

Smoking Out a Deadly Threat

Tobacco Use in the LGBT Community



Preface

The American Lung Association is committed to preventing lung disease and improving lung health. In particular, we are working to address the needs of those populations and communities that are disproportionately affected by lung disease. It is my pleasure to present this report on the burden of tobacco use on the lesbian, gay, bisexual and transgender (LGBT) community. I hope that this report—*Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community*—will help to spur individuals and organizations to raise awareness, take action, and reduce the uncommonly high smoking rate among LGBT individuals.

Smoking is the leading cause of preventable illness and death in the country. It is the primary cause of two of the deadliest lung diseases: lung cancer (which causes more American deaths than any other cancer), and chronic obstructive pulmonary disease (COPD), the fourth leading cause of death in the nation.

Since the smoking rate within the LGBT community is roughly double that of the general population, more members of the LGBT community are at greatly increased risk of these deadly diseases, as well as other tobacco-related health threats such as heart attacks and strokes. Tobacco's toll on this underserved community is far too great, and with this report, the American Lung Association calls for decisive action to better understand the root causes and find effective solutions to this deadly threat to the LGBT community.

Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community is the second report in the Disparities in Lung Health Series. Each report in the series will take an in-depth look at the needs of a population that bears an unequal burden of risk and disease. These reports build on the American Lung Association's long-standing mission to save lives by improving lung health and preventing lung disease for all Americans.



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Tobacco Use in the LGBT Community



Introduction

Reducing tobacco use remains a major public health imperative in the United States. Tobacco use is the number one cause of preventable disease and death in the United States, accounting for 393,000 deaths a year.¹ A growing body of evidence indicates that lesbian, gay, bisexual and transgender individuals are considerably more likely to use tobacco than the general population, with some studies estimating smoking rates as much as double the national average.

Although it's difficult to verify, it's estimated that lesbian, gay, bisexual and transgender (LGBT) individuals represent roughly 3 percent of the total population of the United States. They live in every state and county in the nation, and are part of every racial, ethnic, religious, age and socioeconomic group.² Although social conditions and public acceptance of the LGBT community have been slowly improving, it appears that they still face high levels of health disparities in a number of areas, tobacco use included. Reasons for this disparity may include the stresses of social stigma, peer pressure, aggressive targeting by the tobacco industry, and limited access to effective tobacco treatment. Unfortunately, most surveys and studies of health status and behavior do not collect information on sexual orientation and gender identity. This has created an information gap that makes it difficult to get a complete picture of the impact that tobacco has on the LGBT community.

To develop an effective public health response to this disparity, specific data is needed about lesbian, gay, bisexual and transgender people. However, enough information exists already to show that LGBT people should be treated as a priority population for tobacco control, similar to those racial and ethnic groups disproportionately affected by smoking. Specific interventions targeted to LGBT people are needed in order to help reduce the impact of tobacco use in this population. Since there are multiple reasons for this disparity, several different strategies are required to address the problem.

The American Lung Association calls on

states and the federal government to expand and improve data collection and reporting to provide an accurate picture of health conditions and behaviors, especially tobacco use, in the U.S. LGBT population. In addition, local and state tobacco control programs should engage with the LGBT community to ensure that they are included in programs to both prevent youth from starting to smoke and to help smokers quit. Finally, LGBT organizations should recognize tobacco use as a public health priority in their community, and should include tobacco control advocacy and programs in their scope of activities.

Definition of Terms

Bisexual	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with people of both sexes.
Gay	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with persons of the same sex. This term can be used for both men and women but is generally associated with men.
Gender	A socially-constructed category referring to specific characteristics such as appearance, behaviors and roles that distinguish between the categories of being a man or woman, boy or girl.
Gender identity	Refers to an individual's sense of belonging or not belonging to a gender category such as man or woman, boy or girl, queer, or transgender.
Lesbian	A woman who identifies as being sexually attracted to and/or engaging in sexual behavior with another woman.
LGBT	Lesbian, Gay, Bisexual and Transgender. Variations of this acronym are used to reflect relevant identities. For example, LGB is used when data reflects only lesbian, gay and bisexual respondents.
Queer	A more all-encompassing and politicized term to define gender and/or sexual identity used by men, women or transgender people who are sexually attracted to and/or engaging in sexual behavior with members of the same sex or gender.
Sex	The biological distinction between male and female.
Straight	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with persons of the opposite sex. This term is used for both men and women.
Transgender	Refers to an individual who identifies as belonging to an opposite or different gender category from the individual's biological sex.



Don't Ask, Don't Know

National and state surveys, as well as smaller research studies, routinely collect data about age, gender, race and ethnicity, income and education levels. This information shows if the people who were surveyed are similar to the population at large and allows for comparisons to be made between different groups. But questions about sexual orientation and gender identity are often not included. When information is collected, the lack of standardized questions and differences in study design make it difficult to combine data, and compare results.

There has been an assumption among some in the research community that survey respondents would be uncomfortable answering questions on sexual orientation or identity, and either refuse or answer untruthfully. Recent experience with surveys that have included such questions has shown that this fear is unfounded. In the Arizona Tobacco Survey's combined data set from 2002 and 2005, the sexual orientation question was well received, with roughly 92 percent of respondents providing a response.

By comparison, around 86 percent responded to the question on income.³ The state of Washington added a sexual orientation question to its Behavioral Risk Factor Surveillance Survey (BRFSS) in 2003. In a combined data set from 2003 through 2006, just 1.2 percent of men and 1.6 percent of women refused to answer that question and survey managers reported very few complaints about it.⁴ In New Mexico, the refusal rate for questions about sexual orientation is only 1 percent, compared to 5 percent for questions about household income.⁵

Definitions Vary

The relatively few tobacco use-related surveys and studies that attempt to include sexual orientation vary considerably in what information they collect, and how that information is used to classify respondents. This is important because the choice of how to define sexual orientation can have a substantial effect on the results. Some surveys ask respondents to *self-identify* as straight, gay, lesbian, or bisexual. Other surveys

ask about sexual *behavior*, including relationships and/or sexual contact with same-sex partners. Still other surveys ask respondents about their sexual *attraction* to each gender, regardless of whether the respondents have acted on any desire. Each of these questions would capture different groups from the survey respondents, and thus produce different results regarding the proportion of smokers.

Gathering information about transgender people is especially problematic. They often remain invisible in survey results because little progress has been made in developing reliable questions that can be used to identify transgender individuals in broad population-based surveys. Because of this and other limitations, many of the studies cited in this report focused only on gays, lesbians and bisexuals.⁶

An additional problem is the various ways studies measure smoking behavior. Some studies, for example, have defined a smoker as someone who has a cigarette on most days of the previous month, while others define a smoker as someone who has smoked even one cigarette in the last month. Even if the same group of people was surveyed, these two definitions would provide very different pictures of their smoking

behavior. This problem is not unique to studies of tobacco use in the LGBT community, but when combined with the problem of differing definitions of sexual orientation, it becomes quite difficult to make comparisons between studies and draw reliable conclusions.

Too Few Included

Until more national and state tobacco use surveys ask questions about sexual orientation and gender identity, the research and public health community has to rely primarily on information collected by smaller, often localized studies. Small numbers of participants, as well as regional differences, can unfortunately yield results that may not be representative of the nation at large. In addition, significant findings about small subsets of the study population, including transgender individuals and LGBT people of color, can be missed if too few participants were included in the study.⁷ It should be noted that a small number of studies have reported smoking rates in LGBT populations as no different or lower than in the general population.⁸ These findings are clearly at odds with the overall trend of national data and are likely due to random variation and differences in study methodology.



Validated Questions on Sexual Orientation and Gender Identity

While no consensus questions exist, the following questions have been validated in some capacity. To allow for comparison between surveys, the National LGBT Tobacco Control Network strongly urges the use of these questions in future initiatives.

Option 1 – Sexual orientation only

In 2005, LGBT researchers cognitively tested an LGB question for inclusion on surveys. Cognitive testing is the gold standard for developing a survey question because it can uncover many problems with interpretation that go undetected in less rigorous testing methods. This testing was in part spurred by the findings that a similar question on the National Health And Nutrition Examination Survey (NHANES) was subject to significant response error among low socioeconomic status and Spanish language respondents.^A

Thus be cautious about using any questions where the exact wording has not been subject to cognitive testing. The tested and recommended question is as follows.^{B,C}

Do you consider yourself to be:

- Heterosexual or straight
- Gay or lesbian
- Bisexual

Interviewer note: can code DK for "Don't know" or NA for "No answer".

Option 2 – Gender identity

Other strategies have also been used to capture transgender status. The following question has been successfully cognitively tested with youth. The report is currently in development.^D

Sex/gender

- Female
- Male
- Transgender male to female
- Transgender female to male
- Transgender do not identify as exclusively male or female
- Not sure

Option 3 – Tested combined sexual orientation and gender identity question^E

In 2007, Blue Cross and Blue Shield of Minnesota commissioned the National LGBT Tobacco Control Network to use state-of-the-art methods to cognitively test a single question for use on survey instruments that captured sexual orientation (lesbian, gay or bisexual) and gender identity (transgender). The question tested successfully with all population groups, including oversamples of both people of color and low-income respondents. The final successfully tested question is below.

[OPTIONAL QUITLINE PREFACE: "Several communities have been targeted by the tobacco industry or have higher smoking rates. We have some special materials for people in these communities so we'd like to ask you some demographic questions. Please remember your answers are completely confidential."]

Do you consider yourself to be one or more of the following: [Say the letter so that they can respond by letter.]

- A) Straight
- B) Gay or lesbian
- C) Bisexual
- D) Transgender

[IF pause or refusal/none of above, also say:
You can name a different category if that fits you better: _____]

Source:

Scout. 2008. LGBT Surveillance and Data Collection Briefing Paper. Online publication. Downloaded from National LGBT Tobacco Control Network website at <http://www.lgbttobacco.org/files/Surveillance%20Briefing%20Paper%2004.doc>. Last updated Sept 7, 2008

Citations

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- B. Sell R. Gay Data. www.gaydata.org. Accessed March 15, 2007.
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- E. Scout, Senseman S. Cognitive Testing of an LGBT Surveillance Question: National LGBT Tobacco Control Network; 2008.



Smoking Rates: What We Do Know

In spite of the data limitations discussed above, a growing body of evidence has shown that LGBT adults and youth are more likely to smoke than the population as a whole and more than straight people: sometimes a lot more. To evaluate the magnitude of the disparity in tobacco use between the LGBT community and the general population, it is helpful to look at smoking rates in the U.S. overall. In 2008, an estimated 46 million, or 20.6 percent of all adults age 18 and older, were current smokers. This reflects a decline in smoking rates by more than half over the last several decades, down from a high in 1965 of 42.4 percent. Men of all races and ethnicities smoke more than women. In 2008, 23.1 percent of all American men smoked, compared to 18.3 percent of women. The highest smoking rate of any racial or ethnic group is 42.3 percent for American Indian and Alaska Native men. The lowest rate is 4.7 percent for Asian and Pacific Islander women.⁹

Data Sources

The findings presented here come from a combination of research studies with results collected in several state surveys. In 2009, researchers reviewed 42 separate studies measuring smoking prevalence in gay, lesbian, and bisexual populations, including those with same sex attraction or relationships. They found a generally increased risk of cigarette smoking among these groups.⁸ We used this pooled data where available, but also went directly to some of the individual studies to illuminate specific points as needed.

A dozen or so states have collected sexual orientation information on routine health surveys. However, only 6 states have published reports on tobacco use by sexual orientation: Arizona, California, Massachusetts, New Mexico, and Oregon and Washington together. All 6 of these states found significantly elevated smoking rates in the LGBT community. Although these various sources can result in comparing “apples

to oranges”, this paper makes every effort to be clear about what exactly is represented by the data, including limitations on that data.

Gay Men

The 2009 review found that gay men had between 1.1 and 2.4 times the odds of smoking, compared to straight men. In California, gay men smoke at 1.4 times the rate of straight men, and in Washington the difference is just a little more.^{10,11}

Very little data are available by racial and ethnic background. One study that looked at gay and bisexual men together found elevated smoking rates among whites and Hispanics, but not among Native Americans or Asian/Pacific Islanders.¹²

Lesbians

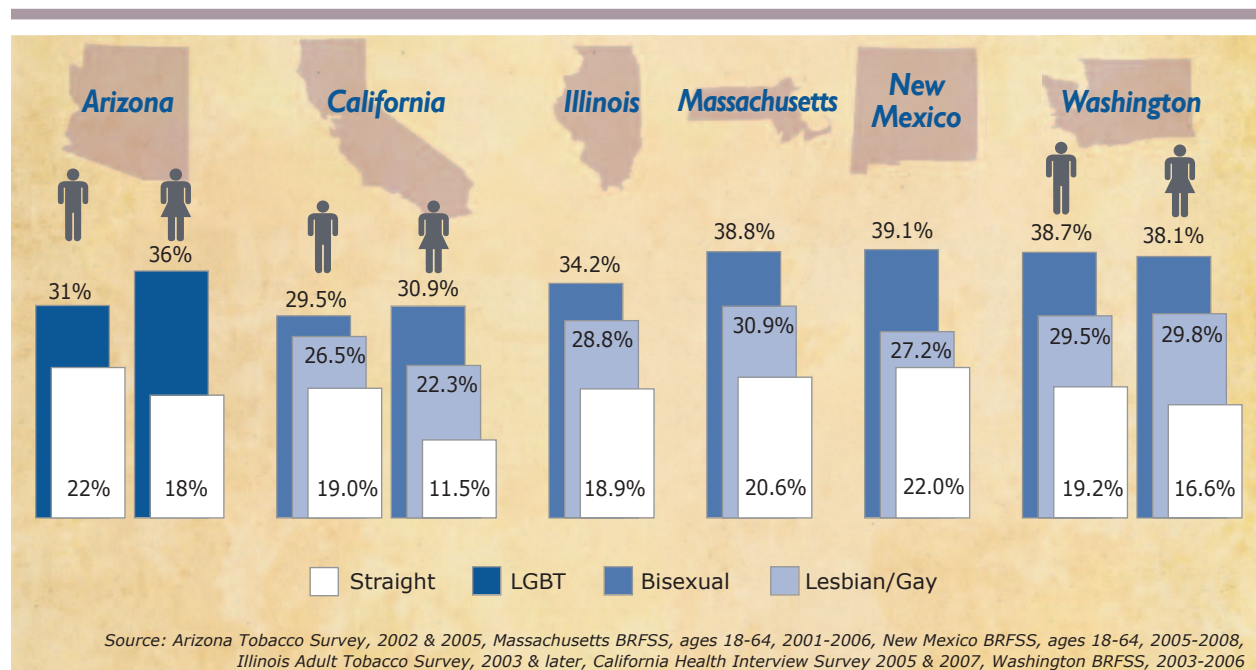
The 2009 review found that for the most part lesbians had between 1.2 and 2.0 the odds of smoking compared to straight women. Older women were found to smoke less than younger women, and researchers speculated that the younger women were more likely to socialize in bars, which might explain the difference. Arizona, California and Washington all reported that lesbian women had higher smoking rates than men.^{13,10,11}

Bisexuals

On the whole, bisexual men and women seem to have the highest smoking rates of any subgroup for which data is readily available. All of the state surveys that collected data on bisexuals found smoking rates higher than 30 percent, and ranging up to a high of 39.1 percent.^{10,11,13,14,15,16} Among women in the state of Washington, bisexuals were found to be 2.2 times more likely to smoke than straight women, and 1.2 times, or 20 percent, more likely to smoke than lesbians.¹¹

The term bisexual encompasses everyone who is not exclusively heterosexual and homosexual, which represents a wide spectrum of attraction and behavior. Some studies even asked about a category they called “mostly heterosexual”. It is important to note that about half of the studies did not look at bisexuals separately from gay men and lesbians. But because there are some significant differences between groups, the results from those studies are not aggregated here. Significantly more data will be needed to determine if differences exist in smoking rates or other health behaviors.

Smoking Prevalence in Adults by State



Transgender

Almost no information exists on smoking rates among transgender people. The 2009 review did not include any studies that included results for this small but vulnerable population. The 2004 California Tobacco Use Survey found that about 2 percent of all LGBT adults identify as transgender. At 30.7 percent, their smoking prevalence was very close to the overall LGBT rate of 30.4 percent.¹⁷

Youth

LGBT youth are a group of particular concern, and although the data are limited, there appear to be some patterns that differ from adults. One large study of multiple behavioral risk factors, including smoking, found that bisexual youth seem to be at highest risk compared with both heterosexual and homosexual youth. Researchers found that bisexual boys were twice as likely to smoke regularly as either gay or straight boys. Notably, exclusively homosexual (gay) boys did not differ significantly from straight boys in their likelihood of smoking regularly. The pattern for girls was very similar.¹⁸

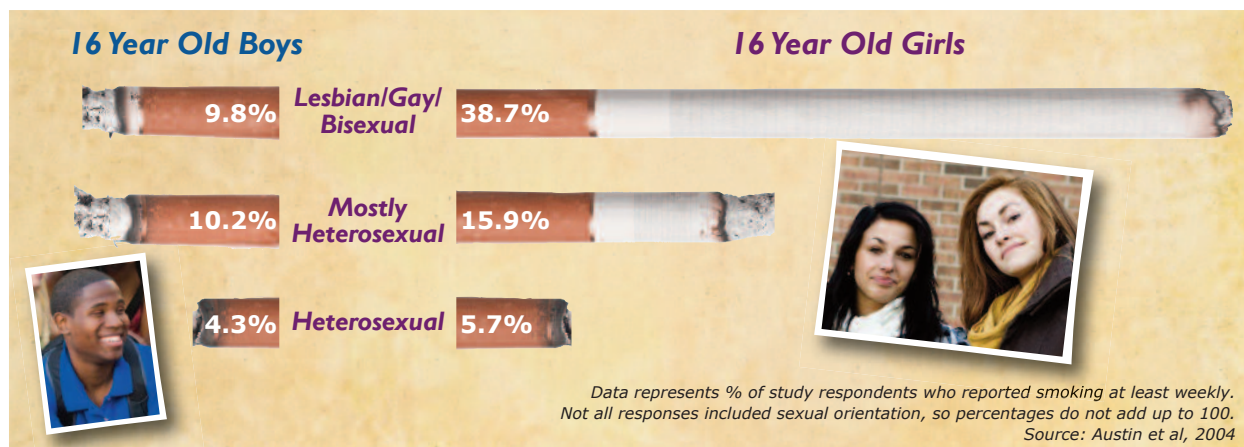
Another large study had somewhat similar outcomes, although unfortunately it did not look at bisexual youth separately. They compared heterosexuals, youth who were identified as “mostly heterosexual”, and lesbians/gays combined with bisexuals. They found that compared to heterosexuals, “mostly

heterosexual” girls were 2.5 times more likely, and lesbian/bisexual girls were an alarming 9.7 times more likely to smoke at least weekly. Boys identified as “mostly heterosexual” were 2.5 times more likely than heterosexual boys to smoke at least weekly, but gay/bisexual boys were no more likely to smoke than heterosexual boys.¹⁹

Other Tobacco Products

Little is known about the use of other tobacco products in the LGBT community. One study conducted in California indicated that they may be less likely to use cigars and smokeless tobacco than the general population. Researchers conducted telephone surveys with 1,950 LGBT individuals in California during 2003 and 2004. Although the survey included a question on gender identity, there weren’t enough transgender people in the final sample to permit a separate analysis. Responses to questions about other tobacco use were compared with those from the 2002 California Tobacco Survey. For both men and women, people in the general population were more likely to have ever used cigars and smokeless tobacco than people in the LGBT sample.²⁰ It should be noted that the survey size was small and not necessarily representative of specific subsets of the population. Patterns of use of other tobacco products, especially smokeless tobacco, also varies considerably by region of the country, so it would be unwise to draw conclusions from one state.

Smoking Prevalence in Youth



“It had been 13 years since I quit smoking. I was at a club with a friend and when he went outside to smoke, I decided to try one. I was amazed how easy it was to get back into the habit. Within a month, I was back up to a pack a day.”

–Steve, 45, New York City

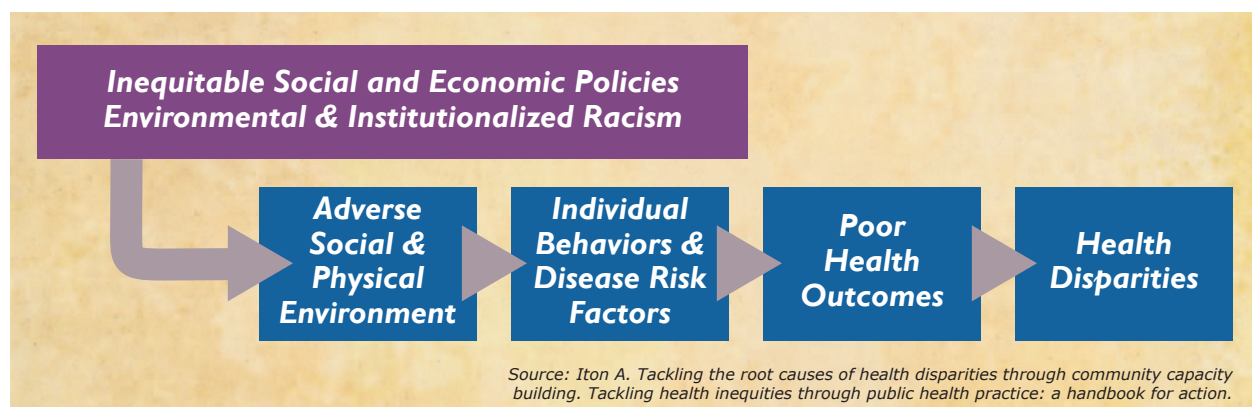
Contributing Factors

The vast majority of smokers in all population groups begin smoking before the age of 21, and they start smoking for many different reasons. Many young people say that they started smoking as a way to fit in with peers or to rebel against authority figures. Young people are also influenced by the tobacco industry’s marketing efforts and by friends and family members who smoke. Smoking is a highly addictive behavior, and while nicotine addiction is likely the largest factor ensuring that smokers continue, social factors also contribute to continued smoking behavior. But given that these factors affect all Americans, what makes LGBT people more likely to smoke?

Social Stigma

The additional risk for tobacco use is not intrinsic to sexual orientation or gender identity. Many of the factors associated with an increased likelihood of smoking among heterosexuals are the same in the LGBT population, often at higher rates. Stress, depression, social influence and cultural factors all contribute to smoking prevalence in all population groups. However, the social environment in which LGBT individuals come out to themselves, their families and the community can have a significant impact on their health and well-being. Although social acceptance has been slowly improving, there is still a lot of stigma associated with being in a sexual minority. Actual or even perceived stigma causes stress, and research has shown that smoking rates, as well as other negative health behaviors and outcomes, are higher in groups that experience high levels of stress.²¹

Social Determinants of Health



“I think tobacco products are heavily promoted in the bar/club scene. The same is true in the straight community but I think the difference is more people in the LGBT community rely on the bar/club scene to be social.”

–Zeb, 27, Washington DC



According to some recently published studies, the negative influence of stigma and discrimination begins at home at an early age. Researchers studying the influence of family and friends’ reactions on the physical and mental health of lesbian, gay and bisexual youth found that those who reported higher levels of rejection and hostility were significantly more likely to engage in risky health behaviors, including tobacco use. Conversely, reactions from friends and loved ones that were accepting of their sexual orientation were seen as protective.^{22,23}

Another study that examined the attitudes of LGBT youth found that stress was by far the most frequently named cause of smoking, followed by fitting in and peer pressure. When asked about the reason(s) for this stress, study participants mentioned a number of factors including homelessness, coming out at an early age, rejection by family and peers, lack of support, discrimination, anxiety and homophobia. Tobacco use was seen as a way to mitigate stress and get closer to others by serving as an icebreaker, bonding activity or social experience. The youth also reported that smoking at school makes them look tough and can help prevent bullying.²⁴

Interestingly, the impact of discrimination is felt not just from personal interactions, but extends to the behavior of organizations and even governments. Researchers following the health and well-being of a national sample of lesbian, gay and bisexual adults over time recently found that their study participants who live in states that have passed constitutional amendments banning same-sex marriage have shown an increase in mood disorders like depression, and substance abuse.²⁵

Social Bonding and the Bar Culture

Historically, bars were among the few safe spaces for LGBT people, and they have played an important social role in the LGBT community for many decades. Because there is a biological and behavioral link between drinking and smoking²⁶, it is likely that the bar culture would have contributed to elevated smoking rates in this population. There is also the social aspect of smoking together with peers, which seems to be an especially strong risk factor among young people.^{24,27}

Lack of Access to Treatment

The widely-used and respected Clinical Practice Guideline Treating Tobacco Use and Dependence: 2008 Update, published by the U.S. Public Health Service, defines tobacco dependence (addiction) as a chronic disease that often requires repeated intervention and multiple attempts to quit.²⁸ Physicians and other healthcare professionals provide essential counseling, cessation medications and other treatment for smokers. Unfortunately, it appears that LGBT individuals have more difficulty getting access to health care than the general population. The reasons for this may include lack of health insurance, discriminatory healthcare practices and avoidance and delay in seeking treatment.

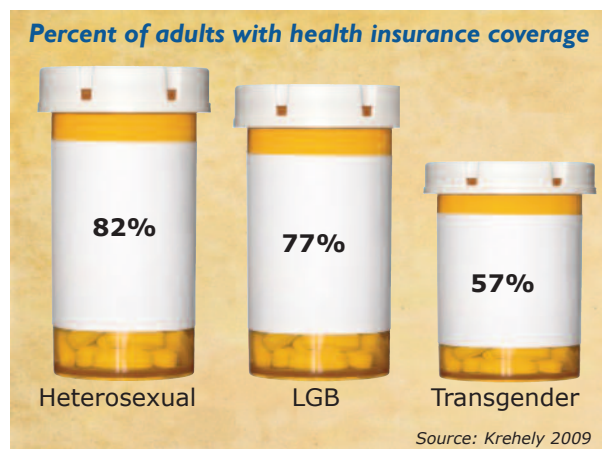
According to one analysis of data from various sources, the percentage of adults that have health insurance ranges dramatically, from 55 percent of transgendered adults, 77 percent of gay, lesbian and bisexual adults, to 82 percent of straight adults.²⁹ Another recent study of data from a large national survey found that individuals in same-sex relationships were significantly less likely to have health insurance

“The tobacco industry definitely targets the LGBT community. They advertise for cigarettes the same way they advertise for alcohol, and really make it look alluring. And back in my 20’s, those things worked! Even though everything about that community was frowned upon, they had a way of grabbing that community with their ads. The whole idea of being ‘the cool dyke in the bars’ really impacted me, because, of course, I wanted to be cool.” **–Susan, 52, San Francisco**

than those in opposite-sex relationships.³⁰ The fact that most people get their health insurance through their employers has meant that unmarried couples, including same-sex couples, are two to three times more likely to be uninsured than married people.³¹ Fortunately, that is beginning to change, as more employers offer domestic partner benefits and more LGBT couples are able to marry.

Some LGBT people, especially transgender individuals, have expressed a distrust of healthcare providers and a reluctance to seek care. As part of a study of the health effects of perceived discrimination in 2001, researchers found that lesbian, gay and bisexual study participants were twice as likely to report being denied or given inferior medical care as their straight counterparts.³²

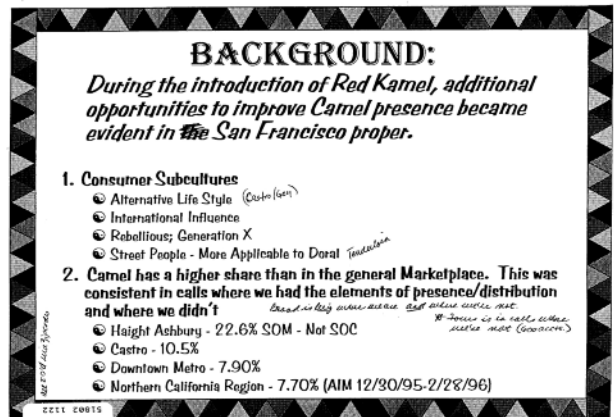
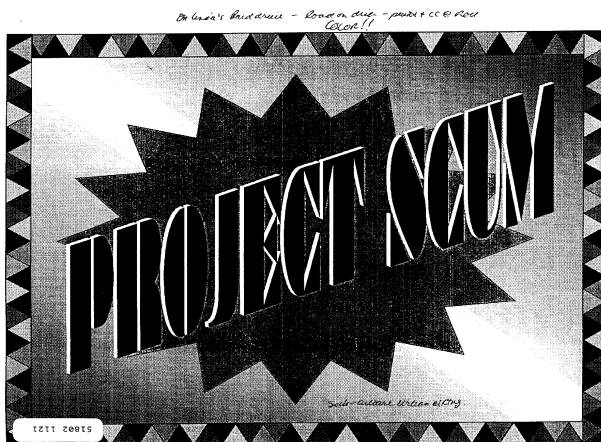
Disparities in Health Insurance Coverage



Targeting by the Tobacco Industry

The tobacco industry was one of the first to develop marketing materials specifically targeting the LGBT community, and it has over time cynically reaped the benefits of the attention paid to a group that had been largely ignored by mainstream advertisers.³³ Perhaps the most infamous example of this is Project SCUM, a plan by RJ Reynolds in the mid-1990’s to market their Red Kamel brand in “alternative lifestyle” areas of San Francisco. SCUM stands for “subculture urban marketing” and the campaign was specifically aimed at gay men in San Francisco’s Castro District and homeless people in the Tenderloin. Documents related to Project SCUM were released during the State of California’s litigation with the tobacco industry and through them, it became very clear the degree to which the tobacco industry has held its gay, lesbian, bisexual and transgendered customers in contempt.

Tobacco advertising had been widespread in publications aimed at LGBT audiences and remains common today. In 2005, researchers conducted a retrospective analysis of advertising that had been published in gay and lesbian periodicals between January 1990 and December 2000. The researchers examined almost 3,500 ads. The researchers coded the ads for both their intent and relative size. Ad size was measured in page equivalents: a full page ad equaled a one page equivalent, each half-page ad was recorded as 0.5 page equivalents and so forth. About 20 percent of the ads were for specific tobacco products, but these ads occupied 39 percent of the total number of page equivalents. This was considered disproportionate relative to the



tobacco advertising presence in other media. But the most striking finding was the degree to which tobacco use had been made a “normal” part of the LGBT life, as shown in the high number of non-tobacco advertisements that showed tobacco products. These ads made up 30

percent of the total sample and occupied 34 percent of the total number of page equivalents. These ads promoted entertainment products and venues, sexual services, clothing, and even rehab programs. Ninety-eight percent showed tobacco use in a positive light.³⁴



The ads above appeared in various LGBT publications. The images and messages used in these ads were clearly designed to appeal to LGBT audiences.

“Tobacco use is a social justice issue because it affects the LGBT community at a higher rate. No one wants to bring down community organizations that are needed but some leaders are addicted to tobacco industry money. That money’s just a lure and real lives are at stake.” – Gloria Soliz

Acceptance of the Status Quo by LGBT Advocacy Organizations

Despite the impact of tobacco use on the health and well-being of the LGBT community, many LGBT organizations do not seem to view tobacco control as a relevant issue. Researchers at the University of California, San Francisco interviewed the leaders of 74 LGBT organizations between 2002 and 2004. These interviews were

recorded, reviewed and coded to identify major themes. Only 24 percent of the leaders surveyed named tobacco use as a pressing LGBT community health concern. The rest indicated that other issues were more important or that their organizations should focus on issues that weren’t being addressed by the general population. Some of those interviewed said that drinking and smoking were central to many people’s coming out process. This is an unfortunate indication of the degree to which tobacco use has been normalized in a community beset by the challenges of functioning in a homophobic society.

While these leaders recognized that smoking is dangerous to one’s health, some noted that combating smoking could be bad for an organization’s bank account. Twenty-two percent of the organizations surveyed had accepted tobacco industry funding. The leaders of those groups recognized that these donations were ideologically difficult to defend, but felt they were necessary to keep their programs solvent and “continue their work in the community.” Even those groups that had not accepted tobacco industry funding in the past said they might do so under the right circumstances, such as including a no-smoking message for youth as part of the funded activity.³⁵ This is a disturbing possibility, as tobacco companies have been known to offer funding to groups contingent on those groups using their youth cessation interventions and to improve their image.³⁶ Industry-created interventions have been proven ineffective at best, and some have been shown to actually increase youth susceptibility to smoking.³⁷



The ad on the left appeared in Out, an LGBT magazine. It shows two women – possibly a lesbian couple – with a man. The version on the right depicts a heterosexual couple and appeared the same month in mainstream publications.



“I’m a daily smoker. I want to quit because I have to do a lot to make sure my mouth doesn’t taste like a dumpster.”

–Daniel, 27, Washington DC

Making A Difference

Proven-effective interventions are slowly but steadily reducing the rate of tobacco use nationwide, and are becoming more widely available. Research demonstrates that a comprehensive approach works best: a combination of policy change, prevention messaging campaigns, and tobacco cessation services. Interventions that are developed for the general public, however, only go so far to address disparities. Continued progress in these areas must involve the LGBT community in all stages of planning and implementation to ensure that their needs are being met.

Policy Change Protects Everyone

The American Lung Association advocates for several key tobacco control policies that have been proven to reduce tobacco use across all populations. These policies form an important backdrop that can make interventions targeting priority populations including the LGBT community most effective.

The Lung Association works to increase taxes on cigarettes and other tobacco products and to

prohibit smoking in all public spaces and workplaces. The Lung Association also believes that evidence-based programs to prevent children and adolescents from starting to smoke and to help smokers quit should be funded by all states at the levels recommended by the Centers for Disease Control and Prevention. Finally, all smokers should have access to the full range of evidence-based tobacco cessation treatments under all public and private health insurance plans.

Each of these policies can individually reduce the death and disease caused by tobacco use among the general population, including the LGBT population. When combined, these policies can have an even greater impact. At the federal level, the American Lung Association is working on the implementation of the 2009 passage of the Family Smoking Prevention and Tobacco Control Act giving the U.S. Food and Drug Administration the authority to regulate tobacco products. Among other things, this legislation will significantly curtail the advertising and marketing of tobacco products to children and youth.

“I didn’t want to be a regular smoker and I knew the longer I smoked, the harder it would be to quit. When my partner and I were about to move in together, I decided to quit because I didn’t want him to have to live with a smoker.”

–Steve, 45, New York City

“The thing that stuck out for me throughout The Last Drag was the way that tobacco companies play on the LGBT community. They play on our health just to make a dime, off our life and our death. And that’s the kind of information I would like to get out there. There are people making millions of dollars, hoping I would continue to smoke whether it would kill me or not, and I find that horrific. It’s just criminal.” **–Susan, 52, San Francisco**

Targeted Prevention Awareness Campaigns

Media campaigns that work to counter the advertising assault of the tobacco industry have been shown to successfully prevent the general population, especially youth, from smoking. Such media campaigns have educated the public about the deceptive marketing tactics of the tobacco industry. This, in turn, has resulted in an increased negative view of tobacco companies, stronger anti-tobacco attitudes, and lower rates of smoking. There is evidence that similar efforts, specifically tailored for the LGBT community, would be as effective. For example, the California Tobacco Control Program found that about three-quarters of the LGBT population recalled having seen an anti-tobacco message in the last 30 days, which is about the same level of recall for the general population. But many of these LGBT adults also reported that they did not find the messages appealing.¹⁷ This suggests that there is a need for anti-smoking campaigns that target the LGBT population, with a strong likelihood that such work would be successful.

Providing Effective Cessation Services

Experts agree that cessation programs that are sensitive and tailored to the needs of the target population are likely to be the most effective. Unfortunately, the lack of evidence remains a critical limitation. Recently, the U.S. Public Health Service’s Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* was unable to make a recommendation regarding cessation interventions aimed at LGBT smokers,

due to a lack of evidence. Specifically, there have been no long-term research studies on the effectiveness of LGBT-specific tobacco cessation programs. Effective approaches likely exist; however, missing is the rigorous research that provides definitive evidence.

One promising tobacco cessation program aimed at the LGBT community is *The Last Drag*, based on the American Lung Association’s *Freedom From Smoking*[®] program. Created in 1991 by the Coalition of Lavender Americans on Smoking and Health, *The Last Drag* has been offered in several cities throughout California and around the country. *The Last Drag* provides a safe space for LGBT smokers to go through the quitting process in a supportive, group environment. Program facilitators are certified to lead the *Freedom From Smoking*[®] program and receive additional training to increase their LGBT cultural competency. Results of the program are encouraging. A 2007 report on *The Last Drag* classes in San Francisco shows that of those who completed the program, 85 percent were able to quit smoking. Six months after the program ended, 55 percent of those contacted were still smokefree.*³⁸

Research has identified some considerations for the successful development and

* These evaluation results do not include people who started but did not complete the program. If everyone who started the program is included in the calculation (a more conservative “intent to treat” analysis), quit rates are considerably lower but still compare favorably with other smoking cessation programs.

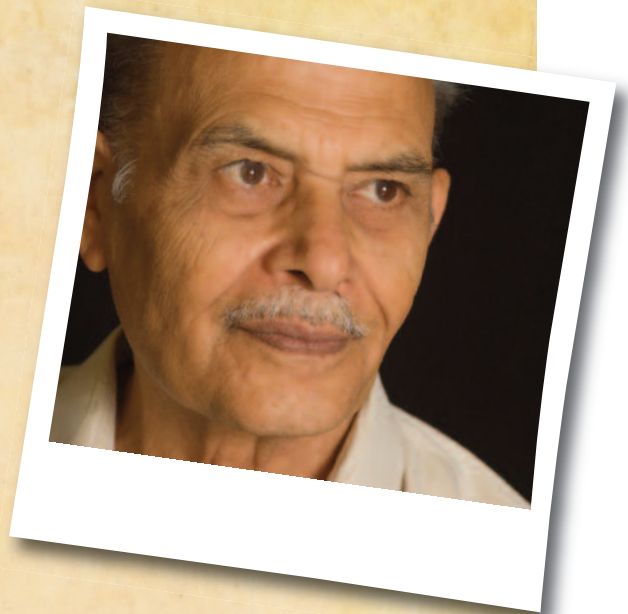
“Smoking is a restrictive lifestyle. When people join The Last Drag and pursue quitting, their frame of reference is enlarged and they’re able to see more opportunities. It’s a life-changing program and facilitating this program is a wonderful way to be a part of the community.” – Gloria Soliz

implementation of services to help quit smoking. In many ways they are not that different from the needs of other populations. One study examined the factors correlated with quitting among urban gay and bisexual men, and found that respondents who reported that “none or almost none” of their gay or bisexual friends smoked were almost four times more likely to have quit smoking compared with those who said “all or almost all” of their

friends smoked.³⁹ Another, more recent survey of LGBT beliefs and attitudes about quitting smoking found that more positive attitudes, and a greater sense of self-empowerment were strongly associated with the intent of LGBT participants to quit smoking. The respondents with the strongest intention to quit were those that believed that quitting would allow one to “feel more like the person I want to be – my ideal self.”⁴⁰

Suggestions for Culturally Competent Stop Smoking Services to the LGBT Community

1. Recruit LGBT-friendly facilitators who have prior experience leading support groups. Facilitators should be knowledgeable about interests, issues and concerns in the lesbian, gay men, bisexual, transgender, queer, questioning, intersex and HIV-positive communities.
2. Find a welcoming and accessible venue that is well-known and respected in the LGBT community.
3. Culturally relevant stop-smoking curricula should be provided in the context of a comprehensive tobacco control program within the LGBT population. Such a program would be part of a wider spectrum of tobacco control programs that include tobacco prevention, policy change, media and research for the LGBT community.
4. Facilitator should be certified by a recognized agency such as the American Lung Association.
5. When possible, order education materials designed to be appropriate for LGBT audiences and use vendors who are familiar with LGBT communities.
6. Culturally competent staff and volunteers should work to ensure safety and confidentiality for LGBT participants in cessation services.



*Developed by Gloria Soliz, October 2007
Adapted by the American Lung Association, May 2009*

Taking Action

In spite of the progress that has been made on tobacco control in this country, the deadly threat continues to claim lives and rob millions of their health. In many ways, what needs to be done is clear, and we must maintain our vigilance and resolve until we are successful. But we also need fresh approaches and new allies, especially if we are to make progress in disproportionately affected communities. The American Lung Association calls on governmental agencies, the healthcare system, LGBT health advocates and community members themselves to work together to take the following actions:

- The Centers for Disease Control and Prevention (CDC) and all state Departments of Health should include sexual orientation and gender identity questions in the core demographic questions of state and national public health surveillance systems such as the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance Survey (BRFSS).
- The North American Quitline Consortium (NAQC) should include sexual orientation as a standardized core demographic question in quitline intake.
- Public and private funders should recognize LGBT communities as a priority population for prevention and cessation services, along with other groups that exhibit a disparity in tobacco use.
- The research community should evaluate promising innovations and interventions to prevent tobacco use and promote quitting in LGBT communities.
- State and local tobacco control programs should include representatives from LGBT organizations in disparity reduction planning and intervention development.
- State and local tobacco control programs should ensure prevention and cessation program staff and volunteers are culturally competent and able to effectively serve the LGBT community.
- Healthcare systems and provider member organizations should offer training on LGBT health issues to increase cultural competence among providers and staff.
- LGBT advocacy organizations should advocate for policies to promote tobacco prevention and cessation programs as part of LGBT health promotion.
- LGBT advocacy organizations should work to protect community members from secondhand smoke by supporting comprehensive clean indoor air initiatives.
- LGBT advocacy organizations should identify alternative funding sources to tobacco industry sponsorship.

“The community and its allies need to advocate for funding to establish culturally-specific programs. Civil rights and health are both important in our community.”

– Gloria Soliz

Acknowledgments

Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community is the second report in the *Disparities in Lung Health Series* that takes an in-depth look at the needs of populations that bear an unequal burden of risk and disease. These reports build on the American Lung Association's long-standing commitment to saving lives and improving lung health and preventing lung disease for *all* Americans. For a compendium of information about lung disease in various racial and ethnic populations, see the recently released *State of Lung Disease in Diverse Communities: 2010*, available at www.lungusa.org.

As with all Lung Association reports, *Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community* was a collaborative undertaking, and we gratefully acknowledge the many contributors who made it possible.

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