

# The LGBT Community

## A PRIORITY POPULATION FOR TOBACCO CONTROL

Lesbian, gay, bisexual and transgender (LGBT) adults and youth smoke at substantially higher rates than the general population. The factors driving LGBT disparities in tobacco use include stress due to social stigma and discrimination, peer pressure, aggressive marketing by the tobacco industry and limited access to effective tobacco treatment.<sup>1</sup> Data highlighted in this issue brief present compelling evidence for designating the LGBT community as a priority population for tobacco control, similar to racial and ethnic groups disproportionately affected by smoking. This issue brief also outlines how policymakers, health care organizations, and LGBT health advocates can reduce the impact of tobacco on the LGBT community through culturally appropriate policy, research, and community-based strategies.

### SMOKING RATES: What We Know

Although few studies have examined the link between sexual orientation and smoking, it is clear that LGBT individuals have a higher smoking rate than the general population. Only six states have published reports on tobacco use by sexual orientation: Arizona, California, Massachusetts, New Mexico, Oregon, and Washington. All six of these states found significantly elevated smoking rates in the LGBT community. A 2009 review of 42 separate studies measuring tobacco use among lesbians, gays, and bisexuals reported consistently higher prevalence of smoking among sexual minorities.<sup>2</sup> Other studies have reported smoking prevalence among gay and bisexual men is 27% to 71% higher and for lesbians and bisexual women, 70% to 350% higher than prevalence observed for comparable gender groups in the general population.<sup>3</sup>

### Facts at a Glance

- *Smoking is the primary cause of lung cancer and the leading cause of preventable disease and death in the U.S., accounting for 393,000 deaths each year.<sup>1</sup>*
- *Among all U.S. adults age 18 and older, 20.6% currently smoke.<sup>1</sup>*
- *The LGBT smoking rate is higher than the national average.*
- *LGBT persons experience stigma, discrimination and other stressors that increase the likelihood of smoking.*
- *Most national and state surveys of tobacco use do not collect information on sexual orientation and often include insufficient numbers of LGBT persons to yield representative results.*
- *More research is needed on the effectiveness of tobacco treatment programs for LGBT populations.*

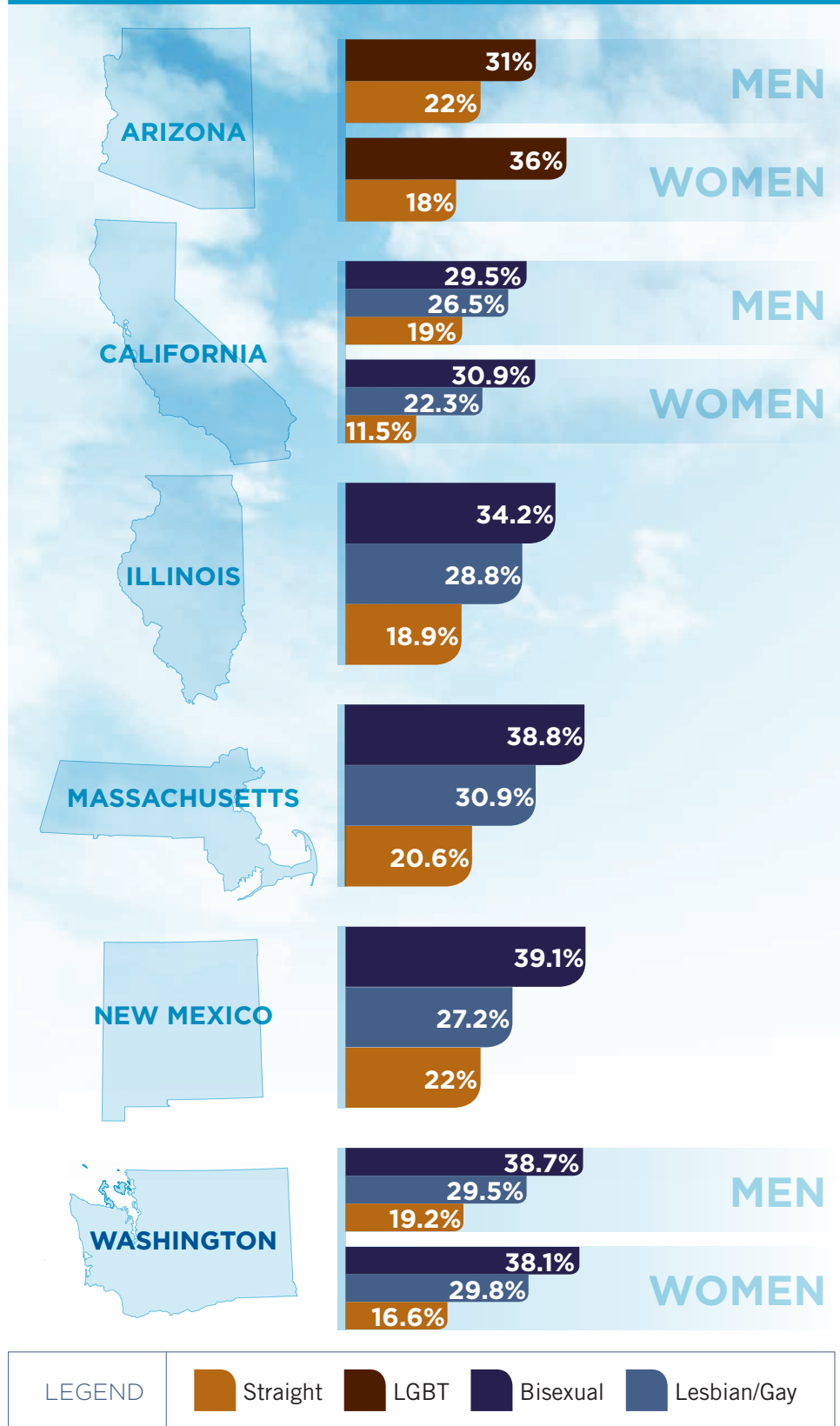
# ADULTS

On the whole, bisexual men and women appear to have the highest smoking rates of any subgroup for which data is readily available.

- For all of the state surveys that collected data on bisexuals, smoking rates for this group was higher than 30 percent, peaking at a high of 39.1 percent.<sup>4,5,6,7,8,9</sup>
- Among bisexual women, the odds of smoking ranged from 1.5 to 3.5 higher than for straight women. Lesbians had between 1.2 and 2.0 times the odds of smoking compared to straight women. The odds of smoking for bisexual men were 0.9 to 2.6, when compared to straight men. Compared to straight men, gay men have between 1.1 and 2.4 times the odds of smoking.<sup>5</sup>
- 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.<sup>10</sup>

Almost no information exists on smoking rates among transgender people. However, this population is considered especially vulnerable given their high rates of substance abuse, depression, HIV infection, and social and employment discrimination, all of which are characteristics associated with higher smoking prevalence in the general population.<sup>11</sup> 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.<sup>12</sup>

## Smoking Prevalence In Adults By State



Sources: Arizona Tobacco Survey, 2002 & 2005, Massachusetts BRFSS, ages 18-64, 2001-2006, New Mexico BRFSS, ages 18-64, 2005-2008, Illinois Adult Tobacco Survey, 2003 & later, California Health Interview Survey 2005 & 2007, Washington BRFSS, 2003-2006

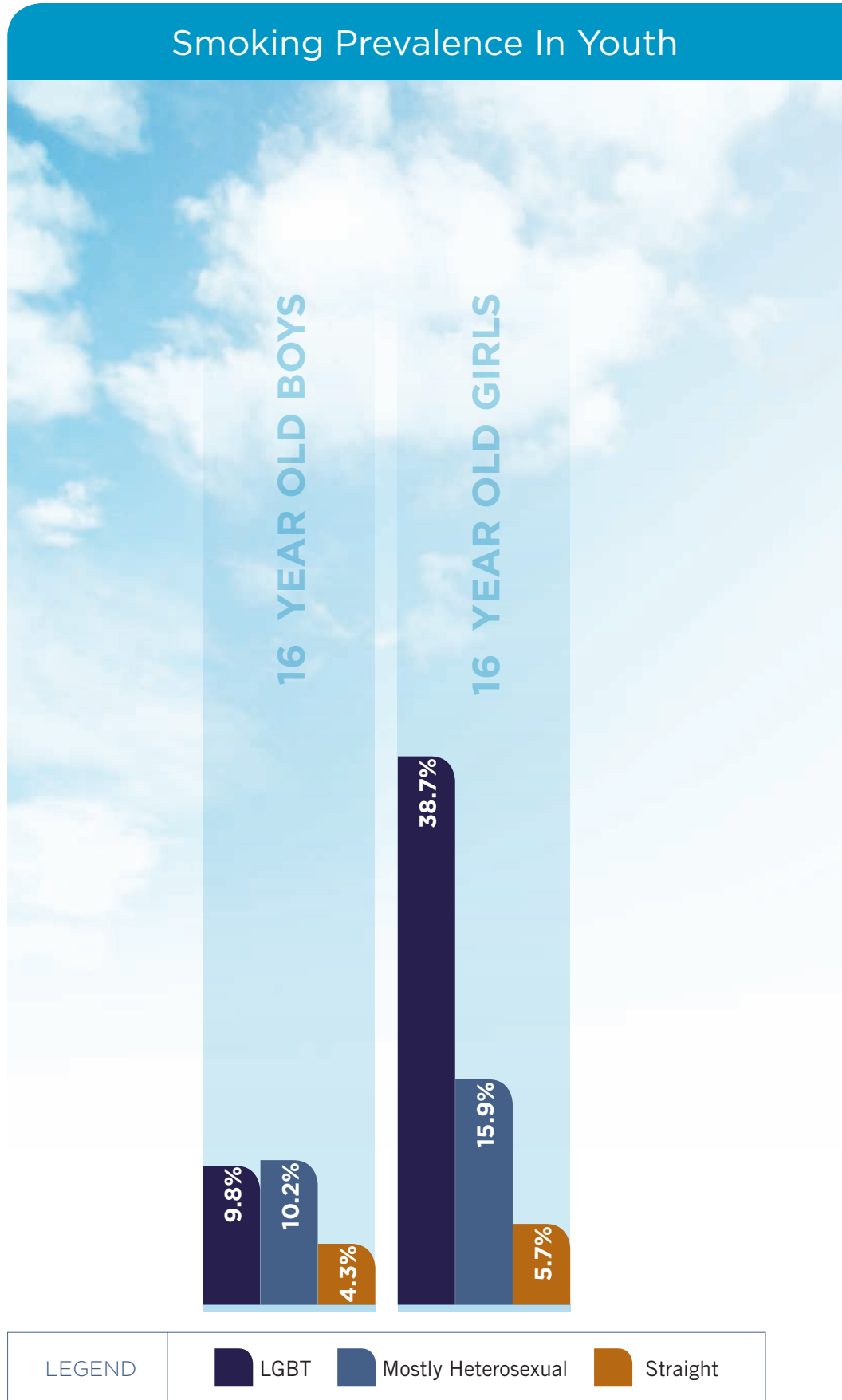
# YOUTH

Estimates of smoking prevalence among LGBT youth range from 38% to 59%, compared to a prevalence rate of 28% to 35% for the total youth population, according to the 2009 review.<sup>2</sup>

- In a large study of multiple behavioral risk factors, bisexual boys were twice as likely to smoke regularly as either gay or straight boys. Exclusively homosexual (gay) boys and girls did not differ significantly from their straight counterparts in their likelihood of smoking regularly.<sup>13</sup>
- In a study of 10,685 adolescents living throughout the U.S., researchers 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.<sup>14</sup>

Until more national and state tobacco use surveys include 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 yield results that may not be representative of the nation at large. In addition, significant findings about smaller 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.<sup>15</sup>

## Smoking Prevalence In Youth



Data represents % of study respondents who reported smoking at least weekly. Not all responses included sexual orientation, so percentages do not add up to 100. Source: Austin et al, 2004

## CONTRIBUTING FACTORS

Young people are especially susceptible to smoking. Indeed, the vast majority of smokers start smoking before the age of 21. While LGBT people face the same pressures to smoke as the general population, LGBT individuals are at risk for a number of additional reasons including:

### Stigma and Discrimination

LGBT populations often experience high stress due to marginalization and discrimination in personal interactions and in society at large. 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.<sup>16</sup> Among LGBT youth, stress due to homelessness, coming out at an early age, rejection by family and peers and discrimination are among the most frequently cited reasons for smoking.<sup>17</sup>

### Social Bonding and the Bar Culture

LGBT people in some areas have limited opportunities to interact with peers outside of smoking venues.<sup>18</sup> 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.

### Lack of Access to Quality Treatment and Care

Individuals in same-sex relationships are significantly less likely to have health insurance than those in opposite-sex relationships.<sup>19</sup> Additionally, in one study, LGBT participants were twice as likely to report being denied or given inferior medical care as their straight counterparts.<sup>20</sup>

### Targeting by the Tobacco Industry

The tobacco industry aggressively targets LGBT audiences for advertising. Tobacco advertisements in gay and lesbian publications often depict tobacco use as a “normal” part of LGBT life. According to a 2005 study, 30% of non-tobacco advertisements in LGBT publications, such as those that promote entertainment products and venues, sexual services, clothing, and even rehab programs—feature tobacco use.<sup>21</sup>

### Acceptance of the Status Quo by LGBT Advocacy Organizations

Many leaders of LGBT organizations do not view tobacco control as a priority health issue. In interviews with 74 LGBT leaders, some expressed the opinion that drinking and smoking were central to the coming out process for many people. While leaders recognized that smoking is dangerous to one’s health, some also noted that combating smoking could jeopardize tobacco industry funding to their organizations.<sup>22</sup>

#### ***Promising Intervention: The Last Drag***

*Created 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. A 2007 report on The Last Drag classes in San Francisco showed among 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.<sup>24</sup>*

## MOVING FORWARD

# Policy And Environmental Change Protects Everyone

Research demonstrates that a comprehensive approach works best: a combination of policy change, prevention messaging campaigns targeted to vulnerable populations, and tobacco cessation services. The American Lung Association calls on governmental agencies, healthcare systems, LGBT health advocates, and community members to work together to take the following actions:

### 01 Support Evidence-Based Tobacco Control Policies

Interventions targeting priority populations including the LGBT community are more likely to succeed when communities adopt proven tobacco control policies, such as higher taxes on cigarettes and other tobacco products, prohibiting smoking in all public spaces and workplaces and coverage for tobacco cessation programs by both public and private health insurance plans.

### 02 Recognize LGBT Communities as a Priority Population

Public and private funders should recognize LGBT communities as a priority population for tobacco prevention and cessation services. Funding should be provided to encourage the research community to evaluate promising innovations and interventions to prevent tobacco use and to promote quitting in LGBT communities.

### 03 Collect Data on Sexual Orientation and Gender Identity in Health Studies and Tobacco Cessation Programs

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). Smoking cessation programs including members of The North American Quitline Consortium (NAQC) should include sexual orientation as a standardized core demographic question during intake.

### 04 Ensure LGBT Cultural Competency in Tobacco Control Planning and Cessation Programs

State, local, and health care systems' tobacco control programs should include representatives from LGBT organizations in disparity reduction planning and intervention development and should ensure prevention and cessation program staff and volunteers are culturally competent and able to effectively serve the LGBT community.

### 05 Consider Alternative Funding Sources

To effectively advocate on behalf of LGBT communities, LGBT advocacy organizations should identify alternative funding sources to tobacco industry sponsorship. Tobacco companies have been known to offer funding to groups contingent on those groups using their cessation interventions. Industry-created interventions have been proven ineffective at best, and some have been shown to actually increase youth susceptibility to smoking.

## Conclusions

In spite of the progress that has been made on tobacco control in the United States, smoking continues to claim lives and rob millions of their health. To develop an effective public health response to smoking in lesbian, gay, bisexual and transgender communities, more data is urgently needed about the impact of smoking on these groups. By focusing on the challenges and recommendations highlighted in this issue brief, communities can make significant strides in improving the health of their LGBT populations.



## References

- <sup>1</sup> Ryan H, et al. Smoking among lesbians, gays and bisexuals: a review of the literature. *American Journal of Prevention Medicine*. 2001; 21:142-149; Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Raw Data, 2008. Analysis performed by the American Lung Association Research and Program Services Division using SPSS and SUDAAN software.
- <sup>2</sup> Lee JG, Griffin GK and Melvin CL. Tobacco use among sexual minorities in the USA, 1987 to May 2007: A systematic review. *Tobacco Control*. 2009;18:275-282.
- <sup>3</sup> Burkhalter J, et al. Intention to quit smoking among lesbian, gay, bisexual, and transgender smokers. *Nicotine & Tobacco Research*, 2009; 11(11):1312-1320.
- <sup>4</sup> California Health Interview Survey. 2005 & 2007, UCLA Center for Health Policy Research.
- <sup>5</sup> Behavior Risk Factor Surveillance System (BRFSS). 2003-2006, Center for Health Statistics, Washington State Department of Health. Available online: [www.doh.wa.gov/ehsphl/chs/chsdata/brfss/BRFSS\\_tables.htm](http://www.doh.wa.gov/ehsphl/chs/chsdata/brfss/BRFSS_tables.htm).
- <sup>6</sup> Tobacco Use and Interventions Among Arizona Lesbian, Gay, Bisexual and Transgender People. 2006, Arizona Department of Health Services. Available online: [www.tobaccofreearizona.com/reports/pdf/O5\\_lgbt-survey.pdf](http://www.tobaccofreearizona.com/reports/pdf/O5_lgbt-survey.pdf).
- <sup>7</sup> Query Builder for New Mexico's Behavioral Risk Factor Surveillance System (BRFSS) Data. 2005- 2008, New Mexico's Indicator-Based Information System (NM-IBIS), New Mexico Department of Health. Available online: <http://ibis.health.state.nm.us/query/builder/brfss/BRFSSAgeAdj/BMIAdj.html>
- <sup>8</sup> Behavior Risk Factor Surveillance System (BRFSS). 2001-2006, Health Survey Program, Massachusetts Department of Public Health. Available online: [www.mass.gov/dph/hsp](http://www.mass.gov/dph/hsp).
- <sup>9</sup> Adult Tobacco Survey: Illinois. 2003 and later, Illinois Department of Public Health. Available online: [www.gaydata.org/O2\\_Data\\_Sources/ds010\\_ATS/Illinois/ds010\\_ATS\\_IL.html](http://www.gaydata.org/O2_Data_Sources/ds010_ATS/Illinois/ds010_ATS_IL.html).
- <sup>10</sup> Stall R D, et al. Cigarette smoking among gay and bisexual men. *American Journal of Public Health*. 1999;89(12):1875-1878.
- <sup>11</sup> California Lesbians, Gays, Bisexuals and Transgender Tobacco Use Survey. 2004, California Department of Health Services Tobacco Control Section.
- <sup>12</sup> Udry J R and Chantala, K. Risk assessment of adolescents with same-sex relationships. *Journal of Adolescent Health*. 2002;31(1): 84-94.
- <sup>13</sup> Austin S B, et al. Sexual orientation and tobacco use in a cohort study of US adolescent girls and boys. *Archives of Pediatrics & Adolescent Medicine*. 2004;158:317-322.
- <sup>14</sup> Lesbians, Gays, Bisexuals, and Transgenders of Color Sampling Methodology: Strategies for Collecting Data in Small, Hidden, or Hard-to-Reach Groups to Reduce Tobacco-Related Health Disparities. 2009, Tobacco Research Network on Disparities (TReND), National Cancer Institute. Available online: <http://cancercontrol.cancer.gov/tcrb/trend/lgbt/docs/LGBTReport508.pdf>.
- <sup>15</sup> Health Care Needs of Gay Men and Lesbians in the United States. Council Report. *Journal of the American Medical Association*. 1996;275(17):1254-1359.
- <sup>16</sup> Ryan C, et al. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*; 2009;123(1):346-352.
- <sup>17</sup> Remafedi G. *Lesbian, gay, bisexual, and transgender youths: who smokes, and why? Nicotine Tobacco Research*.2007;9(Suppl 1):S65-S71.
- <sup>18</sup> Buchmueller T and Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health*. 2010;100:489-495.
- <sup>19</sup> Mays V and Cochran S. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*. 2001;91(11): 1869-76.
- <sup>20</sup> Smith EA, Offen N and Malone RE. What makes an ad a cigarette ad? Commercial tobacco imagery in the lesbian, gay and bisexual press. *Journal of Epidemiology & Community Health*. 2005;59:1086-1091.
- <sup>21</sup> Offen N, Smith EA and Malone RE. Is Tobacco a Gay Issue? Interviews with leaders of the lesbian, gay, bisexual and transgender community. *Culture, Health, and Sexuality*. 2008; 10(2):143-157.
- <sup>22</sup> Tesler L. and Malone R. Ethical Conduct in Public and Private Arenas. *American Journal of Public Health*. 2008;98(12):2123-2133.
- <sup>23</sup> Wakefield M. et al. Effect of televised, tobacco company-funded smoking prevention advertising on youth smoking-related beliefs, intentions and behavior. *American Journal of Public Health*. 2006;96(12):2154-2160.
- <sup>24</sup> Gordon B and Soliz G. The Last Drag: Final Report July 2005-June 2007. Coalition of Lavender Americans on Smoking & Health. June 29, 2007.

[www.lung.org](http://www.lung.org)