reported that they valued the formalisation of the partnership, as it enhanced effectiveness, advanced understanding and helped to make the (understanding of) purpose of the project clear. Given the weight that the project managers apportioned to this formalised partnership agreement, with respect to evaluation, the formalised partnership entity/process is considered to be a key requisite ingredient of the programme/intervention.

Equity

Possible unintended consequences also need to be considered. One equity-related concern is that smokefree policies in subsidised housing could worsen socioeconomic disparities by adversely affecting low-income people and displacing residents who refuse to comply (Drach et al., 2010). However, the CCC's no-smoking policy only prohibits the act of smoking indoors, not the occupation of units by people who smoke. However, one comment in the Tenant Satisfaction Questionnaire did illustrate the potential for a form of displacement, that of stigmatising residents who were forced outside their homes to smoke, highlighting that they were subject to different [external] rules and regulations to most of the population (although many private landlords may not allow smoking inside either⁷⁸ or they may not take on smoking tenants at all). Another concern raised by the Tenant Satisfaction Questionnaire was the potential to exacerbate existing social conflicts amongst tenants, when smokers moved outside to smoke, thus mixing with their neighbours more. This concern was related to the issue of second-hand smoke, which could cause tension amongst neighbours.

Various arguments about the 'fairness' of the policy emerged from tenant and Tenancy Advisor interviews. Tenancy Advisors suggested that the policy could become problematic if neighbouring tenants had different rules about whether or not they were allowed to smoke inside, depending on whether they were on a new contract or not. Indeed, one Tenancy Advisor suggested that the rule should apply to "all tenants". However, other interviews highlighted the potential difficulty of extending the policy to all

⁷⁷ Note that this project evolved progressively (rather than being implemented as a fully developed programme) and, using a HiAP approach, 'best practice' systems and structures were advised/considered/adapted and implemented over time/place.

⁷⁸ And they are unlikely to provide any smoking stop-smoking support.

tenants. The AKP practitioner, for example, had observed long-term tenant smokers in Council flats who would find it very difficult to observe such a rule. Possibly a key concern in terms of equity is that only some of this vulnerable population are currently offered stop-smoking support (and in practice, this is inconsistently given even to those who sign up to new contracts). There are probably many smokers amongst the tenant population who do want to quit, however, smoking stop-smoking support may not be [equally] available to those tenants on 'old' contracts. Therefore, as discussed by the CDHB project manager, there is a high need for smokefree interventions amongst this vulnerable⁷⁹ population. This need underpins the rationale for the CDHB working in partnership with the CCC and further opportunities exist for expanding resources and strategies that are focused on meeting this need.

Generally, international research suggests that smokefree housing policies can help motivate smoking cessation and reduce cigarette consumption (Pizacani et al., 2012). Tenants who quit smoking in response to smokefree policies would be likely to experience improved health and reduced expenditures on healthcare services (and of course tobacco purchases) (Farrelly, Nonnemaker, & Watson, 2012). These health and economic benefits can be maximised if policy implementation is coupled with the provision of evidence-based culturally appropriate smoking cessation resources (Drach et al., 2010; Winickoff, Gottlieb, & Mello, 2012).

⁷⁹ Broadly, the CCC social housing population could be described as 'low resources and high needs' — tenants include the elderly, disabled persons, sickness or unemployment beneficiaries and people on very low incomes — approximately half of all tenants are on either a sickness or invalid's benefit (now 'Supported Living Payment').

Conclusion

This evaluation has so far assessed the process of developing and implementing a no-smoking rule in a social housing context. These findings support the establishment of smokefree policies in subsidised social housing in New Zealand, as a useful and viable strategy to reduce the tobacco burden among low socioeconomic status populations. However, for smoking to be eliminated entirely (or to reach the $\leq 5\%$ level), there would likely need to be more resources devoted to staff training and the systematic provision of stop-smoking support, follow-up, and perhaps stronger enforcement.

The current no-smoking rule was considered “about right” with regard to restrictiveness and coercion, fairness and enforcement actions (by managers, Tenancy Advisors and tenants). The ongoing promotion of building cleanliness, fire safety and health is also seen as important. However, it may be necessary to incrementally ‘firm-up’ the policy parameters over time to help maintain hard-won shifts in social norms, and to build momentum in achieving near-zero prevalence in this population in accord with New Zealand’s Smokefree 2025 goal.

This evaluation has confirmed the utility of the smokefree social housing policy. The findings presented here suggest that further opportunities exist for an even more comprehensive and intensive health intervention to be focused and delivered within this sensitive population. Focused delivery may help address issues of access to health care (not only stop-smoking support) and equity of outcome, leading to improved population health. Unquestionably, there are certain efficiencies and enhancements that could be made to improve the practical implementation of the policy. However, the intensification of the CCC’s smokefree programme will likely require greater resource allocation⁸⁰ and would need to be balanced against other non-health business-as-usual activities. Several recommendations are listed below to guide future policy/implementation developments.

⁸⁰ For example, the resources needed to provide consistent provision of stop-smoking support to tenants, ongoing systematic follow-up of people who do want help to quit smoking, and ongoing comprehensive staff training.

Recommendations

The following recommendations are based on the analysis of all data collected during this process evaluation as well as information derived from the international literature (where relevant comparison to best practice is deemed useful). The recommendations are listed below in three groupings:

- **Box 5** lists a number of technical/procedural/operational recommendations and these recommendations relate specifically to ‘in house’ Christchurch City Council systems and processes (including Human Resources),
- **Box 6** lists a number of more in-depth recommendations that focus on future policy development and implementation, and these recommendations describe actions that might be taken or shared between one or more of the project partners (the ‘assigned’ project partners are shown in parenthesis after each recommendation), and
- **Box 7** lists four final and overarching recommendations that focus specifically on enhancing and strengthening the partnership via joint planning, innovation and advocacy.

Special notes

— These recommendations were current at the time that the data were first collected (a data collection period spanning approximately the first 12-months of programme implementation) and it is acknowledged that some of the points listed below have now been actioned (in part or in full) prior to report writing/publication.

— The applicability of these recommendations to the proposed 2016 *Community Housing Provider* model has not been specifically analysed here. However, in principle, applicability can reasonably be assumed (with or without adaptations as necessary).

— Further, during the evaluation period, the ‘pending’ transfer to the new CHP model may have influenced the extent to which some system, training and operational tasks were (or were not) embedded into business-as-usual. Anecdotally, the transitional stage caused a level of uncertainty, generally — this may have influenced policy implementation in ways that were not captured by this evaluation.

— While the recommendations listed below relate specifically to the Christchurch City Council’s smokefree social housing project, the recommendations may be used by other housing providers as a ‘check list’ for policy design and implementation (with or without adaptation). In addition many of the recommendations could be applicable to other working groups (CCC, CDHB) as guidance for partnership-working within a Health in All Policies (HiAP) approach.

Box 5: Operational and administrative recommendations (CCC systems and processes)

1. Update the CCC website social housing pages (and application form) to prominently display the smokefree message (policy/rules) with explicit mention of the National Smokefree 2025 goal (include partnership logos and links to support services).
2. Document all smoking-related interactions/conversations with tenants (at sign-up, annual inspections, opportunistic interactions, exit-surveys). This should include robust systems for linking sign-up survey data with annual inspection data and other opportunistic smoking status data, at an individual tenant level (allowing the calculation of quit rates as well as facilitating programmed follow-up). Also, ensure that the CCC databases (including data collection and data entry methods) correctly record ethnicity, with a focus on accurately recording Māori ethnicity using the New Zealand Census ethnicity question.
3. Provide Tenancy Advisors with housing unit/person case notes that are available for every visit (including smoking status and history of smoking-related interactions, damages, a subjective assessment of compliance, breaches and other relevant information) – ideally available in the field via suitable mobile devices.

4. Develop and formally implement a protocol for the recording, assessment, coding and recovery of the costs associated with tenants smoking in their smokefree units.
5. Design and produce door/window stickers with the CCC logo that identify the no-smoking status of the unit and the rules. Systematically work through the portfolio to apply these stickers to all non-smoking units. Systematically record where stickers have been applied (add these data to the administrative database on an ongoing basis).
6. Plan to improve the response rate to the Tenant Satisfaction Questionnaire to 80% by employing systematic follow-up and higher value incentives. Consider administering a full survey each year (rather than every second year) and review the format/methods to ensure anonymity for sensitive questions (including reviewing the instructions to tenants to potentially improve the response rate and to reduce social desirability bias). Ideally, the data collection and data entry methods used for the Tenant Satisfaction Questionnaire should permit individual tenant-level analyses to be performed (current data were provided at the housing complex level only). Feedback key survey findings and action points to tenants and Tenancy Advisors.
7. Ensure there are receptacles for cigarette butts at each location and that current smokers are aware of these.
8. Consider designated smoking areas/wet weather areas on a case-by-case basis (some complexes are currently adequately covered, others less so).

Box 6: Policy design, implementation, and future development (CCC-CDHB partnership)

9. Embed all policy implementation tasks into Business-As-Usual (a systems approach) and these tasks should not be standalone. This means embedding all smoking-related clauses, information and record keeping into all relevant documents and databases (CCC).
10. Adequately resource Managers and Tenancy Advisors to carry out the day-to-day activities related to policy implementation (i.e. match resourcing to the agreed level of stop-smoking support intervention) (CCC).
11. Consider periodic (e.g. six-monthly) refresher training for Tenancy Advisors in stop-smoking support (including nicotine management) and implementation/enforcement tools – make this a systematic process (CCC & CDHB).
12. Develop Tenancy Advisors' position descriptions to specifically include the no-smoking rule implementation tasks (including proactive stop-smoking support to all tenants who smoke) (CCC).
13. Include the smoking cessation ABC pathway in the list of basic competencies that Housing Unit staff are expected to achieve (including Tenancy Advisors being able to enquire more deeply into smoking habits by going beyond the census question) (CCC with guidance from the CDHB).
14. Identify and train stop-smoking (smoking cessation) champions at each complex (CCC & Smokefree Canterbury).
15. Pro-actively and systematically work to target and update old contracts via voluntary contract variations (this could be part of a wider tenant wellbeing initiative) (CCC with referral to Smokefree Canterbury for stop-smoking support as needed).

16. Stop-smoking support should be offered to Māori tenants based on a Māori framework and values, and using culturally appropriate providers (*CCC & CDHB & Smokefree Canterbury & other current and future kaupapa Māori smoking cessation providers*).
17. Consider making all re-built/new complexes 100% smokefree (i.e. no smoking anywhere on the site within 25m of buildings). Such extension of the no-smoking zone is consistent with the international literature and potentially offers greater protection to non-smokers (while also giving consideration to fairness). This approach might include dedicated smoking shelters within the property/perimeter (while still maintaining a specified separation from buildings, e.g. 10m) (*CCC*).
18. Explore the creation of voluntary exemplar complexes where total smokefree status is achieved and endorsed by tenants (consider options for audit, feedback and incentivisation) (*CCC*).
19. Plan a future review of the policy including setting/updating the organisational goals (include formalising a position on e-cigarettes). These goals should reflect (reaffirm) the intent of the policy across the various domains (e.g. economic, health, wellbeing, equity) and be set out to define the expected evaluable outcomes over time (e.g. 1-5+ years) (*CCC & CDHB*).

Box 7: Partnership

20. Maintain and strengthen the CCC – CDHB – Smokefree Canterbury partnership, particularly in the area of systems support, implementation guidance, and CCC staff training.
21. Review and plan for the coordinated delivery of stop-smoking support over the long term (i.e. 2-5yrs and beyond). This should include a formal plan that sets out the relative contributions and responsibilities of the project partners and details how the balance of these contributions and responsibilities might shift over time [also consider recommendations 14 & 16] (*CCC & CDHB & Smokefree Canterbury*).
22. Work in partnership to continually improve smoking cessation outcomes for all tenants who smoke – maintaining a focus on equity. Identify opportunities to extend recommendations 14-18 by applying/trialling innovative intervention components (such as incentives, social support, buddy systems, cessation champions and systematic pro-active follow-up) to enhance the overall policy/programme (*CCC & CDHB & Smokefree Canterbury*).
23. Promote this partnership (including the use of formalised joint work plans and a HiAP approach) as a ‘model’ for working across [and within] health and non-health agencies (*CCC & CDHB*).

References

- Baker, M., Zhang, J., & Howden-Chapman, P. (2012). Health Status of Housing New Zealand Housing Applicants and Tenants Key indicators for 2004-2010. Wellington: He Kainga Oranga / Housing and Health Research Programme, University of Otago.
- Ballor, D., Henson, H., & MacGuire, K. (2013). Support for No-Smoking Policies Among Residents of Public Multiunit Housing Differs by Smoking Status. *Journal of Community Health, 38*(6), 1074-1080. doi: 10.1007/s10900-013-9716-7
- Beaglehole, R., Bonita, R., Yach, D., Mackay, J., & Reddy, S. (2015). A tobacco-free world: a call to action to phase out the sale of tobacco products by 2040. *The Lancet, 385*(9972), 1011-1018. doi: 10.1016/s0140-6736(15)60133-7
- Becquemin, M. H., Bertholon, J. F., Bentayeb, M., Attoui, M., Ledur, D., Roy, F., . . . Dautzenberg, B. (2010). Third-hand smoking: indoor measurements of concentration and sizes of cigarette smoke particles after resuspension. *Tob Control, 19*(4), 347-348. doi: 10.1136/tc.2009.034694
- Community & Public Health. (2016). *Third-hand tobacco smoke exposure and implications for public health*. [A background paper]. Canterbury District Health Board, Christchurch.
- CPH & CCC. (2014). *Evaluation Plan: Evaluation of the adoption, implementation and outcomes/impact of the Christchurch City Council smokefree housing policy*. Community and Public Health, a division of the CDHB. Christchurch.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and Conducting Mixed Methods Research* (2 ed.): SAGE publications.
- Destailats, H., Singer, B. C., Lee, S. K., & Gundel, L. A. (2006). Effect of ozone on nicotine desorption from model surfaces: evidence for heterogeneous chemistry. *Environ Sci Technol, 40*, 1799-1805.
- Drach, L. L., Pizacani, B. A., Rohde, K. L., & Schubert, S. (2010). The acceptability of comprehensive smoke-free policies to low-income tenants in subsidized housing. *Prev Chronic Dis, 7*(3), A66.
- Ferrante, G., Simoni, M., Cibella, F., Ferrara, F., Liotta, G., Malizia, V., . . . La Grutta, S. (2013). Third-hand smoke exposure and health hazards in children. *Monaldi Arch Chest Dis, 79*(1), 38-43.
- Ferrence, I. A., Einarson, T., Selby, P., Soldin, O., & Koren, G. F. (2009). Methods for Quantification of Exposure to Cigarette Smoking and Environmental Tobacco Smoke: Focus on Developmental Toxicology. *Therapeutic Drug Monitoring, 31*, 14-30.
- Freiler, A., Muntaner, C., Shankardass, K., Mah, C. L., Molnar, A., Renahy, E., & O'Campo, P. (2013). Glossary for the implementation of Health in All Policies (HiAP). *J Epidemiol Community Health, 67*(12), 1068-1072. doi: 10.1136/jech-2013-202731
- Grimm, P. (2010). Social Desirability Bias *Wiley International Encyclopedia of Marketing*: John Wiley & Sons, Ltd.
- Hennrikus, D., Pentel, P. R., & Sandell, S. D. (2003). Preferences and practices among renters regarding smoking restrictions in apartment buildings. *Tob Control, 12*(2), 189-194.
- Hoffman, S., & Tan, C. (2015). Overview of systematic reviews on the health-related effects of government tobacco control policies. *BMC Public Health, 15*(744). doi: 10.1186/s12889-015-2041-6
- Hyland, A., Higbee, C., Travers, M. J., Van Deusen, A., Bansal-Travers, M., King, B., & Cummings, K. M. (2009). Smoke-free homes and smoking cessation and relapse in a longitudinal population of adults. *Nicotine Tob Res, 11*(6), 614-618. doi: 10.1093/ntr/ntp022
- Ivory, V. C., Blakely, T., Richardson, K., Thomson, G., & Carter, K. (2015). Do Changes in Neighborhood and Household Levels of Smoking and Deprivation Result in Changes in Individual Smoking Behavior? A Large-Scale Longitudinal Study of New Zealand Adults. *Am J Epidemiol*. doi: 10.1093/aje/kwv097

- Kickbusch, I. (2008). *Healthy societies: addressing 21st century health challenges*. Department of the Premier and Cabinet, South Australia.
- Koh, H. K., Joossens, L. X., & Connolly, G. N. (2007). Making smoking history worldwide. *N Engl J Med*, 356(1496), e8.
- Koster, B., Brink, A. L., & Clemmensen, I. H. (2013). 'Neighbour smoke'--exposure to secondhand smoke in multiunit dwellings in Denmark in 2010: a cross-sectional study. *Tob Control*, 22(3), 190-193. doi: 10.1136/tobaccocontrol-2011-050393
- Leas, E. C., Zablocki, R. W., Edland, S. D., & Al-Delaimy, W. K. (2015). Smokers who report smoking but do not consider themselves smokers: a phenomenon in need of further attention. *Tob Control*, 24(4), 400-403.
- Lemp, C. S. (2010). Combating Secondhand Smoke in Multi-Unit Housing: A summary and analysis of 21 Final Evaluation Reports addressing Communities of Excellence Indicators: Tobacco Control Evaluation Center.
- Levy, D. T., Hyland, A., Higbee, C., Remer, L., & Compton, C. (2007). The role of public policies in reducing smoking prevalence in California: results from the California tobacco policy simulation model. *Health Policy*, 82(2), 167-185. doi: 10.1016/j.healthpol.2006.09.008
- Malone, R., McDaniel, P., & Smith, E. (2014). It is time to plan the tobacco endgame. *BMJ*, 384(g), 1453.
- Matt, Quintana, P. J., Destailats, H., Gundel, L. A., Sleiman, M., Singer, B. C., . . . Hovell, M. F. (2011). Thirdhand tobacco smoke: emerging evidence and arguments for a multidisciplinary research agenda. *Environ Health Perspect*, 119(9), 1218-1226. doi: 10.1289/ehp.1103500
- Matt, Quintana, P. J. E., Zakarian, J. M., Fortmann, A. L., Chatfield, D. A., Hoh, E., . . . Hovell, M. F. (2011). When smokers move out and nonsmokers move in: residential thirdhand smoke pollution and exposure. *Tob Control*, 20(e1). doi: 10.1136/tc.2010.037382
- Matt, Romero, R., Ma, D. S., Quintana, P. J., Hovell, M. F., Donohue, M., . . . Chatfield, D. (2008). Tobacco use and asking prices of used cars: prevalence, costs, and new opportunities for changing smoking behavior. *Tob Induc Dis*, 4, 2. doi: 10.1186/1617-9625-4-2
- McKegg, K. (2006). *Intervention logic: a tool for demonstrating and understanding results*. Wellington.
- Ministry of Health. (2004). *A Portrait of Health. Key Results of the 2002/03 New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. (2013). *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016*. Wellington: Ministry of Health.
- Ministry of Health. (2014a). *Annual Update of Key Results 2013/14: New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. (2014b). *Background and Recommendations of the New Zealand Guidelines for Helping People to Stop Smoking*. Wellington: Ministry of Health.
- Ong, M. K., Diamant, A. L., Zhou, Q., Park, H. Y., & Kaplan, R. M. (2012). Estimates of smoking-related property costs in California multiunit housing. *Am J Public Health*, 102(3), 490-493. doi: 10.2105/ajph.2011.300170
- Orme. (2014). Tenant Profiles.xls In Central Tenancy Advisor Housing Unit Operations Group (Ed.). Christchurch.
- Pizacani, B. A., Maher, J. E., Rohde, K., Drach, L., & Stark, M. J. (2012). Implementation of a smoke-free policy in subsidized multiunit housing: effects on smoking cessation and secondhand smoke exposure. *Nicotine Tob Res*, 14(9), 1027-1034. doi: 10.1093/ntr/ntr334
- Satterlund, T. D., Treiber, J., Kipke, R., & Cassady, D. (2013). A qualitative evaluation of 40 voluntary, smoke-free, multiunit, housing policy campaigns in California. *Tobacco Control*. doi: 10.1136/tobaccocontrol-2012-050923
- Singer BC, H. A., Guevarra KS, Hawley EL, Nazaroff WW. (2002). Gas-phase organics in environmental tobacco smoke: Effects of smoking rate, ventilation, and furnishing level on emission factors. *Environ Sci Technol*, 36, 846–853.

- Singer, B. C., Hodgson, A. T., & Nazaroff, W. W. (2003). Gas-phase organics in environmental tobacco smoke. 2. Exposure-relevant emission factors and indirect exposure from habitual smoking. *Atmos Environ*, 37, 5551–5561.
- Singer, B. C., Revzan, K. L., Hotchi, T., Hodgson, A. T., & Brown, N. J. (2004). Sorption of organic gases in a furnished room. *Atmos Environ*, 38, 2483–2494.
- Sleiman, M., Gundel, L. A., Pankow, J. F., Jacob, P., Singer, B. C., & Destailats, H. (2010). Formation of carcinogens indoors by surface-mediated reactions of nicotine with nitrous acid, leading to potential thirdhand smoke hazards. *Proc Natl Acad Sci USA*, 107, 6576–6581.
- Thomas, J. L., Hecht, S. S., Luo, X., Ming, X., Ahluwalia, J. S., & Carmella, S. G. (2013). Thirdhand Tobacco Smoke: A Tobacco-Specific Lung Carcinogen on Surfaces in Smokers' Homes. *Nicotine & Tobacco Research*. doi: 10.1093/ntr/ntt110
- Thomson, G., Edwards, R., Wilson, N., & Blakely, T. (2012). What are the elements of the tobacco endgame? *Tobacco Control*, 21(2), 293-295. doi: 10.1136/tc.2010.040881
- van der Deen, F. S., Ikeda, T., Cobiac, L., Wilson, N., & Blakely, T. (2014). Projecting future smoking prevalence to 2025 and beyond in New Zealand using smoking prevalence data from the 2013 Census. *N Z Med J*, 127(1406), 71-79.
- WHO. (1978). *Report of the International Conference on Primary Health Care*. Paper presented at the International Conference on Primary Health Care, 6-12 September 1978, Alma-Ata, USSR.
- WHO. (1986). Paper presented at the First International Conference on Health Promotion, 17–21 November 1986, Ottawa, Canada.
- WHO. (2013). *8th WHO Global Conference on Health Promotion*. Official website. <http://www.healthpromotion2013.org/health-promotion/health-in-all-policies>, Helsinki, Finland.
- Wilson, L. M., Avila Tang, E., Chander, G., Hutton, H. E., Odelola, O. A., Elf, J. L., . . . Apelberg, B. J. (2012). Impact of Tobacco Control Interventions on Smoking Initiation, Cessation, and Prevalence: A Systematic Review. *Journal of Environmental and Public Health*, 2012, 36. doi: 10.1155/2012/961724

Appendix

Survey and interview questions

Tenant Satisfaction Questionnaire (pen-and-paper, administered by the CCC)

Q10. Do you smoke cigarettes regularly? (that is one or more per day) COUNT ONLY tobacco cigarettes, DON'T COUNT pipes, cigars, or cigarillos.

☐ Yes

☐ No → Have you ever been a regular smoker of one or more cigarettes per day? ☐ Yes ☐ No

Q11. If you smoke where do you smoke now when you're at home? (please tick ALL that are true for you) → Non-smokers skip this question

☐ In my unit ☐ Outside on my porch, patio or balcony ☐ Outside in my parking lot or other common area

☐ Other: Please tell us

Q12. What do you think about this "No Smoking" Policy? Please tick ONE option (as of February 2014, any new Council tenants are not allowed to smoke inside their units)

☐ It's a good idea ☐ It's O.K. ☐ It's a bad idea ☐ Don't know, I haven't heard of this policy

Tenancy Advisor Questionnaire (on-line, administered by C&PH)

1. What is your opinion of the no-smoking policy?
2. When did you personally start implementing the no-smoking rule?
3. What information and/or training have you received about the policy? Please select all that are true
4. Generally, how comfortable do you feel asking applicants/tenants about their smoking status and giving those applicants/tenants who smoke some brief advice to quit smoking, at the time of contract signing?
5. Please rate all of the ways of implementing the policy as listed below
6. Have there been occasions when you have not taken any enforcement action against a tenant who you knew was disregarding the smoking rules?
7. How difficult or easy is the policy to enforce? (i.e. ensuring that tenants don't smoke inside)
8. In your view, what impact has the no-smoking rule had on tenants who smoke...
9. In your view, what impact is the policy having on the quality of the indoor environment?
10. We would like to find out more detail about the way(s) that you provide cessation support What support do you routinely offer to tenants about quitting smoking (either at the time of contract signing or at any other time)? Please select all that are true.
11. How do most tenants respond to your offer of smoking cessation support?
12. In terms of your normal day-to-day work, would you say that implementing the policy ... Note: you may select more than one answer.
13. Please make any further comments here

Semi-structured face-to-face interview: Tenancy Advisor

1. Please describe your role with the Council [Note: interviewer to ask/record smoking status of advisor at some point in the interview in a non-confrontational way].
2. To your knowledge, what led to the Council deciding to implement a smokefree policy? Did you and/or your colleagues have any input into this decision?
3. In your view, how does tenant smoking impact on the maintenance and refurbishment of units? What do you anticipate the impact of the new policy will be on cost and time in terms of maintenance and refurbishment?
4. What is your involvement in the process of tenants signing contracts? How have tenants responded, at the time of signing? What happens if tenants don't agree to sign the contract?
5. What protocols are in place for implementing the smokefree contracts and for enforcing them? Are these written?
6. Please tell us how *likely* you are to abide by these protocols and to enforce the policy (or how *able* you are to follow the protocols, given the other demands of the job)? What factors are likely to impact on you following protocol/enforcing policy?
7. What is your specific role in implementing the policy?
8. What training regarding the smokefree policy have you received?
9. What role do you have in terms of offering support to tenants to quit smoking – how do you do this?
10. How confident do you feel in providing smoking cessation support to tenants?
11. What breaches of the contract have you experienced so far? How have you dealt with these? What problems does this raise?
12. What, if any, complaints about the policy have you received? How have you responded to these?
13. Please describe the housing units for which you are responsible: (e.g. where are they, what is the general configuration, how many tenants do they house, how many units in each block, are they free-standing/joined, what style/type/age of construction are they, describe the interiors – furnishings etc, what shared spaces/common areas exist for tenants, what outdoor spaces are available for individual tenants)

14. Overall, how do you think the smokefree policy is working out (what's good about it)? How successful do you think it will be? ('A' ... in terms of managing the properties and 'B' in terms of helping people reduce or quit smoking? anything else?)
- How well do you think tenants are complying with the policy?
 - What difficulties/challenges have you had with the policy so far?
 - What has worked well in terms of implementing the policy?
 - What have you learnt so far regarding implementing the policy?
 - What, if anything, would you do differently if you were to start again?
 - How does this policy impact on your day-to-day work?
 - What other priorities do you have in your day-to-day work? Where does enforcing this policy fit with those priorities?
15. Do you have any other comments or thoughts regarding the policy?

Semi-structured face-to-face interview s: partnership questions (common to CCC managers, CDHB, Smokefree Canterbury)

1. From your perspective, what was the overall reason for establishing a working relationship between CCC and CDHB?
2. What do you understand to be your role in this working relationship?
(Prompt for specific responsibilities if not addressed)
3. What do you think have been the benefits of the CCC and CDHB working together so far?
4. Has the joint project lived up to your expectations? How?
5. What do you think will be the long-term benefits of the CCC and CDHB working together?
6. How would you describe your working relationship with CDHB?
7. Please explain the impact of individual personalities on the working relationship between the two organisations – what factors are important?
8. What is it that supports your working relationship with CDHB?
9. What are the challenges of working with CDHB?
10. Other than your relationship with them, is there anything else that has enhanced your capacity to work with CDHB?
(Prompt for organisational and contextual factors if not addressed e.g. practical factors)
11. Is there anything that has made working with CDHB difficult?
12. Can you talk to us about any potential barriers you might foresee regarding the CCC and CDHB continuing to work together?
13. How would you describe your level of commitment to working with CDHB?

CCC Housing Unit manager (to mid-2015)

1. Please describe your role with the CCC.
2. What is your understanding of the Council's rationale for implementing a smokefree policy for its social housing? (ie what led to them developing the policy)? Did you and any other Tenancy Officers have any input into this decision?
3. How would you describe the nature of the relationship (partnership?) between the CDHB and the CCC at an organisational level and at an individual staff member level, as it relates (related) to the development and implementation of the CCC smokefree housing policy. What qualities and attributes were important? (thinking about organisational and individual people and their attributes (or perhaps barriers?)what was important?)
4. What is your own view about how tenant smoking impacts on the maintenance and refurbishment of units? What do you anticipate the impact of the new policy will be on cost and time in terms of maintenance and refurbishment?
5. Please talk us through the 'new contract' and 'contract variation' process. Has this stayed consistent since January 2014?
6. How have tenants responded, at the time of signing? What happens if tenants don't agree to sign the contract?
7. What protocols are in place for implementing the smokefree contracts and for enforcing them? Are these written?
8. In your own role as a tenancy officer, how *likely* are you to abide by these specific protocols and to enforce the policy (or how *able* are you to follow the protocols, given the other demands of the job)? What factors are likely to impact on you following protocol/enforcing policy?
9. What role do you and Tenancy Officers have in terms of offering support to tenants to quit smoking – how do you do this?
10. What training have you yourself received regarding how to offer cessation support? What training in ABC do other tenancy officers receive?
11. In terms of offering ABC, how often do you/other Tenancy Officers offer this to tenants?
12. How confident do you feel in providing smoking cessation support to tenants?
13. What is your understanding of the system for referral (i.e. if a tenant accepts an offer of cessation support ... what happens next?). Is this documented? If so how?
14. What resources are available to tenants who indicate that they want to quit? (i.e. what level of intervention e.g. Quitline, one-on-one cessation counselling/support, group interventions, NTR, other?).
15. What is your understanding of any follow-up system or process?
16. What breaches of the contract have you experienced so far? How have you dealt with these? What problems does this raise? Is there a written procedure for dealing with problems?
17. What, if any, complaints about the policy have you received? How have you responded to these?

18. Please describe the CCC housing units: (e.g. where are they, what is the general configuration, how many tenants do they house, how many units in each block, are they free-standing/joined, what style/type/age of construction are they, describe the interiors – furnishings etc, what shared spaces/common areas exist for tenants, what outdoor spaces are available for individual tenants)
19. Overall, how do you think the smokefree policy is working out (what's good about it)? How successful do you think it will be? ('A' ... in terms of managing the properties and 'B' in terms of helping people reduce or quit smoking? anything else?)
- How well do you think tenants are complying with the policy?
 - What difficulties/challenges have you had with the policy so far?
 - What has worked well in terms of implementing the policy?
 - What have you learnt so far regarding implementing the policy?
 - What, if anything, would you do differently if you were to start again?
 - How does this policy impact on your day-to-day work?
 - What other priorities do you have in your day-to-day work? Where does enforcing this policy fit with those priorities?
 - Do you have any other comments or thoughts regarding the policy?
20. Considering all of the points above, what changes do you think could be made to the programme/policy to improve either cost and/or health outcomes? (i.e. reduce smoking-related damage and/or improve quit rates or further reduce smoking-related harm).
21. Please provide any other comments or relevant information.

Semi-structured face-to-face interview: C&PH/Smokefree Canterbury staff

1. Please describe your role with the CDHB.
2. What is your understanding of the Council's rationale for implementing a smokefree policy for its social housing?
3. What is your understanding of the process by which the policy/protocol was developed? How have you been involved in this process?
4. How would you describe the nature of the relationship (partnership?) between the CDHB and the CCC at an organisational level and at an individual staff member level, as it relates (related) to the development and implementation of the CCC smokefree housing policy. What qualities and attributes were important? (thinking about organisational and individual people and their attributes (or perhaps barriers?)what was important?)
5. To what degree was the policy designed to create an opportunity for a targeted smoking cessation intervention (i.e. an opportunity for engagement by cessation services)?
6. ... and ... to what extent do you think the smokefree policy meets this goal (of creating an opportunity for a targeted smoking cessation intervention)?
7. Please describe yours or the ABC team's involvement in training CCC staff to provide cessation support to tenants.
8. What is your understanding of the system for referral (i.e. if an applicant/tenant accepts an offer of cessation support ... what happens next?). Is this documented? If so how?
9. What resources are available to tenants who indicate that they want to quit? (i.e. what level of intervention e.g. Quitline, one-on-one cessation counselling/support, group interventions, NTR, other?).
10. What is your understanding of any follow-up system or process?
11. To your knowledge, when you trained the Tenancy Advisors in cessation support, did you advocate a pro-active approach (i.e. suggesting that the Tenancy Advisors apply the ABC framework repeatedly with tenants [at every tenant interaction]? Please tell us how often you suggest they offer ABC.
12. Please tell us what your expectation (or ideal) is with regard to Tenancy Advisors being pro-active vs reactive (i.e. how intensive do you think the smokefree programme is or could be or should be?).
13. Please describe the wider context of this policy and its potential impact (perhaps with reference to Smokefree 2025).
14. Considering all that you have told us so far, what changes do you think could be made to the programme/policy to improve health outcomes? (i.e. improve quit rates or further reduce smoking-related harm).
15. Please provide any other comments or relevant information.

Semi-structured face-to-face interview: Smokefree Canterbury, support service (AKP)

1. Please describe your role with the CDHB/CPH.
2. Please describe your role with this particular project – ie the CCC smokefree social housing policy. How does your work with the CCC fit within your usual work role? How does it extend your usual work?
3. What is your understanding of the Council's rationale for implementing a smokefree policy for its social housing?
We'd like to ask you about your experience in working as a partnership with the CCC
4. What is your understanding of the working relationship or partnership between the CDHB and the CCC for this policy?
5. How do you personally contribute to this partnership? With whom at the CCC do you work and how?
6. What specific qualities or attributes do you think are important for a successful working partnership? Are there any qualities of those you work with at the CCC that you think help the partnership?

7. What are the barriers to effective partnership? (ie keeping in mind that the overall goals are to increase quitting/reduce smoking as well as reduce council's operating costs for cleaning smoke-damaged units)
We'd now like to ask you about your experience with the tenants themselves
8. Please tell us about all the different types of housing complexes you have visited so far
9. From your visits to CCC housing complexes, have you been able to estimate smoking prevalence at all? Would you be able to give a rough overall smoking prevalence??? Please tell us your estimate of the proportion of tenants who smoke – does this differ by housing complex/age?
10. From the tenants that you have spoken to, what else are you able to tell us about tenants who smoke e.g. their reasons for smoking, attitudes towards quitting, barriers to quitting etc?
We'd now like to ask a few questions about the policy itself
11. In your view, how easy/difficult do you think it will be for tenants to comply with this smokefree policy? Have you had any feedback (either positive or negative) from tenants about the policy?
12. To your knowledge, to what degree is the smokefree council housing policy designed as an opportunity for offering a targeted smoking cessation intervention with council tenants?
13. ... and ... to what extent do you think the smokefree policy meets this goal (of creating an opportunity for a targeted smoking cessation intervention)?
We're keen to find out more detail about the type of support you provide
14. Have you had any involvement in training CCC staff (ie Tenancy Advisors) to provide cessation support to tenants? (including any informal support, such as conversations with Tenancy Advisors etc...)
15. Please talk us through the cessation support that you offer (ie as if you were talking to a client). How long does this process take for each client, and what follow-up do you put in place? Ideally, how would a client respond to your support? How do those clients at the CCC you have worked with usually respond to your support? How is your support/services documented?
16. How many smoking tenants have accepted cessation support?
17. What further resources are available to tenants who indicate that they want to quit? (i.e. what level of intervention e.g. Quitline, one-on-one cessation counselling/support, group interventions, NRT, other?) (ie other than what you yourself provide)
18. In your view, how has this policy influenced tenants' smoking behaviour/quit attempts (including their attitude towards quitting, as well as acceptance of cessation support, adoption of nicotine management strategy etc)
19. [How does the work you are doing with CCC tenants fit within the wider context of your work? (e.g. Smokefree 2025 goal)]
We'd like to know about any unintended consequences and/or unfairness of the smokefree policy
20. To your knowledge, has the policy resulted in any unintended consequences? If so, have you had to resolve any problems arising from the policy?
21. Do you see any disadvantages/unfairness of the policy for tenants?
22. In your opinion, does it reach those who are most disadvantaged and offer an opportunity to reduce health inequalities??
We'd also like to know how you think the policy or its implementation could be improved
23. Is there any way that the policy/implementation of the policy could be improved to ensure **fairer** outcomes for tenants?
24. Considering all that you have told us so far, what changes do you think could be made to the programme/policy to improve health outcomes? (i.e. improve quit rates or further reduce smoking-related harm).
25. Please provide any other comments or relevant information.

Semi-structured face-to-face interview: Current-smoker

1. Are you aware of the council's "No Smoking" policy that started in January last year (2014)? (ie new tenants, or those having their units redecorated, are not allowed to smoke inside their units)
If yes:
2. How did you hear about the policy? (*Prompts: how much have the Council told you; what happened at the sign-up interview with your Tenancy Advisor?*)
3. How do you feel about the "No Smoking" policy? Do you think the policy is a good idea? (*e.g. what do you think about the way the Council went about introducing the rule?*)
4. Have you had a visit from your T.A. since you signed up for this flat? If so, has your T.A. said anything about the no-smoking rule when they visited? Have they given you any more information or help about the no-smoking rule when they visited?
5. What do you think about making all of the Council grounds where you live 100% smokefree (ie no smoking anywhere), including all common and outdoor areas? (e.g. entrance, patios, parking & gardens).
Thinking about your own flat, and any other flats in this complex that you know are smokefree...
6. As far as you know, what happens if either you or other tenants are smoking inside? [*ie charging for damage*]
7. How often (if at all) do you think Council staff follow up on the smokefree rule? (*e.g. Reminding you that you are not allowed to smoke inside, telling you that you will have to pay for damages etc...*)
8. If you are aware of any (other) units in this complex that the rule applies to... Since the "No Smoking" policy started in January last year, how often do you see people smoking inside non-smoking units/flats?
We'd like to know how other people's smoking affects you (2nd-hand smoke)
9. What about NOW - how often do you smell or breathe someone else's smoke in and around your unit/flat? (If a problem now, can you recall what it was like before?)

10. Can you remember before the smokefree rule started in January 2014 – how much did other people’s smoking (in or around your flat) bother you then?
 11. You are talking to us today because you have recently signed a contract to say that your unit is smokefree. Can you tell us about how easy or difficult it is for you to keep your unit smokefree?
 12. What happens when you have visitors who are smokers?
 13. Before you signed your most recent contract (including the no-smoking rule), what were your own rules about smoking inside? E.g. did you *choose* to smoke outside?
 14. Have you heard about the Tobacco Quit Line? Have you ever called the Tobacco Quit Line?
 15. What other support services (for helping you quit smoking) have you heard about?
 16. Have you tried to quit smoking over the last year? If so, did it have anything to do with the Council’s new no-smoking policy?
 ➔ *Skip if no quit attempts post-policy* - What happened for you if you were trying to quit smoking and you saw or smelled other tenants smoking outside? How did this affect you trying to give up smoking?
 17. Please tell us about any help to quit smoking that your Tenancy Advisor has given you (at any stage, including at the sign-up interview). (e.g. *does he/she ask about your smoking, suggest anything to help, offer a referral to smoking cessation services or Quit-Line??*)
 18. Would you like to get more information from your Tenancy Advisor about how to quit? If so, what help would you like?
 19. Please tell us what effect this no-smoking rule has on (a) when, (b) where and (c) how much you smoke. Does this rule bother you? Why/why not?
 20. Please tell us about any other positive effects that you might have experienced as a result of the no-smoking policy: for example, ... saving money, being able to buy better food, or having a better quality of life.
 21. Do you feel that you have been treated unfairly (by anyone at all) or have become worse off because of the CCC non-smoking policy? e.g. *increased levels of second-hand smoke, noise from people smoking outside, ‘heavy-handed’ approaches to enforcing the rule, inconvenience, annoyance, stress or lack of enjoyment/relaxation, undue difficulty because of a physical disability ... a sense of unfairness because some people can still smoke in their units and you can’t????*
 22. Can you think of anything the Council could do to make this smokefree rule work better? Any improvements it could make to the policy?
- Please feel free to make any other comments:

Semi-structured face-to-face interview: non-smoker

1. Are you aware of the council’s “No Smoking” policy that started in January last year (2014)? (ie new tenants, or those having their units redecorated, are not allowed to smoke inside their units)
 If yes:
 2. How did you hear about the policy? (*Prompts: how much have the Council told you; what happened at the sign-up interview with your Tenancy Advisor?*)
 3. How do you feel about the “No Smoking” policy? Do you think the policy is a good idea? (e.g. *what do you think about the way the Council went about introducing the rule?*)
 4. Have you had a visit from your T.A. since you signed up for this flat? If so, has your T.A. said anything about the no-smoking rule when they visited? (*Have they given you any more information about the no-smoking rule when they visited?*)
 5. What do you think about making all of the Council grounds where you live 100% smokefree (ie no smoking anywhere), including all common and outdoor areas? (e.g. entrance, patios, parking & gardens).
Thinking about your own flat, and any other flats in this complex that you know are smokefree...
 6. As far as you know, what happens if either you or other tenants are smoking inside? [*ie charging for damage*]
 7. How often (if at all) do you think Council staff follow up on the smokefree rule? (e.g. *reminding you or others that you are not allowed to smoke inside, telling you that you will have to pay for damages etc...*)
 8. If you are aware of any (other) units in this complex that the rule applies to... Since the “No Smoking” policy started in January last year, how often have you seen people smoking *inside* non-smoking units/flats?
 -How often do you see them smoking *outside*? Do you see more people smoking outside now? (than before the smokefree policy)
We’d like to know how other people’s smoking affects you (2nd-hand smoke)
 9. What about NOW - how often do you smell or breathe someone else’s smoke in and around your unit/flat? (If a problem now, can you recall what it was like before?)
 10. Can you remember before the smokefree rule started in January 2014 – how much did other people’s smoking (in or around your flat) bother you then?
 11. You are talking to us today because you have recently signed a contract to say that your unit is smokefree. What happens when you have visitors who are smokers?
 13. Before you signed your most recent contract (including the no-smoking rule), what were your own rules about smoking inside? e.g. for visitors
 14. *If an ex-smoker:* Does seeing or smelling other tenants/visitors smoking outside ever tempt you to start smoking again?
 15. Do you feel that you have been treated unfairly (by anyone at all) or have become worse off because of the CCC non-smoking policy? e.g. *increased levels of second-hand smoke, noise from people smoking outside, ‘heavy-handed’ approaches to enforcing the rule, inconvenience, annoyance, stress or lack of enjoyment/relaxation, undue difficulty because of a physical disability ... a sense of unfairness because some people can still smoke in their units and you can’t????*
 16. Can you think of anything the Council could do to make this smokefree rule work better? Any improvements it could make to the policy?
- Please feel free to make any other comments:

End of document