

# **If We Build It, Will They Come? Challenges of Adapting and Implementing a Smoking Cessation Program for the LGBTQ Community in Southcentral Texas**

## **Abstract**

Studies indicate that tobacco use among LGBTQ community members is consistently higher than the general population. The Centers for Disease Control and Prevention has identified possible reasons for the increased smoking risk including discrimination, social bonding within the bar culture, reduced access to quality healthcare, targeted tobacco industry marketing, and status quo acceptance by LGBTQ organizations. *The Last Drag* is a tobacco-cessation program developed and implemented in 1991 in San Francisco, California which has shown promise in assisting LGBTQ members with tobacco cessation. This article describes the practical challenges of adapting *The Last Drag* to be implemented in a southcentral Texas community. Primary challenges included limited funding, short timeline to expected implementation, issues with culturally insensitive language, and barriers to participant recruitment. Acknowledging and overcoming these challenges can assist public health educators who are addressing tobacco cessation in populations who may face marginalization and discrimination based on sexual orientation or gender identity.

**Keywords:** smoking cessation, LGBTQ, health promotion programs, program adaptation

## Introduction

Compared to heterosexual populations, people who identify as LGBTQ experience higher prevalence of cigarette smoking, face increased smoking-related risk factors such as prejudice and stigma, and are less likely to access health care and cessation services (Buchting et al., 2017; CDC, 2015; CDC, 2018; Hoffman, Delahanty, Johnson, & Zhao, 2018; Smalley, Warren, & Barefoot, 2016). Tobacco-related disparities and contributing factors are likely under-reported, as many surveillance systems ask only a limited set of items, if any, related to sexual orientation or gender identity (Patterson, Jabson, & Bowen, 2017). Additionally, the LGBTQ community has also been the target of tobacco industry marketing attempts to normalize smoking behaviors. Within this context, the CDC has identified the LGBTQ community as a priority population for tobacco control efforts (CDC, 2015). LGBTQ-specific cessation programs were ranked among the most favored interventions by members of this community (Bryant, Damarin, & Marshall, 2014), while two of the most important cessation program attributes sought by LGBTQ youth and young adults are that a program be LGBTQ-specific and offers LGBTQ peer support (Baskerville et al., 2018). This paper examines the challenges experienced with adoption and implementation of an LGBTQ-specific cessation program in a southcentral Texas community.

In our capacity as public health education faculty at a state university with experience in tobacco prevention and substance abuse research, the authors of this paper were approached by officials from the Texas Department of State Health Services (DSHS) with a request to accept unsolicited grant funds to implement a pre-selected LGBTQ-specific smoking cessation program in southcentral Texas. We agreed to receive the funds and serve as the lead facilitators of the program. The program selected, *The Last Drag*, was a six-week program developed by the Coalition of Lavender-Americans on Smoking and Health (CLASH) in San Francisco in 1991.

*The Last Drag* was developed to offer a low-cost, group support intervention for tobacco cessation to LGBTQ populations (Baskerville et al., 2017; Eliason, Dibble, Gordon, & Soliz, 2012). The lesson themes and topics for each are presented in Table 1 (Soliz, 2015).

The seven program sessions were designed to be delivered in six weeks with session four occurring 48-72 hours after session three. Each session included specific activities, handouts, and topics to be explored in the group setting with session three serving as the intentional quit date and subsequent sessions focusing on support for quit maintenance.

[Insert Table 1 here]

*The Last Drag* has been shown to increase quit rates among LGBTQ populations in both California and Colorado (Eliason et al., 2012; Walls & Wisneski, 2011), but it was not clear how well this intervention would work in other regions (Burkhalter, 2015; Lee, Matthews, McCullen, & Melvin, 2014). No published reports existed of the program's adoption in a more politically conservative region like southcentral Texas. While *The Last Drag* curriculum had been revised in prior implementation sessions in other regions of the U.S. (Baskerville et al., 2017), adapting the program to deliver culturally relevant and appropriate sessions was a significant challenge for the program facilitators in southcentral Texas. The local implementation of *The Last Drag* in this particular Texas community faced significant challenges which led to an overall failed program implementation and very little impact on the local priority population. These challenges are shared with hopes that other health educators and tobacco cessation practitioners in similar situations may recognize some of the early barriers and more effectively address these issues prior to an implementation attempt. The following sections share these challenges, which

included inadequate pre-implementation planning, cultural sensitivity issues with program components, and failure to appropriately recruit participants.

### **Challenges and Lessons Learned**

As stated, the funds were earmarked by the Tobacco Prevention and Control Branch of DSHS for LGBTQ tobacco cessation and *The Last Drag* was pre-selected as the intervention. Implementation of the program in southcentral Texas was assigned to public health education faculty at Texas State University with one senior and two mid-career faculty researchers serving as program facilitators. Prior to participant recruitment and implementation, each facilitator attended a program training session led by staff from the Texas Comprehensive Cancer Control Program. This training provided an overview of the curriculum, as well as guides on data collection processes and project timelines. While the local facilitators were each practiced in community health programming and tobacco prevention, they had limited experience working with an LGBTQ priority population for tobacco cessation services. This proved a major barrier from the outset of the planning stages.

**Pre-Implementation Challenges.** As evidenced by prior successful implementations, *The Last Drag* curriculum was appropriately designed and utilizes many traditional health promotion strategies commonly used in behavior change interventions including development of outcome expectations, behavioral contracts, and assertive communication (Soliz, 2015). However, a significant problem in the pre-planning phase was the selection of this program without any state- or community-specific needs assessment. The small amount of funding allocated to this project (~\$5,000) and the short timeline to implementation (~1 month) were significant barriers which precluded a comprehensive assessment taking place prior to implementation.

Conducting an appropriate and comprehensive needs assessment is a time- and resource-consuming task and should be an essential component of public health programming (Pennel, McLeroy, Burdine, and Matarrita-Cascante, 2015). The program facilitators did recognize this challenge yet overestimated their ability to successfully recruit participants from the local LGBTQ community and offer a sustainable cessation program. Had a formal assessment taken place, facilitators may have been able to more effectively examine need-related data, develop community partnerships, and identify appropriate stakeholders and gatekeepers in the local community. The impact of community input in the assessment process cannot be overstated, as this often shapes not only the prioritized needs, but also the direction for future program goals and objectives and the development of sustainable partnerships and community buy-in (Bias, Abildso, Vasile, & Coffman, 2017).

Due to the unsolicited nature of this funded program and the lack of an appropriate assessment of localized tobacco-related data, it is possible that the need for LGBTQ-specific smoking cessation services was overestimated. State officials selected the region due to the visibility of the local LGBTQ communities and a perception that the program would be necessary, yet the lack of evidence indicating level of need, interest, or community readiness was highly problematic. While a local community health needs assessment is publicly available, it did not examine tobacco as a behavioral risk and does not include LGBTQ-specific data (Ascension Seton, 2019).

The importance of a pilot study or pre-testing phase is well-documented (Bell, Whitehead, & Julious, 2018), yet, as often happens in practice, the circumstances of a project may dictate that this phase be omitted. The short timeline expectation for implementation also meant that a formal pilot testing period was not implemented. This proved a major barrier as

program facilitators were unable to explore implementation protocol or program acceptability prior to offering the first official program session. In lieu of a pilot phase, facilitators did attempt to examine the curriculum for cultural sensitivity prior to implementation by meeting with local members of the LGBTQ community and staff from the local university's Office of Student Diversity and Inclusion. Modifications to the program were suggested, particularly as it related to culturally-specific language used in some program activities.

**Culturally Sensitive Language.** After the initial DSHS training, program facilitators attended a second workshop called “Allies” training offered by the local university's Office of Student Diversity and Inclusion. This workshop, delivered by university faculty and students who identify as members of the local LGBTQ community, included training on the elements of being an LGBTQ Ally (awareness, education, skills, action), using gender neutral language, examining stereotypes, avoiding patronizing individuals from different groups, among other issues specific to working with LGBTQ persons. As part of this workshop, the Allies staff examined the program curriculum and expressed concerns with the cultural relevancy of some program activities, particularly those with potentially insensitive language. For example, an icebreaker activity used in session one of the program was called “Bunch of Fruits”. The activity simply used physical fruit as an item to trigger discussions related to perceived challenges of quitting smoking among the participants. For example, if a participant selected an apple then, using the letter A, the facilitator could stimulate conversation by asking the participant “How has smoking affected your life so far?” If a participant selected a banana, the facilitator may ask, “What barriers do you anticipate encountering when you quit smoking?” Despite the perceived benign nature of the activity, Allies staff strongly advised against offering the activity and

suggested that the use of the term “fruit” may be highly insulting to program participants, particularly in an introductory session.

Likewise, the program curriculum included a group session game called “Queer Lives in Jeopardy” which was an educational activity sharing tobacco-related statistics specific to California LGBTQ populations. Allies staff similarly noted that in this region of southcentral Texas, many people still use and identify the term “queer” as insulting to LGBTQ persons. There is a long history of the various words being used as an insult to gay men and despite recent attempts to reclaim the use of offensive terms (Cheves, 2017; Robinson, 2017), these terms were perceived to be very insulting to members of the LGBTQ population. While the terms may be considered derogatory to individuals in many areas, Allies staff and program facilitators felt this to be a major issue locally as Texas is considered one of the worst states for LGBTQ equality in the U.S. (Movement Advancement Project, 2015).

To address these language issues during these program, problematic activity language was changed using culturally appropriate terms; for example, rather than using fruit, facilitators adapted the activity to use colored sheets of paper and used the same letter-matching strategy to generate questions for discussion. The “Queer Lives in Jeopardy” activity was amended to “Our Lives in Jeopardy” along with updated the activity to use more regionally specific data. While these changes were relatively simple, they may not have occurred without assistance from the local Allies staff. When health educators plan to work with specific marginalized communities, it is essential to minimize culturally insensitivity in language, activities, and other strategies to improve health services (Tucker, Arthur, Roncoroni, Wall, & Sanchez, 2015).

**Recruitment Barriers.** While the participating institutions and surrounding community do have visible LGBTQ populations, participant recruitment proved extremely difficult. To

recruit student participants, program facilitators collaborated with university-affiliated LGBTQ organizations, a student health advocacy group, and two student support centers. To recruit community members, program facilitators contacted the two local LGBTQ groups, as well as a local LGBTQ-friendly bar. In addition to these LGBTQ-specific organizations, program facilitators also recruited participants through regional substance use treatment and prevention organizations, community health coalitions, and local employee wellness programs. Printed flyers, social media posts, and digital campus announcements were made through each outlet highlighting the availability of *The Last Drag* program and noting that participation was free of cost. All recruitment materials included LGBTQ-friendly imagery and stated explicitly that the program was designed for the LGBTQ community. Despite the recruitment efforts, program participation was very limited with only one participant fully completing the seven-session curriculum.

Additionally, program facilitators initially approached a local community center with a proposal to host cessation services at the community site since community-based organizations can play a key role in LGBTQ health service administration (Berger & Mooney-Somers, 2017). However, funding was insufficient to support this implementation site and the short timeline for implementation were deemed too challenging for center participation. Ultimately, facilitators decided to host the cessation services on the university campus in a strategic area with easy access for off-campus community participants. The building site where the program was located sits on the outskirts of campus with easily accessible non-resident parking. Nonetheless, the implementation site may have served as a major barrier as hosting cessation services at an off-campus health center who prioritize LGBTQ populations may have increased community trust in the program and reduced the transportation barriers of coming to the local university campus.



Several other issues may have contributed to the failure in participant recruitment. First, literature has described the challenges some members of the LGBTQ community face when choosing to come out in public organizations (Benozzo, Pizzorno, Bell, & Koro-Ljungberg, 2015). After the first round of recruitment and implementation, program facilitators realized that in order to participate in the program, participants were being asked to openly identify themselves as a member of the LGBTQ community which has been suggested is a major barrier in recruitment for tobacco cessation services (Baskerville et al., 2017). Despite the existing community resources, there may still be a significant portion of the local LGBTQ population that is hesitant to seek needed health services that will cause them to “come out by proxy”. In a state like Texas where partisan politics and public policies restrict healthcare access (e.g., lack of Medicaid expansion, Medicaid work requirements, lack of laws that prohibit discrimination based on sexual orientation or gender identity), social pressures of identifying as an LGBTQ member may be increased, making it difficult for a person to seek the services necessary for health improvement if those services openly identify an LGBTQ priority population. Research has indicated LGBTQ persons experience less access to health care (Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2018; Mizra, 2018), while some members of the LGBTQ community such as those who identify as transgender, may experience even more difficulty with access in regions where practitioners may not be culturally competent or where the patient may face societal stigma based on their gender identity (Shafer et al., 2016; White-Hughto, Murchison, Clark, Pachankis, & Reisner, 2016).

### **Implications for Practice**

Future smoking cessation programs that prioritize marginalized communities, particularly in regions where healthcare access may be limited by partisan healthcare policies, should

consider implementation approaches that will maximize the utility of cessation services. Sexual minorities experience significant disparities related to healthcare (Gonzales & Henning-Smith, 2017; Gonzales, Przedworski, & Henning-Smith, 2016) including tobacco disparities (McCabe et al., 2019), so tobacco cessation services targeting the LGBTQ community should be properly planned, developed, and pilot-tested prior to implementation. This includes developing and implementing suitable procedures for a comprehensive assessment of needs and readiness, as well as developing collaborative partnerships with local community gatekeepers and stakeholders. Despite a program facilitators' professional experience in tobacco control and services, if one has not worked directly with marginalized communities, the importance of having a stakeholder to serve as a program champion is magnified (Mantovani, Pizzolati, & Gillard, 2017). Even health centers who routinely provide tobacco cessation to an LGBTQ population will experience implementation barriers (Lee et al., 2018), so facilitators with limited experience working with LGBTQ communities will need to develop an appropriate professional network to improve services.

When selecting evidence-based programs for implementation, a critical component is the cultural sensitivity relative to the local priority population. Although programs have shown success in generating positive health outcomes, social, cultural, and political factors may influence the implementation or acceptance of a program in local regions. This can be particularly true for programs targeting sexual minorities where issues such as language and terminology can have very different connotations in varying geographical regions of the U.S. Strategies to modify existing evidence-based programs to improve cultural competency include working with local program champions, establishing collaborative community partnerships,

evaluating cultural appropriateness of program curricula, and pilot testing the modified program (Samuels, Schudrich, & Altschul, 2009).

Social media recruitment strategies appear to be most successful in reaching LGBTQ populations for tobacco-related studies (Emory, Buchting, Trinidad, Vera, & Emery, 2019; Guillory et al., 2018). While program facilitators did use Facebook as a tool to reach out to LGBTQ community organizations, efforts could have been improved through the development of more-targeted recruitment as well as the use of additional social media outlets more commonly frequented by younger populations (e.g., Snapchat, Instagram). If a needs assessment had been conducted and appropriate gatekeepers identified, it is possible that social media outreach from these gatekeepers would have been more likely to generate interest or participation in the program. Program facilitators simply had not built enough trust with the priority population. Additionally, the delivery of online cessation services through the advancement of distance-meeting technologies such as Zoom or Skype may improve participation by improving access and reducing the likelihood of “coming out by proxy.”

There is a clear, documented need for initiatives which promote health equity in tobacco prevention and cessation services, particularly those which address the LGBTQ community (CDC, 2015). However, when unexpected funding opportunities arise, health educators may need to temper expectations if the necessary resources are limited and an inadequate amount of time is available to appropriately implement programs. Health educators should also recognize their own limitations related to implementation readiness. Refusing unsolicited funding may be a difficult choice in the current higher education landscape; however, it may ultimately be the best decision so that limited resources available are allocated to practitioners who have a better chance of impacting overall health of the communities being served.

## References

- American Lung Association. (2019). State of Tobacco Control 2019 – Texas. Retrieved from <https://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/state-grades/>.
- Ascension Seton. (2019). Community health needs assessment – South Region 1: Hays County. Retrieved from <https://www.seton.net/wp-content/uploads/2019/05/Hays-CHNA-May-2019.pdf>.
- Baskerville, N. B., Dash, D., Shuh, A., Wong, K., Abramowicz, A., Yessis, J., & Kennedy, R. D. (2017). Tobacco use cessation interventions for lesbian, gay, bisexual, transgender, and queer youth and young adults: A scoping review. *Preventive Medicine Reports*, 6, 53-62.
- Baskerville, N. B., Wong, K., Shuh, A., Abramowicz, A., Dash, D., Esmail, A., & Kennedy, R. (2018). A qualitative study of tobacco interventions for LGBTQ+ youth and young adults: Overarching themes and key learnings. *BMC Public Health*, 18(1), 155
- Bell, M. L., Whitehead, A. L., & Julious, S. A. (2018). Guidance for using pilot studies to inform the design of intervention trials with continuous outcomes. *Clinical Epidemiology*, 10, 153-157.
- Benozzo, A., Pizzorno, M. C., Bell, H., & Koro-Ljungberg, M. (2015). Coming out, but into what? Problematizing discursive variations of revealing the gay self in the workplace. *Gender, Work, and Occupation*, 22(3), 292-306.
- Berger, I., & Mooney-Somers, J. (2017). Smoking cessation programs for lesbian, gay, bisexual, transgender, and intersex people: A content-based systematic review. *Nicotine and Tobacco Research*, 19(12), 1408-1417.
- Bias, T., K., Abildso, C. G., Vasile, E. V., & Coffman, J. (2017). The impact of community input

- in community health needs assessments. *Journal of Public Health Management*, 23(4), s29-s33
- Bryant, L., Damarin, A. K., & Marshall, Z. (2014). Tobacco control recommendations identified by LGBT Atlantans in a community-based participatory research project. *Progress in Community Health Partnerships*, 8(3), 269-279.
- Buchting, F. O., Emory, K. T., Scout, Kim, Y., Fagan, P., Vera, L. E., Emery, S. (2017). Transgender use of cigarettes, cigars, and e-cigarettes in a national study. *American Journal of Preventive Medicine*, 53(1), e1-e7.
- Burkhalter, J. E. (2015). Smoking in the LGBT community in U. Boehmer & R. Elk (Ed.), *Cancer and the LGBT community: Unique perspectives from risk to survivorship*. (pp. 63-82). New York, NY: Springer.
- Cheves, A. (2017). 21 words the queer community has reclaimed (and some we haven't). Retrieved from <https://www.advocate.com/arts-entertainment/2017/8/02/21-words-queer-community-has-reclaimed-and-some-we-havent#media-gallery-media-1>.
- Centers for Disease Control and Prevention. (2015). *Best practices user guide: Health equity in tobacco prevention and control*. 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, Atlanta, GA.
- Centers for Disease Control and Prevention. (2018). Current cigarette smoking among adults – United States, 2016. *Morbidity and Mortality Weekly Report*, 67(2), 53-59.
- Eliason, M. J., Dibble, S. L., Gordon, R., & Soliz, G. B. (2012). The Last Drag: An evaluation of an LGBT-specific smoking intervention. *Journal of Homosexuality*, 59, 864-878.
- Emory, K., Buchting, F. O., Trinidad, D. R., Vera, L. , & Emery, S. L. (2019). Lesbian, gay,

- bisexual, and transgender (LGBT) view it differently than non-LGBT: Exposure to tobacco-related couponing, e-cigarette advertisements, and anti-tobacco messages on social and traditional media. *Nicotine and Tobacco Research*, 21(4), 513-522.
- Gonzales, G., & Henning-Smith, C. (2017). Health disparities by sexual orientation: Results and implications from the Behavioral Risk Factor Surveillance System. *Journal of Community Health*, 42(6), 1163–1172.
- Gonzales, G., Przedworski, J., & Henning-Smith, C. (2016). Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: Results from the National Health Interview Survey. *JAMA Internal Medicine*, 176(9), 1344–1351.
- Guillory J., Wiant, K. F., Farrelly, M., Fiacco, L., Alam, I., Hoffman, L.,...Alexander, T. N., (2018). Recruiting hard-to-reach populations for survey research: Using Facebook and Instagram advertisements and in-person intercept in LGBT bars and nightclubs to recruit LGBT young adults. *Journal of Medical Internet Research*, 20(6), e197.
- Hoffman, L., Delahanty, J., Johnson, S. E., & Zhao, X. (2018). Sexual and gender minority Cigarette smoking disparities: An analysis of the 2016 Behavioral Risk Factor Surveillance System data. *Preventive Medicine*, 113, 109-115.
- Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2018). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. Retrieved from <http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US>.
- Lee, J. G. L., DeMarco, M. E., Beymer, M. R., Shover, C. L., & Bolan, R. K. (2018). Tobacco-

- free policies and tobacco cessation systems at health centers serving lesbian, gay, bisexual, and transgender clients. *LGBT Health*, 5(4), 264-269.
- Lee, J. G. L., Matthews, A. K., McCullen, C. A., & Melvin, C. (2014). Promotion of tobacco use cessation for lesbian, gay, bisexual, and transgender people: A systematic review. *American Journal of Preventive Medicine*, 47(6), 823-831.
- Mantovani, N., Pizzolati, M., & Gillard, S. (2017). Engaging communities to improve mental health in African and African Caribbean groups: A qualitative study evaluating the role of community well-being champions. *Health and Social Care in the Community*, 25(1), 167-176.
- McCabe, S. E., Hughes, T. L., Matthews, A. K., Lee, J. G., West, B. T., Boyd, C. J., Arslanian-Engoren, C. (2019). Sexual orientation discrimination and tobacco use disparities in the United States. *Nicotine and Tobacco Research*, 21(4), 523-531.
- Mizra, S. A. (2018). Discrimination prevents LGBTQ people from accessing health care. Retrieved from <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>.
- Movement Advancement Project. (2015). Mapping LGBT equality in America. Retrieved from <https://transgenderlawcenter.org/equalitymap>.
- Patterson, J. G., Jabson, J. M., & Bowen, D. J. (2017). Measuring sexual and gender minority populations in health surveillance. *LGBT Health*, 4(2), 82-105.
- Pennel, C. L., McLeroy, K. R., Burdine, J. N., & Matarrita-Cascante, D. (2015). Nonprofit hospitals' approach to community health needs assessment. *American Journal of Public Health*, 105(3), e103-113.

- Robinson, P. (2017). Faggots, punks, and prostitutes: The evolving language of gay men. *The Conversation*. Retrieved from <https://theconversation.com/faggots-punks-and-prostitutes-the-evolving-language-of-gay-men-73136>.
- Samuels, J., Schudrich, W., & Altschul, D. (2009). *Toolkit for modifying evidence-based practice to increase cultural competence*. Orangeburg, NY: Research Foundation for Mental Health.
- Shafer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to health care for transgender individuals. *Current Opinion in Endocrinology, Diabetes, and Obesity*, 23(1), 168-171.
- Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2016). Differences in health risk behaviors across understudied LGBT subgroups. *Health Psychology*, 35(2), 103-114.
- Soliz, G. B. (2015). *The Last Drag: A lesbian/gay/bisexual/transgender/HIV positive stop smoking program facilitator guide*. Coalition of Lavender-Americans on Smoking & Health, San Francisco, CA.
- Tucker, C. M., Arthur, T. M., Roncoroni, J., Wall, W., & Sanchez, J. (2015). Patient-centered, culturally sensitive health care. *American Journal of Lifestyle Medicine*, 9(10), 63-77.
- Walls, N. E., & Wisneski, H. (2011). Evaluation of smoking cessation classes for the lesbian, gay, bisexual, and transgender community. *Journal of Social Service Research*, 37, 99-111.
- White-Hughto, J. M., Murchison, G. R., Clark, K., Pachankis, J. E., & Reisner, S. L. (2016). Geographic and individual differences in healthcare access for U.S. transgender adults: A multilevel analysis. *LGBT Health*, 3(6), 424-433.