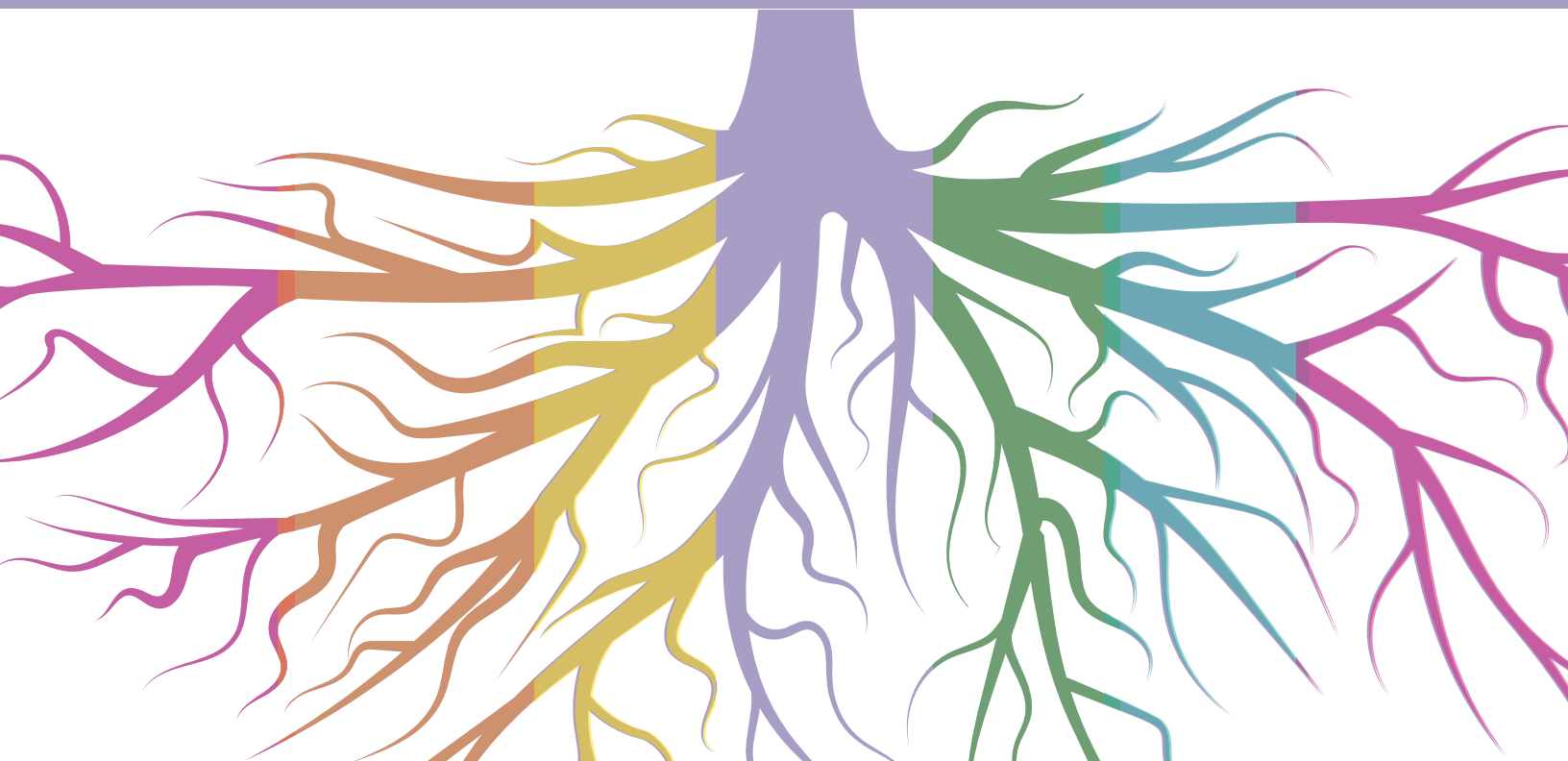
WE BREATHE

SUPPORTING TOBACCO-FREE LGBTQ COMMUNITIES

POLICY PLATFORM

Tobacco Control
An Intersectional Approach



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californialgbtqhealth.org/we-breathe

TABLE OF CONTENTS

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We Breathe: Supporting Tobacco-Free LGBTQ+ Communities was honored to collaborate with California Tobacco Control LGBTQ Regional Projects, LGBTQ+ community members, various Statewide Technical Advisory Organizations and our evaluators, Harder+ Co, to develop and disseminate our Policy Platform “Tobacco Control: An Intersectional Approach”. These champions helped inform, develop, consumer test, and/or organize survey events and gallery walks—allowing We Breathe to learn more about the state of LGBTQ tobacco usage and gather data for this Platform.

“Social Justice requires individual and social action to eliminate oppression.”

- Changing Landscape Countering New Threats. 2015-2017 Master Plan of the Tobacco Education and Research Oversight Committee for California (TEROC)

INTRODUCTION AND TERMINOLOGY

THE LGBTQ+ ACRONYM

The LGBTQ+ Acronym*
"The acronym LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning) is used in this Policy Platform because it is recognizable, it is consistent with the language used in recent California policy (some of which funds this work), and it provides for brevity in this Policy Platform. Although some professional and governmental entities (e.g., National Institute of Health) are using the term "sexual and gender minorities" (SGM), this is not a term that is necessarily familiar to or used by the communities the term represents." [1]

"It is our experience that many people within LGBTQ+ communities see SGM as a term that reduces LGBTQ+ people down to their sexual behaviors when people are so much more. Terminology sets the tone for communities to follow, we therefore acknowledge that our usage of LGBTQ+ in this Policy Platform comes with the caveat that the LGBTQ+ acronym does not represent all individuals or populations whose sexual orientation, gender identity or gender expression is seen as outside society's expected norms. The myriad of self-described identities, attractions and expression by individuals from all races, ethnicities, cultures, genders, ages, and background cannot begin to be covered by a simple acronym developed predominantly in a white, Western, comparatively affluent context." [2]

"There are many individuals, cultures, and communities who identify as sexual orientations and/or gender identities which fall outside the LGBTQ+ acronym; they too face health disparities, lack of targeted research, and do, anecdotally, struggle with barriers to health access in California. The acronym does not take into account 'We Breathe's' constant recognition that no person is ever just their sexual orientation or gender identity, as they are also a person living at the intersections of racial, ethnic, class, national, religious, ability, and additional identities. Although the LGBTQ+ acronym is used in this 'Policy Platform, We Breathe' writes with the entirety of our diverse communities in mind and a commitment to raising up the voices of those least heard." [1]

QTPOC is generally used by LGBTQ+ communities of color, rather than LGBTQ+ POC, and is considered both an inclusive and uniting term. [3]

Unlike most other California Priority Populations, We Breathe has not been afforded the luxury of compiling what is known about the best tobacco control policies to reduce tobacco use among LGBTQ+ people and populations. This data, for our communities, simply doesn't exist. Our background is rife with structural and systemic invisibility, as state funded surveys and research are still not required to capture data needed to count us within the diverse communities to which we belong. Our invisibility will continue to exist for as long as our funding institutions allow this to happen.

*The introduction to the LGBTQ acronym is being utilized from #Out4MentalHealth's State of LGBTQ Communities Report: "Surveying the Road to Equity" (2019) and the California LGBTQ Reducing Disparities Project Population Report, "First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Queer, & Questioning Populations in California" (2012). For more information on the #Out4MentalHealth Annual State of the LGBTQ Communitiesy Reports, please visit: https://californialgbtqhealth.org/about-us/out4mentalhealth/

Terminology and Definitions

L (Lesbian): A lesbian is a woman/woman-aligned person who is predominantly or only attracted to people of the same/similar gender.

G (Gay): Gay is usually a term used to refer to men/men-aligned individuals who are predominantly or only attracted to people of the same/similar gender. However, lesbians can also be referred to as gay. The use of the term gay became more popular during the 1970s. Today, bisexual and pansexual people sometimes use gay to casually refer to themselves when they talk about their similar gender attraction.

B (Bisexual): Bisexual indicates a person who can be emotionally, romantically or sexually attracted to more than one sex, gender or gender identity. Someone who is attracted to gender identities similar to their own and different to their own. Also used as an umbrella term for all people who are attracted to more than one gender (pansexual, fluid, etc).

T (Transgender): Transgender is a term that indicates that a person's gender identity is different from the gender associated with the sex they were assigned at birth.

Q (Queer or Questioning): Though queer may be used by people as a specific identity, it is often considered an umbrella term for anyone who is non-cisgender or heterosexual. But it is also a slur. It should not be placed on all members of the community, and should only be used by cisgender and heterosexual individuals when referring to a person who explicitly identifies with it. Questioning refers to people who may be unsure of their sexual orientation and/or gender identity.

+ (Plus): The 'plus' is used to signify all of the gender identities and sexual orientations that are not specifically covered by the other five initials. An example is Two-Spirit, a pan-Indigenous American identity.

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer, and others. The "plus" represents additional sexual orientations and/or gender identities including pansexual Two-Spirit, and non-binary.

LBT: Lesbian, Bisexual, Transgender

GBT: Gay, Bisexual, Transgender

TGNC: Transgender, Gender Nonconforming

ACEs: Adverse Childhood Experiences

Heterosexism: discrimination or prejudice against gay people on the assumption that heterosexuality is the normal sexual orientation.

Cissexism: prejudice or discrimination against Transgender people.

Defunding the Police: reallocating or redirecting funding away from the police departments for services better addressed by other government agencies funded by the local municipality such as social services. Reallocating or redirecting funding can improve things such as, but not limited to, mental health, addiction, and homelessness.

LGBTQ+ serving programs, centers, and organizations: whose mission statement and vision statement centers around LGBTQ+ lives.

EXECUTIVE SUMMARY

WE BREATHE

SUPPORTING TOBACCO-FREE LGBTQ COMMUNITIES

The purpose of the California Tobacco Control Program's Policy Platform (CTCP) is designed for jurisdictions to guide what policies work for each priority population such as LGBTQ+, African American/Black, Hispanic/Latino, etc. However, data does not exist for us to answer that question for LGBTQ+ people. After completing a comprehensive literature review, reviewing hundreds of LGBTQ+ tobacco industry documents,[4] and reviewing state funded tobacco research projects[5] no research institution or Tobacco Related Disease Research Project (TRDRP) has conducted research on how policies such as outdoor dining bans, flavor tobacco bans, multi-unit housing bans, etc. have impacted LGBTQ+ tobacco use, nor has research been done to review how such bans may negatively and unintentionally harm LGBTQ+ communities.

Instead, what you will find in this document are community voices based on Key Information Interviews, Public Intercept Surveys, Gallery Walks, and LGBTQ+ coming out timelines (funded by TRDRP) that provide recommendations for systemic environmental changes, cultural sensitivity/humility, funding recommendations, and more. As California rolls out the Tobacco Endgame goals, LGBTQ+ communities are still under-resourced and struggling to reduce tobacco use rates to that of the general population; our community has yet to meet prior state tobacco use rate goals. To address this and ensure that LGBTQ+ communities are not left behind again as California seeks to extinguish tobacco use rates of the general community by 2035, our communities need funders and policy makers to focus more on social determinants of health, provide access to comprehensive behavioral health services within trusted LGBTQ+ organizations, and focus on the extreme homophobia and transphobia experienced by LGBTQ+ communities from childhood, adulthood, and as senior citizens. Until we address the root cause of tobacco usage within LGBTQ+ communities , our communities will continue to experience an 8x (or more) higher tobacco-usage rate compared to their cisgender/straight peers.

Systemic Environmental Changes

Systemic Environmental Changes

- Programs across the California Department of Public Health (CDPH) should work together to address the health inequities of LGBTQ+ communities. Collaboration between departments can assist in addressing the health inequities experienced by LGBTQ+ communities. This includes addressing social determinants of health such as food insecurity, lack of housing, etc. and how these challenges may increase tobacco usage.
- Streamline collection of sexual orientation and gender identity (SOGI) data within CDPH and TRDRP.
    - LGBTQ+ people exist in ALL California Tobacco Control Program (CTCP) priority populations, yet we are so often rendered invisible in the work of other programs
- The California Department of Education to include LGBTQ+ Tobacco learning module in secondary school health class curriculum.
    - Include LGBTQ+ youth specific Quitline services and/or allow counselors/school psychologists to assist in cessation services
    - Fund Gender & Sexuality Alliances (GSAs) and the campus support staff
        i. Many teachers volunteer their time to host GSAs, which creates a lack of access to GSAs as most educators are overwhelmed with their regular duties
- Create minimum tobacco pricing for tobacco products.

FUNDING RECOMMENDATIONS

Funding Recommendations

- Fund LGBTQ+ focused Centers and LGBTQ+-serving organizations* to provide support groups where members of LGBTQ+ communities can make positive connections (nightclubs, peer-to-peer support groups, etc).

"You cannot implement [programs and policies] without a good partnership, a trusted partnership with the LGBTQ gatekeepers, which are usually the centers. And, I think that really is untapped."

- LGBT HEALTH LINK

- Fund LGBTQ+ culturally competent mental health providers within LGBTQ+ focused organizations* to address the fatalist outlook** and address mental health disparities due to discrimination, family rejection and social determinants of health.

"They don't really talk about queer people. Recently, there was a substance abuse grant, and no LGBTQ+ organization was funded for this particular substance abuse grant.
And that speaks volumes to me—how people, how these governments, are thinking about our community."

- Alameda County Community Member
#O4MH Listening Session

- Fund a CA LGBTQ+ specific cessation line and program
  - Create a national program that States can contract with to provide LGBTQ+ cessation services. STOP funding referral programs and divert that funding towards the under resourced cessation programs.

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

** Fatalism is the belief that events are predetermined by fate or destiny, and that humans cannot do anything to change them.

- Fund LGBTQ+ serving organizations* to serve as trusted messengers to provide community education where it will be more accepted by members of LGBTQ+ communities.
    - LGBTQ+ organizations* provide tobacco education workshops where community members have an opportunity to learn how tobacco impacts health as an LGBTQ+ individual (example: how tobacco use affects gender transition)
        - i. Include: History of tobacco as the first corporation who acknowledged and funded LGBTQ+ communities, as this directly led to widespread tobacco use.
        - ii. Address the cultural change policies from within LGBTQ+ community -based organizations (CBO) (i.e. Tobacco Free Prides, Smoke-free LGBT+bars).
    - Avoid kink shaming, and any other shaming, in tobacco messaging and instead incorporate LGBTQ+-ism such as “Suck on this instead”. Messaging can also include creating group challenges (quitting together), mental health awareness, and saving money.

“I really wish that we had more of a focus on our organizations around the country in having policies related to tobacco use, even adopting tobacco funding, things like that. Because too often our own organizations have not been approached related to tobacco controls. They’ve been approached related to HIV over, and over, and over again. But not about tobacco control. The public health industry funding community is not teaching us that tobacco control is important.”

- LGBT HEALTH LINK

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

Research Needs

Research: By Us, For Us

In order to increase representation, our funding institutions should adopt more community based participatory research (CBPR)[6] RFAs and require that all LGBTQ+ research includes one or more LGBTQ+ research scientist(s) and a partnership with an LGBTQ+ serving CBO*.

We Exist Here (and there) - SOGI Data Collection

There are LGBTQ+ folks within every demographic/community that any research project could be targeting. We are Black, Hispanic/Latino, Asian, Pacific Islander, Urban, Rural, Indigenous and so much more. Our communities have been rendered invisible by the fact that non-LGBTQ+ specific research rarely includes questions about sexual orientation and gender identity (SOGI) within their demographic sections. Research and survey funding agencies can easily resolve this issue by making it mandatory to include SOGI questions as a condition of receiving funding. All projects should be required to include an LGBTQ+ subject-matter expert in the collection, analysis, and reporting of SOGI demographic data to ensure cultural sensitivity, data accuracy, and current best practices are being utilized.

Research Intersectionality

LGBTQ+ research should identify how tobacco policies and legislation has affected our communities, including differences within LGBTQ+ subgroups. This may include the intersectionality of LGBTQ+ communities such as, but not limited to, tobacco and those who are unhoused, struggling with food security, those on unemployment, impact of access to health care, ACEs, etc.

"We need to make sure there are policies about data collection and that states in particular should make sure they are including sexual orientation and gender identity in their health system surveillance surveys so we can document and address tobacco use disparities."

- EAST CAROLINA

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

Cultural Sensitivity/Humility

Cultural Sensitivity/Humility

- LGBTQ+ people exist within all other Priority Populations
    - ALL CTCP funded projects should attend an LGBTQ+ cultural sensitivity/humility training
    - Trainings should be conducted by LGBTQ+ serving organizations*
    - Trainings will include recruitment of community members onto Community Advisory Boards as well as compensation for committed time
- Affirming SOGI data questions should be included within demographic data sections of every survey for every project
- Create an RFA for an LGBTQ+ TA provider to serve ALL CTCP projects/LLAs/Statewides/ Grantees with their SOGI data collection, LGBTQ+ inclusion,and training needs.

Guidance from LGBTQ+ Communities

- Take the Justice System/Policing out of schools. Police should not provide prevention work in schools and instead focus should be on enforcement with retailers and Tobacco Retail Licensing.
    - Create alternate suspension programs such as an education learning model, youth services that collaborates with mentorship/senior services, and/or create funding for LGBTQ+ elders to share their stories online that is easily accessible for students who need a sense of belonging.
- Do not use Prop 56/99 funds for policing in schools.
    - Students of color, students with disabilities, and low income communities experience harsher policing tactics that continue to contribute to trauma and mental health distress, which increases tobacco usage.
- Remove policing from LGBTQ+ public health initiatives - Funders, coalitions, and Local Lead Agencies (LLAs) should not use mandatory collaboration with policing systems as a criterion to withhold funding from LGBTQ+ projects or community members, as these systems have historically oppressed and targeted LGBTQ+ communities, particularly Queer Trans People of Color (QTPOC).
- Make cessation products accessible
    - 100% coverage for cessation products from insurance companies
    - Understand that cessation products aren't a one-size-fits-all

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

- Collaborations
    - Collaboration between cessation service providers and LGBTQ+ focused organizations.* This includes referring community members to medical providers who will provide a prescription for a cessation product. We can look at HIV/STI collaborations as an example.
    - Fund a Mobile Lung Unit for lung screenings at LGBTQ+ focused organizations*.
- Bring back The Last Drag Intervention Program and host it at LGBTQ+ serving organizations*. This includes hosting online/Facebook support groups and disability access groups.
- Quitline and state websites to have LGBTQ+ specific resource pages and call in numbers. The Quitline should offer staff who are trained in LGBTQ+ issues and can provide culturally tailored services. To support these efforts, the Quitline can ensure internal policies are affirming and culturally competent.

"Because even accessing medical services, doctors, and they just don't have the time to go into all of these things with people. It's more of, 'You need to stop this for your lungs.' They don't have the time to address, or the training, I think, to go into all these factors with people."

- University of California Los Angeles

"In the Public Health Service Clinical Practice Guideline 2008 update, they are all supposed to have a point person for tobacco who is supposed to make sure everyone's trained and the clinicians are receiving updates on how many people they are screening or assessing for tobacco and they are supposed to do trainings on referring to the quit line."

- EAST CAROLINA

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

LGBTQ+, SOCIAL DETERMINANTS OF HEALTH AND TOBACCO USE

Mental Health

While many consider health to be influenced solely by internal factors, a plethora of research indicates that external and environmental factors strongly influence health and well-being. Research shows that discrimination and oppression can adversely impact mental and physical health.[7] Among LGBTQ+ communities, social factors such as stigma, discrimination, and stress have led to harmful health disparities.[8] Due to increased stress from these social and environmental factors, LGBTQ+ people experience higher rates of mood and anxiety disorders than their cisgender/heterosexual peers.[9] In addition to negatively impacting mental health, LGBTQ+ discrimination can also adversely affect physical health. Evidence suggests that negative health impacts related to discrimination can range from weakened immune systems to heightened cortisol levels, and more.[10]

According to The American Journal of Psychiatry low socioeconomic status interacts with an array of other factors to influence smoking behavior, including race/ethnicity, cultural characteristics, social marginalization (e.g., LGBTQ+ communities, people with mental health disparities and substance use disorders), stress, and lack of community empowerment. There is a growing awareness that these social determinants of health, largely outside the realm of traditional medicine, have a great impact on health and well-being. While low education and income are the main social determinants of health that can determine increased tobacco use, other related ones, such as the unequal distribution of resources and services, can also lead to inequities in tobacco prevention, control, and disparities in tobacco use. Taking a social determinants of health approach in tobacco prevention and control involves changing environmental context and ensuring equal distribution of resources and services, and will be necessary to achieve health equity and eliminate tobacco-related disparities.[11]

Studies conducted in other States[12] show that there is a significant relationship between smoking and several general social determinants of health, including employment status, education, income, and binge drinking. The list of LGBTQ+-specific determinants of health used in this survey was not exhaustive, and there may be additional factors experienced by LGBTQ+ communities that impact health and well-being. Public health programs and interventions may want to consider a more holistic approach to smoking cessation grounded in the social–ecological model.[13]

Education

Outside of the home, schools are the primary vehicles for educating, socializing, and providing services (such as psychological and social) to young people in the United States. Schools can be difficult environments for many students, regardless of sexual orientation or gender identity, but are often explicitly unwelcoming for LGBTQ+ youth, or those perceived to be LGBTQ+. LGBTQ+ youth experience bullying, exclusion, invisibility, discrimination, and are underserved and excluded within the education system itself. All of these factors place LGBTQ+ youth at greater physical and psychological risk that acts to limit their education.

The CA Healthy Kids Survey offers educators, school administrators, and state officials an important opportunity to explore how LGBTQ+ students perceive their school climate and how those perceptions relate to their academic success and emotional well-being. WestEd reviewed two years of data from this survey to publish a comprehensive report "Understanding the Experiences of LGBTQ Students in California" [14]

The report showed that LGBTQ+ students* reported significantly fewer positive perceptions of their own well-being and fewer positive experiences at school compared to their cisgender/heterosexual peers. Students who identified as LGB or "something else" in the survey were less likely to report the presence of key school support, be engaged in school, and reported a lower grade point average. Transgender students reported experiencing chronic sadness and suicidal behaviors. This strongly suggests that if LGB students received the same level of developmental support and safety at school as heterosexual students, then disparities in school connectedness would potentially be erased completely, while disparities in mental health, academic motivation, and academic performance in school would be reduced by half.[14]

Due to bullying, isolation, lack of access to supportive services, lack of connectedness, etc., 40% of LGB high school students actively use at least one type of tobacco product, a rate that is higher than among heterosexual students. Double the rate of LGB high school students smoke cigarettes, compared to heterosexual students, while 31% of transgender youth smoke cigarettes.[15] [16] LGB youth are twice as likely to be daily smokers and more likely to use multiple tobacco products than are heterosexual youth.[17]

If we do not address the lack of support within the education system and address discrimination experienced by LGBTQ+ youth, then tobacco-related health disparities will follow LGBTQ+ youth throughout their lifetime.

"[We need] more visibility for LGBTQ people in schools. Schools aren't buying LGBTQ-inclusive text books, so teachers have to decide to incorporate LGBTQ info. There's no training or support for LGBTQ inclusion."

- #Out4MentalHealth Mapping the Road to Equity 2018 State of the Community Report[66]

*Survey options included transgender, gay/lesbian, bisexual, "something else", and students who were unsure of their gender identity or sexual orientation.

Access to Housing and Food Insecurity

There is a misconception and popular stereotypes of LGBTQ+ communities as affluent. There is not only widespread economic diversity among LGBTQ+ people, but LGB people are more often more likely to be poor than their straight peers and transgender people face extremely high rates of poverty.

Our homes provide access to job markets, schools, health care, and economic opportunities. LGBTQ+ people experience discrimination that restricts access to stable and decent housing. Although many federal, state and local laws prohibiting housing discrimination specifically include sexual orientation and/or gender identity as protected classes, access to stable housing continues to be less assured for LGBTQ+ Californians.

According to a national study on youth homelessness, 1 in 10, or 3.5 million, youth ages 18 to 25 experienced homelessness over a 12-month period. After controlling for other variables, such as race or ethnicity and high school completion, LGBTQ+ youth had more than twice the homelessness risk of non-LGBTQ+ youth.[18]

The Williams Institute at the University of California, Los Angeles, School of Law surveyed homeless youth service providers located in four midwestern states to understand the experiences and service needs of LGBTQ+ homeless youth compared with other homeless youth. LGBTQ+ youth clients have worse mental health disparities than non-LGBTQ+ youth clients, and transgender youth clients are also in worse physical health. This aligns with other findings of disparities in physical health, public health risks, depression, and anxiety between homeless LGBTQ+ youth and other homeless youth. Additionally, transgender youth clients were more likely than LGB youth clients to have experienced abuse, intimate partner violence, harassment, family rejection, and other traumas. Homeless LGB youth were more likely than heterosexual homeless youth to have histories of abuse or survival sex* compared to their heterosexual peers.[19] Experiencing a lack of access to housing not only induces experiences of stress, but this creates higher tobacco usage rates within LGBTQ+ communities.[20]

"Housing and transportation difficulties can create isolation. It can feel like your life has shrunk."

- #Out4MentalHealth Mapping the Road to Equity
2018 State of the Community Report[66]

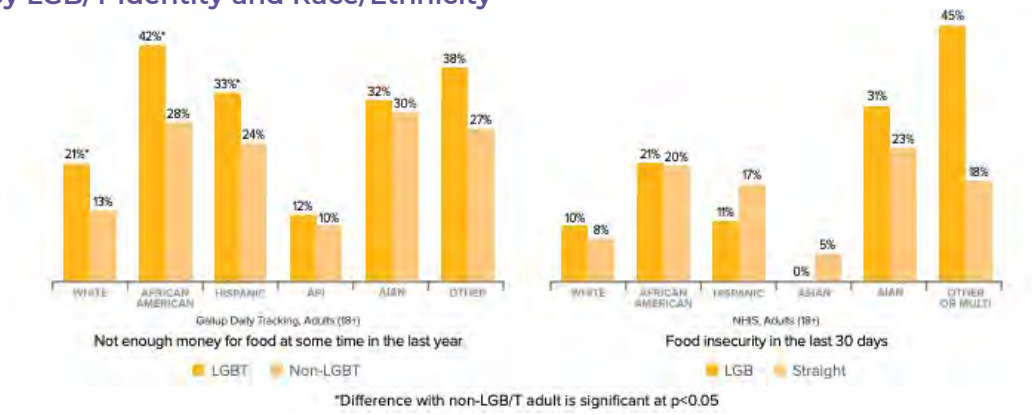
*Engaging in sexual activities to secure basic human needs (food, clothing, or shelter).

In addition to experiencing housing insecurity, LGBTQ+ communities, including women, racial and ethnic minorities, and adults with children, are particularly vulnerable to food insecurity. Food insecurity is defined as limited access to adequate food due to lack of money and other resources.[21]

A Rainbow Health report "Voices of Health 2018 Full Report"[22] found that QTPOC experienced food insecurity at higher rates (46%) than white LGBTQ+ people (33%). Black respondents (54%) experienced the highest rates of food insecurity, followed by Latine/Hispanic (47%) respondents. Respondents who identified as multiracial or checked multiple options to describe their race/ethnicity (42%) and Asian-Pacific Islander respondents (41%) both had similar rates of food insecurity, still at higher rates than white respondents.

In 2019 The Williams Institute published "Food Insecurity and SNAP Participation in the LGBT Community".[23]

The graph depicts Not Having Had Enough Money to Pay for Food and Having Experienced Food Insecurity, by LGB/T Identity and Race/Ethnicity



*Difference with non-LGB/T adult is significant at p<0.05

A lack of food security can lead LGBTQ+ homeless youth to shoplift or trade things of value, such as sex or drugs. In the 2015 U.S. Transgender Survey, 19% of respondents had exchanged sex for money, food, or a place to sleep.[24]

Through an emphasis on LGBTQ+ inclusion, service providers, housing developments, and food pantries can strengthen access to housing, food and services. LGBTQ+-specific housing programs, food programs, and services can offer targeted supports and a welcoming environment, even without restricting access by sexual orientation or gender identity. Such programs are especially common (and needed) for LGBTQ+ youth experiencing homelessness and for LGBTQ+ seniors seeking service-enriched housing and food pantries. Mainstream housing, food pantries, and service providers can also improve their work through staff training to improve awareness and cultural sensitivity.

Income Level and Workplace Safety

LGBTQ+ communities experiences high rates of poverty, job discrimination, and harrassment, all of which leads to Minority Stress and its contribution towards tobacco usage.

In 2019, The Williams Institute released a report[25] that utilized data from the Behavioral Risk Factor Surveillence System to examine how sexual orientation and gender identity affected the likelihood that an individual would experience poverty.

The report found that LGBTQ+ people collectively have a poverty rate of 22%, which is much higher than the rate for cisgender heterosexual people (16%). Transgender people and bisexual cisgender women have especially high rates of poverty at 29%.

Poverty was also particularly high at the intersection of racial and LGBTQ+ statuses. Black, White, Asian, and other-race LGBTQ+ people have statistically significant higher poverty rates than their same-race cisgender heterosexual counterparts. For example, 31% of Black LGBTQ+ people live in poverty, whereas 25% of Black cisgender heterosexual people live in poverty. The patterns of racial disparities in poverty rates were similar for both LGBTQ+ and heterosexual/cisgender people. That is, for nearly all LGBTQ+ communities, members of QTPOC communities had significantly higher poverty rates than their white counterparts.

Geography also appears to play a role in poverty rates. LGBTQ+ people in rural areas have the highest poverty rates (26%), compared to LGBTQ+ people in urban areas (21%) and compared to cishet people in both rural and urban areas (16%).[25]

Poverty levels can be influenced by workplace discrimination due to a person's sexual orientation and/or gender identity. According to the General Social Survey (GSS), a nationally representative survey on American social trends done by the University of Chicago, 16% of LGB respondents reported ever having lost a job because of their sexual orientation.[26] Additionally, LGB respondents reported being denied promotions or job opportunities, with 18% of respondents reporting employment discrimination in applying for and/or keeping a job because of their sexual orientation.
Verbal, physical, and sexual harrassment was also an issue, as 35% of LGB respondents reported ever having been harassed at work and 58% reported hearing derogatory comments about sexual orientation and gender identity in their workplaces.

According to the National Center for Transgender Equality's 2015 U.S. Transgender Survey (USTS)[24] 16% of respondents also reported having lost a job in their lifetime because of their gender identity or expression and 30% of respondents reported being fired, denied a promotion, or not hired for a job because of their gender identity or expression. For those respondents who held a job in the past year, 15% were verbally harassed, physically attacked, or sexually assaulted in the workplace.

Most recently, during the COVID-19 pandemic in 2020, LGBTQ+ people were 36% more likely to have been laid off or had their hours reduced than the general population.[27]

"Employment discrimination changes what resources you have. And so to me there is this sort of causal pathway between one of the mechanisms that discrimination may matter and not just like the stress from it, but also that it could change the resources one has available. And since resources are so important for having the bandwidth to quit smoking or the, protective, whatever it is that keeps you from smoking, then that stuff, that employment side of it must or I think is important as a social determinant of health in a way we don't normally think about it."

- EAST CAROLINA

Social Support and Community Inclusivity

Journey Together: The Annual State of LGBTQ+ Communities 2021[28] showed a need for LGBTQ+ communities to have community spaces and social support groups, including LGBTQ+-identifying and culturally affirming mental health providers, as well as funding for these services. Community spaces and social support groups for LGBTQ+ people create a sense of belonging and a place for folks to feel safe in their communities. The need for these spaces become more apparent when looking at LGBTQ+ people of color.

"I would love...to see BIPOC safe spaces. There are days that I am weathered more than others...I need to be around other BIPOC individuals that get the microaggression that I experience on a day-to-day basis, whether that's being queer, or being an individual of color."

- Shasta County Community Member
#O4MH Listening Session

The report reveals LGBTQ+ Californians seeing a lack of funding for LGBTQ+-serving organizations that provide programming and social services for LGBTQ+ communities, especially for Black, Indigenous, and transgender people. Across California, LGBTQ+ people shared having experienced some form of anti-LGBTQ+ harassment or discrimination, which can lead to feeling unsafe in accessing support groups and mental and physical health services.

"I find basic safety to be lacking. For example, I went to the post office in the middle of the day, happened to be wearing a shirt about Pride, and ended up with somebody yelling at me about how I was going to Hell. To me, I'm just trying to go to the post office."

- Shasta County Community Member
#O4MH Listening Session

There are multiple challenges and barriers facing LGBTQ+ Californians who are looking to receive care. LGBTQ+ people face barriers in finding culturally competent therapists who are transgender, Black, Indigenous, or an LGBTQ+ person of color. Costs to access mental health services serve as a secondary barrier to getting care, and most if not all of the existing therapists who meet the criteria are at capacity, have too long a wait time, and/or are unaffordable. Finding providers who are accepted by a person's health insurance and having to bill the insurance providers for those services, in addition to ensuring the provider meets the above criteria, creates an additional barrier to care. Finally, the report reveals that many survey respondents held a fear of discrimination on the basis of sexual orientation or gender identity by their providers as a major barrier to care.

"When I go for my mental health appointments...they would...out me in front of everyone...Once I'm outed as transgender...it puts a more negative view in people's minds of who I am."

- Shasta County Community Member
#O4MH Listening Session

The report states that over 25% of survey respondents endorsed policies to ensure access to LGBTQ+ mental health and medical care, and funding for LGBTQ+ specific interventions, programs, and organizations. Supporting LGBTQ+ communities' spaces and social support groups by funding LGBTQ+-serving organizations led by LGBTQ+ people will help improve safety, reduce stigma and discrimination, and help create access to care for LGBTQ+ Californians.

Crime Rates and Exposure to Violent Behavior

Members of LGBTQ+ communities experience disproportionate rates of victimization as compared to their cisgender, heterosexual counterparts. However, the data has not been available until the National Crime Victimization Survey began documenting sexual orientation and gender identity in 2016. Public data was released for the first time in 2019, which found that LGBTQ+ communities are disproportionately victims across a variety of crimes.

LGBTQ+ people (16+) are nearly 4 times more likely to experience violent victimization, compared to non-LGBTQ+ people. LBT* women are 5 times more likely than straight/cis-gender women to experience violent victimization. The risk of violence for GBT** men is more than twice that of straight/cisgender men.[29]

* LBT - Lesbian, Bisexual, Transgender
**GBT - Gay, Bisexual, Transgender

Of the 7,120 hate crime incidents reported in 2018, more than 1,300 — or nearly 19% — stemmed from anti-LGBTQ+ bias, according to the FBI's 2018 Hate Crime Statistics report.[30] According to the FBI data, of the nearly 1,200 incidents targeting people due to their sexual orientation, the majority targeted gay men (60%), while roughly 12% targeted lesbians, 1.5% targeted bisexual individuals, 1.4% targeted heterosexuals and the remaining incidents targeted a mixed group of LGBTQ+ people.

The Uniform Crime Reporting Program's Hate Crime Statistics 2020 report[31] found that incidents motivated by gender-identity bias jumped by nearly 20% for the second year in a row.[32]

Although hate crime incidents motivated by anti-trans bias appear to be increasing, advocates have said government data often don't tell the full story. Advocates have said the discrepancy between FBI data and trans people's lived experiences is a common theme when it comes to data collection on LGBTQ+ people. "This data is critical, but it doesn't tell the whole story of anti-transgender violence," Rodrigo Heng-Lehtinen, Executive Director of the National Center for Transgender Equality, said in a statement. "Many transgender people do not feel comfortable or safe reporting crime to the police. In fact, according to our U.S. Transgender Survey,[24] more than half (57%) of respondents said they would feel uncomfortable asking the police for help if they needed it."

"Police don't know how to track or record gender or sexuality-based violence."

- #Out4MentalHealth Mapping the Road to Equity
2018 State of the Community Report[83]

Barriers exist when trying to receive assistance, which includes but not limited to:

- Dangers of "outing" oneself when seeking help and the risk of rejection and isolation from family, friends and society
- The lack of, or survivors not knowing about, LGBTQ+-specific or LGBTQ+-friendly assistance
- Potential experiences of homophobia from service providers' office staff
- Low levels of confidence in the sensitivity and effectiveness of law enforcement officials and courts for LGBTQ+ people, especially transgender and nonbinary people[33]
    - Transgender and nonbinary people, in particular, are at higher risk of experiencing police antagonism compared to the general population in the United States[24 33]
    - This distrust is reflected in the findings of the 2015 U.S. Transgender Survey, where 57% of Law Enforcement and Criminal Justice 27 respondents reported feeling uncomfortable calling the police for help[24]
    - Owen, Burke, Few-Demo and Natwick (2017) also found that LGBTQ+ people were less likely to trust that police would treat LGBTQ+ people and people of color fairly
- Law Enforcement: LGBTQ+ people frequently cite law enforcement as unhelpful sources of assistance
- Shelters: Studies suggest that some LGBQ+ men and women do not believe shelters to be helpful. LGBTQ+ survivors may fear homophobia at shelters, and gay & bisexual men and transgender people may be concerned that shelters are not open to them.

[LGBTQ Service Provider] "When we try to refer trans women to a shelter, they end up leaving the shelter because they are being misgendered [and] harassed."

- #Out4MentalHealth Mapping the Road to Equity
2018 State of the Community Report[83]

- Health Care Providers: Studies suggest that LGBTQ+ survivors have low confidence in health care providers' ability to help. Some transgender people have reported that their health care providers lack competency on transgender issues. Therefore, transgender people may have particular difficulty seeking help for IPV and IPSA from health care providers.[34]

Federal, state, and local interventions to reduce victimization should take into account the different rates of victimization of LGBTQ+ people and cisgender/heterosexual people and the unique and common ways in which LGBTQ+ communities experience and are susceptible to violence and other forms of crime. However, research finds that law enforcement and anti-violence programs and services are sometimes not equipped to serve LGBTQ+ members covered by their jurisdictions.[34 35]

According to research conducted by the National Institute of Health, daily cigarette smoking is temporally associated with multiple forms of violence compared to never and former cigarette smokers, even when common variables associated with violence are controlled. Smoking status should be carefully controlled in studies designed to identify risk factors for violence, and may be a useful component of violence risk assessment.[36]

Access to Affirming Health and Mental Health Care

The relationship between providers and consumers is considered essential to strengthen the quality of care. Unfortunately, LGBTQ+ communities experience prejudice and discrimination when accessing and using medical services. Based on a systematic review conducted using PubMed, Cochrane, SciELO, and LILACS from the period of 2004-2014, it is revealed in 667 studies that LGBTQ+ populations have difficulties in accessing health care services as a result of homophobic attitudes imposed by health professionals.[37]

According to the World Health Organization, "The right to the highest attainable standard of health" implies a clear set of legal obligations on states to ensure access to timely, acceptable, and affordable health care of appropriate quality for all people without discrimination. This right is one of a set of internationally agreed upon human rights standards. Discrimination in the delivery of health services is therefore a human rights violation, and not only acts as a powerful barrier to health services, but contributes to poor quality of care.

The barriers to care that LGBTQ+ communities experience can be summarized in three categories:

1. Limited Access: LGBTQ+ people are less likely to have health insurance either due to family rejection, or because they are unemployed or unhoused.
2. Negative Experiences: Experiencing discrimination or prejudice from health care professionals can include bad experiences due to inadequately-trained professionals.
3. Lack of knowledge: Many providers do not have knowledge or experience in caring for LGBTQ+ patients.

These barriers present a challenge for LGBTQ+ individuals and health care staff throughout the nation.[38]

Due to negative experiences within health care settings such as discrimination, homophobia and transphobia, many LGBTQ+ people do not want to use their insurance to access cessation services, or do not trust cessation services based off previous experiences within health care settings.

"I have no idea where to start and I know I'm not the only one. I can't find resources if I'm interested in transitioning. If I'm still on my parents' insurance, how can I get help without alerting them? I can't get to San Francisco or LA on a moments notice."

"We have to refer trans youth to Planned Parenthood [in a different city because our local one] doesn't have a doctor in the area [who can provide trans services]. Kaiser and Planned Parenthood are the few places to offer transgender services."

- #Out4MentalHealth Mapping the Road to Equity 2018 State of the Community Report[83]

Minority Stress Theory

Minority Stress Theory has provided an important framework and insight to understanding health inequities experienced by LGBTQ+ communities and people. This theory states that stress caused by experiences of discrimination, stigma, and prejudice against LGBTQ+ communities can lead to worsened health outcomes and create health disparities.[7] This model outlines how external stressors such as discrimination and internal stressors such as internalized homophobia and transphobia can both increase stress and deteriorate health.[39] Furthermore, stress related to discrimination is associated with higher rates of substance and tobacco use.[40] This further worsens the cycle of stress and health complications because smoking has been shown to actually worsen symptoms of anxiety and depression.[39]

LGBTQ+ communities are more diverse than the general population. This speaks to the need for the consideration of multiple minority stressors that impact LGBTQ+ people all at the same time. These can lead to compounding microagressions and negative social climates as well as compounded discrimination based on both race/ethnicity and LGBTQ+ identity. Due to the increased intersectionality within our communities compared with our non-LGBTQ+ peers, our QTPOC siblings are at even higher risk of all of the negative impacts that are correlated with minority stress.

LGBTQ+ people are placed at a higher risk of suicide because of the way they are treated by society. In fact, in a 2022 survey, the Trevor Project found that 45% of LGBTQ+ youth and more than half of transgender and nonbinary youth had seriously considered attempting suicide in the last year.[41] Suicide risk likely varies by age group due to experiences of discrimination, and stressors vary for LGB individuals across lifecourse stages and generations. In 2019, roughly 12 million or 4.8% of American adults thought about ending their lives. Among adults aged 18–24 years, 2.9% of men and 2.6% of women identified as lesbian or gay, and 3.7% of men and 13% of women identified as bisexual. Among the older age groups, the proportion of men identifying as gay ranged from 2.2% to 3.1%, and for women identifying as lesbian/gay, the range was 1.5%–2.3%; the proportion of older men identifying as bisexual ranged from 1.4% to 2.5%, and for women, the range was 2.4%–8.1%.[42]

"Smoking is a way that people can cope with these kinds of experiences of stress or kind of chronic ongoing discrimination."

- University of California San Francisco

These suicide rates among LGBTQ+ people are particularly alarming, and are one of the many manifestations of minority stress among our community members. Further analysis of these surveys and studies has shown that these rates drop among transgender and nonbinary people who have access to competent gender affirming care services. These same studies have also shown that tobacco, and other substance use also declines with access to these services.[43] Therefore, one of the best ways to decrease tobacco use among the most marginalized members of LGBTQ+ communities is to ensure broad access to culturally competent gender affirming care.

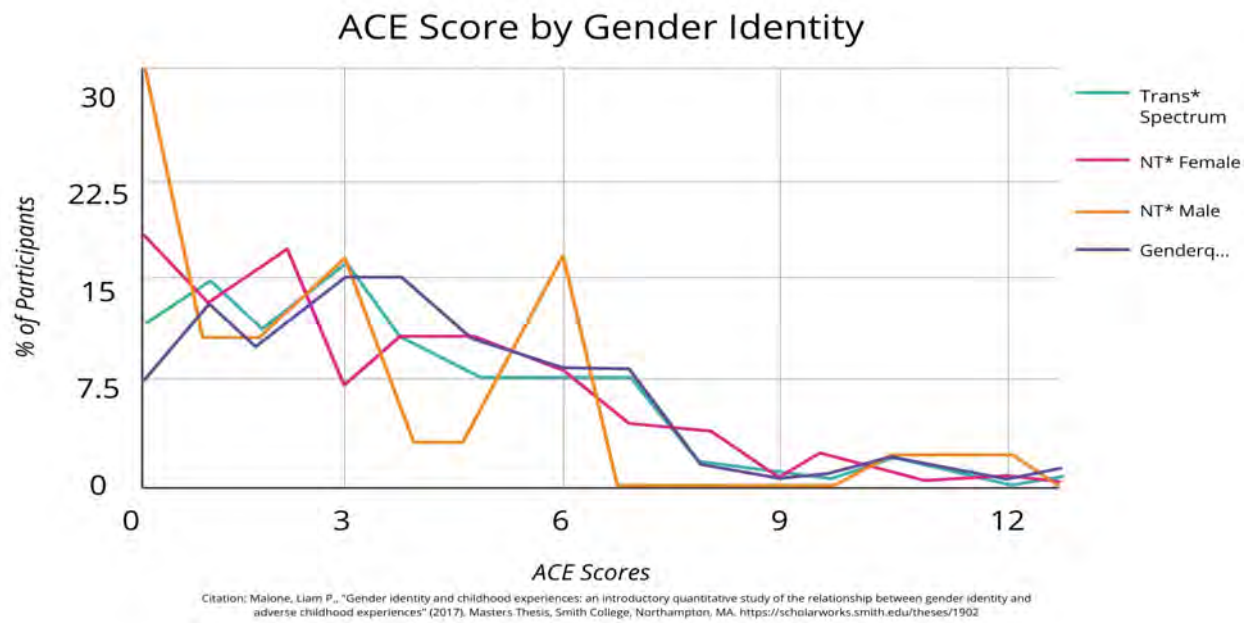
ACEs

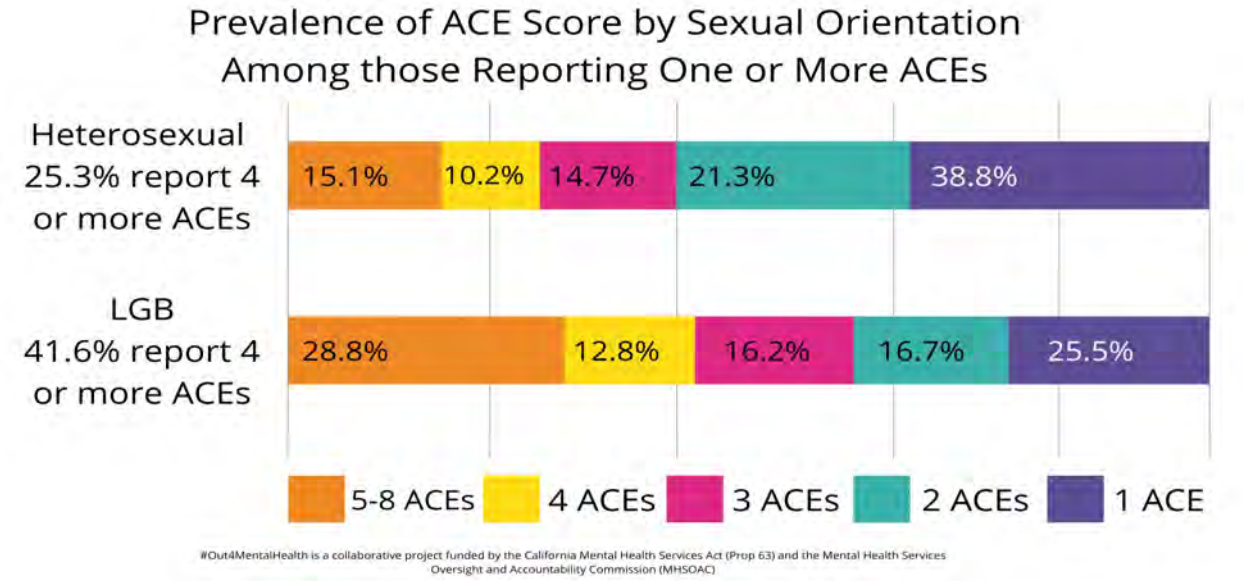
Adverse Childhood Experiences (ACEs) describe high stress experiences such as abuse and trauma experienced during childhood. Such experiences can cause chronic stress that negatively impacts health and development.[44] Additionally, multiple ACEs can lead to the development of high risk health behaviors later on such as drug and tobacco use.[44] In fact, youth with ACEs were more likely to report daily cigarette use in both 2013 and 2016.[45] LGB populations report disproportionately higher rates of ACEs when compared to their straight counterparts.

Research shows that LGB were more likely to have experienced poly-victimization compared to their straight counterparts, LGB individuals report:[46]

- Disproportionately higher prevalence of ACEs
- They are more likely to experience patterns of abuse
- High rates of abuse and poly-victimization by parents
- In a study conducted by Smith College, respondents who identified as trans-spectrum identity reported being bullied or humiliated by their family, as well as feeling unsupported within their family at higher percentages than respondents with non-trans identities.

Overall, multiracial and gay, lesbian, and bisexual individuals carry the greatest burden of experiencing ACEs.





In addition, ACEs screenings do not capture family/caregiver rejecting behaviors, which can also create high stress experiences and risk of multiple negative outcomes.* The higher than average numbers of ACEs experienced by LGBTQ+ individuals, along with family/caregiver rejecting behaviors, significantly heightens the risk for tobacco use within LGBTQ+ communities.

* Ryan, C. (2009). Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University.

Racism

Queer and transgender people of color (QTPOC) often experience simultaneous oppressions and are discriminated against through individual, systemic, and institutional practices of sexism, heterosexism, cissexism, and racism. Research shows that those who experience multiple forms of discrimination based on intersecting identities including race, gender, and sexual orientation report poorer mental health outcomes compared to individuals who report experiencing discrimination based on just one identity. Experiencing multiple levels of oppression can have negative impacts on both mental and physical health, which include anxiety, depression, suicide behaviors, weakened immune system, and heightened cortisol levels.[10]

Policymakers and researchers alike are currently confronting racism in law enforcement and weighing calls to invest in communities by defunding police departments.* It is instrumental for funders, coalitions, and Local Lead Agencies (LLA's) to not force or withhold funding from LGBTQ+ projects or community members and force projects to work with, and/or collaborate with, policing systems that have historically oppressed and targeted QTPOC.

According to Lambda Legal's "Protected and Served?" Survey,[47] many respondents reported that police officers' attitudes toward them had been hostile. Among the 1682 respondents who reported having face-to-face contact with police in the past five years, the percentages who reported hostile attitudes from officers included 32% of respondents of color (including 26% of Native American, 27% of African American and 40% of Latina/o respondents), 30% of transgender and gender nonconfirming, and 35% of low-income respondents.

People of color, low-income people, and people living with HIV reported harassment and assault by police more frequently than survey respondents as a whole. Self-reported incidents of false accusations and false arrest, not verified by Lambda Legal, indicated troubling disparities in police treatment of people who are LGBTQ+ and people living with HIV according to race/ethnicity, income level, and gender identity.

According to an American Medical Association (AMA) panel of Public Health experts, police brutality and the racism that exacerbates violence are further sources of systemic health inequity. The AMA views excessive police force as a communal violence that significantly drives unnecessary and costly injury, and premature morbidity and death.[48]

"Experiencing racism and any other types of violence, those add to my mental health in a way that is really difficult to sum up when it comes to just defining something as depression or anxiety because of who I am as being queer. There's other layers to it."

- LA County Community Member, #O4MH Listening Session

*Defunding the police refers to reallocating or redirecting funding away from the police departments for services better addressed by other government agencies funded by the local municipality such as social services. Reallocating or redirecting funding can improve things such as, but not limited to, mental health, addiction, and homelessness.

Political Determinants of Health

Political determinants of health occur when health is impacted by power groups, institutional policy and process, interests, and ideological positions held within political systems and cultures at various levels of governance. Examples can be as blatant as the vast number of anti-LGBTQ+ bills that are being passed across the nation, to something as insidious as no federal census collection of sexual orientation and gender identity data. Without the same robust data collected for other populations, LGBTQ+ disparities and inequities remain invisible. All of these levels of policy from the institutions that we work for or interact with on a daily basis (i.e. employers, schools/Universities, medical offices) to the local, state, and federal jurisdictions we reside in impact our health and well-being. The lasting impact of this is abundantly clear when looking at the history of research and research funding inclusive of LGBTQ+ people.

Lack of Research Funding, Research By Us and For Us, and Research Intersectionality

"We don't know which interventions work for which subgroups of the LGBTQ communities. I'm not aware of any bisexual culturally targeted interventions for bisexual smokers or other tobacco product users."

- University of California San Francisco

There are three ways to improve the visibility of LGBTQ+ people and populations within research data. One is to fund research targeting LGBTQ+ communities; the second is to recognize that LGBTQ+ people exist within every population; and third is to understand the intersection of LGBTQ+ communities, tobacco, and social determinants of health. Therefore a three-pronged simultaneous approach is required. This approach should ensure that LGBTQ+ targeted research follows a "By Us, For Us" research model as well as requiring that all government funded studies/surveys collect SOGI data alongside other demographic data.

The current research data on LGBTQ+ communities tends towards studies with small sample sizes,[49] a focus on only sexual orientation which actively excludes transgender and nonbinary people from the data,[50] or isn't designed with an informed understanding of LGBTQ+ communities.[51] Academic institutions have often been a part of the problem by not requiring that their Institutional Review Boards (IRB) are culturally competent to review LGBTQ+ studies to ensure the safety and well-being of LGBTQ+ participants. Until we are visible in the data, we will remain under-funded, under-resourced and under-represented in the solutions.

The conversation about Menthol flavored tobacco products tends to highlight just how many decades of information are missing for LGBTQ+ tobacco use and targeted marketing. The amazing strides that have been made by the African American Tobacco Control Leadership Council (AATCLC) nationally to bring the racist actions of the tobacco industry to light (https://www.savingblacklives.org/) are based on decades of research, survey data, and a substantial number of peer reviewed publications on the issues of tobacco use and targeted marketing within African American communities. For our LGBTQ+ communities, we are still asking for our existence to be recognized within studies and surveys. LGBTQ+ people exist within every single CDPH and TROC priority population, we are diverse and intersectional. **We deserve to be represented and affirmed in the data.**

Research into the social and political determinants of health, tobacco usage, and targeted cessation interventions for LGBTQ+ people is lacking because the funding is lacking. When the funding is provided, the scientists will produce the data. When we look specifically at LGBTQ+ research scientists, the disparities in representation are abundant. Freedman 2020[52] outlines specific recommendations that funding institutions can take to increase LGBTQ+ representation within STEM fields. In addition to increasing representation, our funding institutions should adopt more community based participatory research (CBPR)[53] RFAs and require that all LGBTQ+ CBPR funded projects include an LGBTQ+ research scientist and a partnership with an LGBTQ+ serving community based organization* (CBO). Funding general population organizations, even those who happen to hire an LGBTQ+ person to run a project, puts funding into the hands of organizations that are not equipped to adjust their programmatic requirements to meet the needs of LGBTQ+ communities they are funded to work within. Funding for LGBTQ+ targeted research and programs would be better utilized by LGBTQ+ programs, centers, and organizations that are intimately familiar with political and social determinants of health and should be an integral part of developing research questions and research projects directed at our communities.

CBPR research[54] is the best model we currently have for ensuring intersectional research and data outcomes. With that said, funding institutions should do the necessary work to identify and recruit reviewers who are LGBTQ+ knowledgeable and competent in order to ensure there is an equitable review of LGBTQ+ grant applications. Many LGBTQ+ scientists who develop research grant proposals in collaboration with LGBTQ+ communities face comments from funding reviewers that include borderline or blatant anti-LGBTQ+ remarks, gatekeeping comments, and disparaging remarks about the types of journals community organizations may have published their research in. These types of institutional and systemic barriers to funding further reduces the representation of LGBTQ+ scientists in STEM fields and greatly reduces the funding for LGBTQ+ focused research projects whose questions are driven by community input.

When we dive into what is known about LGBTQ+ tobacco use it rapidly becomes apparent that we lack data about tobacco use within subgroups of LGBTQ+ populations. Many studies will look only at lesbian, gay, and bisexual (LGB) people, excluding the entire transgender and nonbinary communities. There are some studies which indicate that substance use, including tobacco, is higher among LGB cisgender women when compared to their LGB cisgender male peers. As these types of preliminary studies show, it is imperative that any research funded to study LGBTQ+ populations should include measures to compare data and results between subgroups of LGBTQ+ people.

"Include LGBT people in community coalitions run by health departments to make sure there is representation and feedback from communities."

-EAST CAROLINA

*LGBTQ+ Centers and LGBTQ+-focused organizations or programs are those whose mission statement and vision statement centers around LGBTQ+ lives.

"A lot of healthcare providers don't even have SOGI or record SOGI, so it is hard to look. I'm not a quantitative researcher, but I do know from my colleagues it's hard to look across data sets because their SOGI is measured so differently across so many different studies. So I think that's definitely a big issue."

- University of California San Francisco

There are LGBTQ+ folks within every demographic/community that any research project could be targeting. We are Black, Latine, Asian, Pacific Islander, Urban, Rural, Indiginous and so much more. Our communities have been rendered invisible by the fact that non-LGBTQ+ specific research rarely includes questions of sexual orientation and gender identity (SOGI) within their demographic sections. Research and survey funding agencies can easily resolve this issue by making it mandatory to include these questions as a condition of receiving funding. Since there are no current standards for SOGI data collection, all projects should be required to include LGBTQ+ SOGI data subject-matter experts to ensure that the Q&A sets used for SOGI data collection are appropriate. The consensus recommendation from the National SOGI Data Advocacy Workgroup, made up of prominent LGBTQ+ advocacy organizations from across the nation, is for SOGI data questions to be implemented everywhere, THEN we do the work to modify them to meet the needs of the community.

History of LGBTQ+ Tobacco Usage

Historical Industry Tactics and Current Advertising Tactics

Big Tobacco has targeted LGBTQ+ communities since at least 1991, when tobacco company Philip Morris settled a boycott by pledging large donations to AIDS research and programs. The boycott, led by the AIDS Coalition to Unleash Power, protested the company's support of Senator Jesse Helms (R-North Carolina), a leading opponent of AIDS funding and LGBTQ+ civil rights. Using corporate philanthropy as evidence of its support of LGBTQ+ communities, Philip Morris quickly gained access to the market, leading the way for other tobacco companies to follow suit. [55]

"The tobacco industry is so clever and has been and continues to be in terms of ingratiating themselves to particular communities that are actually most vulnerable, most at harm and suffer the most."

-LGBT TOBACCO EDU PARTNERSHIP

In 1995, R.J. Reynolds Tobacco Company recognized an opportunity to target community members who lived "alternative lifestyles" in the San Francisco area, in particular the Castro District, and people experiencing homelessness in the Tenderloin. Thus, Project SCUM (subculture urban marketing) was born. Later realizing the offensive nature of this label, Project SCUM was relabeled by Reynolds Tobacco Company as Project Sourdough.[56]

Project Sourdough continued to target what Reynolds Tobacco Company called "Street People", with the aim to increase the distribution and presence of their Camel tobacco products in impoverished and targeted areas. This specific targeting of LGBTQ+ and unhoused populations posed a dangerous risk to these communities' health, so much so that Kathleen DeBold, Director of Washington D.C. Project for Lesbians with Cancer, labeled this as a hate crime.[57] In addition to these targeted areas consisting of LGBTQ+, and unhoused populations, this area was also home to large POC communities.[57] The specific targeting of the Tenderloin and Castro districts show the racist, heterosexist, and classist nature of the R.J. Reynolds Tobacco Company's tactics through Project Sourdough.

R.J. Reynolds Tobacco Company took the pain and stressors of LGBTQ+ communities including family rejection, discrimination, racial profiling, homelessness, etc. and created a false sense of LGBTQ+ "affirmation" through targeted tobacco advertising tactics and funding of LGBTQ+ organizations. Additionally, Philip Morris not only targeted LGBTQ+ communities the same way R.J. Reynolds did, but Philip Morris became the number one contributer to the Gay Men's Health Crisis, donating $50,000 out of $150,000 raised.[56]

Just five years later, Reynolds Tobacco Company used Camel cigarette ads to tout more than a dozen events it was sponsoring at San Francisco Pride over the course of 5 days.[58] The tobacco industry spent millions providing funding to LGBTQ+ communities, including making campaign contributions to LGBTQ+ elected officials[59] funding AIDS and LGBTQ+ organizations directly or indirectly through other (non-tobacco) companies they owned, and sponsoring Pride marches, LGBTQ+ street fairs and film festivals.[60] The tobacco industry continues to position themselves as "allies" of LGBTQ+ communities by sponsoring Pride events, purchasing booths at Pride events and having Pride-sponsored floats; purchasing ads in LGBTQ+ media; and formulating language in their ads such as "take Pride in your flavor" and "When someone yells, 'Dude, that's so gay,' we'll be there."

Historical and Current LGBTQ+-Specific Tobacco Control Interventions

Researchers have acknowledged the need for culturally tailored cessation programs for LGBTQ+ communities. In 2017, researchers identified only 13 LGBTQ+-specific smoking cessation groups that included counseling interventions, were primarily community driven, and lasted between 6 to 8 weeks on average.[61] Two of the group cessation interventions[62 63] included the combination of counseling and nicotine replacement therapy[64] (NRT) or pharmacotherapy, as the combination of behavioral counseling and pharmacotherapy is more effective than pharmacotherapy alone.[65]

A Canadian cessation program titled *Stop Dragging Your Butt* produced self-reported data where 45% of participants reported quitting completely and 85% felt the program was excellent and very useful when tailored toward LGBTQ+ communities.[66] The tailored cessation program, *Stop Dragging Your Butt* conducted a focus group with gay men who identified the following issues for inclusion in programming: isolation, bar culture, self-esteem, empowerment, high-risk behaviours, peer pressure, image and lifestyle, and desire for connection and authenticity.[66] Other adaptations to general population cessation resources included reflecting the language and context of LGBTQ+ communities, recognizing social life is linked to bars and group outings, giving attention to physical appearance, and recognizing living situations of community members.[66]

Another commonly cited LGBTQ+-tailored cessation program is *The Last Drag*, which was created initially by the Coalition of Lavender Americans on Smoking and Health (CLASH) in 1991. This program has been adapted and offered in the U.S. for a number of years with favorable results. Implementation of this program in San Francisco found 59% of participants had quit (Intent To Treat: ITT) at the seventh session and 36% had remained tobacco-free (ITT) at the six month follow-up.[67] Implementation of a similar program in Colorado found that 89% of individuals reported having quit by the final session.[68] However, Eliason et al. (2012)[67] found that those who were female, POC, and/or transgender were less likely to attend more than one class and had lower rates of success. A similar program in San Francisco entitled *QueerTIPS* also found a 40% self-report quit at the final session, but few transgender individuals and youth attended the program.[69] This program identified a need for interventions to be multi-leveled in targeting those in each stage of change.*

The *LGBT SmokeFree Project* in New York is a successful cessation program specifically tailored to those who are LGBTQ+ and are HIV+.[70] This *LGBT SmokeFree Project* provides programming dependent on a person's stage of change, including a workshop for those thinking about quitting, and group sessions for those in the preparation/action stages.[70] Program-level data indicated that individuals appreciated the group experience that kept them coming back, trusted the community center, and many returned incentives for participation in gratitude for quitting successfully.[70] The majority of participants in this program felt an LGBTQ+-specific program to be important.[70]

Intervention with strong communication strategies to educate LGBTQ+ communities all had an online presence, media coverage, and face-to-face peer outreach events in bars and nightclubs. *The Last Drag* was adapted in Los Angeles for LGBTQ+ persons with the campaign slogan "Breath Easier. Play Harder".[71,72] This program obtained media coverage (unpaid), with many hits to their website, print impressions, and blogs discussing the campaign.[71,72] *Delicious Lesbian Kisses* targeted lesbians and women who partner with women through a social marketing campaign, and found that women who were seeking cessation services in Washington increased by 100%. *Delicious Lesbian Kisses* campaign promotional items were still in use in 2012, seven years after the end of the campaign.[73] *CRUSH* took the campaign one step further by encouraging LGBTQ+ young adults to text brand ambassadors in order to receive a text messaging cessation program.[73,74] Evaluation of *CRUSH* found that 53% of survey respondents reported exposure to the campaign and of those, 61% liked the campaign and 86% understood the campaign message.[73,74] In a cross-sectional survey of *CRUSH*, tobacco use dropped from 47% currently smoking at baseline to 40% at follow-up.[74] Overall smoking rates in Nevada, where *CRUSH* took place, fell from 63% in 2005 to 47% in 2008.[73]

*The Stages of Change: Pre-contemplation (not thinking about quitting)...Contemplation (thinking about quitting but not ready to quit)...Preparation (getting ready to quit)...Action (quitting)...Maintenance (remaining a non-smoker)

A literature review identified a lack of interventions for transgender populations. For example, the review identified studies where the transgender participation rate was only between 2.3% and 4.1%. Research on within-group differences (e.g., transgender versus bisexual and racial/ethnic differences) is important for practitioners to understand what is needed to reach and help specific LGBTQ+ sub-populations to quit smoking.[75][76] A key finding from the review was the absence of evidence to guide cessation and prevention programming for LGBTQ+ Youth and Young Adults (YYA). This is despite the fact that over 200 school-based effectiveness studies on smoking prevention programs have been published, albeit none with consideration of LGBTQ+ students.[77] However, evidence supports that the presence of GSAs in schools, as well as school policies (non-discrimination and anti-bullying) that specifically protect LGBTQ+ students, results in lower tobacco use.[78]

Current State of LGBTQ+ Tobacco Control: CA vs U.S. Review

Through the Center for Disease Control and Prevention's (CDC) Office on Smoking and Health, the CDC measures tobacco use and translates the data into effective action. By collecting, studying and sharing information to assess tobacco use and its effects on health, promote evidence-based approaches, and measure progress towards goals, the CDC utilizes this information to:

- Monitor changes and trends in the use of tobacco products among young people and adults.
- Understand tobacco-related knowledge, attitudes, and behaviors among young people and adults.
- Study the impact of comprehensive tobacco control programs and policies.
- Provide answers to important questions about tobacco use and tobacco control.[79]

Utilizing this information, the CDC created "Networking2Save: CDC's National Network Approach to Preventing and Controlling Tobacco-related Cancers in Special Populations," which supports a consortium of national organizations to advance the prevention of commercial tobacco use and cancer in special populations.

The consortium is jointly funded by CDC's Office on Smoking and Health and their Division of Cancer Prevention and Control. It is intended to enhance the quality and performance of specific public health programs, data and information systems, practice and services, partnerships, and resources that focus on tobacco- and cancer-related health disparities in special populations.

Strategies and activities focuses on:

- Network administration and management.
- Training and technical assistance.
- Engagement of the priority populations in national, state, tribal, territorial interventions.
- Mass-reach health communications that complement OSH, DCPC, and other CDC-funded chronic disease programs.[80]

In 2018 the CDC awarded eight national networks to work on the Networking2Save project. The National LGBT Cancer Network became home to the CDC-funded tobacco related cancer project, aiming to reduce tobacco and cancer-related disparities in LGBTQ+ populations. 2019 saw the National LGBT Cancer Network hit the ground running, developing an online resource library that contains up-to-date information on tobacco and cancer, with a particular focus on LGBTQ+ populations; conducted an inaugural Needs Assessment to evaluate the current status of inclusive best practices for reaching and engaging LGBTQ+ communities among CDC cancer and tobacco grantee programs; and drafted a white paper titled "Advancing Sexual Orientation/Gender Identity (SOGI) Measures in Behavioral Risk Factor Surveillance System (BRFSS)", which was published in April 2021.[81]

The California Department of Public Health's Tobacco Control Program (CTCP) published the 2015-2017 Master Plan of the Tobacco Education and Research Oversight Committee for California (TEROC) titled *Changing Landscape Countering New Threats*.[82] The Master Plan identified 7 objectives and strategies to continue progress toward a tobacco-free California, which required a renewed commitment from the people of California.

Page 45, Objective 3: Achieve Tobacco-Related Health Equity Among California's Diverse Populations of the Master Plan provided 6 strategies that target priority populations.

1. Adopt and enforce tobacco control policies and regulations that promote health equity and social justice.
2. Incorporate health equity, language access, and cultural competency standards in all tobacco control agencies, programs, processes, and practices.
3. Increase support to priority populations' advocacy and leadership alliances in tobacco control.
4. Accelerate the rate of achieving tobacco-related health equity for priority populations.
5. Strengthen the capacity of agency and institution personnel to achieve tobacco-related health equity.
6. Conduct monitoring, surveillance, evaluation, and research; disseminate findings to reduce tobacco related health disparities and measure progress toward achieving health equity and social justice.

Priority Populations were identified as groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, and have higher rates of tobacco-related disease compared to the general population. CTCP and TEROC identified and mentioned that individuals may be members of more than one priority population such as African American or Latinx and LGBTQ+-identified.

In 2017 CTCP released RFA CG 17-10593: Statewide Coordinating Centers for Priority Populations. The purpose of the RFA was to fund up to four Statewide Coordinating Center grants, one for each of the following priority population groups: 1) African American/Black, 2) Asian/Pacific Islander, 3) Hispanic/Latino, and 4) Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) populations.

The purpose of the Coordinating Centers is to foster interactive and integrative collaboration and communication among awardees of priority population regional projects funded by *RFA #17-10569 Regional Initiative to Mobilize Communities and Reduce Tobacco–Related Disparities among African American/Black; Asian/Pacific Islander; Hispanic/Latino; and Lesbian, Gay, Bisexual, Transgender, Queer Populations* as well as their networks and CTCP. Coordinating Centers are expected to accelerate the adoption, implementation and impact of policy and system change campaigns conducted by projects funded under RFA #17-10569.

The goals of the Master Plan and working within Priority Populations was achieving **Health Equity**: the highest level of health for all people; **Culture**: ongoing, lifelong process of self-reflection, dialogue, and learning between tobacco control advocates, researchers and community members; **Social Justice**: acknowledging the social power dynamics that result in some social groups having privilege, status, and access, while other groups were disadvantaged, oppressed, and denied access. The strongest statement within the TEROC Master Plan is **“Social Justice requires individual and social action to eliminate oppression.”**

It is through this Policy Platform that We Breathe hopes to achieve the elimination of systemic and political oppression, and identify the policy and systemic needs of LGBTQ+ communities within the California Tobacco Control Program, Policy Advocates, Local and State legislatures, Researchers, and funders.

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