Submission on the next National Tobacco Strategy

17 August 2018

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest health and social service providers for the lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) and people living with HIV (PLHIV) communities. Its services include general practice, health promotion, counselling, and alcohol and other drug rehabilitation programs. Thorne Harbour Health primarily serves the populations of Victoria and South Australia, but also leads national projects. In partnership with other organisations, Thorne Harbour Health works to support all members of LGBTI and PLHIV communities, and is committed to improving the health and wellbeing of all LGBTI people and PLHIV.

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Contents

1. Introduction

Thorne Harbour Health welcomes the opportunity to present this submission and contribute to the development of the next National Tobacco Strategy. Currently, federal, state and territory tobacco strategies do not include lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) people or people living with HIV (PLHIV) as priority populations. This omission comes despite tobacco usage in LGBT people[1] and PLHIV[2] being double that of the general population, despite recognition of LGBTI and PLHIV people as priority populations in other health policy areas such as mental health[3] and aging,[4] and despite a clear association between smoking and diseases relevant to areas such as mental health and aging.[5]

To date, smoking cessation programs[6] targeted to LGBTI Australians have been limited to those who are also PLHIV.[7] To lower tobacco use among people from LGBTI and PLHIV communities, tobacco strategies at all government levels should include LGBTI and PLHIV priority areas and actions, and LGBTI and PLHIV community-controlled health services should receive funding to provide LGBTI and PLHIV smoking cessation programs.

In addition, there is a need for health promotion campaigns and resources that specifically target and cater to LGBTI people and PLHIV; an investigation into the potential to establish a national LGBTI Tobacco Control Network; and further research into LGBTI and PLHIV tobacco use and smoking cessation programs.

2. Summary of recommendations

1. Fund further research into LGBTI and PLHIV tobacco use and smoking cessation programs.
2. Emphasise the need for collaboration between researchers and community-controlled LGBTI organisations in funding arrangements and research guidelines for research into LGBTI tobacco use and smoking cessation programs.
3. Include LGBTI and PLHIV specific priority areas and actions in the next National Tobacco Strategy.
4. Establish LGBTI and PLHIV reference groups to provide advice on progressing LGBTI and PLHIV specific priority areas and actions in the next National Tobacco Strategy.
5. Fund health promotion campaigns and resources that specifically target and cater to LGBTI people and PLHIV who use tobacco.

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[1] Berger, I. and Mooney-Somers, J. (2017). Smoking cessation programs for lesbian, gay, bisexual, transgender, and intersex people: a content-based systematic review. *Nicotine and Tobacco Research*, 19(12): 1408-1417.

[2] Mdodo, R., Frazier, E.L., Dube, S.R., et al. (2015). Cigarette smoking prevalence among adults with HIV compared with the general adult population in the United States: Cross-sectional surveys. *Annals of Internal Medicine,* 162(5): 335-44; Power, J., Thorpe, R., Brown, G., *et al.* (2016). HIV FUTURES 8: Health and Wellbeing of People Living with HIV. Melbourne, Australia. <http://www.latrobe.edu.au/__data/assets/pdf_file/0006/766896/HIV-Futures-8-Broadsheet-1-on-Health-and-wellbeing.pdf> (last accessed 15/08/18).

[3] DHHS. (2015). Victoria's 10-Year Mental Health Plan. Department of Health and Human Services, Victorian Government.

[4] Australian Government, Department of Health and Ageing. (November 2012). National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy. <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2014/national_ageing_and_aged_care_strategy_lgbti_print_version.pdf> (last accessed 13/08/18).

[5] Drescher, C.F., Lopez, E.J., Griffin, J.A, et al. (2018). Mental health correlates of cigarette use in LGBT individuals in the Southeastern United States. *Substance Use & Misuse*, 53(6): 891-900.

[6] Smoking cessation programs are programs, such as behaviour change programs, that assist people to cease smoking. This is not to be confused with health promotion campaigns that aim to influence people to decide to give up smoking and seek help to do so.

[7] Berger and Mooney-Somers. (2017). (n.1).

6. Investigate the potential to establish an LGBTI Tobacco Control Network that acts to coordinate a national response to tobacco use among LGBTI people, and to manage a clearinghouse for LGBTI tobacco control efforts.
7. Fund LGBTI and PLHIV community-controlled health services to provide LGBTI and PLHIV specific smoking cessation programs.

3. LGBTI and PLHIV tobacco use

3.1 High rates of tobacco use

Tobacco use in LGBT people[8] and PLHIV[9] is double that of the general population. Consistent with this, the 2012 Private Lives report found that approximately 26% of LGBT people identified as smokers, 10% of which indicated that they were heavy or chain smokers.[10] Tobacco use is also significantly higher than the general population for those who are both PLHIV *and* LGBTI.[11] Smoking rates in LGBT youth are potentially even higher; with almost 50% of respondents in a study of LGBT youth aged 13 to 24 attending a Queer Festival in Brisbane reporting they use tobacco.[12]

While the 2010,[13] 2013[14] and 2016[15] National Drug Strategy Household Surveys show that smoking rates having declined among lesbian, gay and bisexual people, they remain significantly higher than among heterosexuals. The National Drug Strategy Household Survey does not collect data on tobacco use among the trans and gender diverse, intersex, or PLHIV communities.

3.2 Closing the knowledge gap

There is limited data on smoking rates among intersex as well as trans and gender diverse Australians:

- Evidence of higher rates of tobacco use among intersex people remains anecdotal;[16] and
- The 2006 Private Lives study found 44% of transgender men and 35% of transgender women reported tobacco use.[17]

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[8] Berger and Mooney-Somers. (2017). (n.1).
[9] Mdodo, R., Frazier, E.L., Dube, S.R., et al. (2015). (n.2); Power, J., Thorpe, R., Brown, G., *et al.* (2016). (n.2).
[10] Leonard, W., Pitts, M., Mitchell, A. et al. (2012). Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. Monograph Series Number 86. The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, p.33. <https://www.glhv.org.au/sites/default/files/PrivateLives2Report.pdf> (last accessed 16/08/18).
[11] Power, J., Thorpe, R., Brown, G., *et al.* (2016). (n.2).
[12] Kelly, J., Davis, C. and Schlesinger, C. (2015). Substance use by same sex attracted young people: prevalence, perceptions and homophobia. *Drug Alcohol Rev*, 34(4): 358–365.
[13] Australian Government, Australian Institute of Health and Welfare. (2011). National Drug Strategy Household Survey Report. pp.22-35. <https://www.aihw.gov.au/getmedia/85831350-afb6-4524-8d8d-764fa5d2d1f8/12668-20120123.pdf.aspx> (last accessed 15/08/18).
[14] Australian Government, Australian Institute of Health and Welfare. (2014). National Drug Strategy Household Survey Report. pp.95-96. <https://www.acon.org.au/wp-content/uploads/2015/04/National-Drug-Strategy-Household-Survey-detailed-report-2013.pdf> (last accessed 15/08/18).
[15] Australian Government, Australian Institute of Health and Welfare. (2017). National Drug Strategy Household Survey Report. pp.109-110. <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true> (last accessed 15/08/18).
[16] Berger and Mooney-Somers. (2017). (n1). p.1408.
[17] Pitts, M., Smith, A., Mitchell, A. and Patel, S. (2006). Private lives: A report on the health and wellbeing of GLBTI Australians. Monograph Series Number 57. The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, p.35. <https://www.glhv.org.au/sites/default/files/private_lives_report_0.pdf> (last accessed 16/08/18).

Further research is required to fill the knowledge gap in relation to tobacco use among the intersex as well as the trans and gender diverse communities. One means by which this data collection could occur is the National Drug Strategy Household Survey. It would also be beneficial to collect data on smoking rates among PLHIV in this way.

Importantly, whether tertiary institutions or government agencies conduct research on LGBTI tobacco use and smoking cessation programs, as many previous studies have experienced flaws in LGBTI data collection,[18] there is a need for whomever is conducting such research to collaborate with community-controlled LGBTI organisations. Accordingly, funding arrangements and research guidelines for research into LGBTI tobacco use and smoking cessation programs should emphasise the need for collaboration with community-controlled LGBTI organisations.

Recommendation 1

Fund further research into LGBTI and PLHIV tobacco use and smoking cessation programs.

Recommendation 2

Emphasise the need for collaboration between researchers and community-controlled LGBTI organisations in funding arrangements and research guidelines for research into LGBTI tobacco use and smoking cessation programs.

3.3 Social determinants of health

The World Health Organisation has identified tobacco consumption as a major health inequity and a leading cause of avoidable disease burden in minority populations.[19] Health disparities result from systemic disadvantages and vulnerabilities that disproportionately affect health and quality of life outcomes among different social groups.[20]

High rates of tobacco use are associated with a number of social and environmental risk factors known to be prevalent in LGBTI and PLHIV communities.[21] Compared to the general population, LGBTI people and PLHIV face daily social stressors related to stigma and discrimination, lower socio-economic status, and a greater co-morbidity of mental health conditions linked to high-risk behaviours, such as tobacco use.[22] Environmental factors that support continued tobacco consumption include the centrality of safe and supportive social

[18] Berger and Mooney-Somers. (2017). (n1). p.1413.
[19] WHO Europe. (2014). Tobacco and inequities Guidance for addressing inequities in tobacco-related harm. <http://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf> (last accessed 15/08/18).
[20] CSDH. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health, Geneva, World Health Organisation. <http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=E39B1657AF07B2264073842C989D31F9?sequence=1> (last accessed 16/08/18).
[21] Berger and Mooney-Somers. (2017). (n1). p.1408.
[22] Hamilton, C.J. and Mahalik, J.R. (2009). Minority Stress, Masculinity, and Social Norms Predicting Gay Men's Health Risk Behaviors. *Journal of Counseling Psychology*, 56(1): 132–41.

spaces, such as bars, where substance use is common among peer groups.[23] The relationship between disadvantage and tobacco use is cumulative and structurally embedded; that is, smoking rates increase in direct association with multiple experiences of disadvantage.[24] Moreover, tobacco use and tobacco-related illness can lead to financial stress, and intergenerational tobacco use exacerbates the poverty cycle.

Differences in smoking rates and status, and the disadvantage that drives them, further widen health disparities between LGBTI and PLHIV communities and the general population. LGBTI people and PLHIV also experience unique barriers to smoking cessation, such as smoking being more socially acceptable among, and a lack of culturally appropriate services and smoking cessation programs for, these populations.[25]

4. LGBTI and PLHIV inclusive tobacco strategies needed

The current *National Tobacco Strategy 2012-2018* does not identify LGBTI people or people living with HIV as priority populations in need of targeted support.[26] Unfortunately, this omission is replicated in the *Quit Victoria Strategic Plan 2016-2019*,[27] the *New South Wales Tobacco Strategy 2012-2017*,[28] the *Queensland Smoking Prevention Strategy 2017-2020*,[29] the *South Australian Tobacco Control Strategy 2017-2020*,[30] the *Northern Territory Tobacco Action Plan 2010-2013*,[31] and the *Australian Capital Territory Alcohol, Tobacco or Other Drug Strategy 2010-2014*.[32]

The *Tasmanian Tobacco Control Plan 2017-2021*[33] contains a single mention of LGBTI people as an at-risk population that "we may need to target, depending on evidence and need."[34] However, by 2017 there was already a large body of evidence indicating LGBT people experience higher rates of tobacco use than the general population,[35] so it is unclear why there was recognition of LGBTI people as an at-risk population without any apparent attempt to obtain readily available evidence detailing tobacco usage amongst members of these communities.

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[23] Greenwood, G.H. and Gruskin, E.P. (2007). 'LGBT Tobacco and and Alcohol Disparities', In: *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations* (eds. Meyer, I.H. and Northridge, M.E.), Springer, Boston, MA, p.566.

[24] Sharma, A., Lewis S., Szatkowski, L. (2010) Insights into social disparities in smoking prevalence using Mosaic, a novel measure of socioeconomic status: an analysis using a large primary care dataset, *BMC Public Health*, 10: 755.

[25] See Section 6: Community-controlled smoking cessation programs.

[26] ICD (2012). National Tobacco Strategy 2012-2018. Intergovernmental Committee on Drugs, Commonwealth of Australia. <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/D4E3727950BDBAE4CA257AE70003730C/$File/National%20Tobacco%20Strategy%202012-2018.pdf> (last accessed 16/08/18).

[27] CCV. (2016). Quit Victoria Strategic Plan 2016-2019. Cancer Council Victoria. Endorsed by the Victorian Government. <https://www.quit.org.au/articles/strategic-plan/> (last accessed 16/08/18).

[28] NSWMH. (2012). NSW Tobacco Strategy 2012-2017. NSW Ministry of Health, NSW Government. <http://www.health.nsw.gov.au/tobacco/Publications/nsw-tobacco-strategy-2012.pdf> (last accessed 16/08/18).

[29] <https://www.health.qld.gov.au/__data/assets/pdf_file/0022/651802/health-wellbeing-strategic-framework-smoking.pdf>

[30] DASA. (2016). South Australian Tobacco Control Strategy 2017-2020. Tobacco Control Unit, Drug and Alcohol Services South Australia, Government of South Australia. <http://www.sahealth.sa.gov.au/wps/wcm/connect/b40d38804cf2224a9768f717a0dc4741/SA+Tobacco+Control+Strategy+2017-2020+Final+Print.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-b40d38804cf2224a9768f717a0dc4741-m7ijE7g> (last accessed 16/08/18).

[31] DHF. (2008). Northern Territory Tobacco Action Plan 2010-2013. Department of Health and Families, Northern Territory Government. <http://www.territorystories.nt.gov.au/bitstream/10070/245837/1/NT_tobacco_action_plan_2010-2013.pdf> (last accessed 17/08/18).

[32] ACT Health. (2010). ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014. ACT Health, ACT Government. <https://www.health.act.gov.au/sites/default/files/ACT%20Alcohol%2C%20Tobacco%20and%20Other%20Drug%20Strategy%202010-2014.pdf> (last accessed 16/08/18). p.16

[33] Tobacco Control Coalition. (2017). Tasmanian Tobacco Control Plan 2017-2021. Department of Health and Human Services, Tasmanian Government.

[34] Ibid. p.12

[35] Berger and Mooney-Somers. (2017). (n1).

Western Australia does not have a specific tobacco strategy, but it does have a section on tobacco in the *Western Australian Health Promotion Strategic Framework 2017-2021*,[36] in which it mentions the higher rates of smoking amongst lesbian, gay and bisexual people under the heading "A snapshot of smoking in WA".[37] However, this is the only mention of these communities in the section on tobacco; indeed, it is the only mention in the entire 90-page document. As such, while there is a commitment to "strengthening efforts to reduce smoking rates in populations with higher prevalence of smoking"[38] there is no further reference to tobacco use among lesbian, gay or bisexual populations in sections it would have been appropriate, such as those titled "Reduce smoking in groups with higher smoking rate" and "Targeted interventions". Moreover, despite emerging evidence of even higher rates of tobacco use than lesbian, gay and bisexual people, trans and gender diverse people are not mentioned at all.[39]

There is an opportunity for the Federal Government to lead the way in promoting a strategy to tackle tobacco use that is LGBTI and PLHIV inclusive. This requires the inclusion of LGBTI and PLHIV priority areas and actions in the next National Tobacco Strategy.[40] The establishment of LGBTI and PLHIV reference groups would aid in the progression of these LGBTI and PLHIV priority areas and actions.

Recommendation 3

Include LGBTI and PLHIV specific priority areas and actions in the next National Tobacco Strategy.

Recommendation 4

Establish LGBTI and PLHIV reference groups to provide advice on progressing LGBTI and PLHIV specific priority areas and actions in the next National Tobacco Strategy.

5. International efforts

In 2016, the United States Food and Drug Administration (FDA) launched a U.S. $35M campaign targeting smoking among LGBT young adults.[41] The 'Free Life' campaign specifically cited the unique risk factors associated with tobacco use in young LGBT populations, identifying that the stresses, anxieties, and discrimination involved in the

[36] DHWA. (2017). Western Australian Health Promotion Strategic Framework 2017-2021: A five-year plan to reduce preventable chronic disease and injury in our communities. Department of Health, Government of Western Australia. <http://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports%20and%20publications/HPSF/WA-Health-Promotion-Strategic-Framework-2017-2021.pdf> (last accessed 16/08/18).
[37] Ibid. p.39.
[38] Ibid. p.40
[39] Ibid. pp.39-43.
[40] This would be consistent with the inclusion of LGBTI people as a priority population in the *National Drug Strategy 2017-2026.*
[41] FDA. (2017). This Free Life Campaign. U.S. Food and Drug Administration. U.S. Department of Health and Human Services. (last updated 16/10/17). <https://www.fda.gov/TobaccoProducts/PublicHealthEducation/PublicEducationCampaigns/ThisFreeLifeCampaign/default.htm> (last accessed 16/08/18).

'coming out' process as the primary driver of tobacco uptake and continued use. The targeted public education campaign uses print and digital media, such as video stories, to raise awareness about the negative health consequences of smoking and addiction. An evaluation of the campaign is being conducted a present. There is a need in Australia to develop and evaluate similar health promotion campaigns and resources that specifically target and cater to LGBTI people and PLHIV who use tobacco.

Also in the United States, the Centers for Disease Control and Prevention funds eight cancer and tobacco disparity networks, including LGBT HealthLink,[42] a community-driven network that aims to improve LGBT health by reducing tobacco use, as well as tackling other health disparities. Were Australia to develop a similar LGBTI Tobacco Control Network, it could act as a clearinghouse, or centralised location, for proven methodologies and resources. This would act as a resource for policymakers and LGBTI people. Were it developed in partnership between LGBTI community-controlled health services and mainstream tobacco control organisations like the Cancer Council of Australia and its state branches, an LGBTI Tobacco Control Network would also prevent duplication of work between these organisations and contribute to a coordinated national response to LGBTI tobacco use.

Recommendation 5

Fund health promotion campaigns and resources that specifically target and cater to LGBTI people and PLHIV who use tobacco.

Recommendation 6

Investigate the potential to establish an LGBTI Tobacco Control Network that acts to coordinate a national response to tobacco use among LGBTI people, and to manage a clearinghouse for LGBTI tobacco control efforts.

6. Community-controlled smoking cessation programs

A recent review of international evidence of smoking cessation programs for LGBTI people found that LGBTI community agencies administered the majority of interventions.[43] This may partly explain why the efficacy of smoking cessation interventions among LGBT people is higher than the general population,[44] as group-based interventions and therapy are more effective than self-help,[45] and LGBTI people favour community-controlled services over mainstream health services, due to previous experiences of, or fear of experiencing, stigma and discrimination at the latter.[46]

[42] LGBT HealthLink: The Network for Health Equity. <http://www.lgbthealthlink.org/AboutUs> (last accessed 16/08/18).
[43] Berger and Mooney-Somers. (2017) (n. 1)
[44] Ibid. p.1413.
[45] Stead, L.F. and Lancaster, T. (2009). Group behaviour therapy programmes for smoking cessation. *Cochrane Database of Systematic Reviews*. 44(2): 81-87.
[46] DHHS. (2015). (n.3). p.22.

Community-specific smoking cessation programs meet the needs of specific groups. For example, smoking cessation programs specifically targeted to people living with HIV are important because they allow people to freely discuss HIV-related issues and feel comfortable disclosing their HIV status.[47] The same is true of LGBTI smoking cessation programs, which would allow LGBTI people to freely discuss LGBTI-related issues and feel comfortable disclosing their sexual orientation, gender identity or intersex status.

In short, to date smoking cessation programs targeted to LGBTI Australians have been limited to those who are also PLHIV, and while there is a need to continue and expand PLHIV smoking cessation programs, there is also a need to replicate the internationally successful model of community-controlled LGBTI smoking cessation programs, by funding such programs here in Australia.

Recommendation 7

Fund LGBTI and PLHIV community-controlled health services to provide LGBTI and PLHIV specific smoking cessation programs.

7. Conclusion

Currently, all federal, state and territory tobacco strategies do not include LGBTI or PLHIV as priority populations in need of targeted interventions, despite rates of smoking among LGBT people and PLHIV being double that of the general population, and despite community-controlled smoking cessation programs being more effective for members of these communities than programs for the general population.

The next National Tobacco Strategy should lead the way in Australia in being LGBTI and PLHIV inclusive, namely by including LGBTI and PLHIV priority areas and actions. The establishment of LGBTI and PLHIV reference groups would aid in progressing the LGBTI and PLHIV specific priority areas and actions.

Health promotion campaigns and resources that specifically target and cater to LGBTI people and PLHIV should receive funding. In addition, there should be an investigation into the potential to establish a national LGBTI Tobacco Control Network. Such a network could act to coordinate a national response to LGBTI tobacco use, limit duplication of work between community-controlled LGBTI health services and mainstream organisations working to limit tobacco use, and manage a clearinghouse for information of value to policymakers and people from LGBTI communities.

Finally, further research into PLHIV and LGBTI tobacco use is required. This will help to address the lack of evidence regarding tobacco use in the trans and gender diverse and intersex communities. Funding for such research should require collaboration between researchers and community-controlled LGBTI and PLHIV health services.

[47] Berger and Mooney-Somers. (2017). p.1414