The Check-Out Project

An Examination of Smoking and Tobacco Attitudes in the LGBTQ Community in Missouri

September 2009

Acknowledgements

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September 15, 2009

Dear Reader:

It is with pleasure that I introduce the culmination of over a year of effort by dozens of health disparity advocates and literally thousands of members of the lesbian, gay, bisexual and transgender (LGBT) communities in the Eastern Missouri region. What follows is a historic report on the health status of a traditionally underserved group of people in a region where we know too little detail about health disparities in general. This tobacco needs assessment for the LGBT communities follows precedent set by other states in collecting in-depth data about a population whose tobacco disparities are pronounced, as one step in the development of interventions that are truly tailored and tested effective for that group. Collecting of in-depth community-based data on this health disparity is a best practice, one we strongly recommend for all localities.

I would be remiss though, to present this report as just another in the many local studies needed to help counter the challenge of disproportionate LGBT tobacco use. I would like to draw your attention to the incredible number of participants in this needs assessment, over three thousand in total. Then, note also the strategy of multi-modal data collection, both through different routes of survey administration, and supplementation with focus groups. Finally, please note the distinct inclusion of racial and ethnic minority voices in this dataset, an outcome that I know was won through a full set of deliberate partnerships and strategies integrated into the full research plan. Of course there are some groups who are not as adequately represented; a research study without this would be rare indeed. In all, through the depth of data collection, multi-modal approach, and inclusion of racial/ethnic minority voices, this LGBT tobacco needs assessment is outstanding among state-of-the-art work being done nationally. I sincerely congratulate the researchers, community advisors and many workers on the project for the success of this study. I look forward to further information on resultant interventions. While we rarely think of farmbelt states as leaders in health disparity work, I say with this needs assessment Missouri sets the standard for others to match and gets a grade of A+.

Sincerely,

Scout, Ph.D.
Network Director

Executive Summary

According to the Centers for Disease Control and Prevention (CDC)[1], a lack of evidence-based programs intended to identify and eliminate tobacco-related disparities has hindered efforts to reduce prevalence rates among affected populations. Disparities exist among populations and result in increased tobacco-related deaths and disease. These populations are subject to a disproportionately high use of tobacco, increased targeting by the tobacco industry and a lack of tailored programs to reduce tobacco use in these communities.

This is especially true among the lesbian, gay, bi-sexual, transgender, and gender queer (LGBTQ) residents of Missouri. The following report details findings of an assessment of tobacco use and attitudes among Missouri's LGBTQ community.

Findings

LGBTQ community members in Missouri are 1.5 times more likely to smoke than Missourians in general. 36.1% of LGBTQ responded as a current smoker. This is significantly higher than the general smoking rate for Missouri, 24.5% (2007 BRFSS).

LGBTQ community members in Missouri do not believe they smoke more than Missourians in general. 63% of LGBTQ community members believe they smoke at the same rate or less than Missourians in general. In addition, findings demonstrate a lower level of knowledge about the harmful effects of smoking and exposure to secondhand smoke.

LGBTQ community members in Missouri are *less likely to attempt to quit* in the next six months. When surveyed, 37.0% of LGBTQ responded they intend to quit smoking in the next six months. When the same question was asked of Missourians, in general, in 2007; 63.8% responded they intended to quit in the next six months.

Smoking was seen as a coping tool and immediate stress reducer. Respondents stated that they used smoking to cope with various situations or particular negative emotions.

> "Smoking is definitely for me a way to avoid feeling whatever I'm feeling. So whether it's sad, lonely, whatever…my attempts to not smoke, which I've had one that lasted three months, I had all these feelings come up and I didn't have an outlet for them" – Current smoker

There is a general lack of understanding of targeting by the tobacco industry. Industry documents show tobacco companies' awareness of high smoking rates among sexual minorities, and marketing plans illustrate the companies' efforts to exploit the LGBTQ market.[2, 3, 4, 5] Many

1 Centers for Disease Control and Prevention – Smoking and Tobacco Use (www.cdc.gov/tobacco)

2 Johnson, B. 'CEM's Gay and Lesbian Marketing Efforts.' Legacy Tobacco Documents Library. Philip Morris. October 9, 1997. Access Date: September 10, 2002. Bates No. : 2071145104. URL: http://legacy.library.ucsf.edu/tid/dup28d00.

3 Washington, Harriet A. Burning love: Big tobacco takes aim at LGBT youth. American Journal of Public Health 2002;92:1086–1095.

4 Harris Interactive. Gays and Lesbians More Likely to Smoke than Other Adults Despite Risks. May 14, 2001. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=289http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=289.

5 Ryan H, Wortley P, Easton A, Pederson L, Greenwood G. Smoking among lesbians, gays, and bisexuals: a review of the literature. American Journal of Preventive Medicine 2001. 21(2): 142-149.

surveyed discussed free product handouts at bars; however, they didn't feel they were being targeted any more than other groups. Many respondents embraced the industry as being more "accepting".

Conclusions:

This report identifies significant tobacco-related disparities in Missouri's LGBTQ community and provides a broad description of the LGBTQ community with regards to tobacco issues. There is a higher rate of smoking and a lower rate of successful cessation. There is a lower level of knowledge of the harmful effects of smoking and exposure to secondhand smoke, and a general lack of awareness of evidence-based cessation treatment options.

Unfortunately, there is also a significant lack of awareness of the disparities identified in this assessment. The LGBTQ community of Missouri is unaware of these disparities and the health impact of tobacco use.

Recommendations:

These findings will serve as the evidence base for the development of interventions that will begin to reduce the health disparities caused by tobacco use in the diverse Missouri LGBTQ community.

Use of this information by community leaders can lead to the development of tailored interventions, effective outreach and education activities, and increased access to services in Missouri's LGBTQ community.

Introduction to the Check-Out Project

Tobacco-related health disparities exist in sub-populations due to a combination of the following circumstances: tobacco use initiation rates are high resulting in more daily smoking; low levels of quit attempts reduce the number of persons who achieve long-term abstinence; and persons are exposed to secondhand smoke. In these situations, predictably, there are high rates of tobacco-related morbidity and mortality. In a review of published studies, it is estimated that smoking rates for lesbian, gay, bisexual, transsexual/transgender and genderqueer (LGBTQ) range from 38% to 59% among youth and from 11% to 50% among adults. National smoking rates for the general population range from 28% to 35% for adolescents and about 28% for adults. These higher than average smoking rates for the LGBTQ community suggest this population is at significant risk for health-related disparities. Prior to this study, little information existed with regard to tobacco use and its role in the Missouri community.

The Missouri Foundation for Health's Eliminating Tobacco Health Disparities research funding announcement allowed for leadership of the University of Missouri's Campus-Community Alliances for Smoke-free Environments (CASE) to propose a study using multiple assessment methods to better understand the risk for tobacco-related health disparities of Missourians. With funding beginning in December 2007, The Check-Out Project commenced with a goal of providing an in-depth and comprehensive assessment of tobacco use and a better understanding of factors that could ultimately lead to reductions in health problems caused by tobacco use. The following report provides a description of the project organization, its methods, and findings from analyzed data.

Previous Data on Health for Missouri LGBTQ Communities:

In Kansas City, Missouri, THE PULSE (a community health assessment of LGBTQ in the greater metropolitan Kansas City area) was conducted in 2003 and 2006. In both studies, the smoking rate of the LGBTQ population was significantly higher than the smoking rate of the general population in the Kansas City area. Cigarette smoking represented 86% of those using tobacco products. Of all smokers in the sample, 35% reported smoking 1-9 cigarettes, 54% smoking 10-19 cigarettes, and 11% smoking 20 or more cigarettes per day. Overall, 71.3% of persons identified as current smokers indicated wanting to quit. One conclusion was that further assessment was needed to understand the issues and patterns related to smoking.

Description of Project Procedures & Methods

Four strategies were used in this project including establishing a project organizational structure, and three data gathering strategies: focus groups of current and former smokers, surveys at four Pride Festivals, and a more in-depth web-based survey.

Project Organization

The project was managed on a day-to-day basis by a project coordinator. The project coordinator received oversight from a project director (primary supervision of day-to-day activities of the project) and a faculty principal investigator (scientific and financial oversight). To increase the likelihood of meeting project goals a project advisory board (see Appendix A) was chosen. Members were representative of the LGBTQ population and helped facilitate data collection to meet project goals. The project was further assisted by two consultants working from the LGBTQ Community Center of Metropolitan St. Louis and Dr. Scout from the Fenway Institute and the National LGBT Tobacco Control Network. Over the course of the project three advisory board meetings were convened to receive feedback on survey development, brainstorm recruiting activities, and solicit ideas for disseminating the study findings.

Data Collection Strategies

Survey Collection at Pride Festivals

The development of a survey that could be reliably completed by persons attending Pride Festivals involved a review of other tobacco-related surveys used to assess the LGBTQ communities, discussions with project staff, advisory board members, and project consultants. The result was a 38-item survey with questions on basic demographic information, smoking behavior, and opinions/knowledge about tobacco use and exposure to secondhand smoke. Surveys were collected at four Pride Festivals: Columbia, Springfield, St. Louis and Black Pride for a total of 2,836 completed surveys.

Procedures were developed to establish a presence for the Check-Out Project at the Pride events. A booth was reserved and manned at each event. Free water and candy were provided for festival attendees. Temporary staff (primarily recruited with assistance from the Advisory Board) were trained on study protocol and then recruited adults 18 years and older to complete surveys. Individuals completing the survey were eligible for a drawing for an MP3 player. Pride Festivals gave the project access to a broad range of individuals attending these events.

Web-Based Survey

A more extensive survey was prepared for web-based distribution, with many items from the Pride survey included. The web-based survey provided additional data on a variety of health and relationship behaviors. Additionally, any person indicating they were a current smoker completed a series of extra questions from measures of the Transtheoretical Model. This survey was posted online for six weeks and generated 247 responses. A link to the Student Voice website provided access and data collection functions for this aspect of the project. Respondents were eligible for a drawing for an MP3 player.

Focus Groups

Focus groups served as an additional method to gain insight into the attitudes, opinions and behaviors of the LGBTQ community regarding tobacco use. For each focus group, five to ten individuals were recruited from the LGBTQ community to take part in a 90-minute facilitated discussion. Each group session was held in a location where privacy was assured and participants could feel secure in expressing themselves. A facilitator and a notetaker were

present and the confidentiality of participants' comments was a high priority. A facilitator's question guide was developed and followed for each group.

Current smokers were the participants in three focus groups, while former smokers were the participants in one focus group. The focus groups with current smokers were composed by age: 18 to 24, 25 to 34, and 35 and older. The one former smoker group was composed of people of all ages. Advisory board members played a critical role in identifying participants for each of these groups. Specifically, our advisory board members were known and trusted in the LGBTQ community, and this increased willingness to participate. These sessions were audiotaped and then transcribed. The content of sessions was analyzed by a team to identify emerging themes to more completely describe issues pertaining to smoking and trying to quit for LGBTQ smokers and former smokers.

These varied strategies provided important information about the LGBTQ community in Missouri. The following sections describe the findings of the Check-Out Project.

Findings

This section provides results from analyses of quantitative data from the Pride and web-based surveys and qualitative analyses of the focus groups. A description of our entire sample of participants is provided, with a separate presentation of findings for only the LGBTQ community through a series of tables, charts, and narrative.

Demographics of All Survey Participants

Table 1 is a description of all participants (Pride Festivals and web-based surveys) in the Check-Out Project. There were 2,832 participants who completed Pride Surveys and 247 who completed the web survey. Sociodemographic variables including age, sexual orientation, gender, race/ethnicity, education, employment, smoking status, and general health are presented in Table 1. Our survey participants as a whole are representative of Missouri with regard to race/ethnicity, with 73.1% of the sample white, 15.3% black, 2.4% Hispanic, and 9.2% other. The Pride and web survey participants have significantly higher education levels than other state level surveys, with over 40% (Pride) and over 70% (web) indicating a college degree. About 80% of our participants at the Pride Festivals were under the age of 45, compared to only 60% of web survey participants, while about 80% of Pride and web survey participants are employed. The range of sexual orientation for the sample is as follow: 34% of the sample is lesbian, 32% of the sample is gay, 10% is bisexual, 3% is queer, 19% heterosexual, and 3% unsure/don't know/other. Gender for this sample is as follows: 58% women, 39% men, and 3% transgender, transsexual, or genderqueer. In all data reported, the number of participants may vary as some participants did not answer every question.

Table 1: Participants in Checkout Project Completing Pride and Web Surveys

	Pride (number) %	**Web** (number) %	**Total** (number) %
Age			
18–24	(898) 33.6	(36) 15.7	(934) 32.1
25–34	(746) 27.9	(55) 23.9	(801) 27.6
35–44	(507) 18.9	(60) 26.0	(567) 19.6
45–54	(350) 13.0	(46) 20.0	(396) 13.6
55–64	(132) 5.0	(25) 10.8	(157) 5.4
65–	(43) 1.6	(8) 3.6	(51) 1.7
Sexual Orientation			
Lesbian	(910) 32.4	(82) 34.0	(992) 33.7
Gay	(843) 30.0	(93) 35.6	(936) 31.8
Bisexual	(360) 12.8	(26) 11.1	(286) 9.7
Queer	(65) 2.3	(15) 6.4	(80) 2.7
Heterosexual	(537) 19.1	(14) 6.0	(551) 18.7
Don't Know / Not Sure / Other	(93) 4.1	(5) 2.1	(98) 3.3
Gender			
Male	(1096) 38.7	(101) 43.2	(1197) 39.2
Female	(1649) 58.3	(116) 49.6	(1765) 57.6
Transgender	(32) 1.1	(6) 2.6	(38) 1.2
Transexual	(16) 0.6	(5) 2.5	(21) 0.5
Gender Queer	(29) 1.0	(6) 2.6	(35) 1.2
Other	(8) 0.3	(0) 0.0	(8) 0.2
Race/Ethnicity			
Black / African-American	(437) 16.4	(7) 3.1	(444) 15.3
Caucasian	(1921) 72	(205) 88.7	(2126) 73.1
Hispanic / Latino	(58) 2.1	(4) 1.7	(69) 2.4
Other	(253) 9.5	(15) 6.5	(268) 9.2
Education			
High School or <	(446) 17.4	(5) 2.2	(451) 16.1
Post-High School / Some College	(1067) 41.5	(58) 2.2	(1125) 4.0
College Grad or >	(1058) 41.2	(168) 72.7	(1226) 43.8
Employment			
Employed	(2056) 80.1	(181) 78.0	(2237) 80.0
Not Employed	(335) 13.8	(27) 11.7	(382) 13.6
Full-Time Student	(156) 6.1	(23) 10.0	(179) 6.4
General Health			
Excellent	(33) 1.2	(2) 0.9	(35) 1.2
Very Good	(201) 7.4	(16) 6.8	(217) 7.3
Good	(784) 28.8	(59) 25.1	(843) 28.5
Fair	(1029) 37.8	(122) 51.9	(1151) 38.9
Poor	(678) 24.8	(36) 15.3	(714) 24.1

Smoking Status and Demographics of LGBTQ Community

Table 2 combines the LGTBQ respondents from the Pride and web surveys to determine the smoking status of this group in terms of being a current smoker ("daily" or "some days"), former smoker, and never smoker.

Table 2: Smoking Status

	Current Smoker (n) Row Percent	Former Smoker (n) Row Percent	Never Smoker (n) Row Percent
Lesbian (n= 949)	(360) 37.9%	(186) 19.6%	(403) 42.5%
Gay (n= 891)	(301) 33.8%	(154) 17.3%	(436) 48.9%
Bisexual (n=367)	(131) 35.7%	(46) 12.5%	(190) 51.8%
Queer (n=70)	(29) 41.4%	(13) 18.6%	(28) 40%
LGBTQ Total (N= 2277)	(821) 36.1%	(399) 17.5%	(1057) 46.4%

To further describe the LGBTQ sample, a series of tables present smoking status of LGBTQ (current smoker vs never smoker vs former smokers) and a range of demographic and other lifestyle variables:

Table 3: Age

	Current Smoker (n) Percent	Former Smoker (n) Percent	Never Smoker (n) Percent
18-24 (n=685)	(273) 39.8%	(62) 9.1%	(350) 51.1%
25-34 (n=606)	(257) 42.4%	(96) 15.8%	(253) 41.8%
35-44 (n=470)	(150) 31.9%	(93) 19.8%	(227) 48.3%
45-54 (n=306)	(84) 27.5%	(85) 27.8%	(137) 44.8%
55-64 (n=112)	(18) 16.1%	(46) 41.1%	(48) 42.8%
65 and older (n=31)	(7) 22.6%	(15) 48.4%	(9) 29.0%

Table 4: Education

	Current Smoker	Former Smoker	Never Smoker
High School or Less (n=357)	(167) 46.8%	(41) 11.5%	(149) 41.7%
Some Post HS Training or College (n=909)	(387) 42.5%	(156) 17.2%	(366) 40.3%
College Degree or > (n=939)	(232) 24.7%	(199) 21.2%	(508) 54.1%

Table 5: Race/Ethnicity

	Current Smoker	Former Smoker	Never Smoker
White (n=1621)	(598) 36.9%	(346) 21.3%	(677) 41.8%
Black (n=347)	(96) 27.7%	(24) 6.9%	(227) 65.4%
Hispanic (n=47)	(18) 38.3%	(9) 19.1%	(20) 42.6%
Other (n=189)	(74) 39.2%	(18) 9.5%	(97) 51.3%

Table 6: Employment

	Current Smoker	Former Smoker	Never Smoker
Employed (n=1780)	(619) 34.8%	(318) 17.9%	(843) 47.3%
Not working (n=287)	(117) 40.8%	(62) 21.6%	(108) 37.6%
Fulltime student (n=137)	(50) 36.5%	(16) 11.7%	(71) 51.8%

Table 7: Gender

	Current Smoker	Former Smoker	Never Smoker
Female (n=1201)	(447) 37.2%	(220) 18.3%	(534) 44.5%
Male (n=932)	(310) 33.3%	(164) 17.6%	(458) 49.1%
Transgender (n=29)	(11) 37.9%	(4) 13.8%	(14) 48.3%
Transsexual (n=14)	(6) 42.9%	(3) 21.4%	(5) 35.7%
Genderqueer (n=28)	(14) 50.0%	(3) 10.7%	(11) 39.3%
Other (n=4)	(1) 25.0%	(2) 50.0%	(1) 25.0%

Table 8: Alcohol Use (Number of drinks per week)

	Current Smoker	Former Smoker	Never Smoker
None (n=437)	(134) 30.7%	(82) 18.8%	(221) 50.5%
1-7 (n=1349)	(444) 32.9%	(237) 17.6%	(668) 49.5%
8 -14 (n=210)	(83) 39.6%	(49) 23.3%	(78) 37.1%
15 -21 (n=103)	(56) 54.4%	(13) 12.6%	(34) 33.0%
22 and > (n=94)	(63) 67.0%	(11) 11.7%	(20) 21.3%

Table 9: Frequency of Going Out to a Bar

	Current Smoker	Former Smoker	Never Smoker
Don't go to bars (n=304)	(87) 28.6%	(56) 18.4%	(161) 53.0%
About once per month (n=710)	(209) 29.4%	(165) 23.3%	(336) 47.3%
2-3 times per month (n=688)	(264) 38.4%	(113) 16.4%	(311) 45.2%
One time per week (n=277)	(110) 39.7%	(30) 10.8%	(137) 49.5%
More than once per week (n=210)	(113) 53.8%	(28) 13.3%	(69) 32.9%

Table 10: Self-Report of General Health Status

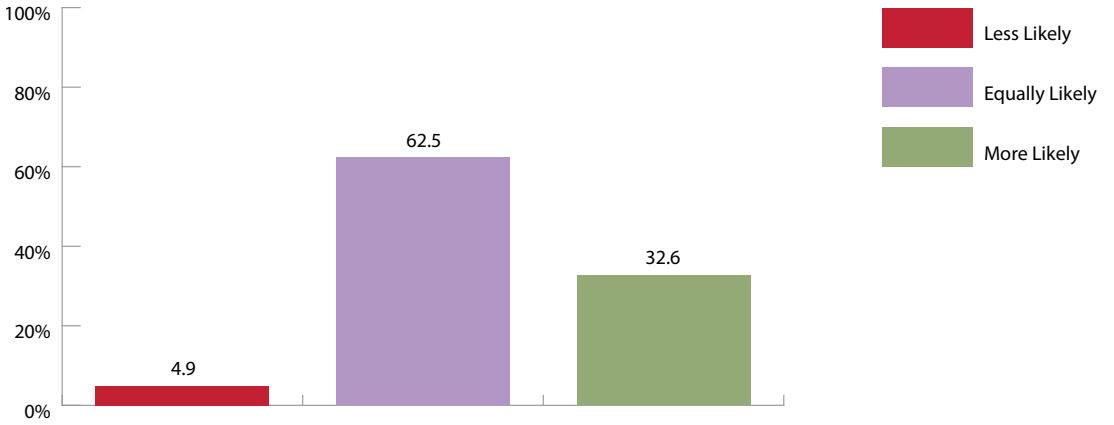
	Current Smoker	Former Smoker	Never Smoker
Excellent(n=506)	(145) 28.7%	(81) 16.0%	(280) 55.3%
Very good/good (n=1506)	(552) 36.7%	(279) 18.5%	(675) 44.8%
Fair/poor (n=178)	(85) 47.8%	(35) 19.7%	(58) 32.5%

Opinions/Knowledge About Tobacco Use Issues

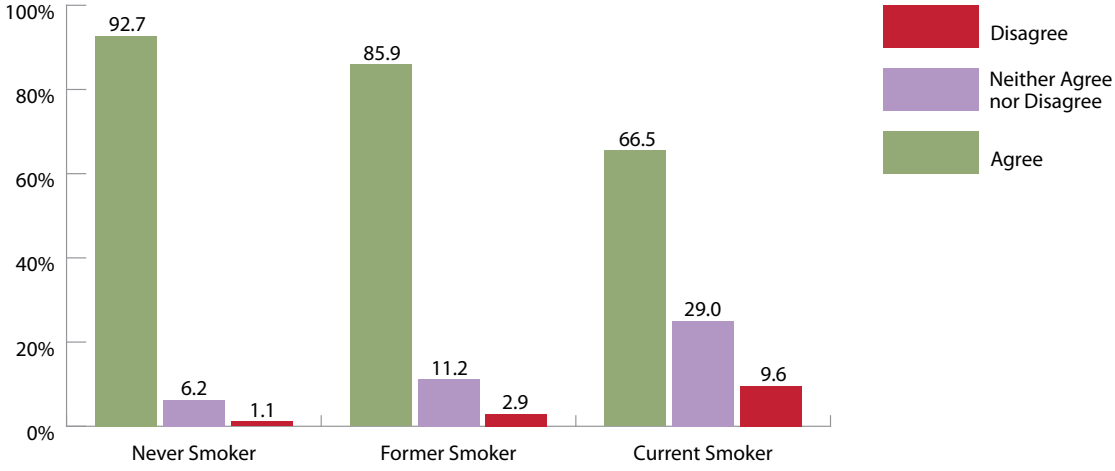
The survey included 11 statements about smoking, exposure to secondhand smoke, and other issues related to tobacco use. The items were designed to examine participants knowledge (e.g., Exposure to secondhand smoke is known to cause cancer; Smoke from other people's cigarettes is harmful to children) and opinions about smoking policies (e.g., It is the responsibility of local government to make laws about indoor smoking at work places; All workers have a right to clean indoor air at work) and other opinions about tobacco use (e.g., I consider cigarette butts to be litter; I hate how my clothes smell after being around cigarette smoke). Participants rated the statements using a Likert-like scale from "strongly agree" to "strongly disagree", including an option of "neither agree or disagree." Current smokers, former smokers, and never smokers ratings are compared on each statement. In all ratings of the statements, never smokers and former smokers are more similar in ratings than current smokers. For instance, 91.2% of never smokers and 85.5% of former smokers compared to 51.8% of current smokers strongly agree/ agree with the statement, "I hate how my clothes smell after being around cigarette smoke."

The item showing the highest percentage of agreement was, "All workers have a right to clean indoor air at work," which was endorsed by 94.1% of never smokers, 91.0% of former smokers and 82% of current smokers. The item showing the lowest level of agreement was the statement, "LGBTQ organizations should not accept money from tobacco companies." In this case, 50.3% of former smokers represented the highest strongly agree/agree rating of the sample subgroups. Analyses of all 11 statements are from Pride Survey data only and are presented in Table 11.

"LGBTQ people are less likely, equally likely, or more likely to smoke than straight people"



"Smoke from other people's cigarettes is harmful to adults"



"I hate how my clothes smell after being around cigarette smoke"

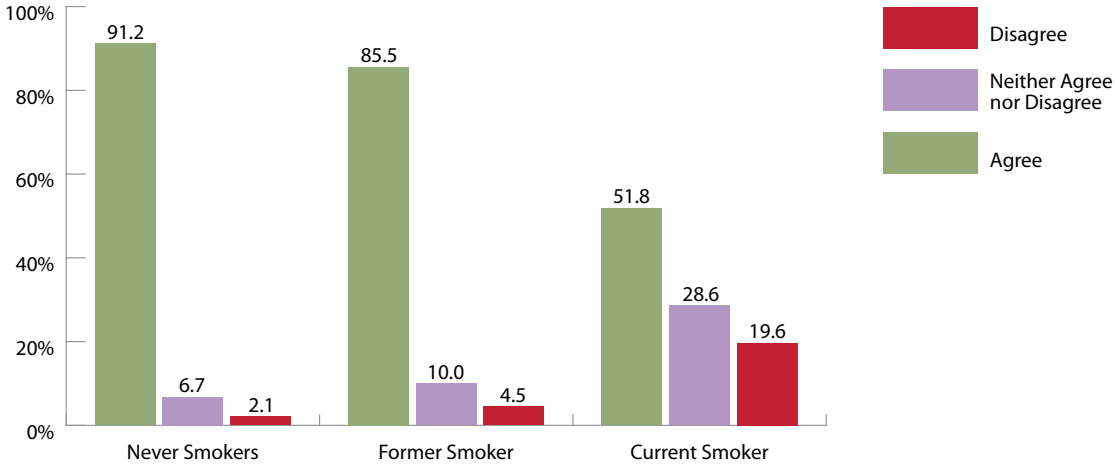


Table 11: Knowledge/Opinions on Smoking Issues
(N=Never smoker; C=Current Smoker; F=Former Smoker)

Questions	Agree			Neither Agree / Disagree			Disagree		
	N	C	F	N	C	F	N	C	F
1. Exposure to secondhand smoke is known to cause cancer.	845 91.5%	534 72.3%	294 75.2%	60 6.5%	142 19.2%	34 8.7%	19 2.0%	63 8.5%	10 2.6%
2. Smokers have a right to smoke indoor when at work.	81 8.9%	212 28.8%	43 12.7%	106 11.6%	164 22.3%	37 10.9%	728 79.6%	360 48.9%	258 76.3%
3. I consider cigarette butts to be litter.	802 89.1%	510 71.2%	301 89.9%	50 5.6%	125 17.5%	14 4.2%	48 5.3%	81 11.3%	20 6.0%
4. All workers have a right to clean indoor air at work.	851 94.1%	585 82.4%	305 91.0%	40 4.4%	97 13.7%	16 4.8%	13 1.4%	28 3.9%	14 4.2%
5. It is the responsibility of local government to make laws about indoor smoking at work places.	658 73.0%	315 43.8%	205 61.4%	143 15.9%	172 22.9%	60 18.0%	101 11.2%	233 32.4%	69 20.6%
6. Smoke from other people's cigarettes is harmful to adults.	856 92.7%	480 65.5%	292 85.9%	57 6.2%	183 25.0%	38 11.2%	10 1.1%	70 9.6%	10 2.9%
7. I hate how my clothes smell after being around cigarette smoke.	823 91.2%	372 51.8%	288 85.5%	60 6.7%	205 28.6%	34 10.1%	19 2.1%	141 19.6%	15 4.5%
8. Constant exposure to secondhand smoke – at work or at home – almost doubles the risk of having a heart attack.	653 71.8%	312 42.9%	223 65.4%	230 25.2%	306 42.0%	103 30.2%	27 3.0%	110 15.1%	15 4.4%
9. It bothers me to be exposed to other people's cigarette smoke.	745 81.2%	172 23.9%	234 69.2%	106 11.5%	185 25.2%	66 19.5%	67 7.3%	377 51.4%	38 11.3%
10. Smoke from other people's cigarettes is harmful to children.	868 94.5%	568 77.5%	304 89.2%	39 4.2%	118 16.1%	28 8.2%	12 1.3%	47 6.4%	9 2.6%
11. LGBTQ organizations should not accept money from tobacco companies.	447 48.6%	155 21.1%	171 50.3%	328 35.7%	302 41.1%	124 36.5%	144 15.7%	277 37.7%	45 13.2%

Preferences and Support for Smoke-Free Environments

The Pride and web surveys asked participants to rate their preferences and support for smoke-free environments. Environments evaluated include: home, work, public places, restaurants, and bars.

The first two tables describe opinions about a smoke-free environment at home. Table 12 shows the percentages of those not allowing smoking in their homes by Pride and web survey results, with 62.5% overall having smoke-free rules in the home. Table 13 compares current, former, and never LGBTQ smokers and smoking rules in the home.

Table 12: Smoking Rules in Home
Excludes don't know response (n=40)

	Pride	Web	Total
Not Allowed	(1,200) 61.2%	(147) 76.2%	(1,347) 62.5%
Allowed	(761) 38.8%	(46) 23.8%	(807) 37.5%

Table 13: Smoking Rules in Home by Smoking Status
Excludes don't know responses (n=40)

	Current Smokers	Former Smokers	Never Smokers
Not allowed	(301) 39.1%	(283) 73.7%	(763) 76.2%
Allowed	(468) 60.9%	(101) 26.3%	(238) 23.8%

The next two tables show preferences about smoking policy in restaurants. The first shows participants' preferences for smoking policy by Pride and web survey, with 48.9% of the overall sample preferring smoke-free restaurants. There were significant differences between the data from the Pride and the web surveys. The second table shows preference according to smoking status.

Table 14: Smoking Policy Preference in Restaurants
Excludes don't know response (n=30)

	Pride	Web	Total
Not Allowed	(917) 47.2%	(127) 66.1%	(1,044) 48.9%
Allowed	(1026) 52.8%	(65) 33.9%	(1,091) 51.1%

Table 15: Smoking Policy Preference in Restaurants by Smoking Status
Excludes don't know responses (n=30)

	Current Smokers	Former Smokers	Never Smokers
Not allowed	(150) 19.8%	(207) 54.3%	(722) 70.1%
Allowed	(609) 80.2%	(174) 45.7%	(308) 29.9%

The next two tables show preferences about smoking policy in bars. The first of the two tables shows participants' preferences for smoking policy by Pride and web survey, with only 27.5% of the overall sample preferring smoke-free bars. The second table shows preference according to smoking status. Only participants who frequent bars were included in these analyses.

Table 16: Smoking Policy Preference in Bars
Excludes don't know response (n=31)

	Pride	Web	Total
Not Allowed	(504) 26.3%	(76) 39.8%	(580) 27.5%
Allowed	(1,416) 73.7%	(115) 60.2%	(1,531) 72.5%

Table 17: Smoking Policy Preference in Bars by Smoking Status
Excludes don't know responses and persons who do not go to bars

	Current Smokers	Former Smokers	Never Smokers
Not allowed	(52) 6.9%	(123) 32.5%	(405) 42.1%
Allowed	(699) 93.1%	(255) 67.5%	(556) 57.8%

The next two tables show preferences about smoking policy for indoor workplaces. The first shows participants' preferences for smoking policy by Pride and web survey, with 68.8% of the overall sample preferring smoke-free workplaces. There are significant difference between Pride and web. The second table shows preference according to smoking status.

Table 18: Smoking Policy Preference for Indoor Work Areas
Excludes don't know response (n=82)

	Pride	Web	Total
Not Allowed	(1,246) 67.2%	(160) 83.3%	(1,406) 68.8%
Allowed	(607) 32.8%	(32) 16.6%	(639) 31.2%

Table 19: Smoking Policy Preference for Indoor Work Areas by Smoking Status
Excludes don't know responses (n=82)

	Current Smokers	Former Smokers	Never Smokers
Not allowed	(331) 46.6%	(274) 75.7%	(801) 82.4%
Allowed	(380) 53.4%	(88) 24.3%	(171) 17.6%

The next two tables show preferences about smoking policy for public buildings. The first shows participants' preferences for smoking policy by Pride and web survey, with 68.8% of the overall

sample preferring smoke-free workplaces. There are significant differences between Pride and Web responses. The second table shows preference according to smoking status.

Table 20: Smoking Policy Preference for Public Buildings
Excludes don't know response (n=64)

	Pride	Web	Total
Not Allowed	(1,201) 64.0%	(147) 77.0%	(1,348) 65.2%
Allowed	(675) 36.0%	(44) 23.0%	(719) 34.8%

Table 21: Smoking Policy Preference for Public Buildings by Smoking Status
Excludes don't know responses (n=64)

	Current Smokers	Former Smokers	Never Smokers
Not allowed	(323) 44.8%	(263) 71.3%	(762) 77.9%
Allowed	(397) 55.2%	(106) 28.7%	(216) 22.1%

An item measuring support of a comprehensive smoke-free workplace policy asks: "Do you support smoke-free workplace policies in all indoor workplaces, including restaurants and bars?"

Table 22: Support of Indoor Workplace Policies

	Current Smokers	Former Smokers	Never Smokers
Yes (n=1190)	(240) 30.7%	(226) 57.8%	(724) 71.4%
No (n=733)	(439) 56.2%	(110) 28.1%	(184) 18.2%
Not sure (n=262)	(102) 13.1%	(55) 14.1%	(105) 10.4%

Another item examined behavioral intentions. Participants responded to the question: "How likely would you be to go out to bars if they were smoke-free?" From our total sample, 75% would be more or equally likely to go to bars if they were smoke-free. Only 47% of current smokers indicate they would go out more/equally.

Table 23: Likely to go to smoke-free bars
(N=Never smoker; C=Current Smoker; F=Former Smoker)

	Pride			Web			Total
	C	F	N	C	F	N	
Less Likely	(366) 55.8%	(37) 12.8%	(47) 6.2%	(0) 0.0%	(8) 1.8%	(9) 10.7%	(467) 24.9%
Equally Likely	(248) 37.8%	(130) 44.8%	(313) 41.0%	(19) 51.4%	(18) 4.0%	(34) 40.5%	(762) 40.6%
More Likely	(42) 6.4%	(123) 42.4%	(403) 52.8%	(18) 48.6%	(19) 4.2%	(41) 48.8%	(646) 34.5%

Information about Smoking and the Challenges Related to Quitting

In this section, additional data from the surveys and our focus groups are presented that give information about behaviors associated with continued smoking and the challenges faced when trying to quit.

We further assessed smoking status by categorizing current smokers into daily smokers and those who smoke only on some days during the week by sexual orientation, inclusive of data from transgender and transsexual persons. The table below presents the average number of cigarettes smoked per day on the days a respondent smokes. Not surprisingly, daily smokers compared to some days smokers are smoking significantly more cigarettes per day.

Table 24: Number of Cigarettes Smoked Per day

	Daily Smokers		Some Days Smokers	
	(n) Average Cigarettes / day	Range	(n) Average Cigarettes / day	Range
Lesbian	(257) 15.6	1–60	(78) 5.1	1–25
Gay	(198) 17.6	5–60	(69) 7.9	1–50
Bisexual	(86) 16.2	1–70	(39) 5.7	1–40
Queer	(17) 15.0	4–40	(11) 7.7	1–39
Transgender	(12) 17.5	7–40	(3) 10.8	1–30
Transsexual	(2) 6.0	5–7	(4) 7.6	2–20

We examined readiness to quit of current smokers (daily and some days smokers). Table 25 below shows that overall only about 10% of smokers indicate a readiness to quit smoking within the next month. Significantly more some days smokers compared to daily smokers are trying to cut down or quit. From this sample of smokers, a majority are only remotely thinking about quitting or indicate no intention to quit.

Table 25: Readiness to Quit Smoking Among Current LGBTQ Smokers

	Daily Smokers (n) %	Some Days Smokers (n) %	Total (n) %
I am currently trying to cut down on, or quit, my smoking.	(65) 14.1%	(90) 48.1%	(155) 23.9%
I am planning to quit. (within 30 days)	(49) 10.6%	(17) 9.1%	(66) 10.2%
I am thinking about quitting. (next 6 months)	(210) 45.6%	(30) 16.1%	(240) 37.0%
I am not thinking about quitting.	(137) 29.7%	(50) 26.7%	(187) 28.9%

The web survey measured data factors that contribute to continuing to smoke as well as processes that facilitate quitting smoking. Current smokers completed measures from the Transtheoretical Model of Change that included: Decisional Balance (Short Form), and Self-Efficacy/Temptations, Processes of Change (Short Form).

Decisional Balance: Decision making was conceptualized by Janis and Mann (1977) as a "balance sheet" of comparative potential gains and losses. The Transtheoretical Model uses two factors: the pros and cons of smoking to form a decisional "balance sheet" for understanding a person's thoughts on continuing to smoke or trying to quit. Participants rated a series of statements about smoking with regard to how important it is to their decision to smoke according to a five point scale: 1 = Not important; 2 = Slightly important; 3 = Moderately important; 4 = Very important; 5 = Extremely important. Results are presented below.

Table 26: Smoking Decisional Balance

	Mean	Range
Pros of Smoking	2.5	
Smoking cigarettes relieves tension	3.1	1-5
Smoking helps me concentrate and do better work	1.8	1-4
I am relaxed and therefore more pleasant when smoking	2.5	1-4
Cons of Smoking	3.1	
I'm embarrassed to have to smoke	2.7	1-5
My cigarette smoking bothers other people	3.5	2-5
People think I'm foolish for ignoring the warnings about cigarette smoking	3.0	1-5
Pros/Cons Ratio	0.9	

Self Efficacy/Temptations (Short Form): Self-efficacy (Bandura, 1977) conceptualizes a person's perceived ability to perform on a task as a mediator of performance on future tasks. A change

in the level of self-efficacy can predict a lasting change in behavior if there are adequate incentives and skills. The Transtheoretical Model employs an overall confidence score to assess an individual's self-efficacy. Situational temptations assess how tempted people are to engage in smoking in a certain situation. Participants rated situations that lead some people to smoke by indicating how tempted they may be to smoke in each situation using the following five point scale: 1 = Not at all tempted; 2 = Not very tempted; 3 = Moderately tempted; 4 = Very tempted 5 = Extremely tempted. Results are presented below. Situations are classified according to the following factors: Positive Affect/ Social Situations; Negative Affect Situations; and Habitual/ Craving Situations. Overall, it appears as negative and positive affect situations are more tempting for smoking than habit-related situations.

Table 27: Smoking Self-Efficacy/Temptations

	Mean	Range
Positive Affect/ Social Situations	2.5	
With friends at a party	2.8	1-5
Over coffee while talking and relaxing	2.1	1-5
With my spouse or close friend who is smoking	2.6	1-5
Negative Affect Situations	2.6	
When I am very anxious and stressed	2.7	1-5
When I am very angry about something or someone	2.7	1-5
When things are not going my way and I am frustrated	2.5	1-5
Habit/Craving Situations	2.0	
When I first get up in the morning	2.1	1-5
When I feel I need a lift	1.8	1-5
When I realize I haven't smoked for a while	2.0	1-5

Processes of change represent a major dimension of the Transtheoretical Model measuring how a person moves from being a smoker to a nonsmoker. Change processes are divided into behavioral and experiential factors. Participants rated the frequency of each event occurring currently or in the past month presented on five-point scale: 1 = Never; 2 = Seldom; 3 = Occasionally; 4 = Often; 5 = Repeatedly. Results are presented below. These statements and their ratings shed light on the thoughts and actions smokers are using to control their smoking.

In general, Table 28 shows low levels of use of change processes in this group--- corroborating Table 25 data showing relatively few smokers report being ready to quit or actively trying to quit. Two behavioral processes are rated a "3=occasionally" or above, with the highest rated endorsed processes being "I tell myself I can quit if I want to" (3.4) and "I tell myself that if I try hard enough I can keep from smoking" (3.0). Experiential processes rated on average "3" or above, including "I notice that nonsmokers are asserting their rights" (3.5), "I recall information people have given me on the benefits of quitting smoking" (3.3), and "I find society changing in

ways that makes it easier for nonsmokers" (3.3). The lowest rated processes were "I am rewarded by others if I don't smoke" (1.3), "I keep things around my home or place of work that remind me not to smoke" (1.4), and "I react emotionally to warnings about smoking cigarettes" (1.7).

Table 28: Smoking Processes of Change

	Mean	Range
Behavioral Processes	2.3	
When I am tempted to smoke I think about something else.	2.5	1 -4
I tell myself I can quit if I want to.	3.4	1-5
I can expect to be rewarded by others if I don't smoke.	1.8	1-4
I remove things from my home or place of work that remind me of smoking.	1.9	1-5
I have someone who listens when I need to talk about my smoking.	2.1	1-5
I tell myself that if I try hard enough I can keep from smoking.	3.0	1-5
I have someone I can count on when I'm having problems with smoking.	2.5	1-5
I do something else instead of smoking when I need to relax.	2.6	1-5
I keep things around my home or place of work that remind me not to smoke.	1.4	1-3
I am rewarded by others if I don't smoke.	1.3	1-3
Experiential Processes	2.6	
I notice that nonsmokers are asserting their rights.	3.5	1-5
I recall information people have given me on the benefits of quitting smoking.	3.3	1-5
I stop to think that smoking is polluting the environment.	2.3	1-5
Warnings about the health hazards of smoking move me emotionally.	2.8	1-5
I get upset when I think about my smoking.	2.3	1-5
I think about information from articles and ads about how to stop smoking.	2.3	1-3
I consider the view that smoking can be harmful to the environment.	2.3	1-4
I find society changing in ways that makes it easier for nonsmokers.	3.3	1-5
My need for cigarettes makes me feel disappointed in myself.	2.4	1-5
I react emotionally to warnings about smoking cigarettes.	1.7	1-3

Focus Groups Analyses

Focus groups were conducted with three groups of individuals who currently smoke and one group who were former smokers. The "current smoker" groups were split by age: 18-24; 25-34; and 35+. A focus group facilitator's guide was developed and used in each group. The focus group script for current smokers covered several topics including: reasons for smoking, smoking behavior, cessation efforts, and the connection between smoking and the LGBTQ community. Questions for former smokers focused on their personal quit process, advice for those trying to quit, and smoking and the LGBTQ community. Analyses reflect major themes observed across all groups and are summarized below.

Participants had smoked for as little as 3 years and as long as 40 years and reported having both negative and positive aspects of smoking. All agreed that they were physically dependent on nicotine and addicted to smoking. A primary positive view of smoking is that this behavior helps a person cope with various situations or particular negative emotions. In fact, for many, smoking as an immediate stress reducer outweighs negative physical health issues. This element was reflected in many comments.

> "I am addicted to the nicotine and tobacco for sure. Sometimes I think I don't know how to think. I don't think I can think without a cigarette." –Current smoker
>
> "When you are stressed out, it's the first thing you go for when you're a smoker." –Current smoker
>
> "If I don't smoke, you don't want to know me. I'm generally a really nice person, but that's because I smoke." –Current smoker
>
> "I can go hours without a cigarette, but the instant somebody tells me that I can't smoke is the instant I need a cigarette. Not being able to have that [cigarette] is like a shut off to life … the doors open and that stress just comes barreling down on me." –Current smoker
>
> "There is certain dependency that I have upon cigarettes to go to if something's wrong. I can depend on a cigarette to make it better for a moment even if it's just a small instant." –Current smoker
>
> "Smoking is definitely for me a way to avoid feeling whatever I'm feeling. So whether it's sad, lonely, whatever … my attempts to not smoke, which I've had one that lasted three months, I had all these feelings come up and I didn't have an outlet for them." –Current smoker

Some smokers expressed thoughts suggesting they were controlling or reducing their risks by when and what they smoked. For instance three participants indicated they smoke American Spirits because they are "natural" and "additive free." In general there was a lack of knowledge about smoking's health risks and risks of exposure to secondhand smoke. Other comments on this theme:

> "A positive thing is that smoking helps me keep my weight down." –Current smoker
>
> "… [I] use additive-free tobacco so it is not as bad as using tobacco. [I] am not

experiencing adverse effects on a daily basis, so [I] don't feel bad about it." –Current smoker

"There are other worse things I could be doing than smoking." –Current smoking

Some places were frequently mentioned as "trigger situations" or places that lead to automatic thoughts to have a cigarette. Commonly mentioned places and institutions were driving in a car, bars, breaks at work and coffee houses.

"Aside from the chemical dependency, it's also a behavior that I've gotten so ingrained in, that pattern of everything I do. It's really hard to break … it's a natural reaction to get in the car and light up a cigarette or if I'm hanging out at a bar, it's natural just to sit there and have a cigarette in your hand." –Current Smoker

"Cigarettes and alcohol, cigarettes and coffee … I've talked to many people who say I only smoke when I drink alcohol, so I think it is very much hand in hand." –Current smoker

"Thankfully when I did quit, they [coffee shop] already added nonsmoking signs so it made it a lot easier." –Former smoker

"… for example, I just bought a new car and I could not make it two days without smoking in it. I wanted to keep the new smell, but I could not do it." –Current smoker

Social and personal relationships were mentioned as reasons for smoking, quitting, and relapsing back to smoking. Some indicated that when becoming involved with a person they would try to quit because the person was a nonsmoker. Alternatively, some indicated they relapsed to smoking when they became involved with a person who smoked cigarettes. The positive aspect of taking a smoke break at work was mentioned several times.

"I work in an office. You find the smokers, and that's who you start hanging out with, and it's very social, very social." – Current smoker

"I don't think it [smoking] helps in a social situation, but there was some kind of binding thing there – a commonality of interests." – Former smoker

Quit for 3 months, but "started again after family visited who smoked a lot." – Current smoker

"It changed my socialization because [now] I don't do a lot with people who smoke." –Former smoker

All but two current smokers had tried to quit at least once. Some participants were not ready to quit and several felt overwhelmed by the process of quitting. They reported being apprehensive about quitting because the process was "miserable." Participants talked about dissatisfaction with cessation aids. While none of the participants had tried counseling or a group to quit—no

one endorsed this method of trying to quit. Several did not like patches or gum. Due to having negative experiences with cessation aids, some participants had come to the conclusion that "going cold turkey" was the best method for quitting.

> "I definitely get a more negative self-image of myself that I am not strong enough to actually quit" –Current smoker
>
> "[I] don't want to quit [smoking], and then continue to crave cigarettes." –Current smoker.
>
> "It's like you have to learn how to live again, how to associate or find another thing that you could do around cigarettes. It's like when I work, I work around cigarettes. Every two hours, it's like clockwork … I really don't like my smoking. I just have to figure another way to live." –Current smoker
>
> "The first thing that hit my mind was Mt. Everest, and I would have to run out of cigarettes on Mt. Everest and have to climb back down that damned mountain to get another pack, I think that would be the only way that would make me quit." –Current smoker
>
> "I quit for two weeks, and then the third week was hard, and then after that it was like, if I start again I don't think I'll ever quit, and I'll die …" –Former smoker
>
> "If I were a nonsmoker just magically, that would be wonderful." –Current smoker

The most commonly cited reasons for quitting were health-related. Many had noticed health issues such as being short of breath and coughing more. Those who had quit successfully were empowered and felt less stress.

> "… finds it easier to socialize now because everyone they care about stopped smoking." –Former smoker
>
> "… used to have to plan where … to smoke when [I] went out. [Don't] have to worry about that now or making sure to have cigarettes and a lighter …" – Former smoker
>
> "[Quitting smoking] doesn't change social life as much as one fears it will." –Former smoker
>
> "… can't stand to be around smoke now. " –Former smoker
>
> "… like being able to ask for the no smoking section." –Former smoker
>
> "… now I don't eat candy or drink soda. Eat lots of vegetables. Not sure if it is a result of quitting, but feel it is only possible because [I] quit." –Former smoker

Participants had mixed responses regarding connections to smoking in the LGBTQ community. The younger focus group mentioned more about the stress of coming out and a possible link to their smoking.

> "I think most of the places that help people come out and get to be part of the

> community are smoking establishments and so I think that probably is something to look at and is a concern that we should have." –Current smoker
>
> "A lot of stress is related to coming out and figuring out who they were. [My] family did not accept me. There is also a lot of smoking out at LGBTQ places." –Current smoker

Most were not well-informed about the actions and influence of the tobacco industry, but several comments noted the presence of free product handouts at bars. Participants didn't think they were necessarily targeted by the tobacco community any more than other groups. Some expressed thoughts that by having a presence at events and bars the tobacco industry was to some extent being "inclusive" of the community compared to other industries.

> "They [tobacco companies] aren't intentionally going out to make something better, but by becoming more present in the community due to the market, they are also accepting those establishments." –Current smoker

Historically, health information for the LGBTQ community has been focused on HIV/AIDS. Participants recalled very little information regarding tobacco and cessation being promoted specifically in the LGBTQ community. They felt intervention services for tobacco cessation should be promoted through LGBTQ venues and media. At the end of each focus group session, participants were asked about cessation options.

Summary of Focus Group Analyses:

- Current smokers recognize they are nicotine dependent, but have not used recommended evidence-based cessation options. Frequently they quit cold turkey and faced significant withdrawal symptoms, leading to failed quit attempts.
- Smoking becomes incorporated into all aspects of life: socializing, coping with stress, and habitual use.
- Those who had successfully quit smoking felt empowered and did not regret quitting.
- Cessation services may need to be tailored for the LGBTQ community in order to increase acceptance of recommended evidence-based cessation treatments.
- There is an absence of health education about tobacco use in the Missouri LGBTQ community. A need exists to highlight the high smoking rates and exposure to secondhand smoke. There is also a need to promote evidence-based cessation services. These campaigns should be in LGBTQ media and venues.

Overall Summary of Presented Data

This report gives a broad overview of the LGBTQ community with regard to smoking rates, opinions about smoking policies, and details about challenges faced by LGBTQ smokers trying to quit. The Missouri LGBTQ population is diverse with a range of experiences and effects from tobacco use. However, in general, compared with published general population surveys, there is a lower level of knowledge about the harmful effects of smoking and exposure to secondhand smoke. These findings match a lower level of support for smoke-free environments at work, home, and hospitality settings. In general, there are higher smoking rates in this community and a lower rate of successful cessation. The community seemed to have a low level of awareness about evidence-based cessation treatment. The basic findings included in this report and subsequent additional analyses of collected data can serve as critical information to begin the process of changing social norms and behaviors in the LGBTQ community throughout Missouri with regard to smoking prevalence and exposure to secondhand smoke.

Planning for the Future

A suggested plan for using this report includes the following:

1) Share this report with key stakeholders. The report provides a broad description of the LGBTQ community with regard to tobacco issues. Allow stakeholders to submit suggestions for improving the report and for the types of audiences to receive this report.

2) Form an evaluation advisory team that can generate research questions answerable by additional analyses of the study data. Data could guide presentations at meetings and manuscript development for publication in professional journals, be used to develop presentations for local LGBTQ groups and groups that serve the health care needs of the LGBTQ community, and can inform a strategic health education campaign.

   This evaluation advisory team could include members of the Check-Out Project Advisory Board, Missouri Foundation for Health's TPCI staff, Center for Tobacco Policy Research at Washington University in St. Louis, and national leaders in LGBTQ tobacco issues.

3) Build a statewide LGBTQ coalition to support tobacco prevention and cessation. The basic infrastructure exists with the Check-Out Project Advisory board, LGBTQ Resource Centers in Missouri, and the list of participants who attended the National LGBTQ Summit in Kansas City. This could include development of a network of LGBTQ health care providers and professionals trained to deliver evidence-based cessation treatment.

4) Convene a meeting with those around the country who have conducted surveys with other LGBTQ communities, and develop a standardized set of questions to be used in future studies.

5) Finally, the analyses and presented findings described above will serve as the evidence base to begin building interventions (strategic communication campaigns, prevention programs and messages, and cessation treatments) that will more specifically reduce the health disparities that tobacco use is causing in the diverse Missouri LGBTQ community.

Appendix A

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