Smoking and health 2021
A coming of age for tobacco control?

A report by the Tobacco Advisory Group of the Royal College of Physicians

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of bespoke smoking cessation support for people with SMI and acknowledge that further research to address the lack of long term effectiveness should be undertaken.

Important steps to ensure that smokers with a mental health condition are appropriately supported in the future have been taken, both in terms of national policies (see also chapter 6.4) and emerging research. Recognising and effectively tackling barriers, including prevailing misconceptions by health professionals and gaps in the evidence (eg further tailoring of behavioural intervention content relevant to SMI and smoking; electronic cigarettes for smoking cessation in SMI; relapse prevention), will be crucial to ensuring further progress. This is particularly pertinent in light of the COVID-19 pandemic, as having a SMI presents a risk factor for experiencing a new set of emerging inequalities in addition to existing ones,\textsuperscript{104} including those related to COVID-19 and smoking.\textsuperscript{105,106}

9.4.5 Smoking among the lesbian, gay, bisexual, and transgender community

In the UK, smoking prevalence is higher among lesbian, gay, and bisexual people (LGB) than in the general population. The most recent available data from the Annual Population Survey\textsuperscript{107} indicate that smoking prevalence in England in 2018 was around 1.4 times higher among people who identified as gay or lesbian (21.9%) and 1.3 times higher among those who identified as bisexual (19.7%) than in heterosexual people (15.2%) (Fig 9.6).

![Fig 9.6 Current smoking prevalence in adults (18+ years) in England by sexual orientation, 2014-2018.\textsuperscript{107}]

© Annual Population Survey
There are currently limited data (particularly in the UK) on smoking prevalence in trans and non-binary people. This failing should improve in the future: there is a project to harmonise and improve data collection on sex, gender identity and sexual orientation across government statistical services in the UK ahead of the 2021 census.108,109 The data that do exist suggest that these groups are also more likely to smoke than cisgender people.103,115 On this basis, NICE guidelines published in 2018 identified lesbian, gay, bisexual and transgender (LGBT) people as a priority for smoking cessation initiatives and services.112

Recent evidence113–115 has shown a narrowing in the smoking prevalence gap between the general population and some (but not all) LGB groups. However, this has not consistently been observed across surveys.116 While LGB people are more likely than heterosexual people to smoke, both groups appear to be equally motivated to stop smoking or likely to make a quit attempt117 and differences in smoking rates may in part be due to other sociodemographic confounders associated with sexual orientation/gender identity.115

9.4.5.1 Barriers to cessation

There are several factors that may contribute to higher smoking prevalence and make cessation more difficult among sexual minority groups.

9.4.5.1.1 Discrimination and mental health

Many smokers mistakenly believe that smoking helps to relieve stress and report smoking as a means of coping with high levels of stress.117,118 For some LGBT people, smoking may be a mechanism for coping with ‘minority stress’ caused by exposure to prejudice, discrimination, harassment, and victimisation.119,120 Homophobia, biphobia, and transphobia remain prevalent in schools, the workplace, and healthcare services. Quitting smoking may be more difficult, or less of a priority, for LGBT people in this context.

LGBT people are disproportionately more likely to experience poor mental health due to social pressures and prejudices.121 Smoking prevalence among the general population with common mental health conditions remains around 50% higher than among those without, despite their higher desire to quit.122

9.4.5.1.2 Social influence

Smoking is a socially contagious behaviour and is initiated and maintained through social networks.123 For many LGBT people, safe places for social gathering have traditionally been bars and similar establishments where there is a culture of smoking.124 Because of this, the introduction of smoke-free legislation in 2007 may have had a disproportionate benefit for this group, resulting in a decrease in smoking disparities.125 However, given the high levels of social exclusion experienced by sexual minority groups, it is also plausible that smoking persists due to fear of exclusion from the social group if the behaviour stopped.125,126

9.4.5.1.3 Industry interference

LGBT smoking has been encouraged by decades of targeted marketing from the tobacco industry, with companies investing heavily in the promotion and depiction of smoking in LGBT media. Other techniques have included sponsorship of pride events, silencing boycotts with large pay-outs, and giving away free cigarettes in LGBT venues.127,128

9.4.5.1.4 Intersectionality with other high-risk smoking groups

Those who identify as LGBT are also more likely to belong to other groups with higher smoking rates. As mentioned above, LGBT people are more likely than heterosexual or cisgender people to have mental health problems. They are also more likely to be single,129 socio-economically disadvantaged,130 and more likely to experience homelessness,131 all of which are associated with higher smoking prevalence.

9.4.5.1.5 Engagement in other health-harming behaviours

LGBT people are also more likely than non-LGBT people to engage in other health-harming behaviours associated with increased risk of smoking, including excessive alcohol use and dependence on controlled substances.131,132 There is evidence these behaviours are linked to use of LGBT social spaces,133 echoing the importance of social influence outlined above.

9.4.5.1.6 Difficulty accessing services

LGBT people also face problems accessing health services. In January 2016, a report by the Women and Equalities Select Committee into ‘transgender equality’ concluded that ‘the NHS is letting down trans people’, noting a number of areas such as a lack of staff training around gender identity and a failure to combat transphobia.134 This sentiment is echoed throughout LGBT patient experience research which has repeatedly identified sexual orientation as a reason for delaying access to services.121

GP advice to quit smoking is received by more than half of smokers visiting their practice in the past year and motivates quit attempts.135 Behavioural support can increase the likelihood that a quit attempt will be successful136,137 so it is vital that LGBT people feel able to access GP and stop smoking services and feel supported when they do so. The evidence suggests however that among LGBT people this is not always the case.125
Coming out to healthcare professionals appears to be beneficial. One in five LGBT people is not ‘out’ to any healthcare professional about their sexual orientation when seeking general medical care. Across all primary care services, the needs of LGBT people are more likely to be met when they disclose their sexual orientation and/or trans status to their healthcare professionals.

However, the 2017 LGBT Patient Survey found that only 53% of LGTB people had a positive response to disclosing their sexual orientation, while only 44% of trans people had a positive response to disclosing their trans status, to a healthcare professional. A substantial minority (18%) of trans people report avoiding medical treatment due to fears of insensitivity, misgendering (being referred to as the incorrect gender), and discrimination.

9.4.5.2 Strategies for boosting quit rates

9.4.5.2.1 Making services welcoming for LGBT people

When a service is designed for everyone, it does not necessarily cater to the specific needs of every user group. As such, services for all smokers may not appeal to LGBT smokers. Discrimination or a lack of understanding of LGBT issues could prevent a smoker from accessing or returning to a service.

It is likely that most LGBT people do not need an LGBT-specific smoking cessation service. Rather, they need the mainstream service to be a safe place for them to be themselves, without fear of discrimination, being misgendered, or having to explain or justify their identity. This potential can be reduced by having staff trained in LGBT awareness and providing visible signs of LGBT acceptance within services and more broadly in campaigns and health initiatives.

There are many simple steps that can be taken to make a service visibly LGBT friendly:

- displaying LGBT posters and literature in GP receptions, pharmacies, etc
- healthcare professionals wearing rainbow lanyards
- appropriate posters signposting to LGBT support (as you would for carers, or people with mental health conditions)
- including LGBT people in campaign communications
- amending registration and health forms to ask appropriately about sex, gender, and sexual orientation
- for events, providing labels that give people the chance to share their preferred pronouns (she/her, he/him, they/them) alongside their name.

It is also important to create an accepting atmosphere by ensuring that staff have a relaxed and welcoming attitude and avoid assumptions that everyone is heterosexual or cisgender (eg assuming that all service users will have opposite-sex partners). These simple steps to inclusion can act as marks of acceptance, improve engagement with services, and boost confidence in service users by breaking down perceived barriers.

9.4.5.2.2 Engaging in LGBT outreach activities

Above and beyond making services LGBT friendly, there are other things that can be done to proactively target LGBT smokers and offer them the support they need to quit. These include working with local LGBT organisations to reach the local LGBT community, and working with the local LGBT community to embed smoke-free spaces in events and festivals (eg prides) and recruit LGBT people to stop smoking services. A recent publication by Action on Smoking and Health provides examples of good practice at a local level. For instance, Greater Manchester has engaged with local tobacco alliances and tobacco control teams to ensure LGBT inequality is a standing item on their agendas to raise awareness among policymakers and promote action. Another region, Calderdale, working as part of Yorkshire Smokefree, has developed a relationship with a charity that supports local LGBT people to improve co-production and knowledge exchange. Examples of their activity include training designated charity staff as stop smoking advisors and the charity supporting national stop smoking campaigns (eg ‘No Smoking Day’ and ‘Stoptober’) to extend the reach of stop smoking support to communities who may not access, or look for information about, generic stop smoking services.

9.4.5.2.3 Regular monitoring of smoking and quit advice in LGBT-focused healthcare provision

Healthcare services that serve members of the LGBT community (eg LGBT health centres, HIV clinics) should monitor service users’ smoking status and be able to direct smokers to appropriate cessation support. Training healthcare professionals working in these settings to deliver brief advice on smoking could provide an effective, time- and resource-efficient intervention to LGBT smokers who may not otherwise seek professional support for quitting.

9.4.5.2.4 Sexual orientation and trans status monitoring

In terms of evaluation, evidence on the LGBT population has traditionally been limited by a lack of routine monitoring of sexual orientation in public services. The Sexual Orientation Monitoring Information Standard provides a standardised format for recording the sexual orientation of patients/service users.
orientation and trans status is important because it enables health and social care bodies to understand the needs of the local population better and target services more effectively and efficiently. There is a lack of evidence about the needs and experiences of LGBT people in general, and of trans people in particular.

Monitoring, correctly implemented, is the best way to address this lack of evidence and ensure LGBT people’s needs and experiences are heard. Monitoring also gives the patient or service user a safe and familiar way to disclose their identity. At present, other characteristics such as age, ethnicity, and marital status are monitored routinely. Additional questions around sexual orientation and trans status can be easily integrated into existing demographic forms for the purpose of compliance with the Equality Act 2010 and the Public Sector Equality Duty.

9.4.5.3 Special considerations for subgroups of LGBT people who smoke

In providing cessation support to LGBT smokers, certain considerations may be relevant for women, trans people, and people living with HIV.

9.4.5.3.1 Women

There is some evidence that differences in health-risk behaviour between sexual minority and heterosexual people are more pronounced in women than men,115,145 which suggests that other gender-specific influences may be implicated. It may be an expression of gender non-conformity for some LGB women looking to break the stereotype that women are less likely to smoke than men.156 It may also reflect the fact that LGB women are more likely than men to experience multiple forms of minority stress,147 which may increase their propensity to engage in risky health behaviours as a coping mechanism. Gender-specific tailoring of health messages could help to reduce smoking disparities between LGB men and women.

9.4.5.3.2 Trans people

Self-identification is all that is required to be trans, but many trans people also seek hormone replacement therapy (HRT) as part of their transition process. For these people, smoking cessation is particularly important because concurrent smoking and hormone use generates substantial health risks.148 In the case of trans women taking HRT, tobacco use may also reduce the efficacy of their treatment. Trans people wishing to undergo gender affirming surgery should also be aware of the significant risks of smoking during and after any surgery. In general, smokers are 30% more likely to die after any surgery and more likely to experience major complications such as wound infection149 and cardiovascular events.150 Preoperative smoking cessation interventions can improve short-term cessation and lead to significant health benefits.151

9.4.5.3.3 People living with HIV

Gay, bisexual, and other men who have sex with men are the population most affected by HIV. There are higher levels of smoking among people with HIV than in the general population.152 With modern anti-viral treatment regimes, smoking has a much greater impact on life expectancy than HIV infection – but the two conditions combine to threaten the health of HIV positive smokers.153 Caution should be taken when prescribing bupropion (Zyban) to someone on anti-HIV drugs due to the way the two drugs interact.154 Anti-HIV drugs can reduce the level of bupropion in the blood and may require a much higher dosage to be effective; NICE guidance is to start bupropion at the recommended dose and titrate as required.155

9.5 Primary care

Almost all clinicians will see patients who smoke under their care, and current national guidelines recommend that clinicians make brief opportunistic interventions to promote smoking cessation.156,157 Patients rarely ask clinicians directly for help to stop smoking; rather, clinicians raise this, typically at the end of a consultation, where they opportunistically offer advice or help to stop smoking. All clinicians are advised to do this, however, GPs in particular are often seen as best placed as they typically have credibility and are well trusted by patients.

9.5.1 Evidence for the effectiveness of opportunistic brief interventions

The Cochrane review, Physician advice for smoking cessation, grades the evidence as strong that physicians can support people to stop smoking – patients who receive advice of some form are more likely to stop smoking than those who receive no such advice.158 People who stop smoking are at substantially lower risks of heart disease in the short term and other diseases over the longer term and therefore the costs of GP time spent on advice are outweighed by the savings that accrue in reduced healthcare costs in the medium and long term.160 Thus, it would be rational for any clinician heeding this evidence to undertake opportunistic interventions to support smoking cessation on every possible occasion. Clinicians do not do so, however.

A systematic review aimed to determine what clinicians should do during a brief opportunistic intervention by reviewing all the opportunistic interventions in the Cochrane review described above.161 Some trials randomised participants to advice to stop smoking or advice to stop smoking plus offering support in achieving abstinence.