United Kingdom between 1956 and 1988, when a relative reduction in acute renal failure due to obstetric and traumatic causes and an increase in cases in elderly patients with complicated medical and surgical conditions were seen.⁷ When the cause of acute renal failure is not obvious, medical teams must consider unusual or rare explanations—such as allergic interstitial nephritis, acute glomerulonephritis, and vasculitis—conditions that require urgent assessment by a specialist and aggressive treatment.

Renal specialists are not necessary, however, for patients to receive continuous renal replacement therapy by pumped venovenous haemofiltration systems.⁸ Continuous renal replacement allows prompt initiation of treatment at the earliest stages of renal dysfunction by anaesthetic staff in the intensive therapy unit. Patients with acute renal failure tend to fall under the care of either nephrologists or anaesthetists, and this split has made it hard to conduct clinical trials during the early stages of the illness.

The meta-analysis by Ho and Sheridan in this issue is therefore timely, and provides a valuable assessment of the role of loop diuretics in the prevention and treatment of acute renal failure.² The use of loop diuretics has a theoretical basis and some support from animal studies, but the evidence from clinical studies is not strong. The results of the meta-analysis show that furosemide has no clinical benefit in the prevention or treatment of established acute renal failure.

In normal practice many clinicians, including nephrologists, think that furosemide may help increase urine output in acute renal failure, ease the management of fluid balance, and reduce the degree of

hyperkalaemia.⁹ The evidence from Ho and Sheridan's paper—that furosemide does not improve mortality, does not reduce the need for renal replacement therapy or the number of dialysis sessions required, and may increase the risk of ototoxicity—must temper this opinion. The priorities in treating acute renal failure are to optimise fluid balance, treat underlying causes, and initiate renal replacement therapy at the appropriate time.

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Exempting mental health units from smoke-free laws

Would worsen health inequalities for people with mental health problems

An estimated five million deaths worldwide will occur from tobacco consumption in 2006. This figure is projected to reach 10 million deaths annually by 2020.¹ Smoking is also the largest single cause of preventable illness and premature death in the United Kingdom, with 106 000 people dying of smoking related diseases in 2002² and more than 10 000 dying each year as a result of passive smoking.³ The Health Act 2006 will make all enclosed public and work places in England and Wales smoke-free environments and represents an important step forward for public health.

Consultation on exemptions to the Health Act continues until October 2006. Among proposed exclusions are mental health units that provide long term accommodation (defined as not less than six months) as well as prisons, care homes, and hospices. We applaud the government for not exempting mental health settings in their entirety as has happened in some other countries that have introduced smoke-free legislation. Making mental health units smoke free ensures improved physical health of mental health

patients and protection of staff and patients from the effects of environmental tobacco smoke.

The prevalence of smoking is high among people with mental health problems. Nearly three quarters of people with schizophrenia, affective psychosis, and other mental health disorders who live in mental health settings are smokers,⁴ and they are more likely to be heavier and more dependent smokers than the general population.⁵ The prevalence of smoking is also significantly higher among people with diagnosed mental health problems who live in private households than in those without such a diagnosis, and a clear relation exists between the prevalence of smoking and the number and severity of depressive or anxiety symptoms.⁶

The consequence of these higher levels of smoking is a substantially greater risk of premature death from smoking related diseases than is seen in the general population.⁵ In a study from Finland, people with schizophrenia had an almost 10-fold greater risk of death from respiratory disease compared with the general population.⁷ The high levels of smoking among

people with serious mental illness, combined with the fact that around one in two smokers dies prematurely,⁸ mean that the death toll from smoking far outweighs the 10% lifetime risk of suicide. Moreover, people with mental illness already experience high levels of social exclusion and health inequality, which are exacerbated by smoking.⁹ Heavy passive smoking is also associated with a 50-60% increased risk of coronary heart disease.¹⁰

Nicotine dependence fulfils the core criteria for mental disorder. It is therefore the most prevalent and deadly of all psychiatric disorders, but it is frequently neglected by mental health professions. Surveys in the UK have shown that around half of smokers with mental health problems would like to stop smoking, but they are less likely than the general population to be offered health promotion interventions such as smoking cessation.⁵ Smoking cessation treatments are extremely cost effective at reducing ill health and prolonging life. Guidance and nationwide stop smoking services are available to health professionals who are trying to help patients with mental health problems stop smoking.¹¹

Arguments for excluding mental health settings from the new smoke-free legislation are that they are places of residence and that some patients are detained under the Mental Health Act. However, health and safety legislation places a duty on NHS employers to protect staff and patients from exposure to environmental tobacco smoke. Infringement of human rights, particularly for detained patients, is also cited as a reason to exempt mental health settings, but the Human Rights Act 1998 allows an individual choice only if that does not endanger others. Furthermore, this argument is not applied to other forms of drug misuse, and people are not allowed to drink alcohol or use illegal drugs in mental health units.

Last December, the Commons health select committee stated that "high levels of smoking in psychiatric institutions are not inevitable."¹² Smoke-free policies have succeeded in mental health settings¹³ in the UK, United States, Australia, and Canada¹⁴; no increases have been seen in aggression, discharge against medical advice, or use of "as needed drugs" in 90% of the sites that have imposed total bans on smoking.¹⁴ Such bans have caused fewer problems than anticipated, and policies applied in a consistent way to all patients were more effective than selective bans. Consistency, coordination, and full administrative support were essential for successful implementation of such bans.

The health select committee has proposed that psychiatric institutions in England and Wales should not be exempt from the Health Act 2006.¹² We strongly endorse this proposal and suggest that all mental health settings should introduce complete smoke-free policies. These policies should be introduced in a flexible and pragmatic way, and free and easily accessible

support and treatment should be available for patients to stop smoking and manage withdrawal. A monitoring process should also be included to ensure appropriate transition.

The proposal to exempt mental health units where patients stay for more than six months appears arbitrary, will make enforcement difficult, and will exempt most NHS mental health units, since in 2006 almost half of psychiatric inpatients stayed longer than six months.¹⁵ Exemption from the Health Act will exclude mental health patients from mainstream health improvement strategies and exacerbate the inequality they already experience. These concerns also apply to other proposed exemptions such as those for prisons,¹³ especially as mental health problems and substance abuse are highly prevalent among prisoners.

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