LGBT Health and Inclusion Project

Report – LGBTQ Smoking and Lung Cancer Consultation

The LGBT Health and Inclusion Project

Brighton and Hove NHS Clinical Commissioning Group (BH CCG) and Brighton and Hove City Council (BHCC) have commissioned the LGBT Health and Inclusion Project at Brighton and Hove LGBT Switchboard to conduct a series of consultation and engagement activities with local lesbian, gay, bisexual, trans and queer people (LGBTQ) people. The aim is to use the information gathered to feed into local service commissioning, planning and delivery.

Please note, the following report presents information about the consultation and engagement work conducted by LGBT HIP, and should not be taken as a position statement of Brighton and Hove LGBT Switchboard or of any participating organisation.

Introduction

This report contains an analysis of our consultation into LGBTQ people's experiences of and opinions on smoking and lung cancer awareness. Public Health England have recommended that smoking cessation interventions should specifically consider evidence on LGBT smoking prevalence, and target LGBT youth as an at-risk group. There is a below-average survival rate for cancer in Brighton & Hove, with high mortality rates and inequalities within the city. This consultation has been commissioned by the Clinical Commissioning Group to identify specific inequalities and additional barriers to access faced by LGBTQ people in relation to lung cancer risks. Findings will be assessed and distributed by the CCG with a view to addressing any such issues and promoting better health outcomes for the LGBTQ community

Background

Prior quantitative and qualitative research has identified a range of additional risks and health inequalities experienced by LGBTQ people around lung cancer risks and related health outcomes. The National LGB&T Partnership recently published smoking cessation resources[1], which pooled data from existing surveys together with Integrated Household Survey data. In findings consistent with those of earlier research projects undertaken by Stonewall[2] and Sigma Research[3], the review found that LGB communities smoke more than their heterosexual counterparts and are therefore at added risk from smoking related illnesses.

[1] Smoking and lesbian, gay, bisexual and transgender communities. National LGB&T Partnership 2015

[2] Prescription for Change: Lesbian and Bisexual Womens Health Check. Hunt. R. & Fish. J: Stonewall 2008. Gay and Bisexual Men's Health Study. Guasp. A et al: Stonewall 2011.

[3] Consuming Passions – the UK National Gay Men's Sex Survey. Hickson. F. et al: Sigma Research 2005

The resource published alongside these findings also highlights:

- Increased risk of HIV positive smokers developing lung and anal cancers, emphysema and dementia because of their positive status, proportionally higher rates of smoking in HIV positive men and contra-indications between HIV medications and smoking-cessation medications.
- Increased risk of adverse side-effects for hormone therapy in trans women who smoke.
- Increased risk of breast cancer in lesbian women who smoke due to a combination of other risk factors.

Locally, smoking in the LGBTQ community has been subject to a number of recent research projects and consultations, and has been investigated both as part of the broader health inequalities faced by LGBT Communities, and also as a demographic within the wider population.

Count Me In Too[4] found that 33% of LGBT people in the survey sample smoked cigarettes, that 71% of LGBT smokers would like help to stop smoking and that over a quarter of those who smoked said that a LGBT stop smoking service would motivate them to give up smoking.

The percentage of smokers in the LGB community in Brighton and Hove was found to be slightly less (30%) in the more recent Health Counts Report[5], though was still higher than that of heterosexuals (22%). The report also found that the highest smoking prevalence is seen amongst bisexuals (40%) – significantly higher than for all respondents. Data for trans respondents were not included in this final report, but were referenced in the 2015 Trans Needs Assessment as being 39%[6].

Recent LGBT HIP community research has also touched upon smoking in the 2015 consultation into Lesbian, Bisexual and Queer Women's Health Needs[7], and responses were broadly in line with these figures with 33% of respondents indicating that they were current regular or social smokers. Seventy-one per cent of regular smokers (12% of all respondents) indicated that they would like to cut down or give up and 29% (5% of all respondents) indicated that they would not like to cut down or give up.

Another recent LGBT HIP survey into Trans peoples use of drugs and alcohol[8] also suggested some preference for LGBT specific services, though the survey did not address tobacco use or smoking cessation services.

[4] Count me in too: Drugs and Alcohol Additional Findings Report 2009, Dr. Kath Browne et al.2009
[5] Health Counts in Brighton & Hove. Brighton & Hove City Council 2012
[6] Trans Needs Assessment. A. Hill and R. Condon. Brighton and Hove City Council 2015
[7] Lesbian, Bisexual and Queer Women's Health Needs. LGBT HIP 2015
[8] Trans Drugs and Alcohol Report. LGBT HIP 2015

Method

Survey

The survey questions were designed by the LGBT HIP Project Manager. Questions were shaped in response to a request to conduct research into smoking and lung cancer awareness for Brighton & Hove Clinical Commissioning Group.

The questions around smoking habits were modelled after questions used in a prior LGBT HIP consultation into LGB women's health needs and the lung cancer awareness questions were modelled on the Cancer Research UK lung cancer awareness measure[9]. Other questions were designed as per the focus outlined in the CCG's briefing for Health Engagement Organisations.

The survey was hosted on Surveymonkey and promoted on Switchboard's facebook page, promoted in the LGBT HIP newsletter and promoted independently via email to the LGBT HIP Mailing list & Organisations mailing list.

Focus Group

The focus group was advertised on the LGBT Switchboard Facebook page, twitter, and the LGBT HIP mailing list and a ten-pound incentive was offered for participants.

Prompts relating to key messages linked to smoking and lung cancer, and the latest evidence around e-cigarettes were directly taken from the CCG briefing and the focus group session was designed and facilitated by the LGBT HIP project manager.

Despite offering incentives and advertising the focus group, only two participants attended. As a result, this cannot be taken as a reflective sample, however it was decided to include this data alongside the survey data to provide additional narrative context.

Report

The data from the survey and the focus group was collated, reviewed and analysed by the LGBT HIP Support Officer, who has proposed a number of recommendations sponsored by the LGBT HIP Project Manager.

[9] Lung Cancer Awareness Measure (Lung CAM) Toolkit. Cancer Research UK 2011

Survey

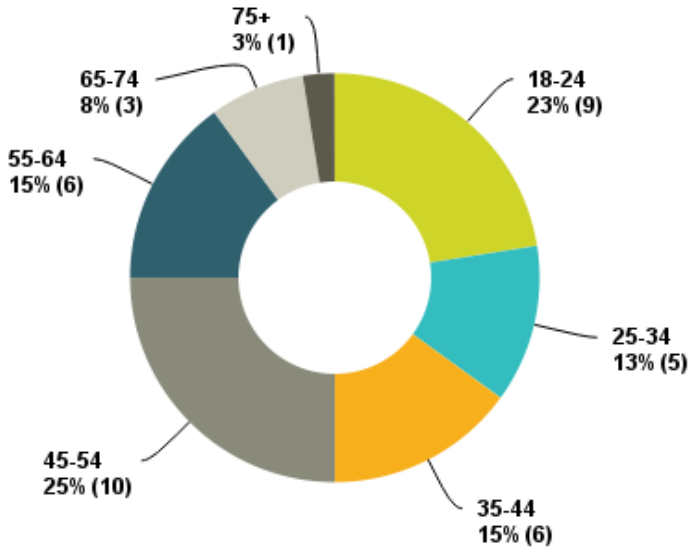
Demographic

Participants were all first presented with an initial screening question, which limited the sample, by self-exclusion of participants who did not meet certain criteria. The screening question limited the sample to '*Lesbian, Gay, Bisexual, Transgender and Queer people who live, work, study or socialise in Brighton and Hove'*. After this question there were a total of 50 eligible respondents.

At the end of the survey, data was collected on participants' age, sexual orientation, gender identity, ethnicity and disability.

Age

(40 respondents)



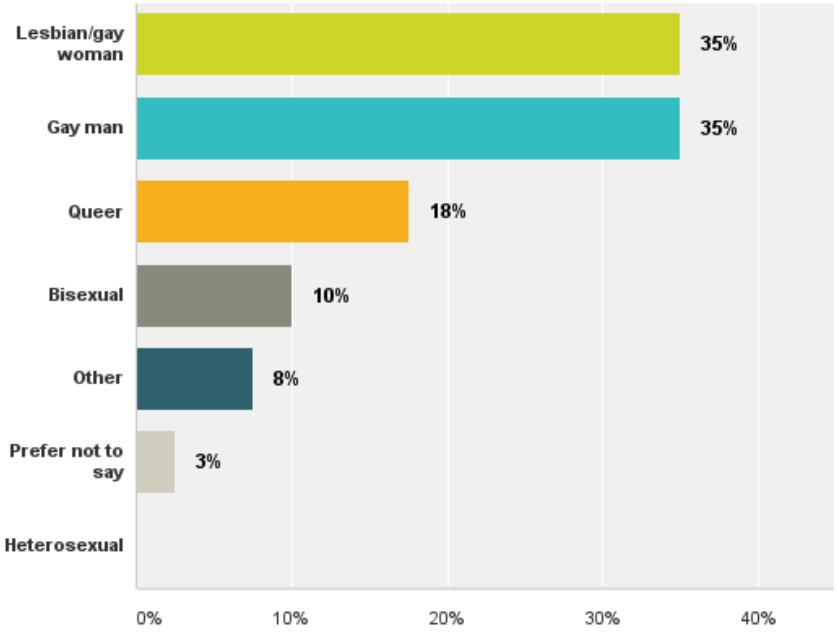
Participants were asked to select their age from a range of banded options. The age distribution was fairly evenly spread across the groups. Only four participants were over the age of 65.

Sexual Orientation

(40 respondents)

Participants were asked to select which of the orientations listed described them and were permitted to select more than one option.

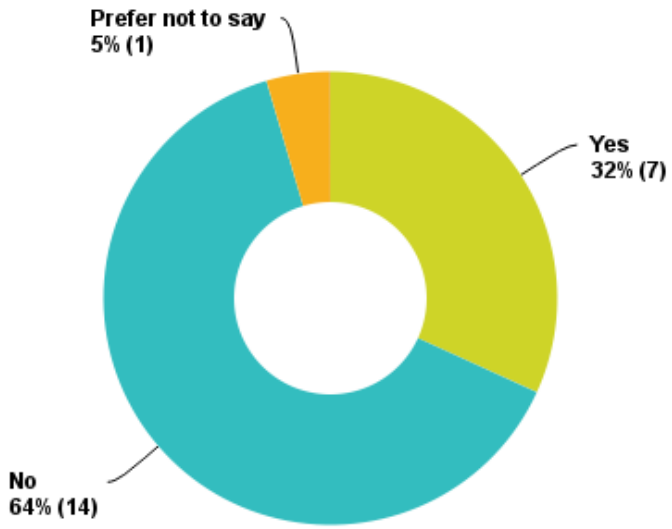
- 35%(14) of respondents indicated that they identified as a lesbian or gay woman
- 35%(14) of respondents indicated that they identified as a gay man
- 18%(7) of respondents indicated that they identified as queer
- 10%(4) of respondents indicated that they identified as bisexual
- 8%(3) of respondents indicated that they identified with an 'other' sexual orientation which was not listed. These included two who identified as pansexual, and one who identified as unsure.



Transgender

(22 respondents)

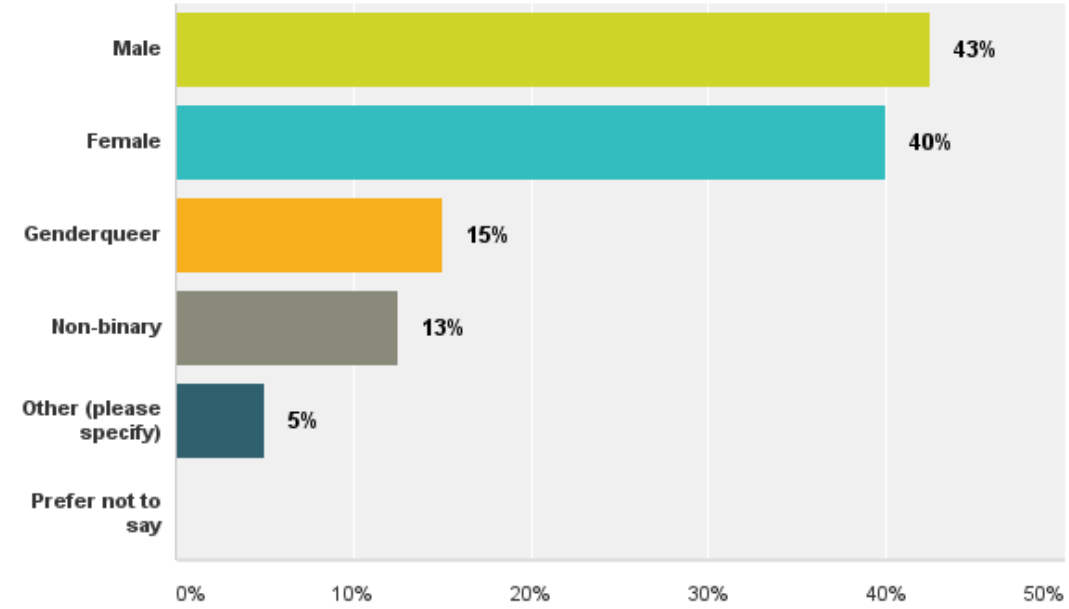
Participants were asked: 'Do you identify as transgender or trans*, or have you in the past?'



32%(7) of respondents to this question indicated that they did identify as transgender or trans* or that they had in the past

Gender Identity

(40 respondents)



Participants were asked to select which of the gender identities from the following list listed best described them –

Male, Female, Genderqueer, Non-Binary, Other, or prefer not to say.

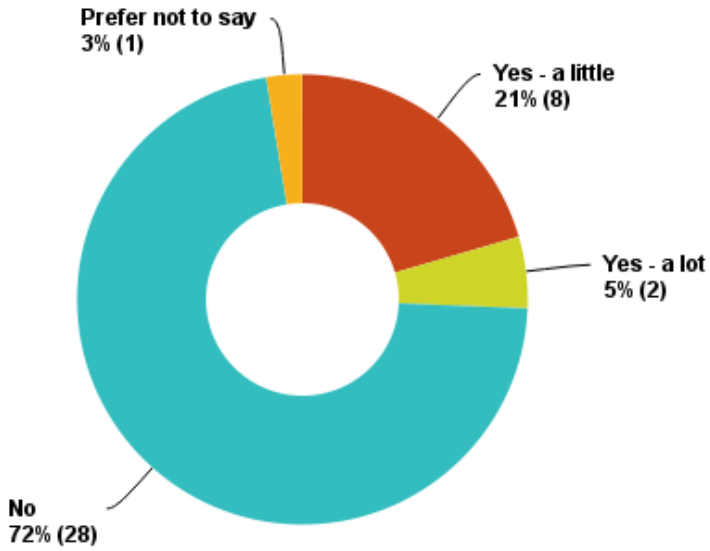
Respondents were permitted to select more than one option and were also presented with an open field in which to describe other gender identities which did not fit into those options.

43%(17) of respondents identified as male, 40%(16) of respondents identified as female, 15%(6) of respondents identified as genderqueer, 13%(5) of respondents identified as non-binary, one respondent completed the 'other' field as 'woman', and another completed the 'other' field as 'Agender'

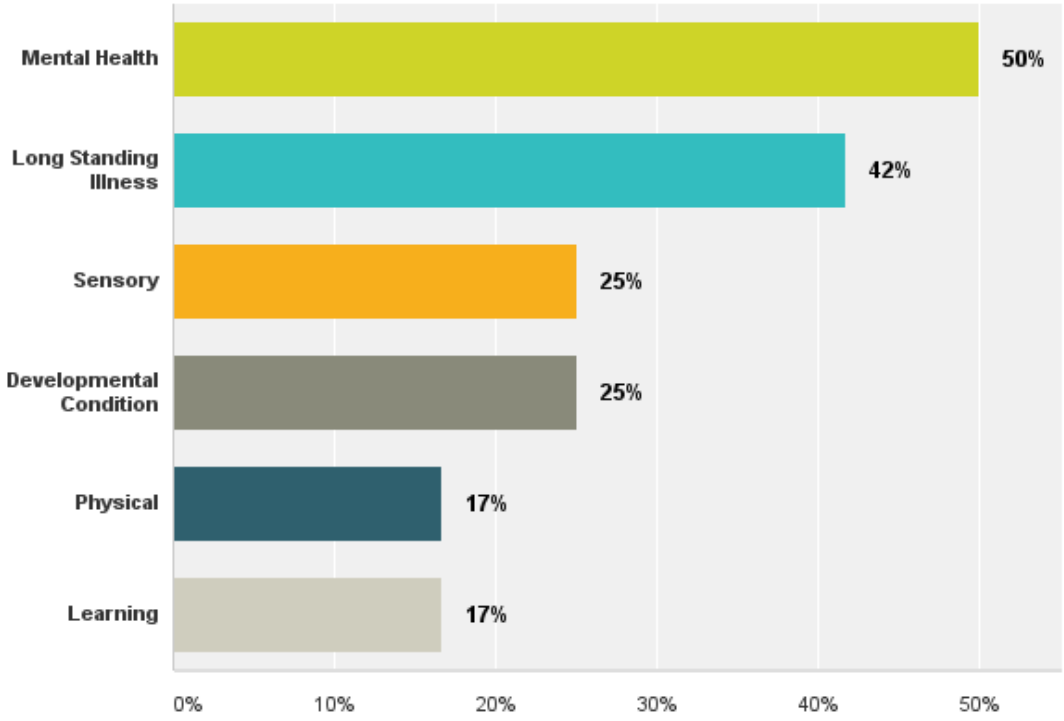
Disability/Long Term Health Condition

(39 respondents)

Participants were asked: *Are your day to day activities limited due to being a disabled person?*



In total, 26%(10) of respondents indicated that their day to day activities were limited due to a disability, 21%(8) indicated that their day to day activities were limited a little and 5%(2) indicated that their day to day activities were limited a lot.



Of those respondents who indicated that their day to day activities were limited due to a disability, 50% (6) indicated that they had a mental health condition, 42%(5) indicated that they had a long standing illness, 25%(3) indicated that they had a sensory disability, 25% (3) indicated that they had a developmental condition, 17% (2) indicated that they had a physical impairment and 17% (2) indicated that they had a learning disability.

Ethnicity

(39 respondents)

Respondents were asked to select from a list of terms to describe their ethnic background. 77%(30) identified as being of White British heritage, with 72% (28) of all respondents identifying as being of White British heritage only. 10% (4) of respondents identified as being of White Irish heritage with 8%(3) of all respondents identifying as being of White Irish heritage only. 10% (4) of respondents identified as being from any other White background.10%(4) of respondents indicated that they were of mixed heritage; one of mixed White British and White Irish heritage, one of mixed White British and Black or Black British African heritage, one of mixed Turkish and Jewish heritage and one of unspecified mixed heritage. The total percentage of respondents identifying as being of BME heritage was 28% (11)

Neighbourhoods

(40 respondents)

Respondents were asked to indicate the first four digits of their postcode. 10%(4) of respondents indicated that they lived outside of Brighton & Hove. The geographic distribution of the remaining respondents is indicated in the table below:

Postcode	Number of Respondents
BN1 1	1
BN1 2	3
BN1 3	6
BN1 4	3
BN1 7	1
BN1 8	1
BN1 9	1
BN2 0	1
BN2 1	4
BN2 3	2

Postcode	Number of Respondents
BN2 7	1
BN2 8	1
BN2 9	2
BN3 1	5
BN3 2	1
BN3 3	1
BN3 4	1
BN3 6	1
BN41 2	1

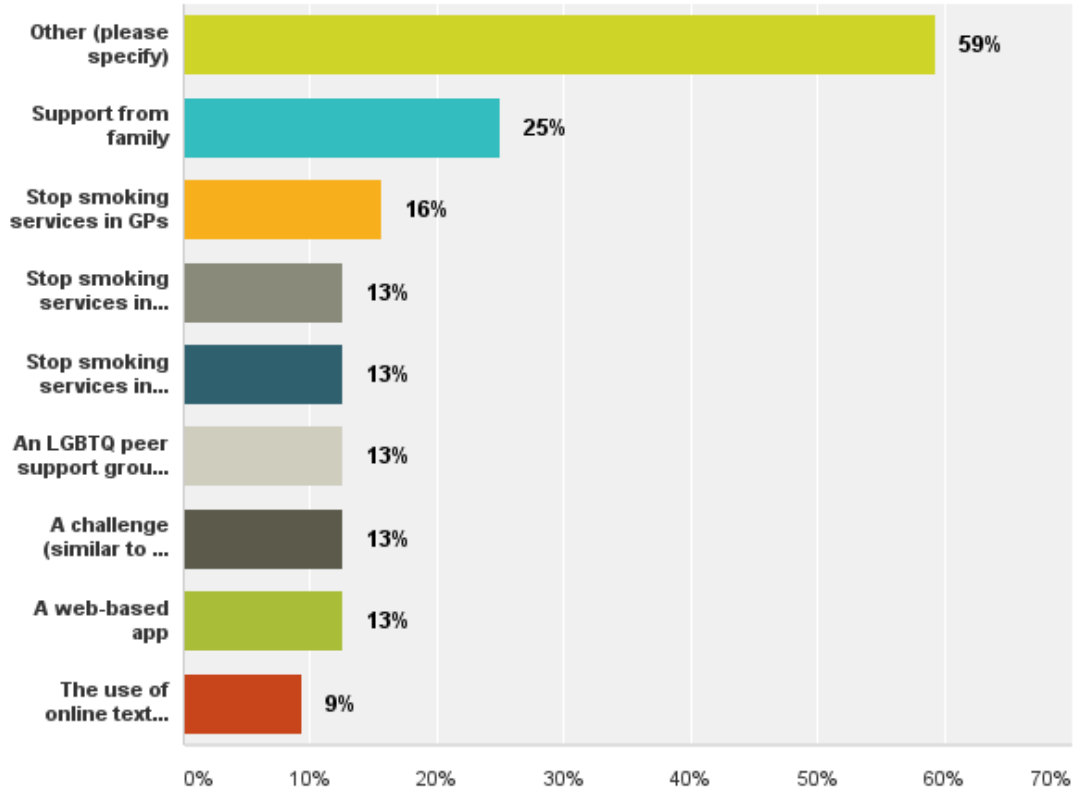
Smoking Habits

Participants were asked:
Do you smoke any tobacco products?
They were presented with a selection of possible answers.
(q1: 48 respondents)

- 62%(30) of respondents indicated that they were non-smokers/ex-smokers:
  - 31%(15) of respondents answered *I have never smoked*
  - 31%(15) of respondents answered *I used to smoke, but I don't now*
- 38% of respondents indicated that they were current smokers:
  - 19%(9) of respondents answered *I smoke regularly and would like to cut down or give up*
  - 10%(5) of respondents answered *I smoke regularly and don't want to cut down or give up*
  - 8%(4) of respondents answered *I'm a social smoker/ I smoke occasionally (less than once a week*
- None of the respondents answered *I only smoke e-cigarettes.*

Suitable Support

Participants who indicated that they were current smokers or had smoked in the past were asked:
In your opinion, what would help (or has helped) you to stop smoking and/or reduce the amount you smoke?
They were presented with a selection of possible answers, as well as the option to suggest alternatives which were not listed.
(*q2: 32 respondents*)



The 'other' suggestions varied considerably, but other than the substantial proportion who cited 'will power', notable themes included support from partners and friends, alternative

therapies such as hypnotherapy and acupuncture, and the use of/education around smoking alternatives (e-cigs and vaporisers).

Two respondents suggested some medical direction - one respondent said that they had been referred to a smoking cessation service through hospital services and another trans respondent stated that smoking interfered with their hormone therapy.

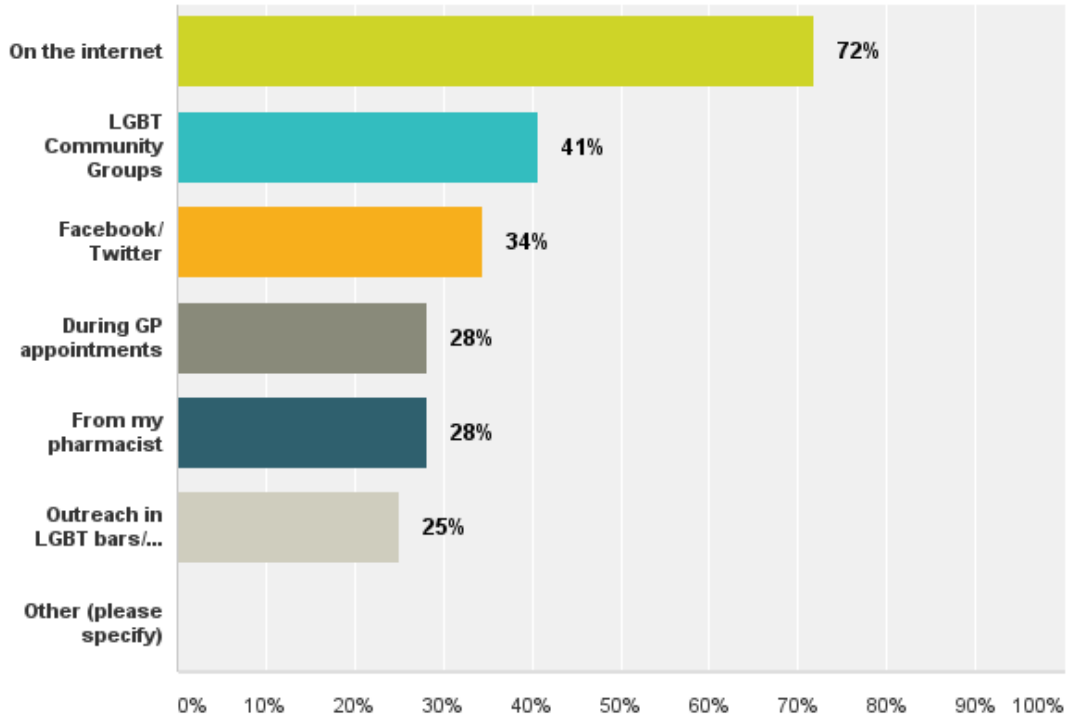
Some other respondents suggested a change in their circumstances such as a reduction in stress, friends quitting or familial intervention had helped them to quit.

Of the multiple choice answers to the question:

- 25% (8) indicated that support from family had helped or would help them to stop or reduce their smoking
- 16%(5) indicated that stop smoking services in GPs had helped or would help them to stop or reduce their smoking
- 13%(4) indicated that stop smoking services in pharmacies had helped or would help them to stop or reduce their smoking
- 13%(4) indicated that stop smoking services in LGBTQ community groups had helped or would help them to stop or reduce their smoking
- 13%(4) indicated that an LGBTQ peer support group around smoking had helped or would help them to stop or reduce their smoking
- 13%(4) indicated that a challenge (similar to dry January) had helped or would help them to stop or reduce their smoking
- 13%(4) indicated that a web-based app had helped or would help them to stop or reduce their smoking
- 9%(3) indicated that the use of online text message support had helped or would help them to stop or reduce their smoking

Accessing Information

Participants who indicated that they were current smokers or had smoked in the past were asked:
Where would you like to access information and support to stop smoking or reduce smoking?
They were presented with a selection of possible answers, as well as the option to suggest alternatives which were not listed.
(*q3: 32 respondents*)



- 72%(23) indicated that they would like to access information and support on the internet
- 41%(13) indicated that they would like to access information and support from LGBT Community Groups
- 34%(11) indicated that they would like to access information and support from Facebook/ Twitter
- 28%(9) indicated that they would like to access information and support during GP appointments
- 28%(9) indicated that they would like to access information and support from their pharmacist
- 25%(8) indicated that they would like to access information and support through outreach in LGBT bars and clubs

Barriers to Stopping Smoking

Participants were asked:
What, if any, do you think are the barriers for LGBTQ people to stop/ reduce smoking?
(*q4: 18 respondents*)

One third of respondents suggested that they did not think there were any particular barriers for LGBTQ people to stop smoking, or that these were the same as for any other group.

Social pressures were broadly considered to be a big factor in barriers for LGBTQ people to stop or reduce smoking – with a number of respondents particularly citing smoking as an ingrained aspect of LGBTQ social culture, particularly where that culture is heavily centred around bars and clubs.

> *As an ex smoker I found it difficult to be in bars whilst trying to stop as alcohol consumption reduced my motivation to stop - with insufficient places for LGBTQ people to socialise other than bars this may be a barrier*
>
> *Most social venues are bars and clubs and the smoking area can be quite an important social area too.*

> *From my experience, many people in the LGBT community smoke so its quite a good way to pick up girls*

Stress and mental health issues were another issue raised by a large number of respondents, with a high proportion of those specifically citing the minority stresses of societal and internalised homophobia and resulting low self-esteem being a key contributing factor.

> *the pervasive daily homophobia we have to field. our internalised homophobia. these, in my view, are some of the most damaging negative messages we carry inside ourselves. smoking, as recreational drugs and drinking, are how we destroy ourselves.*

Another respondent also cited '*badly aimed stop smoking adverts*', suggesting that the LGBTQ community may be poorly served by public health initiatives which are centred around heteronormative values and imagery. This was an issue which was also raised in the focus group (see p16)

Encouragement to Stop Smoking

Participants were asked:
What key messages do you think would motivate LGBTQ people to seek help to stop/ reduce smoking?
(*q5: 33 respondents*)

Messages around the health implications of smoking were broadly cited, as were messages promoting a negative image of smoking, and the negative impact of smoking on personal image. Health was identified as a key motivator, with mortality and the risk of cancer suggested by a number of respondents. More commonly cited than the risk of life-threatening illnesses, however, were the risks to individuals long-term vitality and wellbeing. The risks of debilitating illness, incapacitation and poorer long-term quality of life were common themes – suggesting that people may be more concerned with quality of life than length.

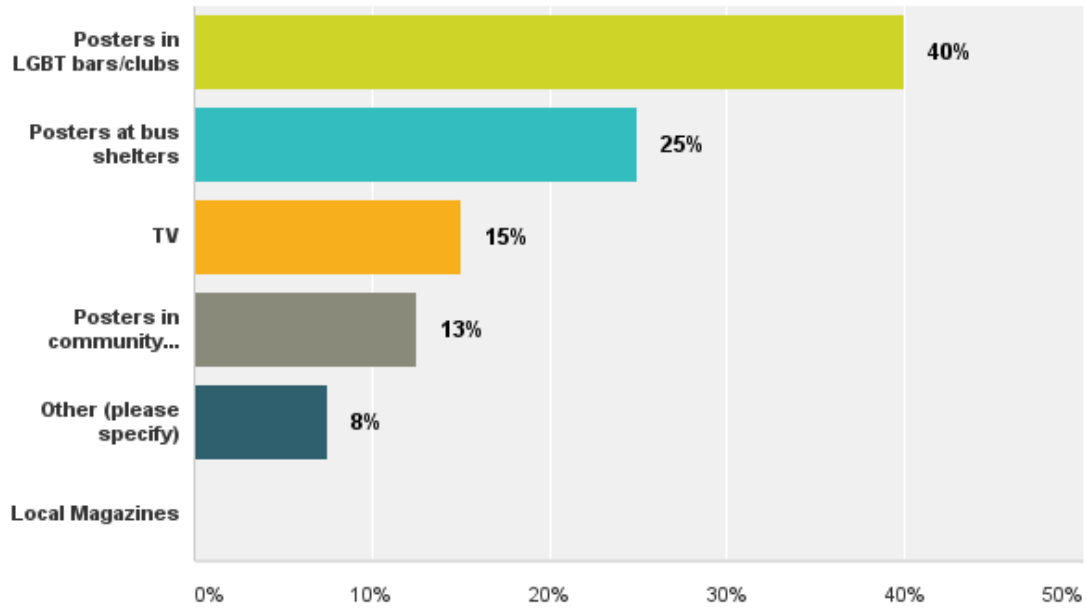
These issues also overlapped with image in terms of premature ageing. Other image-related messages included making you smell bad, bad breath, bad teeth, bad skin, and bad oral and intimate hygiene ('tasting' bad / 'like an ashtray')

Five participants suggested that the financial cost of tobacco and cigarettes could be used as a key message to motivate LGBTQ people to stop or reduce smoking, by highlighting potential savings that people can make.

Following cost, the next most prominent theme was the suggestion that LGBT people may smoke due to a lack of self-esteem and self-worth, with recommendations for initiatives addressing these issues as being central to an anti-smoking message. This was also echoed by a number of respondents suggesting that positive messages of encouragement, and positive role-models within the community could have a beneficial impact.

Smoking Awareness Campaigns

Participants were asked: *How do you think smoking awareness campaigns would be best delivered locally?*
They were presented with a selection of possible answers, as well as the option to suggest alternatives which were not listed.
(*q6: 40 respondents*)



- 40%(16) of respondents indicated that local delivery of smoking awareness campaigns would be best delivered through posters in LGBT bars and clubs, making this the most popular option.
- 25%(10) of respondents indicated that local delivery of smoking awareness campaigns would be best delivered through posters at bus shelters
- 15%(6) of respondents indicated that local delivery of smoking awareness campaigns would be best delivered through TV
- 13%(5) of respondents indicated that local delivery of smoking awareness campaigns would be best delivered through posters in community settings
- One respondent suggested
  'Editorial testimonies & accounts from medical professionals contained in editorial content.'
- One respondent recommended adverts on the sides of buses and taxis

E-Cigarettes

Participants were asked:
What do you think of E-cigarettes?
(*q7: 38 respondents*)

While a number of respondents (9) suggested a predominantly positive perception of e-cigarettes, nearly twice as many respondents (16) suggested a predominantly negative perception of e-cigarettes, and eight respondents suggested a mixed impression, citing both positive and negative perceived aspects.

The most prominently perceived positive aspects of e-cigarettes were that they were useful as an aid to support smoking cessation (5) and they were less harmful than cigarettes (5). In counter to these positive perceptions, however, a considerably higher volume of respondents suggested that e-cigarettes perpetuated negative addictive behaviours(12); a number of respondents cited the health risks associated with nicotine, and over 20% suggested that they felt there was insufficient evidence to confirm that there were not significant health risks related to e-cigarette use. A number of respondents specifically cited historical ignorance around the dangers of smoking, and the associated historical promotion and medical endorsement of smoking as a beneficial activity, as a key factor in their mistrust.

The perceptions and experiences of third parties were also raised, with four respondents suggesting that e-cigarettes may be more tolerable for others, although one respondent suggested that that e-cigarettes were not tolerable and may still have negative implications for the health of others in the surrounding area.

Other issues raised included one respondent citing a negative social image – 'particularly the ones that look like apparatus' and one respondent indicating that they preferred 'vapes' – suggesting a distinction in perceptions between 'e-cigarettes' and vapourisers. Two respondents also cited expense as being a key negative factor – an issue which was also raised in the focus group (see p17).

Lung Cancer Awareness

Participants were presented with a list of symptoms and were asked:
The following may or may not be warning signs for lung cancer. We are interested in your opinion. Which of the following do you think could be a sign of lung cancer?
They were able to indicate whether they thought each symptom could be a symptom of lung cancer by responding from the options *Yes, No* and *Not Sure.*
(*q8: 40 respondents*)

	Yes	No	Not Sure	Total
Coughing up blood	**87%** 34	**5%** 2	**8%** 3	39
A persistent (3 weeks or longer) chest infection	**87%** 33	**8%** 3	**5%** 2	38
Persistent shortness of breath	**85%** 33	**5%** 2	**10%** 4	39
A painful cough	**82%** 31	**3%** 1	**16%** 6	38
A cough that does not go away for two or three weeks	**82%** 32	**13%** 5	**5%** 2	39
An ache or pain when breathing	**79%** 30	**5%** 2	**43%** 6	38
Unexplained weight loss	**75%** 30	**8%** 3	**18%** 7	40
A worsening, or change in an existing cough	**74%** 28	**8%** 3	**18%** 7	38
Persistent tiredness or lack of energy	**74%** 29	**10%** 4	**15%** 6	39
Persistent chest pain	**74%** 29	**10%** 4	**15%** 6	39
Developing an unexplained loud, high-pitched sound when breathing	**64%** 25	**8%** 3	**28%** 11	39
Loss of appetite	**51%** 19	**5%** 2	**43%** 16	37
Persistent shoulder pain	**40%** 15	**18%** 7	**42%** 16	38
Changes in the shape of your fingers or nails	**16%** 6	**30%** 11	**54%** 20	37

Participants were asked:
How confident are you that you would notice a lung cancer symptom?
They were able to rate their level of confidence from a range of options (each with an

associated weighted value) as *not at all confident* (0)*, not very confident* (1)*, fairly confident* (2) or *very confident* (3).
(*q9: 39 respondents*)

Not at all confident 0	Not very confident 1	Fairly confident 2	Very confident 3	Weighted Average
8% 3	**33%** 13	**49%** 19	**10%** 4	1.62 3

Participants were asked:
If you had a symptom that you thought might be a sign of lung cancer, how confident would you feel about going to your GP to discuss this?
They were able to rate their level of confidence from a range of options (each with an associated weighted value) as not at all confident (0), not very confident (1), fairly confident (2) or very confident (3).
(*q10: 39 respondents*)

Not at all confident 0	Not very confident 1	Fairly confident 2	Very confident 3	Weighted Average
5% 2	**18%** 7	**38%** 15	**38%** 15	2.10 3

Focus Group

Response to Key Messages

Focus Group participants were asked to respond to two key messages linked to smoking and lung cancer:

* Living with someone who smokes increases the risk of lung cancer

* Smoking causes almost 90% of lung cancer deaths

Message One – Living with someone who smokes increases the risk of lung cancer

Participants suggested varying levels of acceptance/ awareness in response to this message. One participant initially expressed acknowledgement and acceptance while another expressed doubt, stating that they knew living with someone who smokes may increase risk of asthma, but not necessarily lung cancer.

They each expressed some level of scepticism in relation to the presentation of the message, suggesting that the information presented was not perceived to be reliable. One stated that there was 'no hard evidence' to support the message. It was suggested that statistical information presented in relation to this message would strengthen its impact.

Significantly, both participants raised the issue of how the majority of passive-smoking centred public health campaigns tended to focus on the impact of passive smoking on children – appealing to a protective, parental instinct. The participants suggested that this kind of campaign was alienating to people without children, and presented the impression that children were the only demographic so negatively affected by passive smoking. They felt that passive smoking may not be so harmful for adults and they were unsure of the message's accuracy on this basis.

The participants suggested that messages about one's own health may be less easy to accept and more easy to dismiss, and that they felt excluded from this kind of passive smoking campaign stating: 'If you haven't got kids or friends with kids, people don't really pay attention.'

Message Two – Smoking causes almost 90% of lung cancer deaths

This message was initially met with incredulity and even outright dismissal as 'rubbish' from one participant. Participants cited anecdotal experience where they knew of people who have had lung cancer but have not been smokers, suggesting that the statistic conflicted with their personal experience.

Shortly after, however, it was conceded that it 'could be plausible', but that they would need to be presented with more information for the message to be engaging. One participant suggested that they would like information on the source of the statistic, suggesting that use of a QR code could help the public to access such information.

It was also suggested that, even if more demonstrably true, this statistic would not be shocking enough to have a significant impact on smoking habits. Participants stated that they had been desensitised to such messages by the extreme images presented on cigarette packets.

Positive Messages

Participants were asked what kinds of messages they would like to see, which might encourage them to stop smoking

Participants suggested that people can often become blind to campaign messages and shock tactics, and that presenting a conversational, personable face to smoking cessation support was more valuable. It was stated that people might feel more inclined to access informal support from peers in the LGBT community and that community settings can feel more safe and secure than accessing clinical services. As such, this might present a good platform to direct targeted support and encouragement for LGBTQ people to cut down or give up smoking.

There was a strong feeling that Public Health agencies should be able to signpost to smoking cessation support in community settings and offer support in LGBT community settings. It was suggested that such settings are often a 'first port of call' over clinical environments as they are seen to be less judgemental and more accessible. Participants suggested that Public Health should establish relationships with support groups and organisations, perhaps having a dedicated outreach worker to connect with support groups.

Another key suggestion was that Public Health should provide more information and clarification on the difference between e-cigs and vaping. This was in response to wider confusion over the various health issues – relative risks of different types of smoking substitutes etc.

Response to statements on latest evidence around e-cigarettes

Focus Group Participants were asked to respond to three statements reflecting the latest, Public Health endorsed research on the safety of e-cigarettes:

* While not completely risk free, based on current evidence, e-cigarette use is around 95% less harmful than smoking, with no evidence that e-cigarette vapour causes harm to bystanders.

* Although experimentation with e-cigarettes has increased among young people, regular use is rare and is almost completely limited to current or ex-smokers.

* E-cigarettes are now the most popular quitting aid in England and evidence indicates they can be effective in helping people to stop smoking.

Statement One: While not completely risk free, based on current evidence, e-cigarette use is around 95% less harmful than smoking, with no evidence that e-cigarette vapour causes harm to bystanders.

Participants claimed to be familiar with this message but also stated that they didn't agree e-cigarettes were 95% less harmful as ' *there are still a lot of chemicals in it. I don't see how the risk could have dropped so significantly*.'

They stated that they would not find the message interesting or engaging, and that it would need to be re-enforced and supported by evidence to be taken seriously.

One participant stated that they have dyslexia and that they would prefer to see the information presented in a more interactive/visual format.

Statement Two: Although experimentation with e-cigarettes has increased among young people, regular use is rare and is almost completely limited to current or ex-smokers.

This statement was dismissed as 'complete and utter bollocks', with participants again citing contrary anecdotal evidence, that they had seen '*kids, instead of smoking cigarettes, they're smoking e-cigs'*.

Nonetheless, participants agreed that they would rather kids smoke e-cigs than cigarettes and that they shouldn't be banned in schools if they were helpful in supporting young people to avoid cigarettes as they were 'less harmful to young people.'

Again, it was suggested that stats and images would be helpful in supporting the statement,

Statement Three: E-cigarettes are now the most popular quitting aid in England and evidence indicates they can be effective in helping people to stop smoking.

Participants agreed that this statement was 'probably accurate', but cited challenges faced by LGBT people in using e-cigs and vapes. Participants cited cost as being a prohibitive factor, and there seemed to be something of an 'image problem'

> *If people see you smoking an e-cig or a vape they'll ask 'what are you doing that for?' and offer you a cigarette. So of course you'll smoke the cigarette*
>
> *Smoking Is a very 'LGBT thing to do, when you go to [the smoking areas in] clubs…no-one's smoking e-cigs. There's a sense that 'smoking is cool'*
>
> *I think my gay friends all smoke tobacco, not e-cigs or vapes.*

To counter these issues, participants suggested that if LGBTQ venues supported e-cig use, users might feel more supported to quit. E-cigs were perceived to be more visible in straight clubs and bars.

Participants also suggested that people were often 'turned off' from anti-smoking messages which were perceived to be austere or patronising. They suggested that anti-smoking messages and campaigns need to be more interactive and engaging, and to present a colourful and relatable message and that the LGBT community may just be a suitable vehicle for that kind of message. It was suggested that first person accounts and role models/ community advisers/ reps/anti-smoking champions within the community could have a positive impact

Summary of Findings

Rates of Smoking

Findings of this consultation were broadly consistent with those of earlier studies. The sample appeared to include a higher rate of smokers from the LGBTQ community than identified in previous studies, though this is likely to be attributable to the self-selection of participants, of whom current smokers may have been more likely to take part as they felt the survey was more relevant to them.

Lung Cancer Awareness

Participants were, on the whole, 'fairly confident' that they would recognise a sign of lung cancer, and the level of awareness demonstrated in the awareness measurement questions suggest that this is consistent with actual levels of awareness within the community. Over three-quarters of participants also stated that they would feel fairly confident or very confident about approaching their GP if they were concerned about a possible symptom of lung cancer, though the remaining quarter had rated themselves as 'not very confident' or 'not at all confident' in this area. Anecdotal feedback from the focus group suggested a lack of awareness around some key messages about smoking and lung cancer risk. Whilst not necessarily representative, this does suggest that there is a need to develop the delivery of these messages across the LGBTQ community – promoting positive engagement and addressing ways in which LGBTQ people may find themselves marginalised from public health awareness and intervention campaigns.

Community Support

Participants identified minority stresses which are experienced by the LGBTQ as a key factor in consumption of tobacco, alcohol and other substances. A key factor in people's success in quitting smoking appeared to be in the support available to them from friends, partners and family. Peer-support in community settings was strongly endorsed by focus group participants as well as being cited by a number of survey respondents. In addition, the majority of participants stated that they would like to receive information from the internet and/or from LGBT community groups.

Image and Smoking Culture

Social image was cited across the consultation as being of high importance to the community, though this manifested in different ways. Smoking was described a number of times as being 'cool', with some participants describing smoking in terms of being embedded in LGBTQ culture. Conversely, however, image was also suggested as being a key potential motivation to quit by a considerable number of participants (principally non-smokers) who described smoking as unpleasant and unattractive; with ageing, presentation and the perception of poor personal hygiene seen as effective deterrents.

E-Cigarettes

While opinion on e-cigarettes was mixed, a consistent theme was a lack of knowledge and awareness. Many respondents were considerably sceptical around the health benefits of switching to e-cigarettes or vapourisers, citing historical medical endorsements of tobacco as cause for caution in this instance. There was confusion about the respective risks and benefits of e-cigarettes, as well as the various, comparative risk factors of different consumer choices such as the difference between e-cigarettes and vapourisers, and different kinds of e-cigarette liquid.

Recommendations

These recommendations have been developed out of the findings of the online survey and the focus group. It is hoped that the following recommendations may act as a guide for the CCG:

1. **Partnership work with LGBT Community Groups**: The consultation highlighted the internet and LGBT community groups as the two most popular sources of information for LGBTQ people, with regards to smoking cessation. We recommend the CCG work with LGBT community groups to plan and deliver community-based smoking cessation initiatives including peer-support groups and confidential drop-ins. In addition, we recommend the CCG and Public Health continue to work with LGBTQ community groups to deliver key messages around smoking and cancer awareness via online and face-to-face interventions.

2. **Roles models and peer mentors**: A key theme from this report is the association between image and smoking. Promoting LGBTQ peer mentors and / or using roles models to raise visibility of LGBTQ people who have successfully quit smoking may act as a powerful tool to support community-based interventions.

3. **Inclusive campaigns**: LGBTQ people may not relate to heteronormative/ cisnormative campaigns. We recommend that campaigns should include LGBTQ people/ case studies where possible and materials such as posters and information leaflets should be distributed at LGBTQ bars and community venues. In order to avoid desensitisation to health messaging, materials should be engaging, accessible and dynamic.

4. **Referrals and signposting**: Participants identified that LGBTQ social opportunities can be centred around venues that promote the use of alcohol, tobacco and other substances. We recommend that smoking cessation workers, health trainers, community navigators and other health workers promote alternative social opportunities (including sports groups, community choirs, social meet-ups etc) for LGBTQ people.

5. **E-cigarettes**: The consultation highlighted a need for more information about e-cigarettes and vaporisers including the latest evidence and health risks. We recommend that the CCG work with LGBTQ community groups to relay this information to LGBTQ people.

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