Tobacco Use

Healthy People 2010 Goal

Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.

Overview

This chapter on tobacco use among lesbian, gay, bisexual, and transgender (LGBT) populations provides a literature review of tobacco use and its health implications for the LGBT community. It details tobacco initiation and use trends, and the potential health issues affecting LGBT populations because of smoking and exposure to secondhand smoke. Health disparities by age, race, ethnicity, socioeconomic status, education, biological sex, gender expression, and sexual orientation are summarized. The needs and opportunities to expand research and data collection on LGBT populations and their use of tobacco products are explored. Included in this review are strategies to incorporate LGBT populations in the population data to track the health promotion objectives of Healthy People 2010 concerning tobacco control and smoking cessation; recommendations for the inclusion of LGBT populations, particularly LGBT youth, in tobacco control efforts; and information on ways cultural competency measures may be effectively employed to better reach and serve LGBT populations. This chapter can be used as an educational tool for people interested in promoting healthy behaviors and preventing tobacco-related diseases among LGBT communities.

Issues and Trends

Tobacco use is one of today's most challenging health and social problems. Early use of tobacco as well as alcohol has been linked clearly to later substance abuse and behavioral problems.[1, 2] Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on smoking was released in 1964.[3, 4] The current Surgeon General's Report acknowledges that smoking rates among teens and adults could be cut in half within the next 10 years if the United States would fully implement antismoking programs using effective approaches that are already available.[5]

Rigorous surveillance, prevention, and treatment research are needed to change the cultural, psychosocial, and environmental factors that influence tobacco use, and to improve our understanding of smoking patterns and identify strategic tobacco control opportunities. Community-based programs can address risk factors that are identified for specific population groups. However, little is known about tobacco use among lesbian, gay, bisexual, and transgender populations and the effectiveness of prevention and treatment strategies within LGBT populations.

The single most important high-risk behavior associated with the leading chronic diseases is cigarette smoking.[6] Although cigarettes have multiple components, most attention is accorded to nicotine. This drug—nicotine—is not only highly addictive but also has been proven to contribute to cardiovascular disease.[7] The "safe cigarette," long sought after, has not been found.[8, 9]

Other popular forms of tobacco, such as cigars and bidis (small, imported, brown cigarettes that are hand-rolled in Tendu or Tamburni) are not safe alternatives to smoking commercial cigarettes. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.[10] Research shows that bidis are a significant health hazard to users, increasing the risk of coronary heart disease and cancer.[11] Reports have shown an increase in the popularity of bidis, particularly among youth, despite their potential negative health implications.[12]

The rate of smoking among adults in 1997 was 25 percent.[13] Studies have found higher levels of cigarette use among gay men and lesbians than among heterosexuals.[14,15,16,17] Recent representative studies of tobacco use seem to confirm that the prevalence rate of tobacco use among gay men is dramatically higher than among men in the general population. For

The American Legacy Foundation (ALF) is a philanthropic organization formed as a result of the historic 1999 tobacco settlement agreement. Its purpose is to promote national, State, and local smoking cessation and tobacco control programs. In November 2000, ALF convened more than 50 health researchers and professionals serving the LGBT population for a national health forum focused on tobacco use in the LGBT community. Forum participants discussed the various ways tobacco use impacts the LGBT community and made recommendations to ALF for the promotion of LGBT-specific tobacco control and smoking cessation programs. Forum participants reported a high prevalence of smoking in the LGBT community—particularly among youth, LGBT persons with low socioeconomic status, and LGBT people with mental illness. In addition, forum participants identified secondhand smoke as a potential health risk for LGBT people, since LGBT people are disproportionately represented as employees and consumers in venues (i.e., bars, clubs, and restaurants) with a more tolerant attitude toward smoking. Furthermore, participants reported an increase in smoking as a cultural norm among LGBT youth, particularly rural youth, runaway/homeless youth, and youth who accessed LGBT youth centers. Given the clear health needs of this community, ALF has prioritized LGBT populations for targeted interventions, research, and a range of health promotion activities designed to reduce smoking and other tobacco use. (More information can be found online at www.americanlegacy.org.)

example, a study reporting in 1999 found that 41.5 percent of gay adults in a household-based sample identified as smokers[18]—a rate that far exceeds the rate reported in other studies of men in the general population.[19, 20]

Tobacco initiation and addiction usually begin in adolescence. Among adults in the United States who have ever smoked daily, 82 percent tried their first cigarette before age 18, and 53 percent became daily smokers before age 18.[21]

Specific risk factors affecting youth initiating tobacco use include personal/individual, family, school, peer group, community, and society.[22] Many of the most important risk factors affecting tobacco use can be categorized as uncontrollable variables, such as genetic predisposition, age, and gender. More amenable to change are personal risk factors, including a lower self-image and lower self-esteem than peers, the belief that tobacco use provides a benefit, and the lack of ability to refuse offers to use tobacco.[23] From the prenatal stage through adolescence, the family—parents, caregivers, or parent surrogates—is the main influence in the development of youth and children, and the crucible in which problem behaviors and their antecedents are shaped.[24] For youth, failure in school is one of the strongest predictors of tobacco use.[25] The negative influence of peers is well established as one of the most important factors for youth, and the influence of peers continues to be important through adulthood.[26] There are many community risk factors that have been culled from the research.[27] One community risk factor that is relevant for LGBT youth is cultural disenfranchisement—i.e., a perception among youth that the dominant/mainstream culture is not relevant to them. Societal-level risk factors relate to national economic and employment conditions, discrimination, and marginalization of groups.[28] The relevance of these societal factors to LGBT people, especially youth, cannot be overstated.

The combination of influencing factors increases the risk of LGBT youth initiating tobacco use. In spite of the potential for increased risk, the short- and long-term effects of known risk factors, especially internalized and externalized homophobia, on smoking behaviors among LGBT youth is unstudied. And although youth have emerged as a major focus for tobacco use control efforts, LGBT youth with their specific risk circumstances have not been identified for preventive interventions.

Tobacco use among adolescents increased in the 1990s. Data from the 1999 Monitoring the Future Study indicated that past-month smoking among 8th-, 10th-, and 12th-graders was 18, 26, and 35 percent, respectively. These rates represented increases of 20 to 33 percent since 1991.[29] Data from the Youth Risk Behavior Survey revealed that past-month smoking among 9th- to 12th-graders rose from 28 percent in 1991 to 36 percent in 1997.[30] In 1997, past-month cigar use among 9th- to 12th-graders was 22 percent (11 percent of females and 31 percent of males).[31] The data necessary to determine tobacco use among LGBT youth were not collected in these studies as respondents were not questioned regarding sexual orientation or gender identity.

Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States, representing more than 5 million years of potential life lost.[32] If current

tobacco use patterns in this Nation persist, an estimated 5 million persons under aged 18 will die prematurely from a smoking-related disease.[33]

In addition to smoking tobacco, exposure to secondhand smoke has serious health effects.[34, 35,36] Researchers have identified more than 4,000 chemicals in tobacco smoke. Of these, at least 43 cause cancer in humans and animals.[37] Each year, because of exposure to secondhand smoke, an estimated 3,000 nonsmokers die of lung cancer.[38, 39] Studies also have found that secondhand smoke exposure causes heart disease among adults.[40,41] Data reported from a study of the U.S. population aged 4 and older indicated that, among non-tobacco users, 88 percent had detectable blood levels of serum cotinine, a biological marker for exposure to secondhand smoke.[42] Asthma and other respiratory conditions often are triggered or made more severe by tobacco smoke. Smoking seems to be the cultural norm for many social settings frequented by LGBT people (e.g., bars, circuit parties, dance clubs, youth centers), thereby giving weight to the notion that LGBT persons may be at disproportionately high risk for exposure to secondhand smoke and its associated negative health effects. However, additional research is needed to support or invalidate this thinking.

Disparities

Disparities in tobacco use exist among certain racial and ethnic populations. The 1998 Report of the Surgeon General[43] responded to the need to analyze thoroughly the smoking-related health status of racial and ethnic groups and to determine if there was a differential risk for tobacco addiction.[44] High risk might derive not only from personal characteristics, but also from social factors, such as changes in location, acculturation, and targeted advertising. Tobacco use varies within and among racial and ethnic groups. In general, the data suggest that "acculturation influences smoking patterns in that individuals tend to adopt the smoking behavior of the current broader community. . . ."[45]

American Indians and Alaska Natives (34 percent) are more likely to smoke than other racial and ethnic groups, with considerable variations in percentages by tribe.[46] Hispanics (20 percent) and Asians and Pacific Islanders (17 percent) are less likely to smoke than other groups. Regional and local data, however, reveal much higher smoking levels among specific subpopulation groups of Hispanics and Asians and Pacific Islanders.[47] Smoking levels among Vietnamese and Korean Asian Americans are higher than previously reported, according to a 1997 multilingual survey.[48] Additional research is needed to determine if sexual orientation or gender identity among people of color increases their risk for tobacco use.

Among adolescents, smoking rates differ between Whites and African Americans.[49, 50] By the late 1980s, smoking rates among White teens were more than triple those of African American teens. In recent years, smoking has started to increase among African American male teens, but African American female teens continue to have lower smoking rates.

Education and socioeconomic status are significant factors in determining the likelihood of tobacco use, including that among gay men and lesbians. Gay men and lesbians with higher

education levels are less likely to use cigarettes as frequently as those with lower levels of education.[51] Persons with 9 to 11 years of education (35 percent) have significantly higher levels of smoking than individuals with 8 years or less of education or 12 years or more. Individuals with 16 or more years of education have the lowest smoking rates (12 percent). Individuals below the poverty level are significantly more likely to smoke than individuals at or above the poverty level (33 percent compared to 25 percent)[52]—a fact that has important implications for the prevalence of smoking among LGBT individuals and families living in poverty.

Opportunities

Efforts to reduce tobacco use in the United States range from individually based interventions, primarily smoking cessation strategies, to more population-based interventions. Population-based interventions emphasize prevention of initiation, reduction of exposure to environmental tobacco smoke, and systems changes to promote smoking cessation.[53,54,55,56,57,58,59] Federal, State, and local government agencies and numerous health organizations have joined together to develop and implement these population-based approaches.

Smoking cessation research has generated the most advanced and effective brief and intensive behavioral intervention protocols.[60] Generally, these programs help patients to:

- Set a target date and specific plan for quitting
- Identify and cope with temptations likely to provoke relapse
- Effectively utilize nicotine replacement or other medications
- Solicit support from family or friends
- Secure continued followup and support services
- Prevent relapse

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, in partnership with the American Association of Health Plans and the American Medical Association, has developed a comprehensive Internet-based source for clinical practice guidelines. The National Guidelines Clearinghouse™ makes available a full range of current guidance on treatments for specific medical conditions or behaviors such as tobacco. (More information can be obtained online at www.guideline.gov.) More than 50 guidelines are relevant to tobacco, cigarette smoking, cessation programs, physician counseling, and nicotine replacement therapy.

Population-based community research studies and evidence from California, Florida, Massachusetts, and Oregon have shown that comprehensive programs can be effective in reducing average cigarette consumption per person. Both California and Massachusetts increased cigarette excise taxes and designated a portion of the revenues for comprehensive

tobacco control programs. Data from these States indicate that (1) increasing excise taxes on cigarettes is one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and to prevent initiation among youth, and (2) the ability to sustain lower consumption increases when the tax increase is combined with an antismoking campaign.[61] In addition, recent data from Florida indicate that past-month smoking decreased significantly among public middle school students (from 19 to 15 percent) and high school students (from 27 to 25 percent) from 1998 to 1999 following implementation of a comprehensive program to prevent and reduce tobacco use among youth in the State.[62] Unfortunately, because sexual orientation and gender identity were not variables within these studies, it cannot be determined whether these strategies will yield similar success in LGBT communities.

The goals of comprehensive tobacco prevention and reduction efforts include preventing people from starting to use tobacco, helping people quit using tobacco, reducing exposure to secondhand smoke, and identifying and eliminating disparities in tobacco use among population groups. These principles hold true for LGBT populations as well. To address these goals, several approaches are being implemented: community programs, media interventions, policy and regulation, and surveillance and evaluation. Specifically, the following elements are used to build capacity to implement and support tobacco use prevention and control interventions: a focus on change in social norms and environments that support tobacco use, policy and regulatory strategies, community participation, establishment of public and private partnerships, strategic use of media, development of local programs, coordination of statewide and local activities, linkage of school-based activities to community activities, and use of data collection and evaluation techniques to monitor program impact.

The importance of these various strategic elements has been demonstrated in a number of States, such as Arizona, California, Florida, Massachusetts, and Oregon.[63] In these and other States, tobacco control programs are supported through funding from the Federal Government, private foundations, State tobacco taxes, State lawsuit settlements, and other sources. These programs address issues such as reducing exposure to secondhand smoke, restricting minors' access to tobacco, treating nicotine addiction, limiting the impact of tobacco advertising, increasing the price of tobacco products, and directly regulating the product (e.g., requiring product ingredient reporting).

Tobacco control programs and materials should be culturally and linguistically appropriate. Given the racial, ethnic, age, and gender diversity within the LGBT community, this concept is especially applicable to LGBT populations. It is essential that tobacco control programs, the agencies and organizations that sponsor these programs, and the staff and personnel who administer such initiatives are LGBT-competent, sensitive to the needs of LGBT persons, and respectful of the rights of LGBT individuals to confidentiality and privacy.

Summary of LGBT Research

Smoking among lesbians and gay men. Studies of tobacco use in gay and lesbian populations, like surveys of alcohol use, tend to use nonrandom samples. In most cases, subjects typically include bar patrons who report tobacco use rates that are substantially higher than their heterosexual counterparts.[64] However, unlike studies of alcohol use, more recent representative studies of tobacco use seem to confirm the earlier suspicion that the prevalence rate of tobacco use among gay men is dramatically higher than among men in the general population. For example, 41.5 percent of gay men in a household-based sample identified as smokers[65]—a rate that far exceeds the 28.6 percent rate reported among men in the general population.[66]

Lesbian adults have been found to smoke more than heterosexual women. Data reported by the Institute of Medicine (IOM) point to significant differences in cigarette smoking status by sexual orientation. Two times as many lesbians reported heavy smoking than heterosexual women. The IOM report also suggests that, even though this issue is understudied, lesbians may experience high levels of psychosocial stress, which may be complicated by low socioeconomic status.[67] Smoking has also been found to be more prevalent among poor women than women of higher socioeconomic status,[68, 69] and among women who experience high levels of stress.[70, 71] Smoking rates may be especially high among lesbians of low socioeconomic status who also experience stress.

Some studies have found no indication that cessation interventions differ by gender. However, they acknowledge that the issue is understudied. Women may face different stressors and barriers to quitting, such as greater likelihood of depression, weight-control concerns, and issues surrounding childcare. Thus, cessation programs should be studied for differences by gender as well as sexual orientation to ensure that these suggested differences are identified and addressed.[72]

Representative studies of tobacco use among lesbians have not been completed. Nonrandom studies suggest that lesbians may smoke more and have a higher body mass index than heterosexual women, and that they may be at increased risk for cardiovascular disease and cancer.[73, 74, 75] Comparisons between young gay men and lesbians found that lesbians may actually smoke more than young gay men, which raises serious concerns about their risk of tobacco-related morbidity and mortality and underscores the need for additional research.[76] Lesbians and gay men have consistently reported higher levels of cigarette smoking (current, in the past year, and lifetime use) across all age levels than their heterosexual counterparts.[77, 78] More than 37 percent of LGBT respondents in one survey were current smokers,[79] whereas 36 percent of gay male and lesbian respondents (versus 30 percent of heterosexuals) in another national marketing survey identified as current smokers.[80] In an Australian study, more than half (54 percent) of the gay men in the Brisbane sample currently smoked,[81] compared to nearly 40 percent in the Melbourne sample.[82]

The most scientifically rigorous study to date on tobacco use among gay and bisexual men revealed that they were more likely to smoke cigarettes than men in the general population. Some 47.8 percent of the sample reported current cigarette smoking—significantly higher

than rates found in a general sample of adult men (28.6 percent). Smoking rates for gay men were also significantly higher than for men in general using both national prevalence estimates and State prevalence estimates for Arizona and Oregon separately. This held true even when prevalence estimates were stratified by age and education. Half of the youngest cohort of gay men aged 18 to 24 were current smokers, suggesting that smoking among gay men will continue to represent an enormous public health challenge in the years to come.[83]

Smoking among transgender persons. To date, no empirical data on tobacco use among transgender populations exist. However, smoking may be highly prevalent among transgender persons given identified risk factors: poverty, low educational attainment, a high prevalence of injection and noninjection substance use and abuse, stressful living and work environments (e.g., unstable housing, violence), incarceration, human immunodeficiency virus (HIV) seropositivity, and sexual risk patterns.[84] These risk factors suggest that tobacco use may be high among transgender populations. Additional research is needed to shed new light on the prevalence of tobacco use in this population and to design culturally competent interventions.

Smoking among HIV-positive persons. The medical literature contains conflicting reports on the effect of cigarette smoking on medical conditions related to the course of HIV infection.[85, 86, 87, 88, 89] Researchers have consistently found, however, an association between cigarette smoking and bacterial pneumonia, hairy leukoplakia, oral candidiasis, and dementia related to acquired immunodeficiency syndrome (AIDS) among people with HIV.[90, 91, 92, 93, 94, 95, 96, 97] The effect of cigarette smoking on the development of Pneumocystis carinii pneumonia (PCP) and Karposi's sarcoma (KS) is unclear. However, some research has indicated that cigarette smoking is related to the development of PCP, that smoking predicts a shorter time of progression to a diagnosis of AIDS, and that smoking is associated with a higher risk of death.[98, 99, 100] Other researchers have found no relationship between smoking and incidence of PCP or KS, progression to AIDS diagnosis, or death.[101, 102, 103, 104] One study found that 57 percent of HIV-positive men and women were current smokers.[105] In comparison to HIV-negative individuals, HIV-positive persons were significantly more likely to smoke.[106, 107]

Smoking and tobacco use among LGBT youth. Another study revealed that adolescent males who engage in same-sex sexual behavior also reported increased rates of tobacco use in comparison to their heterosexual peers, and that a higher number of male sexual partners was associated with higher rates of tobacco use, substance use, victimization, and use of violence.[108] However, there is no way to know where gay adolescents fit into initiation of smoking trends, to what degree LGBT youth are initiating smoking, or if LGBT youth are more likely than their heterosexual peers to start smoking or quit at an earlier age.

Tobacco-related illness in LGBT populations. As a result of high smoking rates, the burden of tobacco-related health problems is great among LGBT populations, including an increased risk of lung cancer and chronic obstructive pulmonary disease, and an increased risk for such cancers as esophageal cancer due to the co-occurrence of cigarette smoking and heavy alcohol use among LGBT individuals.[109, 110] Several investigators have

hypothesized that lesbians are at higher risk for breast cancer than heterosexual women due to higher rates of risk factors (e.g., obesity, alcohol consumption, nulliparity) and lower rates of breast cancer screening.[111, 112] Given the high prevalence of smoking among lesbians, tobacco-related health problems—such as lung, breast, and cervical cancer—may be elevated compared to women in general.

Tobacco marketing in LGBT communities. There is evidence that the tobacco industry aggressively targets the LGBT community.[113] A survey of more than 300 gay men and lesbians in Los Angeles revealed that 59 percent of respondents either "disagree" that tobacco companies target the LGBT community or were "not aware" that they were being targeted. Some 44 percent of those same respondents, however, reported that they recalled seeing tobacco companies sponsor bar and night club events to promote their products, and 50 percent reported using cigarettes during the 7 days prior to completing the survey. Some 53 percent also "agreed" that tobacco use is an "acceptable" norm among their peers.[114]

Tobacco companies have been enormously successful in adopting the strategies of alcohol businesses—positioning the tobacco industry as a valuable "friend" to LGBT communities. This is particularly true for community LGBT youth organizations that are dependent on the tobacco industry and funding for prevention of HIV and sexually transmitted diseases (STDs) to provide services to their underserved populations. A spokesperson for Philip Morris Companies, Inc., noted that in 1990 the company contributed more than $800,000 to AIDS-related charities and the following year donated $10,000 to the Gay and Lesbian Alliance.[115] At the same time, LGBT community leaders, organizers, health professionals, advocates, and HIV/AIDS service organizations seem to remain oblivious to the impact of tobacco money on their own work and are often resistant to discussions of these issues. In some instances, this resistance may stem from their own use of tobacco.

Developing partnerships with key individuals within large advertising and marketing firms could help facilitate the development of appropriate media messages that both serve the advertisers' function (e.g., selling a product) and the LGBT community (e.g., increasing positive LGBT images, reducing health-negative behaviors, reducing homophobia, and addressing other issues of concern to the LGBT community). Assisting LGBT youth and adult service organizations dependent on tobacco industry funding to identify and cultivate alternative funding to meet their financial needs would loosen the tobacco industry's grip on the LGBT community.

The need for new, LGBT-specific knowledge. There is a lack of concrete data on tobacco use among LGBT persons. In addition, there is a lack of formative or market research on youth who are either coming out or questioning their sexuality and for whom preventive strategies could be effective in stopping the onset of tobacco use. Within the LGBT network of health and social services, attempts to address tobacco use have been few and far between—and easily overshadowed or abandoned in the face of other more immediate crises, such as HIV/AIDS or breast cancer. Finally, there are no evaluated model programs for preventing tobacco use in LGBT populations, no rigorous evaluations of the very few LGBT-specific smoking cessation programs offered in a handful of localities, and no tracking treatment programs for LGBT people enrolled in managed care organizations.

Discussion of Healthy People 2010 Objectives

27-1: Reduce tobacco use by adults.

Existing research indicates that a broad range of health care providers can effectively deliver cessation interventions, yet only a minority of smokers reports being advised to quit.[116] There are well-documented problems with access to appropriate and culturally competent health care and health insurance for LGBT individuals.[117, 118, 119, 120, 121, 122, 123, 124] If those who want to quit smoking do not have access to a culturally competent health care provider who is educated and prepared to screen for tobacco use and able to administer the appropriate intervention, they may miss out on important counseling and nicotine replacement therapies that also might be covered by insurance. Commonly, over-the-counter nicotine replacement therapies are not covered by health insurance plans and may be cost-prohibitive for individuals to purchase out-of-pocket.

The Urban Men's Health Study is a household-based instrument with a probability sample of men who have sex with men (MSM) in San Francisco, Los Angeles, New York, and Chicago. A followup tobacco study conducted by Dr. Ron Stall and Dr. Greg Greenwood is expected to yield new data on smoking among MSM, including current and lifetime tobacco use, attempts to quit smoking, and attitudes about smoking. The study is funded by the California Tobacco-Related Disease Research Program, Urban Men's Health Study, and National Institute of Mental Health.

Whenever possible, smoking cessation programs should be tailored to the different needs of the diverse populations being served. The Agency for Healthcare Research and Quality guidelines recommend that, when there is a lack of studies on smoking treatment in minority communities, more research should be conducted to better understand the treatment needs of the population and to develop culturally appropriate interventions.[125] This recommendation is directly applicable to LGBT communities and should be considered a top public health priority.

To track the success of targeted interventions for LGBT populations and to document improved outcomes, researchers, policymakers, program planners, and others concerned with reducing LGBT tobacco use must work to obtain a more accurate measurement of how many LGBT persons use tobacco products. Better surveillance data on LGBT tobacco use are urgently needed. Existing research seems to indicate that LGBT populations smoke at significantly higher rates than the general population. However, obtaining accurate estimates of smoking prevalence in the LGBT community is difficult because:

- Large-scale household-based surveys do not ask the sexual orientation or gender identity of respondents.
- Large-scale household-based health studies that have samples of LGBT people do not ask about tobacco use.
- Most studies to date have relied on convenience samples (e.g., people in bars or clinics), where smokers were more likely to be present.

- Due to small sample sizes, studies have been unable to examine effectively whether groups of LGBT populations are disproportionately affected by tobacco use. It is crucial that ethnicity/race, age, gender, education, geography, and socioeconomic status be included as demographic variables in studies of LGBT tobacco use as well as the effectiveness of tobacco use interventions.

27-2: Reduce tobacco use by adolescents.

Little is known about tobacco use among LGBT youth, in part because many young people do not self-identify as LGBT until early adulthood, and because of the distrust LGBT youth frequently have of adults, institutions, authority figures, and the health system. However, Stall and colleagues found that smoking rates were highest among younger gay and bisexual men,[126] theorizing that smoking initiation among this group occurred during adolescence. LGBT youth may be at particularly high risk to initiate tobacco use given risk factors: lack of support from family and peers, depression, low self-esteem, and stressful life events related to "coming out."[127]

27-3: (Developmental) Reduce initiation of tobacco use among children and adolescents.

Psychological and behavioral factors significantly influence the onset of smoking behavior in youth. These include poor self-esteem, peer pressure, misperceptions about the number of youth who actually smoke, and exposure to opinion leaders who influence behavior.[128, 129]

The younger the person is when he or she begins to smoke, the more likely the person is to be a smoker as an adult. Nearly all smoking begins in adolescence. However, if initiation is delayed until adulthood, rates of new smoking decline significantly.[130] Adolescents with fewer coping skills to resist peer influences are more likely to smoke.[131, 132] Youth who smoke are also more likely to attempt suicide and engage in high-risk activities. Although the act of smoking is not causal in nature, these behaviors are found in greater numbers of LGBT youth when compared with the general population and should be considered as a constellation of related behaviors. The exact nature of this relationship or interrelationship is unknown but should be considered an opportunity for a targeted, comprehensive health promotion program.

LGBT youth are more likely to have lower self-esteem because of external and internalized homophobia.[133] LGBT youth often experience low perceived levels of adaptive social support due to internalized or externalized homophobia. Because lower self-esteem is associated with smoking, this places LGBT youth at greater risk for smoking. Smoking behavior is usually the first substance used prior to the initiation of alcohol and other drug use.[134] There is a high rate of substance abuse among LGBT teens, generally associated with difficulty in adaptive coping.[135] If smoking behaviors among LGBT teens can be prevented or delayed, other substance use may be prevented or delayed as well.

27-5: Increase smoking cessation attempts by adult smokers.

Culturally competent smoking intervention services for the LGBT community have not been developed, and research on the topic is lacking. The absence of research on tobacco use cessation treatment or interventions that are specific to the LGBT community pales in comparison to treatment development and research of LGBT-specific interventions for other health risks (e.g., alcohol and drug use, STD/HIV treatment and prevention) as well as ethnic-specific tobacco treatment research and intervention. Existing research indicates that although a broad range of health care providers can effectively deliver cessation interventions, only a small number of smokers report being advised to quit.[136]

The Last Drag Program in San Francisco, an LGBT-affirming, community-based smoking cessation group, serves as a promising smoking cessation model for LGBT populations. Created in the early 1990s, the intervention is based upon the volunteer models of smoking cessation supported by the American Cancer Society and the American Lung Association. Outcome data are minimal, and the model has not been empirically tested. However, 42 to 47 percent of participants reported successfully becoming nonsmokers by the end of an 8-week class. Two-thirds of the clients are men, one-third are people of color, and one-tenth do not identify as gay.

Additional future data may become available through the Queer Tobacco Intervention Project (QueerTIP), which is a 1-year (2000-2001), State-funded Pilot Community-Academic Research Award to build partnerships to reduce smoking in the LGBT community. The program is conducting a community-based pilot research project to design and evaluate tobacco cessation services specifically designed for LGBT populations. Although the long-term goal is to reach every segment of the LGBT community, the current scope of the pilot project is limited due to funding constraints. Over the course of the next year, the project will establish and evaluate a comprehensive tobacco intervention program designed specifically to reach young lesbians, bisexual women, transgender persons, and all LGBT persons. The project is built on four primary goals:

Another potential model is the King County (Seattle, Washington) Sexual Minorities Tobacco Coalition. Launched in 1995, the coalition joined forces with Emily Brucker to develop Out and Free, a smoking cessation guide that applies the skills learned during coming out to quitting smoking. The goal of the coalition is to increase awareness of the risks of smoking, conducting advocacy, encouraging appropriate public policy, and promoting cessation.

- To strengthen collaborations among researchers, health advocates, and community providers and organizations serving the LGBT community in San Francisco
- To review tobacco services and research to date with the LGBT community to identify best treatment and intervention approaches

- To develop comprehensive tobacco intervention services specifically designed for the LGBT community, including a CORE [Commitment, Opportunity, Responsibility, and Education] smoking cessation model and a multicomponent network system for referrals to LGBT-positive treatment providers
- To submit a proposal for a 3-year, community-based, randomized clinical trial of LGBT-positive tobacco intervention services

27-6: Increase smoking cessation during pregnancy.

No data are available on smoking rates during pregnancy among lesbians and bisexual women. Although a significant degree of planning may occur prior to pregnancy among lesbians, a number of issues still merit attention. For lesbians who smoke and are pregnant, many health care providers may be unable to provide culturally competent care and counseling. Some lesbian mothers-to-be may not reveal their sexual orientation to their health care provider and remain closeted throughout the prenatal care process. Specific issues facing adolescent girls and young adult women who are questioning their sexuality and are pregnant need to be addressed. In addition, as in all households, male partners and other individuals living in the household must stop smoking so that the mother and fetus are not exposed to secondhand smoke.

Many individuals in the LGBT community are parents or planning to be parents. As a result, the same tobacco prevention and smoking cessation principles recommended to heterosexual individuals who are parents or planning to be parents should be used in counseling LGBT individuals who are parents or contemplating parenthood. However, such strategies need to be accessible to LGBT individuals and delivered in an LGBT-competent way. In addition, some LGBT youth who live with their families of origin have the same opportunity as their non-LGBT counterparts to assist their mothers in trying to stop smoking if the mothers are pregnant. This educational opportunity is mutually beneficial to all parties.

27-7: Increase tobacco use cessation attempts by adolescent smokers.

Several challenges are associated with introducing tobacco cessation attempts among LGBT youth. Access to adequate health insurance that covers the cost of smoking cessation products presents the most formidable challenge. Some youth who live in metropolitan areas can participate in smoking cessation courses that may be offered by LGBT community centers. QuitNet is an Internet Web site that brings proven scientific methods online to deliver support to smokers whenever they need it. (More information is available online at www.quitnet.org.)

In addition, youth smoking cessation is complicated by the fact that developmental and psychosocial issues can influence the effectiveness of smoking cessation efforts and that few youth report the onset of smoking. In many cases, smoking serves a social function for youth attempting to improve self-image and exhibit what they believe to be normative behavior. LGBT youth often experience a greater sense of being different (cognitive

dissonance) that they may try to decrease though using behaviors that allow them to feel part of the mainstream group of youth. Given the complexity of these factors, smoking cessation efforts aimed at LGBT youth must address the psychological function that smoking serves, or cessation efforts are unlikely to be effective.

27-8: Increase insurance coverage of evidence-based treatment for nicotine dependency.

The American Association of Health Plans (AAHP) was awarded a 4-year, $1.4 million grant from the Robert Wood Johnson Foundation to assist AAHP in developing and managing a broad technical assistance program to support the foundation's recently announced Addressing Tobacco in Managed Care Program. Specific activities of AAHP's National Technical Assistance Office (NTAO) are cofunded by the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality.

AAHP is coordinating the NTAO efforts with its member plan, the Health Alliance Plan in Detroit, Michigan, to develop a multifaceted tobacco resource center. Information will be available to health plans, the medical and academic communities, public health, and health care consumers through numerous ongoing programs and activities. During the 4-year project, NTAO will direct an ongoing process to:

- Develop a comprehensive network of key contacts in health plans responsible for smoking cessation and health promotion
- Establish a clearinghouse of tobacco prevention information gathered from academic and professional journals, conferences, newsletters, and white papers

The goal of NTAO is to provide health plans with all the resources necessary to implement and support comprehensive tobacco prevention and cessation programs within the health plan's membership or the larger community, using proven and available methods as a tool to design interventions most appropriate to the plan's target populations. NTAO expects to compile diverse examples of best practices that will be easily adaptable in a variety of managed care settings. (More information can be obtained online at www.aahp.org.)

Although there appear to be no data on insurance coverage for evidence-based treatment of nicotine dependence for LGBT populations, some LGBT persons lack insurance coverage for nicotine dependency treatment. In addition, treatment interventions were not designed with the needs of LGBT smokers in mind, and providers may not have the skills or knowledge to deliver those interventions in a culturally competent manner.

Diseases related to tobacco use exact an enormous financial toll on the public-sector health care system. Private-sector health care organizations should assume at least partial responsibility for reducing future tobacco-related morbidity and mortality by increasing LGBT access to nicotine treatments and ensuring that LGBT individuals have equal access to early diagnosis and treatment services for tobacco-related illnesses.

27-9: Reduce the proportion of children who are regularly exposed to tobacco smoke at home.

Many children and adolescents living in LGBT families are exposed to secondhand (or environmental) tobacco smoke. LGBT parents who smoke may be reluctant to disclose their smoking habit to health care providers. This presents a barrier to parents receiving smoking cessation counseling and continues to expose their children to risk. LGBT parents and other LGBT adults who smoke tobacco at home need to be educated about the risks to others living in the home and encouraged to seek treatment. In addition, the treatments available to LGBT individuals who want to quit should be LGBT-competent and delivered in a nonstigmatizing, nonjudgmental way.

27-10: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Bars and clubs serve as an important gathering place for many LGBT individuals. However, exposure to secondhand smoke has presented a serious concern for nonsmokers seeking a physically safe, LGBT-affirming place to socialize and congregate.

Several LGBT advocacy groups—such as Community Focus, the Coalition of Lavender Americans on Smoking and Health, and the California Lavender Smoke-Free Network—played a role when California bars and restaurants were required to become smoke-free. One group used the anticipated implementation of smoke-free bar rules to conduct intercept surveys at LGBT pride events in Los Angeles, in part designed to begin preparing the LGBT community for the prospect of nonsmoking gay bar life. The Los Angeles planning group also did some outreach to gay bar and tavern owners in advance of the new regulation's taking effect. A very popular bar in West Hollywood, California, hosted a smoke-free night once a week. The increased patronage on the smoke-free nights was significant in encouraging other such businesses to plan to comply with the new laws rather than ignore or actively resist.

27-12: Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.

Healthy People 2010 recognizes that legislative change is required to ensure that all workers in the United States, including LGBT people, should be protected from secondhand smoke. Such policies not only safeguard the health of nonsmokers but can also provide the impetus for a smoker to quit.

In the LGBT community, gay businesses are often the most common places where LGBT persons gather to socialize. The store or business owners and staff have the right to perform their jobs in a safe environment, and the patrons and customers have the right to shop or safely congregate, without being exposed to secondhand tobacco smoke. Federal, State, and

local governments should work in partnership with LGBT business owners and managers to implement and enforce smoke-free environments that safeguard the health of employees and customers.

27-16: (Developmental) Eliminate tobacco advertising and promotions that influence adolescents and young adults.

Media portrayals directly and indirectly influence how youth and young adults, including LGBT young people, perceive smoking. Advertising affects how youth perceive smoking by influencing their perception of smokers. If the media or advertising is used to promote the onset of smoking, then media can be effective in discouraging smoking or preventing tobacco use. Media messages that overtly include LGBT youth in general are rare, yet media messages represent an untapped resource in conveying positive messages about self-esteem and in discouraging smoking. Federal, State, and local agencies should join forces with LGBT national and community organizations to sponsor counteradvertising that promotes health-positive messages and discourages tobacco use.

27-17: Increase adolescents' disapproval of smoking.

Attitudes and beliefs are an important part of influencing behavior. LGBT youth are likely to differ in key ways from heterosexual youth on general attitudes and beliefs about the desirability of smoking. Exactly how they differ is unknown. However, effective programs need to be specifically tailored to the targeted group. Hence, smoking cessation programs should take into account how attitudes that support smoking may function as barriers to tobacco cessation and prevention strategies and should include modification of these attitudes as part of the program activities directed to LGBT youth or the community.

27-18: (Developmental) Increase the number of tribes, Territories, and States and the District of Columbia with comprehensive, evidence-based tobacco control programs.

Although the LGBT community may not be directly connected to the tobacco control programs in States, Territories, and tribal jurisdictions, LGBT populations should be reflected in local strategies as they are among the general population. It is crucial that LGBT individuals be actively involved in the planning, implementation, and evaluation of tobacco control programs to ensure that they are LGBT-competent, nondiscriminatory, and reflective of the LGBT community's needs.

Services—RECOMMENDATIONS

- Smoking prevention and cessation programs must be LGBT-competent, affordable, and accessible to LGBT individuals.
- LGBT-oriented community centers and other LGBT-affirming community-based organizations should be recognized as resources and included in developing, implementing, and evaluating culturally competent smoking cessation and prevention programs.

Education and Training—RECOMMENDATIONS

- Because clinical cessation guidelines may be used as a training tool for educating health care providers, LGBT-specific concerns regarding tobacco use and LGBT-competent prevention and treatment services should be reflected and addressed in such guidelines.
- Health care providers need training on how to provide culturally competent care to LGBT smokers and to adhere to guidelines on tobacco screening and treatment.
- Counter-advertising campaigns that promote health-positive messages should be conducted and targeted to LGBT populations. Such campaigns could be modeled after the "Truth" campaign and California Department of Health Services antismoking campaigns.

Policy and Advocacy—RECOMMENDATIONS

- LGBT individuals must have access to comprehensive, nondiscriminatory health insurance that covers smoking cessation products and services.
- LGBT communities must be educated about tobacco advertising and its role in promoting tobacco use.
- Health-positive environments for LGBT and questioning youth must be funded, supported, and sustained so that LGBT youth have healthier venues in which to socialize and "come out."

Research—RECOMMENDATIONS

- Sexual orientation and gender identity must be included in national and local data sets to study differences in smoking rates and treatment success.
- Data are needed on a variety of LGBT-specific tobacco-related issues so that culturally competent social marketing and public education campaigns, prevention activities, and cessation programs can be established and implemented.

Terminology

Consumption: The amount of tobacco products consumed or used by the population. Consumption usually is measured in units, such as the number of cigarettes smoked or pounds of spit tobacco used over a given period of time.

Counteradvertising: The placement of pro-health advertisements on TV, on radio, in print, on billboards, on movie trailers, on the Internet, and in other media.

Nicotine dependency: Highly controlled or compulsive use, use despite harmful effects, withdrawal upon cessation of use, and recurrent drug craving.

Secondhand smoke: A mixture of the smoke exhaled by smokers and the smoke that comes from the burning end of the tobacco product.

Serum cotinine: A biological marker for tobacco use and exposure to environmental tobacco smoke measured in the blood. Cotinine is a breakdown product of nicotine.

Spit tobacco: Chewing tobacco, snuff, or smokeless tobacco.

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