Perspective

REDUCING TOBACCO USE WORLDWIDE

The Epidemic of Tobacco Harms among People with Mental Health Conditions

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Throughout the world, people with mental health conditions experience poorer physical health and live shorter lives than the general population. In many cases, poor health and early death are driven by tobacco use. People with mental illness consume 44% of all cigarettes in Western countries, and nearly 80% of tobacco users reside in low- and middle-income countries (LMICs), which also face high burdens of both mental illness and tobacco-related diseases. Although tobacco use is decreasing worldwide in most subpopulations, it remains persistently high among people with mental health conditions.

If the epidemic of tobacco use in this population is ignored, inequities affecting people with mental health conditions will endure, thwarting aspirations of the World Health Organization (WHO)

for ending the tobacco epidemic. Addressing this inequity is particularly critical in LMICs, where health systems are often under-resourced and mental health services are fragmented or minimal. How big is the challenge? And how can clinicians and public health and health care systems combat this driver of health inequity?

People with mental health conditions are about 2 to 3 times as likely to smoke as members of the general population.[1] This disparity contributes substantially to a 10-to-20-year reduction in life expectancy for people with severe mental illness. Cardiovascular dis-

ease, respiratory illness, and cancer are strongly linked to smoking and are leading causes of premature death among people with mental health conditions.[1]

Therapeutic nihilism (the belief that no intervention will work) impedes change and is unjustified in this instance. Some mental health care workers see smoking as inevitable in their patient population and believe that attempts to help patients quit are futile. But many people with mental illness who smoke want to quit and can successfully do so. Nearly 1 billion people live with a mental disorder, and approximately 82% of them live in LMICs.[2] Nevertheless mental health continues to receive limited attention and funding in countries' health strategies.

Since understanding of mental health conditions is profoundly

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influenced by sociocultural and contextual factors, the problem in LMICs cannot be interpreted solely through a Western biomedical lens. Culturally specific characterizations such as "thinking too much" and "spirit possession" are frequently used to convey experiences of mental distress,[3] and treatment-seeking patterns are influenced by these interpretations. Before seeking formal mental health care, many people in LMICs turn to family networks, faith-based healers, or traditional practitioners.

Clinicians may either believe their patients are uninterested in quitting or fear that quitting may destabilize their mental health. Yet evidence shows that many people with mental illness are motivated to quit and can succeed with support.

Furthermore, provision of mental health care in LMICs remains largely centered in tertiary care institutions (medical colleges), which are disproportionately located in urban settings. High volumes in clinics, limited resources and capacity, workforce shortages, insufficient cultural adaptation of interventions, and diagnostic overshadowing by mental illness may all preclude addressing tobacco use. Available treatment varies by country, along with social factors, cultural norms, health literacy levels, attitudes toward tobacco use, and health system characteristics. It remains unknown whether associations between mental illness

and tobacco usage also vary with product type (smoked or smokeless), the gender of users, and the regulatory environment, which are all shaped by sociocultural factors.

In recent years, research on the efficacy and cost-effectiveness of tobacco-cessation interventions has increased, and large-scale clinical trials of behavioral and pharmacologic approaches provide compelling evidence to counter therapeutic nihilism.[4,5] When evidence-based behavioral interventions are combined with pharmacologic support (such as varenicline or nicotine replacement), short- and longer-term cessation can be achieved without deterioration of mental health. The same general approaches that can help other people quit are effective for those with mental illness, if interventions are adapted to their needs.

Since barriers to change impede integration of these interventions into practice, however, tobacco-related inequities affecting people with mental illness have worsened over time.[1] Health care systems should address the key barriers, beginning with clinical and cultural attitudes. Therapeutic pessimism remains common, and the physical health care offered to

people with severe mental illness, including care for tobacco dependence, is generally suboptimal. Clinicians may either believe their patients are uninterested in quitting or fear that quitting may destabilize their mental health. Yet evidence shows that many people with mental illness are motivated to quit and can succeed with support. Trials have demonstrated ways of offering this support.

Related concerns among both staff and patients are that smoking promotes mental stability (so quitting can cause clinical deterioration) and that medications such as varenicline pose suicide risks. Trials and epidemiologic studies consistently show that such fears are unfounded and that quitting has psychological benefits. Cessation is associated with mental health improvements associated with increased self-efficacy and reductions in depressive, anxious, and stress-related symptoms. These underappreciated benefits can be clarified for people who are concerned about their mental health.

Second, people with mental health conditions are often more heavily dependent on nicotine than other tobacco users and often experience more intense cravings and withdrawal. Trials have shown that such symptoms can be managed with intensive support, longer-term engagement, and dosage adjustments.[4] Managing nicotine dependence alongside other dependencies complicates cessation but should not be seen as a barrier.

Third, tobacco smoke can affect the metabolism of antipsychotic medications such as clozapine and olanzapine. Quitting smoking may necessitate dosage adjustments, requiring careful monitoring. Guide-

lines are available for managing these interactions and dose adjustments, and ultimately, quitting may have the benefit of reduced antipsychotic dosage requirements. Since weight gain after quitting remains problematic, minimizing antipsychotic-induced weight gain is essential.

Fourth, mental health and tobacco-cessation services are often siloed, limiting access to coordinated care. Health care facilities may lack tobacco and smoke-free policies or fail to implement them well. Managing tobacco dependence is often not seen as a core clinical role of mental health professionals, and training is fragmented. Yet successful trials and services make clear that integrating tobacco-cessation services leads to improved engagement and outcomes.

Finally, mental health is not highly prioritized in higher-income countries and accounts for less than 2% of total health expenditures in most LMICs.[1] Although treatments such as nicotine replacement therapy are free with a prescription in the United States and the United Kingdom, cessation medications may be unavailable or unaffordable in many countries. There is often a shortage of trained personnel to deliver cessation services. Access to cheap tobacco products in countries that have not implemented smoke-free laws or the recommended price and tax measures exacerbates the problem for people with mental illness: tobacco products remain affordable and available, including as single cigarettes sold by informal vendors.

Although 183 countries and international unions are parties and 168 are signatories to the WHO Framework Convention on Tobacco Control (FCTC), implementation remains incomplete, particularly in LMICs. Articles 12 and 14 of the FCTC are especially relevant. Article 12 calls for training and communication to increase public awareness of tobacco harms, and Article 14 emphasizes the need for accessible cessation support, including counseling and medication, backed by national guidelines and sustainable services. Challenges include weak enforcement of advertising bans and taxation, tobacco-industry lobbying, stigma, and low prioritization of mental health within public health strategies.

There is also a research gap: trials conducted in resource-rich countries dominate the evidence base on effective strategies. Tobacco-related harms in LMICs extend beyond smoking, including a substantial burden from noncombustible tobacco products such as smokeless tobacco; dual use (smoking and smokeless) is particularly common in the most vulnerable groups in South Asia. Tobacco use differs markedly between high-income countries and LMICs. In high-income countries, manufactured cigarettes, pipes, e-cigarettes or vapes, heated tobacco products, and oral nicotine pouches predominate. The products used in LMICs are more diverse, encompassing smoked products (hand-rolled bidis, hookahs, kreteks) and smokeless forms (gutka, khaini, naswar, paan with tobacco, chewing tobacco, etc.), each associated with a distinct nicotine delivery system, gender dynamics, and sociocultural meanings.

Whereas e-cigarettes and oral nicotine pouches are often considered harm-reduction and cessation tools in high-income countries, their uptake in LMICs remains constrained by bans (such as those in India, Ethiopia, and Sri Lanka), unaffordability, and debates over their safety and suitability. Regulatory responses also vary; some parties to the FCTC still have no explicit regulation. Others ban their sale, import, or use, while some permit and regulate electronic nicotine delivery systems, whether through age restrictions, taxation, or advertising controls.

Yet LMICs offer opportunities for innovative approaches. Task-shifting models, whereby lay health workers deliver mental health or cessation advice, represent a promising way forward. Mobile health tools, mass media campaigns, and tobacco taxation can reduce tobacco use but must be paired with targeted support for high-risk groups. For example, India's National Tobacco Quit Line Services provide telephone-based counseling in multiple regional languages; its National Tele-Mental Health Program allows people to seek help for mental health conditions and substance use by telephone, toll-free; and e-learning modules hosted by the National Institute of Mental Health and Neurosciences Digital Academy support capacity building.

To counter the epidemic of tobacco-related harms among people with mental illness globally, five things need to happen. National tobacco-control strategies must explicitly consider mental health. Mental health staff should be trained to integrate tobacco-cessation techniques and challenge outdated attitudes when they encounter them. Access to evidence-based cessation treatments should

be expanded, with due consideration of operational hurdles in LMICs. Smoke-free policies need to be established in mental health institutions, supported by cessation resources. And research must be conducted to establish culturally appropriate and scalable models of care in LMICs.

This epidemic is a major health and human rights concern. Given wide variation in health care infrastructure, sociocultural contexts, and available evidence, strategies for reducing tobacco use among people with mental illness must be context-specific. But ultimately, integration of tobacco cessation into mental health services — supported by political will, training, and equitable resourcing — is both necessary and achievable.

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From Crisis to Action — Policy Pathways to Reverse the Rise in Congenital Syphilis

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Decades ago, syphilis was thought to be close to being eliminated in the United States. But in recent years, cases have surged. Case rates peaked at 447 cases per 100,000 people in 1943, fell to 11 cases per 100,000 people in the early 2000s, and climbed back to 62 cases per 100,000 people in 2023 (see graph).[1]

Untreated syphilis during pregnancy can lead to congenital syphilis, which can cause stillbirth or severe complications, such as hepatosplenomegaly, skeletal deformities, hearing loss, or blindness. Congenital syphilis rates in the United States have mirrored overall syphilis trends: 521 cases per 100,000 live births in 1943, decreasing to 9 cases per 100,000 live births in the early 2000s, and increasing to 106 cases per 100,000 live births in 2023.[1]

By 1936, the U.S. Public Health Service had begun to focus on sexually transmitted infections, including the control of syphilis, which was deemed "the most important and severe of the venereal diseases." Recommendations for controlling syphilis included dedicated public health staff at the state and city levels; state case-reporting laws; premarital serologic testing; free diagnostic services; convenient, high-quality treatment services; robust medication distribution; liberal use of serodiagnostic testing; and "persistent, intensive" public educational programs.[2] By the mid-1940s, premarital syphilis testing was required in 43 of 48 states. Within the first 5 years of enactment, prenatal testing laws prevented an estimated 1000 infant deaths.[3] As penicillin replaced arsenic- and mercury-based therapies, total syphilis cases plummeted, and state premarital testing laws were slowly repealed. Recently, however, opportunities to test for and prevent infection have been repeatedly missed, and cases have started to climb again. High congenital syphilis rates reflect both prenatal care gaps and broader systemic failures, including failures in testing, treatment, and public health infrastructure. Various