Tobacco Use Among Latinos Identifying as LGBTQ or Experiencing Mental Health Concerns

Findings from a Health Needs Assessment

APRIL 2018

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Acknowledgments

We extend our thanks to the many health and mental health providers, community leaders, and community members who shared their experiences and perspectives about tobacco use among Latinos living with mental health concerns and Latinos identifying as LGBTQ. We appreciate the time and thoughtful feedback given by all who participated in interviews, focus group discussions, and the survey.

We want to acknowledge the key staff from Comunidades Latinas Unidas en Servicio (CLUES) who worked closely with us to design and implement this needs assessment: Raul Fernandez, Carla Kohler, and Luis Tellez. We appreciate their help and support in shaping the assessment design; recruiting participants; conducting interviews; collecting surveys; facilitating focus group discussions; translating notes; and providing thoughtful insight into the analysis and reporting.

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Executive summary

Although rates of smoking have declined in the past half century, significant disparities in tobacco use remain across race and ethnicity, sexual orientation and gender identity, education and socioeconomic status, and region of the country.[1,2] In 2016, Comunidades Latinas Unidas en Servicio (CLUES), a human services organization in Minneapolis serving the Latino population, received funding through the Minnesota Department of Health's Tobacco Free Communities to develop and implement a study looking at smoking in two such intersecting communities: Latinos[3] identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ) and Latinos experiencing mental health concerns.

Compared to the U.S. population overall, the Latino population shows lower rates of smoking. According to the Centers for Disease Control, 11 percent of Latino adults smoke, compared to 16 percent of the population as a whole.[2] At the same time, adults identifying as lesbian, gay, or bisexual or experiencing psychological distress are more likely to smoke. More than one in five (21%) of adults identifying as lesbian, gay, or bisexual currently smoke, compared to 15 percent of heterosexual adults (data were not collected on adults identifying as transgender). Likewise, 36 percent of adults experiencing severe psychological distress smoke, compared with 15 percent of adults not experiencing distress.

While studies have looked at smoking within each of these populations, few studies have looked at the intersection of sexual orientation and gender identity, mental health status, and racial/ethnic identity in the Latino community, and their influence on smoking behaviors. The study described in this summary was conducted to help CLUES develop effective strategies to support smoking cessation for these two populations.

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1 U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. (2014). *The health consequences of smoking—50 years of progress: A report of the surgeon general*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

2 Center for Disease Control and Prevention. (2016). *Current cigarette smoking among adults in the United States*. Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm.

3 We understand the preferred term is Latinx for some people in these communities. Latino is used in this report to reflect the term used in data collection activities and CLUES' communications.

Recommendations

The following recommendations, based on results from the study, describe strategies CLUES can use to develop an effective communications and outreach plan to support smoking cessation in the Latino LGBTQ community and among Latinos experiencing mental health concerns.

- **Use relationship-based approaches**, such as one-on-one counseling or coaching, mentorship opportunities with people who had quit smoking, warm hand-offs when making referrals, and direct outreach through partnerships with trusted organizations and establishments.
- For broader communication efforts, **consider including stories or testimonials** from people from the two communities who have quit smoking.
- **Consider trauma-informed approaches** that provide clear and straightforward information, emphasize personal choice, and normalize help-seeking.
- Develop culturally specific supports that **take into account the histories, assets, and stressors of each community**, while also acknowledging individual differences.
- Continue to **build awareness of the tobacco industry's targeted efforts** in communities of color and the LGBTQ community.
- **Advocate for the inclusion of questions about smoking in mental health clinic protocols**, and **provide training to mental health professionals** about available supports and working with clients on smoking cessation.
- **Build a stronger presence in the LGBTQ community** through partnerships and attendance at events, and advocate for greater intersectional approaches in LGBTQ-serving organizations.
- Continue to provide services and supports that **address broader social determinants of health**.
- Provide additional **opportunities for key stakeholders and community members to give input** into these efforts.

About the assessment

In 2016, CLUES partnered with Wilder Research to develop and implement a multi-method health assessment to learn more about smoking in the Latino LGBTQ community and among Latinos experiencing mental health concerns. The health assessment included a survey of 56 individuals from the two populations about beliefs and behaviors related to smoking and smoking cessation (18 respondents identified as LGBTQ, 51 experienced mental health concerns, and 13 fell into both categories). Two listening sessions were also held with members of these communities to explore these topics further (four people participated in the LGBTQ listening session and three people participated in the listening session related to mental health). In this summary, people who completed the survey or attended a listening session are identified as "participants." In addition, nine leaders in the Latino and/or LGBTQ communities and 15 mental health professionals who worked with the Latino population ("key stakeholders") were interviewed about smoking and the types of strategies that would be most helpful in supporting smoking cessation in the two communities. In many cases, themes across the two populations were similar, but there were also key distinctions that are noted below. This summary describes key themes that emerged from the data.

Factors that contribute to smoking

Understanding the factors that influence whether individuals decide to smoke tobacco products and barriers to quitting is important for developing effective smoking cessation approaches. The two groups identified a number of common factors that contributed to smoking:

- Family influences, including growing up with family members who smoked
- Drinking alcohol
- Socializing with others and having friends or family members who smoke
- Managing stress resulting from mental health symptoms or stigma and discrimination
- Limited access to health care
- Stigma around mental health issues
- Mistrust of medical establishments due to historical mistreatment in the LGBTQ community or concerns about reporting to immigration authorities
- Lack of awareness of available smoking cessation resources
- Targeted advertising and outreach by the tobacco industry in communities of color and the LGBTQ community

Participants were most likely to report using regular cigarettes, but findings also indicate some use of menthol cigarettes, e-cigarettes, and other types of tobacco. Within both populations, respondents included regular smokers or occasional (i.e., social) smokers.

Effective messaging and interventions

Many of the participants in the study expressed some interest in quitting smoking, either in the near future or eventually. Findings point to some directions for messaging and outreach, described below. Multiple approaches are likely needed, as there are also differences within each population of focus and among individuals.

Key messages

The respondents identified a number of factors that motivated individuals to consider quitting smoking. Identifying these motivating factors is important in developing communications and outreach strategies that align with the needs and interests of both groups. Motivating factors for both groups included:

- Being a good role model and protecting the health of family and friends
- Improving physical and mental health and well-being
  - However, key stakeholders suggested that messages focusing on the health risks of smoking were not as effective, as most people already know about the dangers of smoking.
- Saving money
- Opposing the tobacco industry's targeting of communities of color and the LGBTQ community

Participants and key stakeholders also suggested other factors to consider when developing messages. Specifically, messages should:

- Offer clear, straightforward information, provide a variety of options, and emphasize personal choice.
- Normalize help-seeking, taking into account stigma and historical distrust of mental health services.

Messengers and channels

Participants and key stakeholders also identified trusted sources of health information, which may provide direction for communication channels and outreach moving forward.

Messengers

Participants in both groups reported that they got important health information from medical professionals and friends and family.

Participants from both groups emphasized the importance of authentic relationships in any outreach efforts, either through hearing from people who had quit smoking themselves, warm hand-offs when connecting people to resources, or outreach from people in the community. Communications materials should also reflect those being reached, but should not rely on stereotypes or caricatures.

Channels

Key stakeholders also recommended making use of organizations and institutions that already have trusting relationships with these communities. Outreach efforts in these settings should allow people to seek out information voluntarily and with some degree of confidentiality. Trusted places included:

- Churches, schools, restaurants, and mental health clinics for individuals experiencing mental health concerns
- Bars, coffee shops, events such as Pride, and organizations that serve the LGBTQ community for individuals identifying as LGBTQ

Social media may also be an effective way to reach people in the LGBTQ community, and web-based support could be helpful in reaching people who may not feel comfortable reaching out for support from medical or mental health professionals. However, key stakeholders also suggested that phone-, text-, or web-based programs that involve support from anonymous counselors would not be as effective as other strategies in the Latino community.

Interventions

Although many participants were likely to try to quit "cold turkey," survey respondents in both groups felt that they would be more successful quitting using outside help. Both groups identified common interventions that they believed would be effective in their community:

- Approaches that increase awareness of available smoking cessation resources and offered a variety of different options, which are more likely to meet people's individual needs and help people feel greater control of the process.
- One-on-one counseling, combined with over-the-counter medications. Interventions that include one-on-one counseling should consider stigma and other barriers to seeking help in formal settings, and might include mental health therapy, a quit coach, or informal relationships in the community.
- Culturally specific programs run specifically for Latinos would make participants feel more confident about quitting, according to the majority of respondents.
- Free or low-cost programs.

Interventions that respondents and stakeholders thought would be less effective included group-based programs, resources with limited information, and services that were not culturally responsive. Community leaders advised against outreach through churches for Latinos identifying as LGBTQ.

Policy and systems change efforts

Continuing to support policy and systems change efforts is also critical to supporting smoking cessation in the two communities. Direct interventions should be balanced with systems-level strategies, such as advocating for smoke-free and other tobacco policies, challenging the tobacco industry's targeting of people of color and the LGBTQ community, addressing broader social determinants of health, and collecting more granular data about tobacco use among different populations.

In addition, there are opportunities to work with mental health professionals to encourage greater integration of smoking cessation into treatment plans. Findings from this study suggest that mental health professionals interviewed did not regularly ask clients about smoking for a variety of reasons, including:

- They did not want the client to feel judged
- Smoking was not relevant to the client's presenting concerns
- They saw smoking as coping mechanism for managing mental health symptoms or recovery from harder substances

- They did not feel that they were equipped with enough information about available smoking cessation resources
  - When mental health professionals did refer clients to smoking cessation programs, they suggested QUITPLAN or health care providers or social workers within the clinic.

However, mental health professionals had some interest in incorporating questions about smoking more regularly into their sessions. They noted that clinic commitment to doing so would be critical to ensuring that it became part of standard practice, and they were interested in additional training on available culturally responsive resources.

Project background

Although rates of smoking have declined in the past half century, cigarette smoking remains the leading cause of preventable disease and deaths in the United States.[4] In addition, significant disparities in tobacco use remain in across race and ethnicity, sexual orientation and gender identity, education and socioeconomic status, and region of the country.[5]

In recent years, research has focused on structural inequities that contribute to differences in health outcomes, including education, employment, access to health care and other health-related resources, and discrimination. Additionally, population groups often intersect, painting a more complex picture of smoking and other health outcomes.

In 2016, Comunidades Latinas Unidas en Servicio (CLUES), a human services organization in Minneapolis serving the Latino population, received funding through the Minnesota Department of Health's Tobacco Free Communities to develop and implement a study looking at smoking in two such intersecting communities: Latinos[6] identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ) and Latinos experiencing mental health concerns. The assessment is the first phase of a formative evaluation of this multi-year initiative, and is intended to inform later communications and outreach efforts by CLUES to support smoking cessation within the two communities.

Compared to the U.S. population overall, the Latino population shows lower rates of smoking. According to the Centers for Disease Control, 11 percent of Latino adults smoke, compared to 16 percent of the population as a whole.[5] At the same time, adults identifying as lesbian, gay, or bisexual or experiencing psychological distress are more likely to smoke. More than one in five (21%) adults identifying as lesbian, gay, or bisexual currently smoke, compared to 15 percent of heterosexual adults (data were not collected on adults identifying as transgender). Likewise, 36 percent of adults experiencing severe psychological distress smoke, compared with 15 percent of adults not experiencing distress.

While studies have looked at smoking within each of these populations, few studies have looked at the intersection of sexual orientation and gender identity, mental health status, and racial/ethnic identity in the Latino community, and their influence on smoking behaviors.

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5 Center for Disease Control and Prevention. (2016). *Current cigarette smoking among adults in the United States*. Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm.

6 We understand the preferred term is Latinx for some people in these communities. The term Latino is used in this report to reflect how it was used in data collection activities and CLUES' communications.

About the assessment

In 2016, CLUES partnered with Wilder Research to develop and implement a health assessment to learn more about smoking behaviors and effective smoking cessation approaches in the Latino LGBTQ community and among Latinos experiencing mental health concerns. In addition, CLUES indicated that they were interested in working with mental health professionals that serve the Latino community to identify the extent to which smoking and smoking cessation are discussed in clinical sessions, and what supports would be needed to do so on a more regular basis.

Accordingly, this assessment was designed to answer the following questions:

- What are the beliefs and behaviors of both populations of focus around cigarette smoking?
- What strategies have and have not been successful in helping individuals who identify with each population quit smoking? To what extent are individuals from each population aware of available resources?
- How do cultural factors and social determinants impact smoking beliefs and behaviors, and interest in and likelihood of quitting, among individuals from each population?
- What types of services or interventions would help individuals from each population with smoking cessation?
- What types of communications strategies or channels would be most effective in supporting smoking cessation among each population?
- To what extent do mental health professionals serving the Latino community assess smoking and readiness to quit in clinical sessions? What factors contribute to whether or not mental health professionals talk to clients about smoking cessation?
- To what extent are mental health professionals aware of available smoking cessation resources?
- What supports would help mental health professionals talk to clients about smoking cessation?

To answer these questions, a multi-method approach was used to gather information from members of the two communities, mental health professionals, and community leaders. Throughout, individuals from the two populations of focus who completed surveys or attended discussion groups are referred to as "participants" in the data collection activities. The mental health professionals and community leaders involved in the assessment are referred to as "key stakeholders." The assessment included the following methods:

- **Survey.** A survey was developed for members of the two populations of focus who were current or former smokers. There were two screening questions to assess eligibility: "Do you identify as Hispanic or Latino?" and "In the past 12 months, have you smoked at least one cigarette?" If participants answered "yes" to both questions, they were eligible to complete the survey. The survey asked about beliefs and behaviors related to smoking, past efforts to quit smoking, thoughts about quitting in the future, where participants went for health information, and the extent to which they had access to health care. The survey included questions related to gender identity and sexual orientation, age, and mental health (see Appendix A and B for the complete survey data). The survey was administered on paper and online, and advertised through social media and shared with professional networks. CLUES staff also administered the survey by tabling at a local college, local bars popular in the LGBTQ community, and CLUES. Participants were given a $10 gift card upon completion of the survey.

  A total of 71 people completed the survey. Information about refusals was not consistently collected, and as a result, a response rate is not able to be calculated. Data were later analyzed by population. Eighteen respondents identified as LGBTQ.[7] Twelve identified as gay, two as lesbian, one as bisexual, one as another sexual orientation, and one noted that they were not sure. One respondent identified as queer on the question about gender. Fifty-one respondents reported experiencing mental health concerns.[8] Thirteen respondents fell into both groups (Figure 1). In this report, data are only presented for the 56 respondents who identified as LGBTQ or reported mental health concerns.

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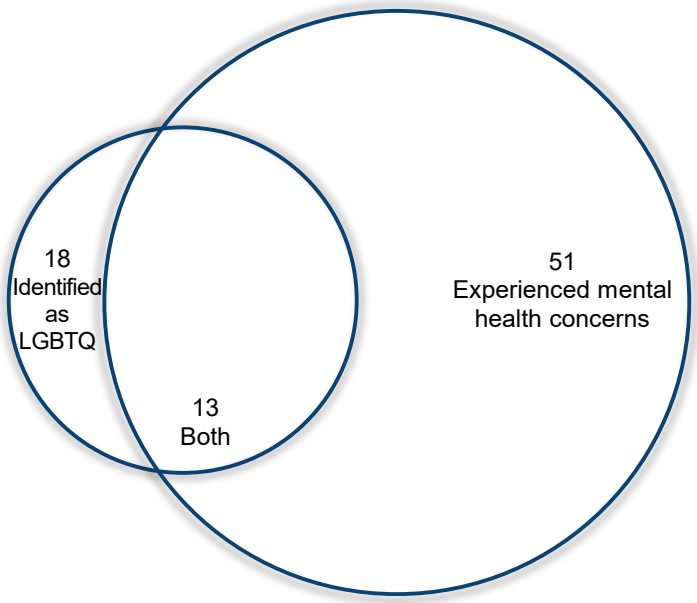
7 LGBTQ respondents selected gay, lesbian, bisexual, another sexual orientation, or I'm not sure on the question about sexual orientation, or transgender M → F, transgender F → M, queer, another gender, or I'm not sure on the question about gender.

8 Respondents were defined as experiencing mental health concerns if they responded:
- "most or all of the time" or "some of the time" to the question, "During the past 30 days, how often did stress, depression, a problem with emotions, excessive worrying, or troubling thoughts keep you from doing your usual activities, such as work, recreation, and taking care of yourself?', OR
- "yes" to the question "Have you ever been told by a doctor or other health professional that you have a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis?", OR
- "yes" to "Are you currently taking any medication that was prescribed for you to treat a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis?"

1. Survey respondents (N=56)



Note. All respondents identified as Latino and had smoked at least one cigarette in the past 12 months.

- **Listening sessions.** Two listening sessions were held, one with members of the Latino LGBTQ community who were past or current smokers, and a second with Latinos who had received mental health services at CLUES and who were referred for smoking cessation resources. Survey respondents were invited to the first listening session if they expressed interest in participating. The contact information for these respondents was collected separately from the survey data to ensure confidentiality. A CLUES staff member who provided smoking cessation consultation invited mental health clients to the second listening session. The listening sessions were facilitated by a CLUES staff member, and asked about smoking, thoughts about quitting and smoking cessation resources, and how organizations such as CLUES could better support members of the community in quitting smoking. Notes were taken during the sessions, and they were also audio recorded and later transcribed. Participants received a $20 gift card and a light meal. Four people participated in the LGBTQ listening session, and three people participated in listening session related to mental health. The listening session protocols can be found in Appendix B.

- **Key informant interviews with mental health professionals.** Key informant interviews were conducted with 15 mental health professionals who work with the Latino community (two participants also worked in sexual health and two worked as social service navigators). Interviews with mental health professionals asked about whether and how they discussed smoking and smoking cessation in sessions with clients, their knowledge of available smoking cessation resources, and what supports would make it easier to talk with clients about smoking. Interviews were completed by CLUES staff. See Appendix C for the interview protocol.

- **Key informant interviews with community leaders.** CLUES staff conducted key informant interviews with nine people they identified as leaders in the Latino and/or LGBTQ communities. Participants were asked about their observations of smoking in their communities, and thoughts on the types of resources and strategies that would be most helpful in supporting smoking cessation. The interview protocol can be found in Appendix D.

Wilder Research analyzed the data, in close consultation with CLUES staff who conducted the interviews and listening sessions and administered the surveys. In many cases, themes from the two populations were similar, but there were key distinctions. This report describes key themes that emerged from the data and is intended to inform CLUES communications and outreach efforts to support smoking cessation in the two communities.

Limitations

Any study describing the needs and interests of broad populations is limited by the fact that there are differences within communities, either within sub-groups, or across individuals. This study recognizes that many cultural communities are included within the broad Latino ethnicity category and multiple factors, including age, nativity, socioeconomic status, and experiences of stigma influence the varied individual experiences and perspectives within the two populations of focus.

While this study presents some themes that emerged across the different data collection methods, it is intended to be a first step. The information gathered as part of this formative evaluation is intended to help CLUES develop communications and outreach strategies related to smoking cessation that they can develop, implement, and refine in their ongoing work with these two communities. Findings should be interpreted carefully. Also, as participants in the study emphasized, it is critically important to continue to involve community members in the development and implementation of any strategies that impact them directly.

There were several limitations in the data collection approaches. While attempts were made to reach as many individuals as possible in each of the populations of focus, the sample of respondents identifying as LGBTQ is small. In addition, individuals that identify as transgender are not represented in the sample, and individuals identifying as lesbian, bisexual, or another sexual orientation or gender are underrepresented. Differences across the two groups should be interpreted cautiously because of the small sizes of the non-representative samples.

Likewise, recruitment for the listening sessions proved more challenging than planned. Participants' reflections from these discussions were important in providing a deeper understanding of this topic and supplementing findings from the survey and interviews, but may not be representative of the full experiences of these communities.

Lastly, the mental health professionals and community leaders ("key stakeholders") were asked to speak to the needs of populations from a third-party perspective, which has some inherent limitations. In some cases, they noted that they were making educated guesses about smoking behaviors in the groups they were asked about or spoke to what they observed in the Latino community overall, rather than in the specific sub-groups. They were often clear in their reluctance to speak for communities. Nonetheless, they highlighted a number of important considerations for working with these communities and ways to support smoking cessation moving forward.

Summary of findings

The following sections present findings from the assessment about tobacco use among Latinos identifying as LGBTQ or experiencing mental health concerns, including factors that contribute to smoking in each population and issues to consider when developing messages and interventions. Directions for additional systems-level work to support smoking cessation in these communities are also discussed. As described above, themes often overlapped across the two communities. Findings specific to each population are noted when relevant.

Use of tobacco

Survey respondents were asked about the types of tobacco they used and the frequency of use, and key stakeholders were asked to comment on the smoking behaviors they observed in the two populations. In some cases, these individuals were reluctant to comment because they felt they lacked solid information. The information below presents themes that were more consistently found across the survey and interviews and is intended to help CLUES more closely target its communications and support services. However, findings should be interpreted with caution, and more information is likely needed to fully understand smoking behaviors of the two populations.

Participants reported that regular cigarettes were the most commonly used type of tobacco, but there is some evidence that individuals used menthol cigarettes, e-cigarettes, and other types of tobacco. The key stakeholders observed that they mostly saw people smoking regular cigarettes. The community leaders suggested that they saw some menthol use in the LGBTQ population. About a third of survey respondents (33% of those identifying as LGBTQ and 37% of those experiencing mental health concerns) reported that they smoked menthol cigarettes "usually or all of the time" (Figures A3 and B3). The key stakeholders noted that they did not often see people using chewing tobacco. However, 56 percent of survey respondents identifying as LGBTQ and 45 percent of those experiencing mental health concerns reported that they had used other tobacco products such as cigars, pipes, snuff, chewing tobacco, bidis, kreteks, snus, or a hookah water pipe in the past year (Figures A4 and B4). The key stakeholders also indicated that they had seen some use of e-cigarettes, but it was mostly among younger people or with those who were trying to quit smoking. The survey did not address e-cigarette use.

> *Mostly the participants make use of the cigarette. – mental health professional*
>
> *Yes, cigarettes in general, but particularly I think, I can't remember the number right now, but a high proportion of LGBTQ folks use the menthol because it's easier to smoke and it's not as harsh as regular cigarettes. – community leader*
>
> *It is not very common among my clients to use chewing tobacco. – mental health professional*

> *Usually cigarette smoking. I don't really see anybody using, chewing tobacco or cigars. – community leader*
>
> *I think I've seen a tendency of usage with electronic cigarettes in the younger Latino adults, but it still does not compare to cigarette use with the general Latino population. – community leader*
>
> *Yes, e-cigarettes sometimes, but that's usually for people trying to quit. People that usually use them [are] white people…Usually Latino and LGBTQ people use those as a method to help them quit, to get off tobacco. – community leader*

Findings suggest a mixture of regular and occasional smoking among both groups. The key stakeholders interviewed had mixed responses about whether they saw more regular smokers or social smokers. Among survey respondents identifying as LGBTQ, 39 percent smoked every day, and 28 percent smoked some days (33% did not currently smoke; Figure A12). Among those experiencing mental health concerns, 40 percent smoked every day, and 36 percent smoked some days (with 24% reporting they did not smoke at all; Figure B12). Likewise, 42 percent of LGBTQ respondents smoked a pack of cigarettes or less, with 6 percent smoking 1-2 packs, and 18 percent smoking more than two packs (35% did not smoke in the last 30 days or were not sure; Figure A2). About three-quarters of respondents experiencing mental health concerns smoked a pack or less a day, with 4 percent smoking 1-2 packs, and 16 percent smoking more than two packs (18% did not smoke at all in the past 30 days or were not sure; Figure B2).

> *I see smokers but I see social smokers like when they're out at the bar but [do] not [smoke] at home. – community leader*
>
> *I have a mixture of people that are regular smokers who are consistently trying to quit and then get back on when things get stressful. [I'm] probably leaning towards [saying I see more] people that are social smokers but I definitely have people who do both. – mental health professional*

There is some evidence that both groups limit exposure to second- and third-hand smoke in their homes, but less so in their cars. The key stakeholders suggested that exposure to second- and third-hand smoke may still be a concern when people lived with other smokers. Some did observe people placing restrictions on where people could smoke in the home, or requiring people to smoke outside. In the survey, two-thirds (67%) of respondents identifying as LGBTQ and three-quarters (75%) of those experiencing mental health concerns responded "no" when asked if anyone, including themselves, smoked regularly inside the home (Figures A6 and B6). Likewise, 61 percent of those identifying as LGBTQ and 71 percent experiencing mental health concerns said that smoking was not allowed anywhere in their homes (28% and 20%, respectively, said that it was allowed in some places or at some times, and 11% and 10% said it was allowed anywhere; Figures A7 and B7). However, two thirds (67%) of LGBTQ respondents and over half (57%) of those experiencing mental health concerns said that they had been in a car in the last seven days with someone who was smoking (Figures A8 and B8).

> *Yes, I've found women who say, "No, I'm not a smoker", but they smell like cigarettes, and I say, "Excuse me, are you not really a smoker?", "No, I'm not", "But I can smell cigar," "Oh, my husband smokes," [I ask] "And how do they do it?", "No…they go outside and come back." And I ask them, "And they take off their clothes and leave it outside, because if they brought it in, they bring smoke into the house through their clothes, and he's walking around in the house and you just smell it." And getting contaminated too, "Oh, no, no, I didn't know that they have to leave the clothes outside," "Yes," I say, "They have to leave their clothes outside. In winter they should leave their jacket and their pants and the shoes out there, because that's what's contaminated. And that hurts you and your child." "But I don't smoke," "But you're pregnant and you're breathing and you're exposed." – mental health professional*
>
> *There's a lot of those who live with smokers, and those are the ones who don't have information because they don't know how to manage the situation when they live with a smoker or have a lot of smokers visit. – mental health professional*

Factors that contribute to smoking

Participants discussed individual, family, and systems-level factors that contributed to smoking in the two communities. Understanding the factors that contribute to smoking, as well as what makes quitting difficult, can help point to areas for intervention.

For both groups, family influences were important contributors in starting smoking. When asked about how they began smoking, listening session participants from both groups described growing up with family members who smoked, where cigarettes were readily available. Almost all of the participants described starting smoking before the age of 18.

> *If I am not mistaken, I was 10 years old. I was with my cousins and they told me to give it a try and that smoking was not bad for me. Also, there was an influence within my family as my grandfather was a smoker all his life [and] it was easy to get a hold of a cigarette. – listening session participant (LGBTQ group)*
>
> *I used to see my mom smoking while she was washing clothes, she was a very anxious woman…She always smoked while she was doing house work so every time I would see her cigarette finishing I would ask if I could light another one up for her, this became a habit after a while. I would light it up for her and I would take a few puffs before. – listening session participant (mental health group)*

Alcohol and social influences contributed to smoking. All of the survey respondents identifying as LGBTQ and 78 percent of those experiencing mental health concerns agreed that they smoked the most when they were drinking (Figures 2 and 3). The key stakeholders interviewed also noted that smoking often went hand-in-hand with alcohol use. Interview and listening session participants said that smoking was a way of bonding with others. Having a lot friends or family who smoked could make quitting more difficult. About half (49%) of the survey respondents experiencing mental health concerns and 39 percent of LGBTQ respondents agreed that most of the people with whom they spent time were smokers (Figures 2 and 3).

I've heard that the social aspect makes it difficult because you have friends that smoke and you go out on breaks and you all smoke together and that's really difficult to give up. – mental health professional

I think of people living in group homes. It's all about cigarettes, and needing cigarettes, and helping each other out and going out together and smoking. – mental health professional

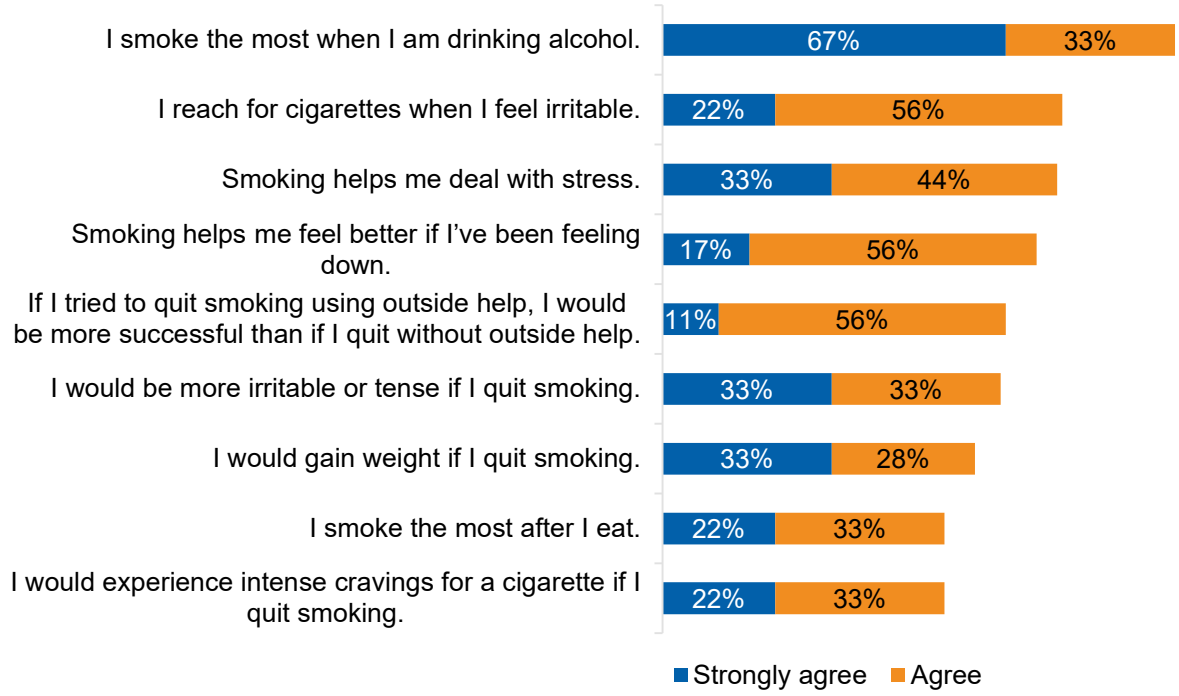
I know migrant workers [where] the bosses smoke and so that was an opportunity to be in that circle… Adults used to tell me that, "That's why I do it because then I can be in that group. Because they go out for a smoke break." – mental health professional

Some don't have anyone in their life who encourages [them] or wants them to quit. Some need help, they're isolated from a healthy people [and] environments. – mental health professional

You sit around outside and the weather is beautiful. You catch [your] closest friends with you, a cocktail, and there's a smoking aspect of it. – community leader

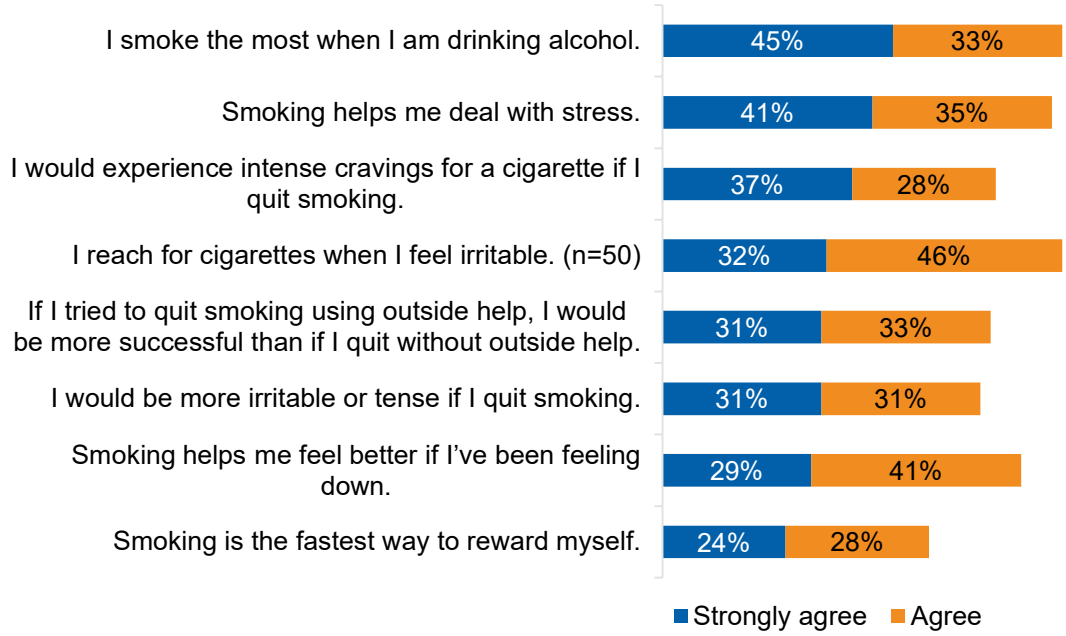
I would mix drinking and smoking like when I would go to the disco night clubs and this led me to smoke even more. It started to increase. – listening session participant (mental health group)

2. Beliefs about smoking: LGBTQ respondents (N=18)



Note. The chart above includes items where at least 50 percent of respondents strongly agreed or agreed. Other items included: "Smoking is the fastest way to reward myself." (22% strongly agreed, 22% agreed); "It would take a pretty serious medical problem to make me quit smoking." (22% strongly agreed, 17% agreed); "I would be less able to concentrate if I quit smoking." (22% strongly agreed, 17% agreed); "Most of the people I spend time with are smokers." (6% strongly agreed; 33% agreed); "It would be embarrassing to me if I tried to quit smoking using outside help." (17% strongly agreed; 17% agreed); and "It would be difficult for me to afford getting outside help to quit smoking." (11% strongly agreed; 17% agreed).

3. Beliefs about smoking: Respondents experiencing mental health concerns (N=51)



Note. The chart above includes items where at least 50 percent of respondents strongly agreed or agreed. Other items included: "I smoke the most after I eat" (27% strongly agreed, 22% agreed); "I would gain weight if I quit smoking." (31% strongly agreed; 16% agreed); "It would be difficult for me to afford getting outside help to quit smoking." (18% strongly agreed, 22% agreed); "I would be less able to concentrate if I quit smoking" (20% strongly agreed, 18% agreed); "It would be embarrassing to me if I tried to quit smoking using outside help" (18% strongly agreed, 16% agreed); "Most of the people I spend time with are smokers" (18% strongly agreed; 16% agreed); and "It would take a pretty serious medical problem to make me quit smoking." (18% strongly agreed; 31% agreed).

Smoking helped participants manage stress. Survey respondents in both groups reported that smoking helped them deal with stress (77% of LGBTQ participants and 76% of participants experiencing mental health concerns strongly agreed or agreed with this statement; Figures 2 and 3). Respondents also noted that they reach for a cigarette when they feel irritable (78% of respondents from both groups) or when they are feeling down (73% of LGBTQ participants and 70% of participants experiencing mental health concerns). Key stakeholders suggested that Latinos experiencing mental health concerns or identifying as LGBTQ may face particular stress from several key factors, as described below.

- ***Smoking helped people manage mental health symptoms and step down from other substance addictions.*** The mental health practitioners interviewed shared that clients often used smoking to manage anxiety, depression, or other symptoms, or in recovery from other substance addictions. These sentiments were reflected by participants in the listening session, with participants describing how they used smoking to manage symptoms or cope with stress.

When they stop using chemical substances like alcohol and drugs, [many clients] go to another type of drug and mostly, it's tobacco to relieve anxiety. – mental health professional

Cigarettes…are the way to deal with having [unresolved] feelings and emotions, and not having another way to deal with them. – mental health professional

For me it was a case of leaving one addiction for another one. I needed something to be addicted to and I found smoking. – listening session participant (LGBTQ group)

It helps me to stop hyperventilating. – listening session participant

- ***Stigma related to sexual orientation and gender identity may contribute to smoking among Latinos identifying as LGBTQ.*** Others noted that Latinos in the LGBTQ community often smoked to cope with stigma and discrimination. They suggested that stigma came from broader social policies and views, but also within their families or the Catholic Church.

I think a big one is family acceptance of your sexuality. When you don't have that, you usually leave home sooner, younger and you pick it up as a vice to cope with the stress. – mental health professional

Many of my families I worked with…were Catholic and [being LGBTQ] was not seen as an option. Like you were going to burn in hell, and many of them told me that…And it's hard, that's their culture and that's their faith and it's very important to them and their family is very important to them and so I think chemical usage goes with that because they just feel like, "What am I supposed to do?" – mental health professional

There's some people that make me feel less of a person…I feel that it's because of my skin color and my sexuality, those have been issues for me. These negative emotions have made me sad and have made me cry and feel helpless. They have cause[d] me to smoke to feel strong again. – listening session participant (mental health group)

- ***Stress related to immigration issues and economic factors may impact smoking within both groups.*** The key stakeholders suggested that smoking helped people cope with stress related to other factors including immigration status and policies, discrimination, low wages, or unemployment. Those interviewed pointed out that these factors may apply to Latinos more broadly but impacted the two populations nonetheless.

In relation to the overall Latino population that smokes, many of the causes come from migratory issues. People feel very unstable in this country and do not feel safe because of their legal immigration status. Economic issues are also a factor affecting the Latino population. Without a doubt the fact that many people arrive in this country in the struggle for the acquisition of the American dream and really encounter the reality of the situation [that] can cause greater stress and anxiety in individuals. Many of our Latino brothers have two or three jobs in order to support their family and many of the times they cannot [cope] with the emotional burden that overwork causes them. – community leader

A lot of times they say "I work nights. I use it to keep from sleeping." – mental health professional

When things get stressful, they'll kind of relapse back into smoking…If the political climate is really difficult, they'll smoke. – mental health professional

Limited health care access and mistrust of medical establishments may contribute to rates of smoking. Even with the passage of the Affordable Care Act, the proportion of Latinos in the uninsured population has grown from 29 percent of the uninsured in 2013 to 40 percent in 2016.[9] Undocumented immigrants remain ineligible for most state and federal insurance programs, which may limit access to health care. In this study, one third (33%) of survey respondents identifying as LGBTQ and one quarter (28%) of those experiencing mental health conditions did not currently have health insurance (Figures A18 and B18).

The key stakeholders noted that even with insurance, people may avoid seeking care for other reasons, such as cost, stigma around seeking help with mental health, or concerns about reporting to immigration authorities. Community leaders also mentioned historical distrust of medical professionals in the LGBTQ community.

> *Because we are currently living in a very difficult time politically and socially people are not sure who they can trust. Some just chose not to come at all for those reasons, that's why we're constantly promoting for the community to come and take care of their physical and mental needs. – mental health professional*
>
> *Clients who come for services do not have health insurance and many of those programs that offer tobacco cessation services are free for the first few months and then clients must pay or use health insurance. That's one of the [reasons] that interested customers do not commit to finish the program. – mental health professional*
>
> *Because of the stigma that comes with seeing or being treated by a psychologist, [many in the Latino community] think that you have to be a crazy (mentally ill) person to receive services... So many Latino patients do not see the connection of working with a psychologist to help them stop smoking. – mental health professional*
>
> *I do not really see people seeking out [services] that they do not know very well [or are unsure whether they are] going to be of good service to them… I think that, a lot of LGBT people do not trust just anybody. – community leader*

These collective barriers may make it difficult for people to get support for mental health concerns or smoking cessation resources. When asked about resources they had used in the past to try to quit smoking, survey respondents from both groups were more likely to report supports outside of medical establishments (e.g., quitting cold turkey, help from family and friends, resources on the internet, or over-the-counter medications; Figures 4 and 5). Other studies have found that members of the Latino community are more likely to rely on themselves for smoking cessation, rather than on outside supports such as nicotine replacement medications.[10]

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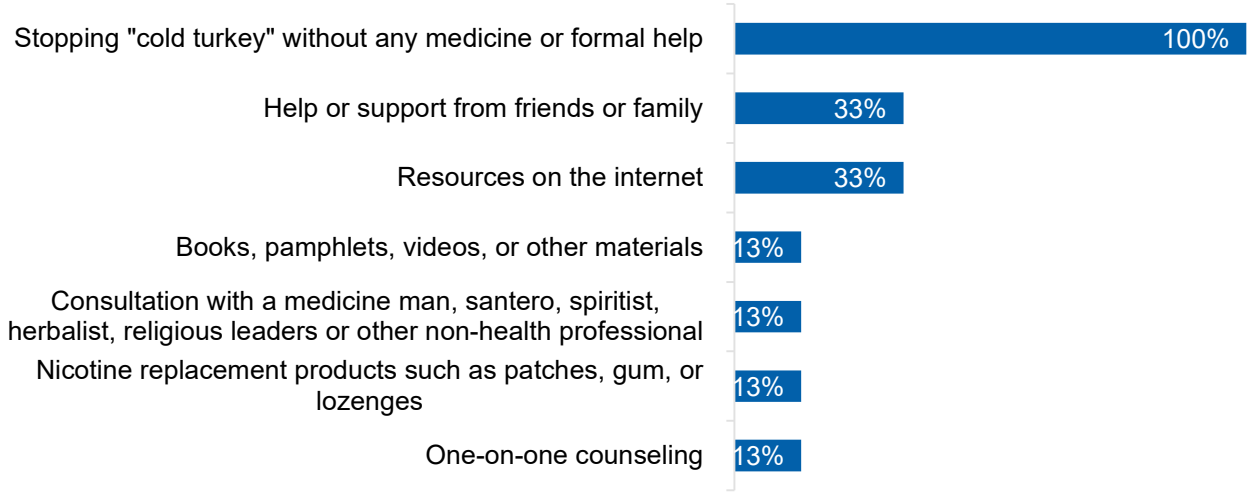
[9] Collins, S.R., Gunja, M.Z., Doty, M.M., & S. Beutel. (2016). *Who are the remaining uninsured and why haven't they signed up for coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.* Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2016/aug/who-are-the-remaining-uninsured.

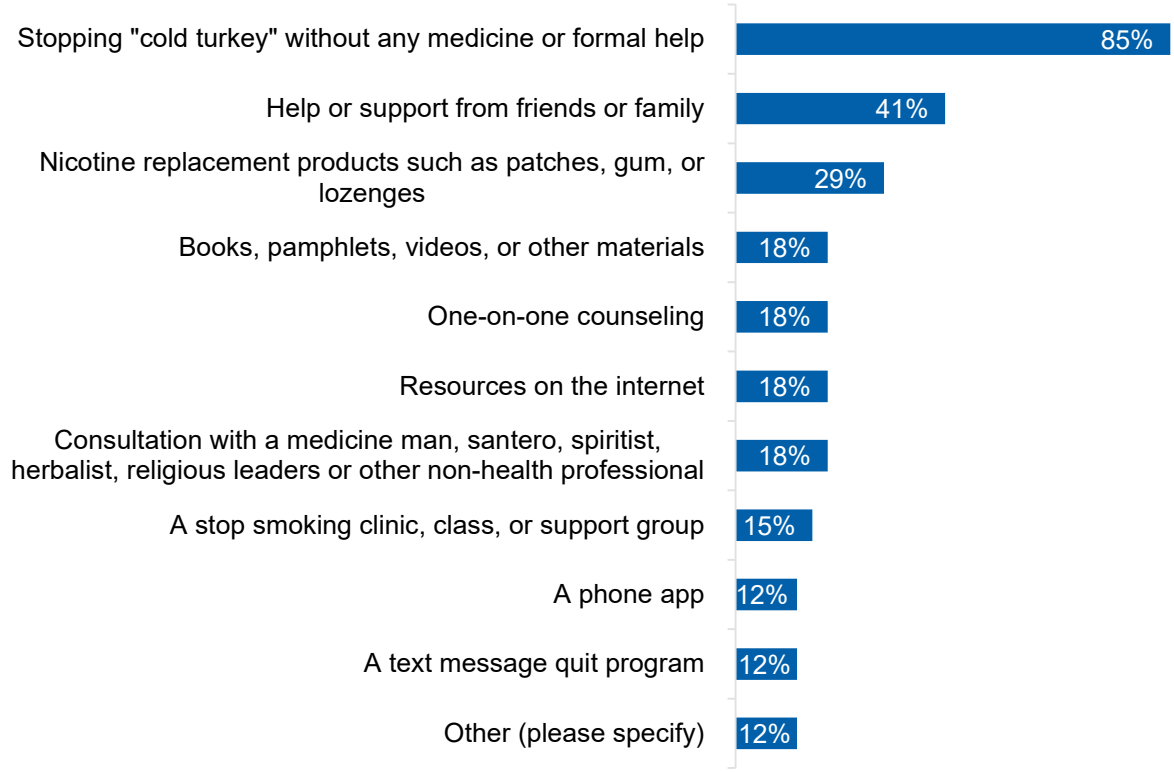
[10] Carter-Pokras, O. D., Feldman, R. H., Kanamori, M., Rivera, I., Chen, L., Baezconde-Garbanati, L., … Noltenius, J. (2011). Barriers and facilitators to smoking cessation among Latino adults. *Journal of the National Medical Association, 103*(5), 423-31.

4. Strategies used in past attempts to quit smoking: LGBTQ respondents (N=15)



Note. The chart above includes strategies that were indicated by at least 10 percent of respondents. Other items included: a phone app (7%); prescription medications such as Wellbutrin, Zyban, or Buproprion (0%); acupuncture (0%); hypnosis (0%); a stop smoking clinic, class, or support group (0%); a telephone help line or quit line (0%); and a text message quit program (0%).

5. Strategies used in past attempts to quit smoking: Respondents experiencing mental health concerns (N=34)



Note. The chart above includes strategies that were indicated by at least 10 percent of respondents. Those who listed "other" specified using e-cigarettes or cutting down gradually. Additional items included: acupuncture (6%); a telephone help line or quit line (6%); prescription medications such as Wellbutrin, Zyban, or Buproprion (3%); and hypnosis (3%).

Participants had limited awareness of existing cessation resources, especially culturally appropriate programs. Key stakeholders suggested that many from these communities may not be aware of available resources. All participants in the mental health listening session stated that smoking cessation resources were not easy to access. Others suggested that there were few resources available in Spanish or that were culturally appropriate. Some suggested that clinics and organizations are not always equipped to serve intersecting identities. For example, organizations that serve the LGBTQ community may not be able to meet the language and cultural needs of Latinos identifying as LGBTQ, or may be perceived as unwelcoming. Participants in the listening session in particular noted that CLUES could have a greater presence in the LGBTQ community.

> *I don't think a lot of people know that there are so many free programs out there to help you quit. – mental health professional*
>
> *I do not hear much of the tobacco cessation resources in any television media, radio, newspapers. – community leader*
>
> *[There is] a difficulty finding solutions in Spanish. I think there was a phone hotline available but my patients did not like that and preferred a…one-on-one, in person contact in their language… Just finding resources available in Spanish here in Minnesota and especially in rural areas where there are less Latinos [is hard]. – community leader*
>
> *You have folks who are distrustful of LGBTQI organizations, because they've been seen as primarily serving white LGBTQI folks. So, even organizations that are maybe doing the work well are still seen with a lot of distrust in a broader [Latino] community. I think that that can be one of the big barriers for folks to want to engage with some of the local organizations. – community leader*
>
> *In the last 21 years that I have been here and have come to CLUES, [CLUES] has never been part of us [in the LGBTQ community]. One time I think I saw them at the Gay Pride Parade. – listening session participant*

Targeted outreach by the tobacco industry may contribute to smoking in the Latino and LGBTQ communities. Key stakeholders discussed past targeting of LGBTQ communities and communities of color by the tobacco industry. They noted that some of these practices continue, especially through advertisements and outreach at bars.

> *The research suggests that… tobacco companies will target communities that have a lot more stress in a way and will specifically target communities who …are oppressed or communities that are systematically targeted. Because those are communities, if they have more stress, and generally speaking they're going to be more likely to want to use things that relieve their stress, such as tobacco. – community leader*
>
> *Now all the ads that they have [are] like, "Oh, that looks like me." Are they Latino, are they Native American, are they mixed? …It used to be Marlboro Man… but now they have ambiguous identities. Are they gay or are they lesbian? They look metrosexual. …They're totally trying to market to a different crowd of people. – mental health professional*
>
> *The Camel and the Marlboro companies go out to the bars and give out free coupons. – community leader*

Effective messaging and interventions

Many of the participants in this assessment expressed some interest in quitting smoking, in the near future or eventually. Eighty-three percent of survey respondents identifying as LGBTQ and 69 percent of those experiencing mental health concerns have tried to quit smoking at least once in the past year (Figures A9 and B9). Likewise, 84 percent of respondents identifying as LGBTQ and 69 percent with mental health conditions indicated that they were currently trying to quit or planned to in the next six months (another 17% and 21%, respectively, were interested in quitting in the future, but not in the next six months; Figures A14 and B14). Participants in the listening sessions also mentioned interest in quitting, suggesting that there are opportunities for organizations like CLUES to continue to support smoking cessation within these two groups.

Key messages

Findings from the survey, listening sessions, and interviews point to motivating factors for quitting, as well as other factors to consider when crafting messaging.

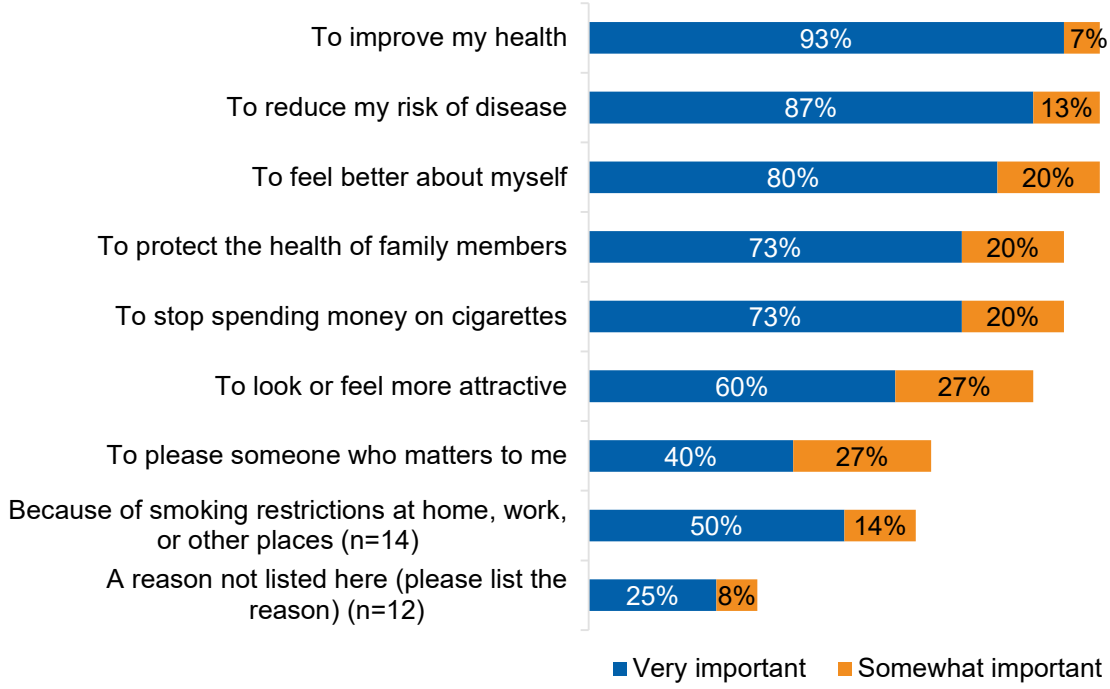
Family relationships may be important motivators for quitting smoking. When asked about reasons for trying to quit in the past, 97 percent of survey respondents experiencing mental health concerns and 93 percent of survey respondents identifying as LGBTQ said that protecting the health of family members was very or somewhat important factor they had considered (Figures 6 and 7). Survey respondents also considered their family when thinking about quitting in the future. Most respondents (83% of those identifying as LGBTQ and 81% of those living with mental health concerns) reported that friends and family members had often encouraged them to quit smoking (Figures 8 and 9). Respondents felt that they would set a good example for others if they quit smoking (92% of LGBTQ respondents and 87% of those living with mental health concerns) and that they would do less harm to family and friends due to secondhand smoke if they quit (84% and 82%, respectively). Listening session participants described family influences as key factors in past attempts to quit, and that family members were often supportive of attempts to quit. At the same time, some cautioned against only quitting for others without internal motivation to do so.

> *My second time I quit because I was in love and my significant other did not like me smoking. [On the third try], a little bird in the family told me that my granddaughter's parents mentioned that they would not let a newborn baby be carried [or] held by a smoker and they were talking about me, so I quit for about a year with the help of a patch.*
> *– listening session participant (LGBTQ group)*
>
> *How do people react when someone states that they quit smoking? People get happy at your victory. In my case my family and friends are worried about me. I'm important to them and they are important to me as well. As a smoker I would feel the need to not worry my friends and family with my smoking. – listening session participant (LGBTQ group)*

> *The only person that I told that I was considering on stopping was my daughter. She told me that she was proud of me and that she believed in me. I feel happy and encouraged because my daughter supports me. – listening session participant (mental health group)*

Other studies have found that concerns about impact on children and family health, as well as role model pressure, were important motivators for quitting smoking among individuals in the Latino community.[11]

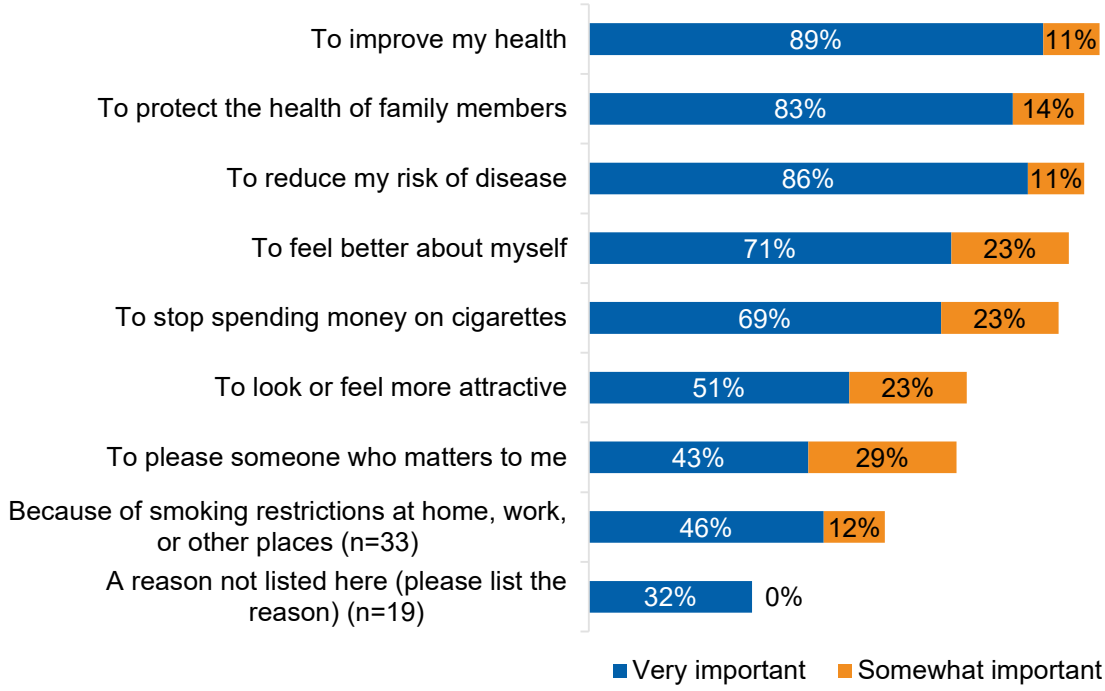
6. Reasons for past attempts to quit smoking: LGBTQ respondents (N=15)



Note. Only one respondent listed a reason for the item "A reason not listed here," and indicated "nothing."

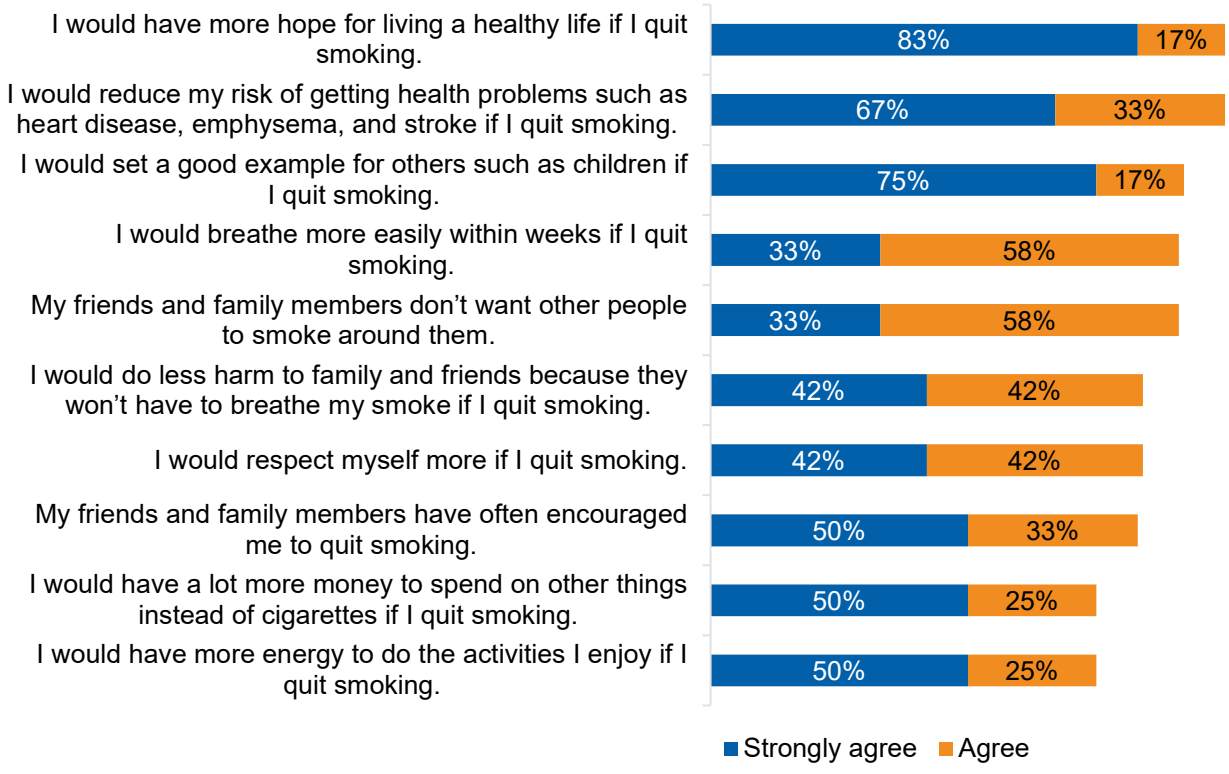
[11] Carter-Pokras et al., 2011.

7. Reasons for past attempts to quit smoking: Respondents experiencing mental health concerns (N=35)



Note. Other reasons included pregnancy or the pregnancy of a family member.

8. Beliefs about quitting smoking: LGBTQ respondents (N=12)



9. Beliefs about quitting smoking: Respondents experiencing mental health concerns (N=36-38)

Physical and mental health and well-being are important motivators, but messages focusing on the health risks of smoking may be less effective. Participants cited concerns about health as reasons they had tried to quit smoking in the past. When asked about factors that went into decisions to try to quit, participants reported improving their health (100% of respondents in both groups; Figures 6 and 7), reducing the risk of disease (100% of the respondents identifying as LGBTQ and 97 percent of those experiencing mental health issues) and feeling better about themselves (100% and 94%, respectively) as key motivations. When thinking about the future, respondents cited the following key reasons for quitting: reducing their risk of health problems (100% of respondents identifying as LGBTQ and 97% of those experiencing mental health concerns); having greater hope for a healthy life (100% and 89%, respectively); and being able to breathe more easily (91% and 90% , respectively; Figures 8 and 9).

> *My objective for quitting smoking is myself. To be clean spiritually and have a stable mind. – listening session participant (mental health group)*
>
> *For me it's about feeling better emotionally because smoking makes me uncomfortable…I feel excited about quitting to smoke. – listening session participant (mental health group)*

Key stakeholders also warned about focusing on health impacts alone. They noted that most people already know about the dangers of smoking, so emphasis on that in key messaging will not be effective, and may in fact turn people away. However, findings from the assessment suggest that messages focused on feeling better and improving health may be effective.

> *[I would recommend] having pamphlets and fliers with just very clear information. Nothing that's like, "Smoking is bad for you and here's why." To me it's not necessary, I think everyone knows smoking's bad. – mental health professional*
>
> *[Showing the health risks] is not going to scare you, you've seen worse in movies and say "I'm already used to seeing that," "It doesn't grab my attention." But there are things you can say that are more real than those grotesque images…Like, "I lost my wife because she was smoking," or I don't know, my family, my kids. – mental health professional*

Other benefits to quitting may be sources of motivation, such as saving money and improving appearance. Most of the survey respondents who tried to quit smoking in the last 12 months cited saving money as a key reason (93% of those identifying as LGBTQ and 92% of those experiencing mental health problems reported this as a "very" or "somewhat" important factor in their decision to quit; Figures 6 and 7). Participants in the listening sessions also discussed their dislike of the smell of cigarette smoke on their clothes and its negative impact on their relationships or other parts of their lives.

> *Money in your wallet, because as us gay people we need to start thinking about a pension, because we don't have kids and if God permits us to grow old we are going to need someone to care for us… If you're smoking you're spending so much money buying cigarettes. – listening session participant (LGBTQ group)*
>
> *Being able to meet someone without smelling like smoke has been great…I like to hug people at work and I can now get close to them and they will not smell that awful smell on me anymore and that [encourages] me a great deal. – listening session participant (mental health group)*
>
> *I bought a new car recently because my old car already had cigarette holes in the seats and the seat belts were burnt with holes. Also, my jackets had smoking holes all over the jacket. – listening session participant (LGBTQ group)*

Messages should offer clear, straightforward information and emphasize personal choice. The key stakeholders suggested that any messages should underscore individual choice to quit. They noted that this approach is especially important in communities that have been traditionally disenfranchised and supports personal agency in choices about health. Others recommended offering clear, straightforward information, rather than marketing gimmicks, especially in the LGBTQ community which is often targeted by marketing campaigns because of their perceived spending power.

> *I feel like messages around that we're not going to judge you [are most helpful]. We're not going to shame you. We're not going to lecture you. We're really here to offer some alternatives and follow your lead around when and if you're ready to either reduce or to stop smoking altogether. – mental health professional*

> *But also being clear about what the person is going to get out of it, rather than…trying to trick somebody into using something or offering them free t-shirts or something just to get your logo somewhere. – community leader*
>
> *The gay population is known as having more money than the rest of the population because people assume they have partners and no kids, so you have double income and no children… So when you are constantly being marketed to, when somebody tries to market no smoking to you… it is just kind of like one more thing. When you are talking about somebody's health… it is even more insulting. – community leader*

Messages and outreach efforts should address psychological barriers to help-seeking. Several key stakeholders mentioned the importance of taking into account stigma and historical distrust of mental health services. They recommended messaging and outreach efforts that normalize help-seeking and intentional efforts to build trusting relationships with communities.

> *I think the first step that could be good is letting [people know] that it's okay to come to mental health services and ask for help because I remember when I was doing the intake[s], usually they tell me, "Hey, I am here but I just want to let you know that I am not crazy. I am here because this or that." Usually they don't want to recognize that they need help. – mental health professional*

Building awareness of the tobacco industry's targeting of communities of color and the LGBTQ community might help energize people to consider quitting. Some key stakeholders suggested messaging that addressed the tobacco industry's targeting of vulnerable communities could help mobilize people to quit smoking. Listening session participants recommended messaging connecting smoking cessation with the health of the LGBTQ community overall.

> *I believe that a good way to promote the cessation of cigarette smoking is to let people know that tobacco companies are using the vulnerability of poor populations and… the most marginalized for profit. – community leader*
>
> *We need to survive as a community, especially being Latino we already have many discriminations towards us as it is. So we need to wake up and live again without smoking because smoking was killing us. – listening session participant (LGBTQ group)*
>
> *If I had to do a commercial for gays to get them to stop smoking, I would ask them to be open and feel liberated once and for all. The world is not ready for us yet, civically they are when it's comes to getting a paper and formalizing a relationship, but we can't kiss in public… [We] would receive all kinds of criticism. When we stop smoking, what [is it] that [is] gained? Liberty…. that's what we all strive for, to be liberated from something or someone who is holding you back. – listening session participant (LGBTQ group)*

Messengers and channels

Medical professionals and friends or family were important sources of health information for participants from both groups. When asked about where they went for important health information, survey respondents were most likely to report doctors and hospitals (78% of those identifying as LGBTQ and 73% of those experiencing mental health concerns) and friends or family (61% and 53%, respectively; Figures 10 and 11). About three-quarters of respondents (72% identifying as LGBTQ and 71% experiencing mental health concerns) reported that they would be "very" or "somewhat" comfortable asking a doctor for help to stop smoking (Figures A19 and B19). Of those who had tried to quit in the past, one-third (33%) of those identifying as LGBTQ and 41 percent of those experiencing mental health problems reported getting help or support from friends or family (Figures 4 and 5). Participants in the listening sessions also reported friends and family as important resources in quitting smoking.

> *The first person I told was my brother. He introduced me to CLUES and has been supporting of my decisions. I told him what I was involved with, the classes and the talks we have and he tells me to keep coming, to keep with my program and to start smoking less. – listening session participant (mental health group)*
>
> *With my doctor I know that they can help me figure out a medication or an actual plan… They'll be honest with you. They'll not try to sell you something. – community leader*

10. Sources of health information: LGBTQ respondents (N=18)

Which of the following do you go to for important health information? (Check all that apply)	N	%
Doctors or hospitals	14	78%
Friends or family	11	61%
Internet	10	56%
Health magazines	6	33%
General interest magazines and newspapers	5	28%
Newspapers and magazines targeted to the Latino community	5	28%
Television	5	28%
Health product stores	4	22%
Radio	3	17%

Note. The table above includes items that were indicated by at least 10 percent of respondents. Other items included: a community-based organization or church (0%); buses or other public transportation (0%); and other (0%).

11. Sources of health information: Respondents experiencing mental health concerns (N=51)

Which of the following do you go to for important health information? (Check all that apply)	N	%
Doctors or hospitals	37	73%
Friends or family	27	53%
Internet	27	53%
General interest magazines and newspapers	17	33%
Health magazines	15	29%
Television	13	26%
Newspapers and magazines targeted to the Latino community	10	20%
Health product stores	9	18%
Radio	9	18%
A community-based organization or church	8	16%

Note. The table above includes items that were indicated by at least 10 percent of respondents. Other items included: buses or other public transportation (4%) and other (0%).

Participants from both groups emphasized the importance of authentic relationships in any outreach efforts. The key stakeholders and the listening session participants suggested that hearing from people who had quit smoking themselves was especially helpful. Mental health professionals noted that warm hand-offs and one-on-one relationships were important in connecting people to resources. They emphasized the importance of outreach from people in the community who can understand the needs and interests of those being reached. Communications materials should also reflect individuals in the community of focus, but community leaders warned against representation that relies on stereotypes or caricatures.

> *Something else that has helped me in the past is life stories of people in the past who have shared their experiences on how they were able to get over their addiction.*
> *– listening session participant*
>
> *It's understanding the culture… and experiences that I think are important. I would say, in building services for somebody in the LGBTQ community…particularly Latino, in my mind, the best option is somebody that's also from that community, to really provide the appropriate mind. – community leader*
>
> *[When I refer clients to resources and] I don't have the exact information - the name of the person that's going to be answering them - I can't say "here, this number, this person is going to answer and help you." That gives them the most trust to be able to call and know that they're going to answer in their own language, and the name of the person who's going to answer, because if not, they feel lost and say "It's a number, I don't know who's going to answer, I don't know if they speak Spanish or English, and I don't want to go."*
> *– mental health professional*

> *I think graphic representation[s] are good to use or [having] a human element to it [but] you don't want it to be too negatively associated or stereotypical…There is one [ad] that had a white dude and he's in a little ballerina thing and he looks super campy and queeny. I was like, "That's so stereotypical." If I was somebody that was looking at this ad and trying to make a decision, and like, "Oh, do I resonate with this thing, and do I want to call this number?" I would… look at it and probably [not] want to do that. – community leader*

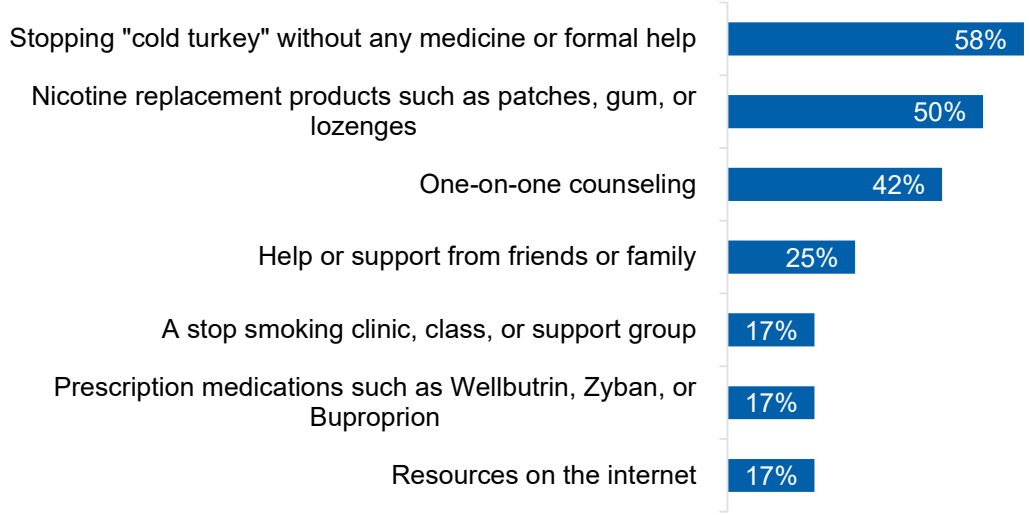
Meeting people in spaces where they are already gathering may be an effective way to reach people. Key stakeholders recommended making use of organizations and institutions that already have trusting relationships with these communities. The mental health professionals suggested that churches may be an important place to connect with people experiencing mental health problems. Participants in the listening session also suggested schools and restaurants. Community leaders suggested bars, coffee shops, LGBTQ events such as Pride, and other organizations that serve the LGBTQ community. However, community leaders in particular warned against being too intrusive in these establishments. They suggested strategies like an information table where people can seek out information voluntarily and provides some degree of confidentiality.

Social media and information on the internet may be another way to reach people, especially in the LGBTQ community. Community leaders in particular suggested that social media may be an effective way to reach people in the LGBTQ community. Several suggested posting short videos of people from the target communities who had successfully quit smoking. Mental health professionals suggested that web-based support could be helpful in reaching people who may not feel comfortable reaching out for support from medical or mental health professionals. Resources on the internet was the third most common source of health information for survey respondents, with over half (56% of those identifying as LGBTQ and 53% of people reporting mental health concerns) that they got important health information from the internet (Figures 10 and 11). However, key stakeholders suggested that services such as text-based support or quit lines that involved support from anonymous counselors would not be effective for members of the Latino community, who may prefer face-to-face interactions.

Interventions

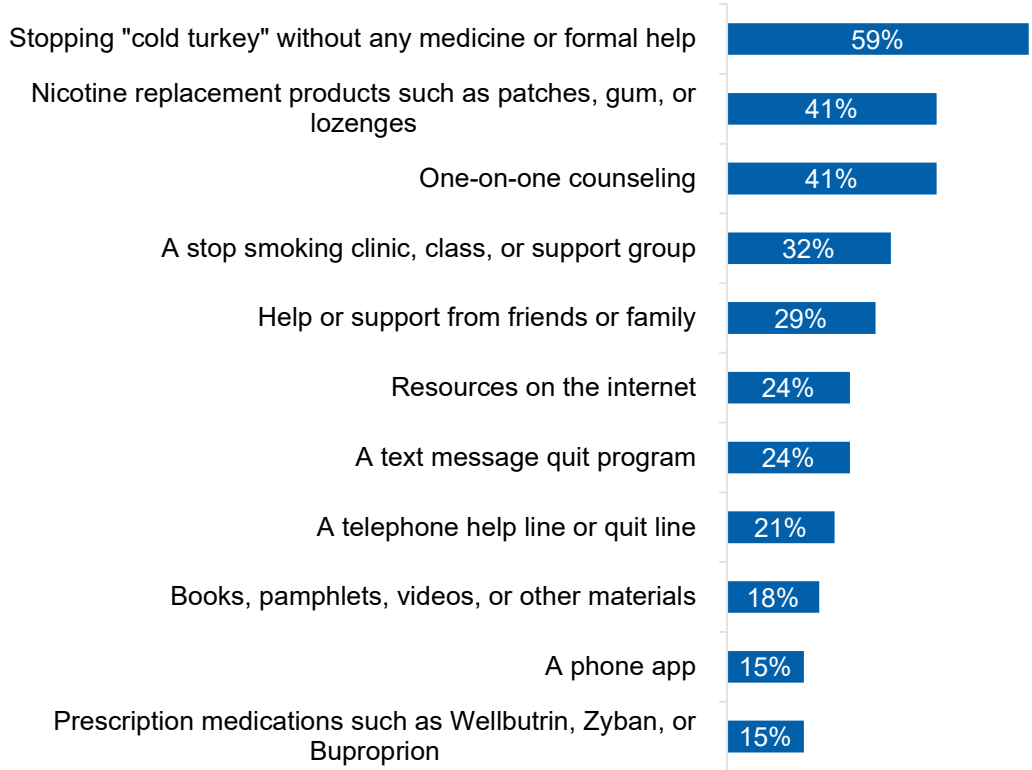
Although many participants were likely to try to quit "cold turkey", they were optimistic that they would be more successful if they used outside help. Almost all survey respondents (100% identifying as LGBTQ and 85% experiencing mental health concerns) who had tried quitting in the past 12 months reported that they had tried going "cold turkey" (Figures 4 and 5). More than half (58% of those identifying as LGBTQ and 59% of those with mental health concerns) thought they would use that as a strategy if they tried to quit in the future (Figures 12 and 13). However, most respondents (67% of those identifying as LGBTQ and 64% of those experiencing mental health concerns) also felt that they would be more successful quitting using outside help (Figures 2 and 3).

12. Strategies for quitting smoking in the future: LGBTQ respondents (N=12)



Note. The chart above includes items that were indicated by at least 10 percent of respondents. Other items included: a telephone help line or quit line (8%); books, pamphlets, videos, or other materials (8%); acupuncture (0%); a phone app (0%); a text message quit program (0%); consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional (0%); hypnosis (0%); and other (0%). Six percent of respondents reported that they did not intend to quit smoking.

13. Strategies for quitting smoking in the future: Respondents experiencing mental health concerns (N=34)



Note. The chart above includes items that were indicated by at least 10 percent of respondents. Other items included: acupuncture (6%); consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional (6%); hypnosis (6%); and other (specifying exercise; 3%). Three percent of respondents reported that they did not intend on quitting smoking.

Increasing awareness of the available resources and presenting a menu of options may be important first steps in supporting smoking cessation in the two communities. Key stakeholders suggested interventions that increased basic awareness of smoking cessation resources. They noted the importance of offering a variety of different options, from medications to one-on-one counseling to phone or text message support. Offering a menu of options is more likely to meet people's individual needs and help people feel greater control of the process.

> *A lot of them are people who have it in their head 'I can't quit smoking, I can't do this' A lot of it is people get scared and they don't know, they are used to this so they don't know how to stop and it's really just a question of what's really going on in their heads. But when you present them with the options that it's there and when you are persistent about it I really believe that you can get the people and get your point across and people would be willing to try that. – community leader*
>
> *I think there needs to be like a whole menu of options. I think it's more personality-based than it is cultural. Some people are going to want the [nicotine] replacements…Some people are going to want talk to people, call the line… I don't know if you could say [broadly that] calling QUITPLAN works for African-Americans [and] patches [are] all for Latinos. – community leader*

Participants reported interest in one-on-one counseling combined with over-the-counter medications to help quit smoking. Although any intervention should provide individualized support, participants indicated some interest in one-on-one counseling and over-the-counter medications. When asked about cessation resources they would be likely to use in the future, the second and third most reported supports were nicotine replacement products (50% of those identifying as LGBTQ and 41% of those experiencing mental health concerns reported they might use this strategy) and one-on-one counseling (42% and 41% respectively; Figures 12 and 13). The key stakeholders also felt that one-on-one counseling or relationship-based strategies, combined with nicotine replacement products, would be especially helpful. They emphasized the importance of building coping skills and resilience in any intervention. However, any intervention should take into account the barriers to seeking help noted earlier in the report. Some of the mental health professionals suggested that relationship-based approaches could occur in more formal settings through mental health therapy or a quit coach, or more informally through relationships in the community.

> *I think at the more local level, supporting face-to-face counseling by agencies that are part of that community. There's a limited number of them. – community leader*
>
> *The impersonal phone help is just not something we Latinos like, we want the human touch, in person, the conversations. – mental health professional*
>
> *My approach is always to add new coping skills before taking things away so I think sometimes people think, "If I go to therapy or counseling, they're going to make me stop or make me feel bad about what I'm doing," and we really try to increase other coping skills before the person is like, "Okay, let me maybe now try to decrease my smoking or drinking," whatever negative coping skills they may be using. – mental health professional*

> *Sometimes you can even put that bug in someone's ear… Someone stopped in the other day and [is] interested in quitting smoking, [so I asked], "Are you still smoking?" Ease it into a conversation even if you weren't talking about it. [Or] hey, I wrote down this website and let them know… It's nonchalant, no pressure. I'm not trying to ruffle your feathers. Some people can be touchy about quitting but I've learned techniques of how to swoop in and get it done. – community leader*

Interventions should be free or low-cost. Key stakeholders stated the importance of offering free or low-cost resources that were easy to access. These factors are especially important for those who may not have health insurance.

Participants were interested in culturally specific programs. The majority of survey respondents (83% of those identifying as LGBTQ and 77% as those experiencing mental health concerns) reported that programs run specifically for Latinos would make them feel more confident about quitting (Figures A16 and B16). Although the survey did not ask about other types of culturally specific programs, organizations may consider programs for intersecting identities, such as Latinos identifying as LGBTQ.

Group approaches, resources with limited information, and programs that were not culturally responsive were identified as less effective. Key stakeholders discussed approaches and interventions that they felt were less effective. Although some thought that group-based interventions such as support groups or classes could be effective, many stated that they would likely be cumbersome for people to get to because of issues such as work schedules, transportation, and child care. Some talked about resources such as pamphlets or text-message campaigns that had limited information as not being especially helpful. Those interviewed also noted that mainstream approaches such as quit lines that were not tailored to the Latino community were less effective, even when they were in Spanish. Community leaders advised against outreach through churches for Latinos identifying as LGBTQ.

> *I lead a diabetes program here at the clinic but it's very hard to recruit people for this group. Some work nights some days and there's never a good time, many barriers. We have thousands of people that qualify for this class, but's [it's] so hard to even recruit 10 patients. – mental health professional*
>
> *If you only have a quit line, I don't know if that's the answer, unless you really modify those quit lines to have people that are representative of the community you're serving. – community leader*
>
> *I think that culturally we like to do things face to face, we don't do many surveys or like to get help from a stranger on the phone. – mental health professional*
>
> *And also, when they don't talk a lot about it, they just give a brochure and they tell them "Well, call here if you're interested," and that's it. – mental health professional*
>
> *I think that the religious community is not open to a lot of LGBTQ issues. It would not be the most appropriate route to try to support them. I know that there are churches that are very open and very friendly but not in the Latino community. – community leader*

> *Not realizing that mental health and marginalization, the impact that that's gonna have on folks. Like it's harder to quit when you're addicted and when you have other things on top of it, like marginalization or [immigration] status. It's more complicated then just, "You need to quit smoking." And I think that tends to be forgotten sometimes. Especially when you work with different populations. – mental health professional*

Other factors to consider

Messages and outreach strategies should take into account differences within communities. Participants in one of the listening sessions discussed the importance of targeted outreach efforts that do not assume all group members are the same. Participants in the LGBTQ listening session noted that there is diversity within the LGBTQ community, with different needs and preferences. Likewise, key stakeholders noted differences within the Latino population based on country of origin and generation, as well as among individuals themselves. They noted the importance of keeping these differences in mind when developing communications materials, interventions or outreach strategies; providing a variety of options; and making sure to consider individual needs and preferences.

> *And anything that anybody does I think that it's [important to be] flexible and adaptable enough…versus trying to find one methodology of doing it. Because in my work… that's the only thing that works with complicated groups. When you're putting mental health and LGBTQ and a cultural identity as Latino or Latina you've just got to [support people in making] their decisions about when they want to quit or how they identify. – mental health professional*
>
> *We have a huge number of new immigrants from Latino countries here in Minnesota that are making up the Latino population [and] we have to make sure we are targeting all Latino people when it comes to helping them quit smoking, those that only speak English like the second or third generation of Latino parents and or grandparents and those that just arrived or are arriving here in Minnesota. – mental health professional*
>
> *I feel that in order to reach out to this community you have to have several different listening sessions based on the different classes of LGBTQ members. There are different groups and we're not unified. We're all scattered in different places with different goals. – listening session participant (LGBTQ group)*

Policy and systems change efforts

Through this assessment, mental health professionals were asked about the extent to which they ask clients about smoking, and what supports would help them do so on a more regular basis. Interviews with key stakeholders highlighted places at the systems level where CLUES and other organizations may be able to exert influence to support smoking cessation within these two populations.

Most mental health professionals did not regularly ask clients about smoking. Some said that they did not see it as a priority unless it was relevant to the client's presenting concerns. Others were hesitant to ask about quitting because they did not want clients to feel judged. This consideration was especially important early on in the therapeutic relationship when they were building trust. Clinicians also felt that smoking was a coping mechanism for more severe mental health symptoms or in stepping down from harder substances, and did not want to take that away from clients. Some shared that they were reluctant to talk to clients about smoking because they did not feel they were equipped with enough information about cessation resources, especially those that were available in Spanish and culturally relevant.

> *I do what the client needs to do, or wants to do. If the client doesn't come to me to stop smoking, and they smoke, I cannot ask that they stop smoking. It has to be…the common goal. And a lot of times people don't come because they want to stop smoking. – mental health professional*
>
> *I might casually talk to [the client] about it in a conversation like, what do you plan to do about smoking? Where are you with your smoking? [But] if I all of a sudden lash out and say, "Hey you need to stop smoking", you know that they will react negatively towards me and I'll lose my connection I had with them. I have to look for a balance with them and build a relationship first. – mental health professional*
>
> *So, if a person comes to me and tells me that they want to cut themselves and then tells me that smoking is the only way they can deal with not doing it, who am I to tell them they should quit smoking? – mental health professional*
>
> *I do not ask the question often because I understand that they have other addictions stronger than tobacco use…. Occasionally, they have to stop substance use in the "cold turkey" method and letting them know that they also have to quit smoking addiction is a bit difficult for me. – mental health professional*
>
> *I feel that sometimes it's because of the lack of information and resources to really help this patient. I don't want to offer the smoker some help and not follow through with professional suggestions and leave him/her hanging is not a good thing to do. – mental health professional*
>
> *It was really easy to just refer them [to other resources] so I think I have unconsciously not wanted to open up something that I wouldn't necessarily know how to work with or help support. – mental health professional*

Research has found that Latinos are less likely to receive a tobacco use screening or be advised to quit smoking during primary care office visits than white patients.[12, 13] At the same time, studies have also shown that incorporating smoking cessation into treatment plans for alcohol or other drugs actually increases the likelihood of longer-term abstinence from these substances.[14]

When mental health professionals did discuss smoking cessation resources with clients, they often referred them to QUITPLAN, health care providers, or social workers; or they have incorporated cessation into the client's treatment plan. Some mental health professionals did talk with clients about smoking cessation, although many still noted that they were not completely confident in their knowledge of available resources. When they did refer clients to resources, it was often to QUITPLAN or to community health workers, health care staff, or social workers within the same organization or health care facility. However, many suggested that they did not know if clients actually followed up with these resources. Some mental health professionals said they incorporated cessation into the client's treatment plan.

Mental health professionals had some interest in incorporating questions about smoking more regularly into their sessions, but noted that clinic commitment to doing so would be critical to ensuring it became part of standard practice. Many mental health professionals interviewed expressed interest in asking about smoking more consistently with clients, although they still shared some hesitance based on the barriers noted above. They suggested that establishing clinic protocols to include questions about smoking in intake sessions and on forms would be an important first step. They also expressed interest in training about available resources and about how to talk with clients about quitting.

> *I think having these interviews and potentially having you do more group [presentations] are really, really helpful. I don't think people are resistant to it necessarily. I don't think it's pushback of like, "Oh, I don't want to talk about that." I think it's more like lack of awareness. – mental health professional*
>
> *It's something that I think would be good to do but it's not on our forms. We do ask about alcohol consumption and so, as we were talking earlier, I was like I should make a note for myself just to ask because I really think it can be helpful but it's just not on our form so sometimes I don't think of it. – mental health professional*

[12] Jamal, A., Dube, S. R., Malarcher, A. M., Shaw, L. & Engstrom, M. C. (2012). Tobacco use screening and counseling during physician office visits among adults — National Ambulatory Medical Care Survey and National Health Interview Survey, United States, 2005–2009, *Morbidity and Mortality Weekly Report, 61*(Supplement), 38-45.

[13] Houston, T. K., Scarinci, I. C., Person, S. D., & Greene, P. G. (2005). Patient smoking cessation advice by health care providers: the role of ethnicity, socioeconomic status, and health. *American Journal of Public Health, 95*(6), 1056-61.

[14] Prochaska, J. J., Delucchi, K., Hall, S. M. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology, 72*(6), 1144–1156.

[Quitting] might not be their top priority or [they may] not even be thinking of quitting smoking. We providers need to remember that. [But] we should at least start the conversation or "plant the seed" so to speak. – mental health professional

I think I always talk with my clients about alternatives, other strategies that can be used to deal with stress, but I think its part of my process of education that I need to be more intentional with my questions. –mental health professional

Continuing to support policy and systems change efforts is critical to supporting smoking cessation and health in the two communities. Key stakeholders noted that direct interventions were important, but should be balanced with work at the systems level. Areas of opportunity they saw included advocating for smoke-free and other tobacco policies and addressing the tobacco industry's targeting of communities of color and the LGBTQ community. They also noted the importance of addressing broader social determinants of health and having more granular data about tobacco use among different populations.

If CLUES is going to be doing this, [and] I know that there are other community organizations, how can we be having a broader conversation with Twin Cities about tobacco marketing? …How can we be talking about tobacco marketing, particularly LGBTQI youth and youth of color around marketing tobacco? – community leader

I think that every year goes by the spaces where people can smoke are becoming more and more reduced. Especially here in Minnesota where they have passed laws about not smoking inside bars and inside public housing units. I understand that the [policy, systems, and environmental] changes take a very important role in the change of any behavior. – community leader

This whole issue of better data, and what they call granular data, is important. Because… you can look at the Latino community in the whole of Minnesota, but you still have to dig down and look at the sub populations, like the LGBTQ. – community leader

I don't think the Latino population and especially in our clinic have an exact idea to what magnitude smoking is affecting our people. – mental health professional

Recommendations

Findings from this assessment point to key issues to consider and effective strategies for supporting smoking cessation in the Latino LGBTQ community and among Latinos experiencing mental health concerns. However, the key stakeholders who participated in this assessment emphasized the importance of gathering ongoing feedback, and involving members from these communities in the design and implementation of any efforts. The following recommendations are offered for CLUES to consider as they develop communications and outreach strategies for work with these two populations. They are intended to be a starting point. CLUES is encouraged to provide additional opportunities for key stakeholders and community members to give input into these efforts.

- **Use relationship-based approaches to outreach.** The key stakeholders interviewed suggested that members of both populations would likely be more receptive to relationship-based outreach efforts and support, rather than broad-based campaigns. Relationship-based approaches were seen as critical to build trust and follow-through on cessation efforts. Effective strategies and supports include one-on-one counseling or coaching, mentorship opportunities with people who had quit smoking, warm hand-offs when making referrals, and direct outreach through partnerships with other trusted organizations and establishments. Participants and stakeholders also suggested that friends and family may be important sources of motivation and support, which may be taken into account when working with individuals to quit smoking.

- **For broader communication efforts, consider including stories or testimonials from people in the two communities who have quit smoking.** Participants noted that stories from people that were similar to them who had quit smoking were especially impactful. Key stakeholders also warned against caricatured portrayals, so CLUES should think about avoiding the use of actors or stock images in materials.

- **Consider trauma-informed approaches that provide clear and straightforward information, emphasize personal choice, and normalize help-seeking.** In any outreach efforts or supports, key stakeholders emphasized the importance of providing clear and straightforward information about different treatment options and supporting personal choice regardless of readiness to quit. They encouraged messaging that normalizes help-seeking, whether through support services or medications. They noted that strategies that were less transparent or used marketing gimmicks and did not provide useful information were likely to alienate people and be less effective.

- **Develop culturally specific supports that take into account the histories, assets, and stressors of each community, while acknowledging individual differences.** Participants from both communities expressed interest in culturally specific supports. The key stakeholders emphasized the importance of taking into account the strengths of each community, as well as the historical traumas and stressors that may contribute to smoking. Findings from this assessment highlight some of the issues that impact both communities, as well as unique factors within each community that may impact smoking behaviors. However, any approach should take into account differences within communities and should not assume that everyone in each community has the same interests and needs. Options for smoking cessation should be available so that individuals can choose what fits best with their personality and preferences.

- **Continue to build awareness of the tobacco industry's targeted efforts in communities of color and the LGBTQ community.** The key stakeholders in particular emphasized the impact of the tobacco industry's targeted outreach efforts in communities of color and the LGBTQ community. They suggested that building awareness around this marketing may help limit its impact in the future and be another source of motivation to quit smoking.

- **Advocate for the inclusion of questions about smoking in mental health clinic protocols, and provide training to mental health professionals about available supports and working with clients on smoking cessation.** Most of the mental health professionals interviewed did not regularly ask clients about smoking, but expressed some interest in doing so. There may be opportunities for CLUES to encourage clinics and mental health professionals to include questions about smoking as a regular part of the intake process. The mental health professionals also indicated that they were not aware of available resources, especially culturally relevant resources, or were reluctant to talk to clients about smoking because they did not want their clients to feel judged. CLUES may consider providing additional training to mental health professionals about available resources and how to talk with clients about smoking in a way that still emphasizes personal agency.

- **Build a stronger presence in the LGBTQ community through partnerships and attendance at events, and advocate for greater intersectional approaches in LGBTQ-serving organizations.** Several participants and stakeholders noted that CLUES was not seen as a key resource within LGBTQ community. There are opportunities for CLUES to have a stronger presence in the LGBTQ community through partnerships with organizations that serve the LGBTQ community or attendance at events such as Twin Cities Pride. CLUES may be well positioned to partner with organizations serving the LGBTQ population to encourage a greater intersectional approach and the inclusion of the voices of LGBTQ Latinos.

- **Continue to provide services and supports that address broader social determinants of health.** CLUES provides a variety of programs and services, from aging and mental health services to workforce development and adult and parenting education. Findings from this assessment indicate that a variety of broader factors may contribute to smoking, including immigration issues, economic factors, access to health care, and stigma and discrimination. CLUES is encouraged to continue to provide high-quality services in all of these areas to support the overall health and well-being of individuals.

Appendix A: Survey data for LGBTQ respondents

Respondents were included in this group if they selected:

- "Transgender M→ F"
  "Transgender F → M"
  "Queer"
  "Another gender" or
  "I'm not sure" on question A24, or

- "Gay"
  "Lesbian"
  "Bisexual"
  "Another sexual orientation" or
  "I'm not sure" on question A25

Smoking and tobacco use

A1. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs) (N=18)

	N	%
Yes	14	78%
No	2	11%
Not sure	2	11%

A2. On average, on days when you smoked during the past 30 days, about how many cigarettes did you smoke per day? (20 cigarettes = one pack) (N=17)

	N	%
1-5 cigarettes	3	18%
6-10 cigarettes	4	24%
11-20 cigarettes	0	0%
21-40 cigarettes	1	6%
More than 40 cigarettes	3	18%
I did not smoke in the last 30 days	5	29%
I'm not sure	1	6%

A3. When you smoke, how often do you smoke menthol cigarettes? (N=18)

	N	%
Usually or all of the time	6	33%
Some of the time	3	17%
Rarely or not at all	9	50%

A4. During the past 12 months have you used other tobacco products such as cigars, pipes, snuff, chewing tobacco, bidis, kreteks, snus, a hookah water pipe, or any other type of tobacco product? (N=18)

	N	%
Yes	10	56%
No	8	44%
I'm not sure	0	0%

A5. Please select the extent to which you agree or disagree with the following statements: (N=18)

	Strongly agree	Agree	Disagree	Strongly disagree	I'm not sure
I smoke the most when I am drinking alcohol.	12 (67%)	6 (33%)	0 (0%)	0 (0%)	0 (0%)
I would be more irritable or tense if I quit smoking.	6 (33%)	6 (33%)	3 (17%)	3 (17%)	0 (0%)
I would gain weight if I quit smoking.	6 (33%)	5 (28%)	2 (11%)	3 (17%)	2 (11%)
Smoking helps me deal with stress.	6 (33%)	8 (44%)	3 (17%)	1 (6%)	0 (0%)
I reach for cigarettes when I feel irritable.	4 (22%)	10 (56%)	1 (6%)	2 (11%)	1 (6%)
I smoke the most after I eat.	4 (22%)	6 (33%)	2 (11%)	4 (22%)	2 (11%)
It would take a pretty serious medical problem to make me quit smoking.	4 (22%)	3 (17%)	5 (28%)	6 (33%)	0 (0%)
I would be less able to concentrate if I quit smoking.	4 (22%)	3 (17%)	5 (28%)	5 (28%)	1 (6%)
I would experience intense cravings for a cigarette if I quit smoking.	4 (22%)	6 (33%)	4 (22%)	2 (11%)	2 (11%)
Smoking is the fastest way to reward myself.	4 (22%)	4 (22%)	5 (28%)	4 (22%)	1 (6%)
It would be embarrassing to me if I tried to quit smoking using outside help.	3 (17%)	3 (17%)	6 (33%)	4 (22%)	2 (11%)
Smoking helps me feel better if I've been feeling down.	3 (17%)	10 (56%)	4 (22%)	1 (6%)	0 (0%)
If I tried to quit smoking using outside help, I would be more successful than if I quit without outside help.	2 (11%)	10 (56%)	2 (11%)	2 (11%)	2 (11%)
It would be difficult for me to afford getting outside help to quit smoking.	2 (11%)	3 (17%)	7 (39%)	5 (28%)	1 (6%)
Most of the people I spend time with are smokers.	1 (6%)	6 (33%)	6 (33%)	3 (17%)	2 (11%)

A6. Does anyone, including you, smoke regularly inside your home? (N=18)

	N	%
Yes	6	33%
No	12	67%

A7. Which option best describes the rules about smoking inside your home? (N=18)

	N	%
Smoking is not allowed anywhere inside my home	11	61%
Smoking is allowed in some places or at some times	5	28%
Smoking is allowed anywhere inside my home	2	11%

A8. In the past 7 days, have you been in a car or other vehicle where someone was smoking? (N=18)

	N	%
Yes	12	67%
No	6	33%
I'm not sure	-	-

Efforts to quit smoking

A9. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? (N=18)

	N	%
Yes	15	83%
No	3	17%

A10. People have various reasons for trying to quit smoking. In your most recent attempt to quit smoking, how important was each of the following reasons to you? (N=15)

	Very important	Somewhat important	Not very important	Not at all important	I'm not sure
To improve my health	14 (93%)	1 (7%)	-	-	-
To reduce my risk of disease	13 (87%)	2 (13%)	-	-	0 (0%)
To feel better about myself	12 (80%)	3 (20%)	0 (0%)	0 (0%)	0 (0%)
To protect the health of family members	11 (73%)	3 (20%)	1 (7%)	-	-
To stop spending money on cigarettes	11 (73%)	3 (20%)	0 (0%)	1 (7%)	0 (0%)
To look or feel more attractive	9 (60%)	4 (27%)	0 (0%)	2 (13%)	0 (0%)
Because of smoking restrictions at home, work, or other places (N=14)	7 (50%)	2 (14%)	1 (7%)	3 (21%)	1 (7%)
To please someone who matters to me	6 (40%)	4 (27%)	2 (13%)	3 (20%)	0 (0%)
A reason not listed here (please list the reason):_____ (N=12)	3 (25%)	1 (8%)	1 (8%)	1 (8%)	6 (50%)

Note. Only one respondent listed a reason for the item "A reason not listed here," and indicated "nothing."

A11. Thinking back to the last time you tried to quit smoking, did you use any of the following strategies? (Check all that apply) (N=15)

	N	%
Stopping "cold turkey" without any medicine or formal help	15	100%
Help or support from friends or family	5	33%
Resources on the internet	5	33%
Books, pamphlets, videos, or other materials	2	13%
Consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional	2	13%
Nicotine replacement products such as patches, gum, or lozenges	2	13%
One-on-one counseling	2	13%
Prescription medications such as Wellbutrin, Zyban, or Buproprion	0	0%
A phone app	1	7%
Acupuncture	0	0%
Hypnosis	0	0%
A stop smoking clinic, class, or support group	0	0%
A telephone help line or quit line	0	0%
A text message quit program	0	0%
Other (please specify)	0	0%

A12. Do you now smoke cigarettes every day, some days, or not at all? (N=18)

	N	%
Everyday	7	39%
Some days	5	28%
Not at all	6	33%

A13. Please select the extent to which you agree or disagree with the following statements: (N=12)

	Strongly agree	Agree	Disagree	Strongly disagree	I'm not sure
I would have more hope for living a healthy life if I quit smoking.	10 (83%)	2 (17%)	0 (0%)	-	-
I would set a good example for others such as children if I quit smoking.	9 (75%)	2 (17%)	0 (0%)	0 (0%)	1 (8%)
I would reduce my risk of getting health problems such as heart disease, emphysema, and stroke if I quit smoking.	8 (67%)	4 (33%)	0 (0%)	-	-
I would have a lot more money to spend on other things instead of cigarettes if I quit smoking.	6 (50%)	3 (25%)	2 (17%)	-	1 (8%)
I would have more energy to do the activities I enjoy if I quit smoking.	6 (50%)	3 (25%)	2 (17%)	0 (0%)	1 (8%)
My friends and family members have often encouraged me to quit smoking.	6 (50%)	4 (33%)	1 (8%)	1 (8%)	-
I would do less harm to family and friends because they won't have to breathe my smoke if I quit smoking.	5 (42%)	5 (42%)	1 (8%)	1 (8%)	-
I would respect myself more if I quit smoking.	5 (42%)	5 (42%)	2 (17%)	0 (0%)	-
I would breathe more easily within weeks if I quit smoking.	4 (33%)	7 (58%)	1 (8%)	0 (0%)	0 (0%)
My friends and family members don't want other people to smoke around them.	4 (33%)	7 (58%)	1 (8%)	0 (0%)	0 (0%)

A14. Which of the following statements best describes you now? (N=12)

	N	%
I am currently trying to quit or cut down on my tobacco smoking	5	42%
I plan to quit smoking soon, in the next six months	5	42%
I think I should quit smoking someday, but not in the next six months	2	17%
I don't think about quitting smoking tobacco	0	0%

A15. The next time you decide to quit smoking, what method do you think you'll use? (Mark every method you're seriously considering using.) (N=12)

	N	%
Stopping "cold turkey" without any medicine or formal help	7	58%
Nicotine replacement products such as patches, gum, or lozenges	6	50%
One-on-one counseling	5	42%
Help or support from friends or family	3	25%
A stop smoking clinic, class, or support group	2	17%
Prescription medications such as Wellbutrin, Zyban, or Buproprion	2	17%
Resources on the internet	2	17%
A telephone help line or quit line	1	8%
Books, pamphlets, videos, or other materials	1	8%
Acupuncture	0	0%
A phone app	0	0%
A text message quit program	0	0%
Consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional	0	0%
Hypnosis	0	0%
I do not intend to quit smoking	1	8%
Other (please specify)	0	0%

A16. If you decide to quit, would a program run specifically for Latino people make you feel more confident about quitting? (N=12)

	N	%
Yes	10	83%
No	1	8%
I don't have a preference/I'm not sure	1	8%

Health care and mental health

A17. In the past 12 months, have you seen a doctor, nurse, therapist, or counselor to get a check-up or any kind of care for yourself? (N=18)

	N	%
Yes	11	61%
No	7	39%
I'm not sure	-	-

A18. Do you currently have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medical Assistance, Medicare, Indian Health Services, or any plan through MNsure? (N=18)

	N	%
Yes	12	67%
No	6	33%
I'm not sure	0	0%

A19. How comfortable would you be asking a doctor or health care provider for help to stop smoking? (N=18)

	N	%
Very comfortable	11	61%
Somewhat comfortable	2	11%
Somewhat uncomfortable	0	0%
Very uncomfortable	1	6%
I do not currently have a doctor or health care provider	3	17%
I'm not sure	1	6%

A20. Which of the following do you go to for important health information? (Check all that apply) (N=18)

	N	%
Doctors or hospitals	14	78%
Friends or family	11	61%
Internet	10	56%
Health magazines	6	33%
General interest magazines and newspapers	5	28%
Newspapers and magazines targeted to the Latino community	5	28%
Television	5	28%
Health product stores	4	22%
Radio	3	17%
A community-based organization or church	0	0%
Buses or other public transportation	0	0%
Other (please describe place)	0	0%

A21. During the past 30 days, how often did stress, depression, a problem with emotions, excessive worrying, or troubling thoughts keep you from doing your usual activities, such as work, recreation, and taking care of yourself? (N=18)

	N	%
None of the time	4	22%
Some of the time	5	28%
Most or all of the time	8	44%
I'd prefer not to answer	1	6%
I'm not sure	0	0%

A22. Have you ever been told by a doctor or other health professional that you have a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis? (N=18)

	N	%
Yes	10	56%
No	5	28%
I'd prefer not to answer	1	6%
I'm not sure	2	11%

A23. Are you currently taking any medication that was prescribed for you to treat a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis? (N=18)

	N	%
Yes	2	11%
No	15	83%
I'd prefer not to answer	1	6%
I'm not sure	0	0%

About you

A24. What is your gender? (N=18)

	N	%
Female	-	-
Male	-	-
Transgender M → F	-	-
Transgender F → M	-	-
Queer	1	6%
Another gender (Please specify)	-	-
I'm not sure	-	-

A25. What is your sexual orientation? (N=18)

	N	%
Gay	12	67%
Lesbian	2	11%
Bisexual	1	6%
Heterosexual or straight	-	-
Another sexual orientation (please specify)	1	6%
I'm not sure	2	11%

Note. The respondent who identified as "another sexual orientation" specified "queer."

A26. What is your age? (N=18)

	N	%
18 or younger	-	-
19-24	4	22%
25-34	6	33%
35-44	6	33%
45-54	2	11%
55-64	0	0%
65-74	0	0%
75 or older	-	-

Appendix B. Survey data for respondents experiencing mental health concerns

Respondents were included in this group if they selected:

- "Most or all of the time" or "Some of the time" on question B21 ("During the past 30 days, how often did stress, depression, a problem with emotions, excessive worrying, or troubling thoughts keep you from doing your usual activities, such as work, recreation, and taking care of yourself?"), or
- Yes" on question B22 ("Have you ever been told by a doctor or other health professional that you have a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis?"), or
- "Yes" on Question B23 ("Are you currently taking any medication that was prescribed for you to treat a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis?").

Smoking and tobacco use

B1. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs) (N=51)

	N	%
Yes	44	86%
No	5	10%
Not Sure	2	4%

B2. On average, on days when you smoked during the past 30 days, about how many cigarettes did you smoke per day? (20 cigarettes = one pack) (N=50)

	N	%
1-5 cigarettes	20	40%
6-10 cigarettes	12	24%
11-20 cigarettes	4	8%
21-40 cigarettes	2	4%
More than 40 cigarettes	3	6%
I did not smoke in the last 30 days	8	16%
I'm not sure	1	2%

B3. When you smoke, how often do you smoke menthol cigarettes? (N=51)

	N	%
Usually or all of the time	19	37%
Some of the time	8	16%
Rarely or not at all	24	47%

B4. During the past 12 months have you used other tobacco products such as cigars, pipes, snuff, chewing tobacco, bidis, kreteks, snus, a hookah water pipe, or any other type of tobacco product? (N=51)

	N	%
Yes	23	45%
No	27	53%
I'm not sure	1	2%

B5. Please select the extent to which you agree or disagree with the following statements: (N=51)

	Strongly agree	Agree	Disagree	Strongly disagree	I'm not sure
I smoke the most when I am drinking alcohol.	23 (45%)	17 (33%)	4 (8%)	4 (8%)	3 (6%)
Smoking helps me deal with stress.	21 (41%)	18 (35%)	7 (14%)	3 (6%)	2 (4%)
I would experience intense cravings for a cigarette if I quit smoking.	19 (37%)	14 (28%)	11 (22%)	5 (10%)	2 (4%)
I reach for cigarettes when I feel irritable. (N=50)	16 (32%)	23 (46%)	5 (10%)	5 (10%)	1 (2%)
If I tried to quit smoking using outside help, I would be more successful than if I quit without outside help.	16 (31%)	17 (33%)	9 (18%)	3 (6%)	6 (12%)
I would be more irritable or tense if I quit smoking.	16 (31%)	16 (31%)	9 (18%)	6 (12%)	4 (8%)
I would gain weight if I quit smoking.	16 (31%)	8 (16%)	10 (20%)	8 (16%)	9 (18%)
Smoking helps me feel better if I've been feeling down.	15 (29%)	21 (41%)	11 (22%)	3 (6%)	1 (2%)
I smoke the most after I eat. (N=49)	13 (27%)	11 (22%)	12 (25%)	10 (20%)	3 (6%)
Smoking is the fastest way to reward myself.	12 (24%)	14 (28%)	14 (28%)	8 (16%)	3 (6%)
I would be less able to concentrate if I quit smoking. (N=49)	10 (20%)	9 (18%)	14 (29%)	14 (29%)	2 (4%)
It would be difficult for me to afford getting outside help to quit smoking. (N=50)	9 (18%)	11 (22%)	16 (32%)	11 (22%)	3 (6%)
It would be embarrassing to me if I tried to quit smoking using outside help.	9 (18%)	8 (16%)	18 (35%)	14 (28%)	2 (4%)
Most of the people I spend time with are smokers.	9 (18%)	16 (31%)	14 (28%)	9 (18%)	3 (6%)
It would take a pretty serious medical problem to make me quit smoking.	7 (14%)	10 (20%)	15 (29%)	12 (24%)	7 (14%)

B6. Does anyone, including you, smoke regularly inside your home? (N=51)

	N	%
Yes	13	26%
No	38	75%

B7. Which option best describes the rules about smoking inside your home? (N=51)

	N	%
Smoking is not allowed anywhere inside my home	36	71%
Smoking is allowed in some places or at some times	10	20%
Smoking is allowed anywhere inside my home	5	10%

B8. In the past 7 days, have you been in a car or other vehicle where someone was smoking? (N=51)

	N	%
Yes	29	57%
No	22	43%
I'm not sure	-	-

Efforts to quit smoking

B9. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? (N=51)

	N	%
Yes	35	69%
No	16	31%

B10. People have various reasons for trying to quit smoking. In your most recent attempt to quit smoking, how important was each of the following reasons to you? (N=35)

	Very important	Somewhat important	Not very important	Not at all important	I'm not sure
To improve my health	31 (89%)	4 (11%)	-	-	-
To reduce my risk of disease	30 (86%)	4 (11%)	-	-	1 (3%)
To protect the health of family members	29 (83%)	5 (14%)	1 (3%)	-	-
To feel better about myself	25 (71%)	8 (23%)	1 (3%)	0 (0%)	1 (3%)
To stop spending money on cigarettes	24 (69%)	8 (23%)	2 (6%)	0 (0%)	1 (3%)
To look or feel more attractive	18 (51%)	8 (23%)	5 (14%)	3 (9%)	1 (3%)
Because of smoking restrictions at home, work, or other places (N=33)	15 (46%)	4 (12%)	8 (24%)	4 (12%)	2 (6%)
To please someone who matters to me	15 (43%)	10 (29%)	2 (6%)	6 (17%)	2 (6%)
A reason not listed here (please list the reason) (N=19)	6 (32%)	0 (0%)	2 (11%)	2 (11%)	9 (47%)

Note. Other reasons included pregnancy or the pregnancy of a family member.

B11. Thinking back to the last time you tried to quit smoking, did you use any of the following strategies? (Check all that apply) (N=34)

	N	%
Stopping "cold turkey" without any medicine or formal help	29	85%
Help or support from friends or family	14	41%
Nicotine replacement products such as patches, gum, or lozenges	10	29%
Books, pamphlets, videos, or other materials	6	18%
One-on-one counseling	6	18%
Resources on the internet	6	18%
A stop smoking clinic, class, or support group	5	15%
Consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional	6	18%
A phone app	4	12%
A text message quit program	4	12%
Acupuncture	2	6%
A telephone help line or quit line	2	6%
Prescription medications such as Wellbutrin, Zyban, or Buproprion	1	3%
Hypnosis	1	3%
Other (please specify)	2	12%

Note. Other responses included using e-cigarettes and cutting down gradually.

B12. Do you now smoke cigarettes every day, some days, or not at all? (N=50)

	N	%
Everyday	20	40%
Some days	18	36%
Not at all	12	24%

B13. Please select the extent to which you agree or disagree with the following statements: (N=36-38)

	Strongly agree	Agree	Disagree	Strongly disagree	I'm not sure
I would set a good example for others such as children if I quit smoking.	28 (74%)	5 (13%)	3 (8%)	1 (3%)	1 (3%)
I would reduce my risk of getting health problems such as heart disease, emphysema, and stroke if I quit smoking.	27 (73%)	9 (24%)	1 (3%)	-	-
I would have more hope for living a healthy life if I quit smoking.	26 (70%)	7 (19%)	4 (11%)	-	-
I would have a lot more money to spend on other things instead of cigarettes if I quit smoking.	20 (53%)	13 (34%)	5 (13%)	-	-
I would have more energy to do the activities I enjoy if I quit smoking.	19 (51%)	10 (27%)	6 (16%)	1 (3%)	1 (3%)
I would respect myself more if I quit smoking.	17 (46%)	11 (30%)	6 (16%)	3 (8%)	-
I would do less harm to family and friends because they won't have to breathe my smoke if I quit smoking.	17 (45%)	14 (37%)	5 (13%)	2 (5%)	-
My friends and family members have often encouraged me to quit smoking.	15 (42%)	14 (39%)	6 (17%)	1 (3%)	-
I would breathe more easily within weeks if I quit smoking.	14 (37%)	20 (53%)	2 (5%)	1 (3%)	1 (3%)
My friends and family members don't want other people to smoke around them.	13 (34%)	19 (50%)	1 (3%)	1 (3%)	4 (11%)

B14. Which of the following statements best describes you now? (N=38)

	N	%
I am currently trying to quit or cut down on my tobacco smoking	17	45%
I plan to quit smoking soon, in the next six months	9	24%
I think I should quit smoking someday, but not in the next six months	8	21%
I don't think about quitting smoking tobacco	4	11%

B15. The next time you decide to quit smoking, what method do you think you'll use? (Mark every method you're seriously considering using.) (N=34)

	N	%
Stopping "cold turkey" without any medicine or formal help	20	59%
Nicotine replacement products such as patches, gum, or lozenges	14	41%
One-on-one counseling	14	41%
A stop smoking clinic, class, or support group	11	32%
Help or support from friends or family	10	29%
Resources on the internet	8	24%
A text message quit program	8	24%
A telephone help line or quit line	7	21%
Books, pamphlets, videos, or other materials	6	18%
A phone app	5	15%
Prescription medications such as Wellbutrin, Zyban, or Buproprion	5	15%
Acupuncture	2	6%
Consultation with a medicine man (curandero), santero, spiritist (espiritista), herbalist (yerbero), religious leaders (priest, pastor, rabbi, etc.) or other non-health professional	2	6%
Hypnosis	2	6%
I do not intend to quit smoking	1	3%
Other (please specify)	1	3%

Note. Other responses were exercise.

B16. If you decide to quit, would a program run specifically for Latino people make you feel more confident about quitting? (N=34)

	N	%
Yes	26	77%
No	2	6%
I don’t have a preference/I’m not sure	6	18%

Health care and mental health

B17. In the past 12 months, have you seen a doctor, nurse, therapist, or counselor to get a check-up or any kind of care for yourself? (N=51)

	N	%
Yes	34	67%
No	17	33%
I'm not sure	-	-

B18. Do you currently have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medical Assistance, Medicare, Indian Health Services, or any plan through MNsure? (N=51)

	N	%
Yes	36	71%
No	14	28%
I'm not sure	1	2%

B19. How comfortable would you be asking a doctor or health care provider for help to stop smoking? (N=51)

	N	%
Very comfortable	28	55%
Somewhat comfortable	8	16%
Somewhat uncomfortable	7	14%
Very uncomfortable	1	2%
I do not currently have a doctor or health care provider	5	10%
I'm not sure	2	4%

B20. Which of the following do you go to for important health information? (Check all that apply) (N=51)

	N	%
Doctors or hospitals	37	73%
Friends or family	27	53%
Internet	27	53%
General interest magazines and newspapers	17	33%
Health magazines	15	29%
Television	13	26%
Newspapers and magazines targeted to the Latino community	10	20%
Health product stores	9	18%
Radio	9	18%
A community-based organization or church	8	16%
Buses or other public transportation	2	4%
Other (please describe place)	0	0%

B21. During the past 30 days, how often did stress, depression, a problem with emotions, excessive worrying, or troubling thoughts keep you from doing your usual activities, such as work, recreation, and taking care of yourself? (N=51)

	N	%
None of the time	4	8%
Some of the time	32	63%
Most or all of the time	14	28%
I'd prefer not to answer	1	2%
I'm not sure	0	0%

B22. Have you ever been told by a doctor or other health professional that you have a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis? (N=51)

	N	%
Yes	29	57%
No	15	29%
I'd prefer not to answer	2	4%
I'm not sure	5	10%

B23. Are you currently taking any medication that was prescribed for you to treat a mental health problem, such as depression, anxiety, PTSD, or some other diagnosis? (N=51)

	N	%
Yes	10	20%
No	38	75%
I'd prefer not to answer	2	4%
I'm not sure	1	2%

About you

B24. What is your gender? (N=51)

	N	%
Female	26	51%
Male	24	47%
Transgender M → F	-	-
Transgender F → M	-	-
Queer	1	2%
Another gender (Please specify)	-	-
I'm not sure	-	-

B25. What is your sexual orientation? (N=50)

	N	%
Gay	9	18%
Lesbian	1	2%
Bisexual	0	0%
Heterosexual or straight	37	74%
Another sexual orientation (please specify)	1	2%
I'm not sure	2	4%

Note. The respondent who identified as "another sexual orientation" specified "queer."

B26. What is your age? (N=51)

	N	%
18 or younger	-	-
19-24	4	8%
25-34	20	39%
35-44	14	28%
45-54	7	14%
55-64	4	8%
65-74	2	4%
75 or older	-	-

Appendix C: Listening session protocol

Thank you for taking the time to talk with me today about smoking. This listening session is part of a health assessment CLUES is doing about tobacco use and smoking cessation needs among Latinos who also identify themselves as LGBTQ or as experiencing mental health concerns.

Today we'll be asking you questions about smoking, including where and when you're most likely to smoke and some of the reasons you smoke. We'll also some questions about quitting smoking, including what makes it hard to quit smoking and any strategies you may have used to try to quit smoking in the past. We'll also be talking where you go to for information about your health, and what resources you know of or would like to see in your community to help with quitting smoking. The information from these listening sessions will help CLUES learn about how they can better support and connect Latino residents with resources to quit smoking.

Privacy

Please know that your participation in this focus group is voluntary, and you can still participate even if you do not plan on quitting smoking. Participating in this discussion will not affect any services you receive from [ORGANIZATION] or CLUES.

Your responses will be kept private. Your names will not be on the notes from these conversations. We will be working with Wilder Research to develop a report summarizing information notes from the conversations. The report may include some quotes from today's conversation, but your comments will be put together so that no one will know what any one person said. Your names will not be included in the report.

I would like to record this conversation so that I can accurately reference what you say. Is that okay?

Ground rules

We want to be able to hear from all of you, so please share your thoughts and also make sure to give everyone else a chance to talk and share their views. You do not have to answer each question. There are no right or wrong answers to any of these questions and so we invite you to speak openly about your perspectives and opinions.

Please be respectful of everyone's comments today and keep their thoughts private as well. Comments shared here today should not be repeated to anyone outside of this group.

Do you have any questions before we start? If there is nothing further, let's start our discussion.

Let's start by doing quick introductions around the circle. Please share your name and one of your favorite things to do during the summer. (Who would like to start?)

For the rest of this discussion, you can answer the question in any order, just as you would in any discussion. Today we'll be talking about smoking, which includes products like cigarettes, cigars, pipe tobacco, and flavored tobacco. If you use other types of tobacco that you do not smoke, such as such as snuff or chewing tobacco, you are also welcome to share your experience. For today's discussion, smoking does not include the use of other drugs such as marijuana.

1. Why did you start smoking? What are some of the reasons you continue to smoke? [Probes: What do you like about smoking? When are you most likely to smoke? Are there certain situations or times of day when you are most likely to smoke?]

2. How do your friends and family feel about you smoking? Does that make a difference in when or why you smoke?

3. What, if anything, are some things you don't like about smoking?

4. What comes to mind when you think about quitting smoking? What makes it difficult to quit smoking? [Probes: If you have tried to quit smoking, what were some challenges you faced in trying to quit? If you did quit smoking, what might make it tempting to start again?]

5. If you were planning to quit smoking, what would make it easier for you? Are there any resources or services that you would plan to use?

6. What types of resources or services do you know about to help with quitting smoking? How did you hear about these resources? Where else would you look or who else would you go to for information about quitting smoking?

7. Are the resources and services you've seen available for people who want to quit smoking relevant to your experience? Are they easy to access? What changes would you make to these services or supports to make them more relevant to your experience or easier to access?

8. What could CLUES do or offer to make it easier for you to quit smoking?

Is there anything else you would like to share?

Thank you!

Appendix D: Community leader key informant interview protocol

Thank you for taking the time to talk with me about tobacco use in your community. You may already know, smoking rates are disproportionately higher among residents who identify as LGBTQ or who experience mental health problems than for the population overall. This interview is part of a health assessment CLUES is doing about tobacco use and smoking cessation needs among Latino residents who also identify themselves within either of these populations. The information from these interviews will help CLUES learn about how they can better support local organizations, health care professionals, and mental health providers in connecting Latino participants with culturally appropriate and personally relevant smoking cessation resources.

This interview should take about an hour and is voluntary and confidential. If there are questions you don't want to answer, just let me know and I will skip them. CLUES is working with Wilder Research to help summarize the findings from these interviews, and Wilder Research will put together the information from these interviews in a report that will be shared with CLUES. Your answers will not be seen by anyone except the staff from CLUES and Wilder Research who are working on the assessment. We will not include any names or personal information in that report.

I would like to record this conversation so that I can accurately reference what you say. Is that okay?

Do you have any questions before we begin?

1. You were invited to participate in this interview because you were identified by CLUES as a leader in your community who could speak to the priorities and experiences of [ex. people in the LGBTQ community]. Can you briefly talk about your work or other personal/professional experience with this population?

2. As we continue through the interview, please continue to think specifically about people you work with who identify themselves as LGBTQ Latinos or Latinos with mental health concerns.

3. What types of tobacco use do you see among [people in this community]? How common and accepted is smoking among [people in this community]? [Probes: Do people mostly smoke cigarettes or do they use other types of tobacco, such as e-cigarettes or chewing tobacco? Are they more likely to smoke regularly or to smoke socially/in specific settings? Does age have any impact on preference/behavior? Have you noticed any trends in tobacco use or acceptance of smoking over the last few years?]

4. From your perspective, what factors contribute to smoking among [people in this community]? [Probe: What, if any, factors specific to this community contribute to smoking?]

5. What do you see as the main barriers to quitting smoking for the [people in this community]? [Probe: What, if any, factors related to being a member of this community, contribute to barriers to quitting smoking?]

6. How familiar are you with available smoking cessation resources? To what extent are people [in this community] aware of these resources? How do people hear about available resources? [Probe: Who is not being reached by current outreach efforts?]

7. To what extent do people use existing smoking cessation resources? What would help people use existing smoking cessation resources more?

8. To what extent are the available smoking cessation resources culturally appropriate and personally relevant to [this population]? How could available resources be improved to be more culturally appropriate and personally relevant to [this population]?

9. From your experience working with people [in this community], what types of cessation programs or supports would be most appropriate or effective [with this population]? Some examples include medications or products like nicotine patches or lozenges, telephone quit line or text message support, classes or support groups, one-on-one counseling, consultation with religious leaders or other non-health related professionals, books or pamphlets, or resources on the internet. [Probe: How do you know that they might be effective?] What types of programs or supports would be less appropriate or effective?

10. What, if any, additional supports or programs would help [people in this community] quit smoking?

11. Is there anything else that you think we should know about as we work to increase awareness and access and improve smoking cessation resources for [this community]?

Is there anything else you'd like to share?

Thank you for your time!

Appendix E: Mental health professional key informant interview protocol

Thank you for taking the time to talk with me about tobacco use among clients or patients you work with and any smoking cessation resources or supports you may offer. As you may already know, smoking rates are disproportionately higher among residents who identify as LGBTQ or who experience mental health problems than for the population overall. This interview is part of a health assessment CLUES is doing about tobacco use and smoking cessation needs among Latino residents who also identify themselves within either of these populations. The information from these interviews will help CLUES learn about how they can better support local organizations, health care, and mental health providers in connecting Latino participants with smoking cessation resources.

This interview should take about an hour and is voluntary and confidential. If there are questions you don't want to answer, just let me know and I will skip them. CLUES is working with Wilder Research to help summarize the findings from these interviews, and Wilder Research will put together the information from these interviews in a report that will be shared with CLUES. Your answers will not be seen by anyone except the staff from CLUES and Wilder Research who are working on the assessment. We will not include any names or personal information in that report.

I would like to record this conversation so that I can accurately reference what you say. Is that okay?

Do you have any questions before we begin?

1. I understand that your organization provides services to individuals with mental health needs. Do many of the people you serve also identify themselves as Latino or as part of the LGBTQ community? Can you briefly describe the reasons that residents seek services from your organization?

2. As we continue through the interview, please continue to think specifically about participants you work with who identify themselves as LGBTQ Latinos or Latinos struggling with mental health issues.

3. How common is tobacco use among the participants you work with? What types of tobacco use do you see among participants? [Probes: Do participants mostly smoke cigarettes or do they use other types of tobacco, such as e-cigarettes or chewing tobacco? Are participants more likely to be regular smokers or to smoke socially?]

4. What do you see as the main barriers to smoking cessation for the participants with whom you work?

5. Do you routinely ask participants if they smoke?

   If yes → How is that built into your work with participants?

   If no → In what situations are you less likely to ask participants about smoking? [Probe: What might keep staff from asking participants about tobacco use?]

6. If a client or patient mentions that they smoke, do you assess their readiness to quit? Why or why not? Do you talk with them about smoking cessation? Why or why not?

7. What, if any, smoking cessation resources do you refer participants to? What, if any, smoking cessation resources does your organization offer? [Probe: Are there any needs of participants you work with related to smoking cessation that fall outside of what you are currently able to offer or refer people to? If so, please describe.]

8. What challenges do you face in referring people to smoking cessation programs?

9. What would make it easier for you to talk to participants about smoking cessation? [Probe: What changes could be made to internal policy or practice to make it easier to talk with participants about smoking cessation? What resources or supports would be helpful for you in referring people to smoking cessation programs?]

10. From your experience working with participants, what types of cessation programs or supports have you found to be most appropriate or effective? [Probe: How do you know that they are effective?] What types of programs or supports are less appropriate or effective?

Is there anything else you'd like to share?

Thank you for your time!

Appendix F: Evaluation questions and data collection methods

The following table describes the data collection methods used to answer each of the evaluation questions.

	Data collection method			
Evaluation question	**Survey**	**Listening sessions**	**Interview – mental health professionals**	**Interview – community leaders**
What are participants' beliefs and behaviors around cigarette smoking?	X	X	X	X
What strategies have and have not been successful in helping participants quit? To what extent are participants aware of available resources?	X	X	X	X
How do cultural factors and social determinants impact participants' smoking beliefs and behaviors, and interest in and likelihood of quitting?	X	X	X	X
What types of services or interventions would help participants with smoking cessation?	X	X	X	X
What types of communications strategies or channels would be most effective in supporting smoking cessation for each population?	X	X	X	X
To what extent do mental health professionals serving the Latino community assess smoking and readiness to quit in clinical sessions? What factors contribute to whether or not mental health professionals talk to clients about smoking cessation?			X	
To what extent are mental health professionals aware of available smoking cessation resources?			X	
What supports would help mental health professionals talk to clients about smoking cessation?			X	