Rob Moodie
Nossal Institute, University of Melbourne, Melbourne, VIC 3010, Australia
r.moodie@unimelb.edu.au

I participated in the Summit.

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Smoking, mental health, and human rights: a UK judgment

In July, 2007, legislation to prohibit smoking in all enclosed and substantially enclosed public and work places in England came into force,[1] completing the implementation of a smoke-free policy throughout the UK. The legislation was comprehensive, except for care homes, hospices, and prisons. Residential mental health units were granted an additional 12 months to prepare for implementation, but are expected to comply fully from July, 2008.[2] However, some mental health-care providers acted more quickly than required by law. The Nottinghamshire National Health Service (NHS) Healthcare Trust implemented smoke-free policies throughout all of residential mental health units from March, 2007, and following national guidance on policy for NHS Trusts, they adopted the most comprehensive policy, including grounds and buildings.[3,4] One such unit involved was the high-security forensic hospital at Rampton.

In March, 2008, the England and Wales' High Court heard a case by three inpatient smokers at Rampton. They said that prohibition of smoking constituted a breach of Article 8 of the European Convention on Human Rights, guaranteeing respect for family, private life, and home. The judgment, which rejected their claim, was published on May 20, 2008.[5] Rampton is one of three highly secure forensic hospitals in England, where patients who pose substantial risks to the public are detained for treatment under the Mental Health Act 1983. The Nottinghamshire NHS Healthcare Trust policy allowed case-by-case exceptions for individual patients to smoke outdoors and supported plans to promote smoking cessation tailored to their needs. However, these exceptions were not made at Rampton because of the logistical difficulties of a high-security hospital and the challenge of escorting patients to a secure place to smoke. The appellants sought either to quash the application of smoke-free legislation to mental health units, or to gain an exemption for mental health units where it is not feasible to permit patients to smoke outdoors.

The Court dismissed the claim on several grounds, notably: rejecting the notion of an absolute right to smoke wherever one is living; rejecting the argument that those responsible for the care of detained people are obliged to make arrangements to enable them to smoke; and concluding that in the interests of public health, strict restrictions on smoking and a complete ban in appropriate circumstances are justified. The Court also noted that none of the various disturbing consequences of a smoke-free policy feared by the claimants, such as an increase in the prescription of sedative drugs, had actually materialised. It also established that the distinction between Rampton, a forensic hospital with a focus on treatment for mental health conditions, and prisons, which are exempted from the smoke-free legislation, was justified.

This judgment is a milestone in ensuring that legal protection against exposure to tobacco smoke, which is now enjoyed by most of British society, is extended to those with mental health problems. Although the judgment applies to a secure unit, the arguments put forward by the appellants are commonly voiced by staff, patients, and the public in many other contexts, including mental health facilities. The prevalence of smoking in people with mental health problems is high,[6,7] and especially so in inpatient units where smoking has for years been institutionalised and in many cases embedded in the relationship between patients and staff.[8]

Making mental health units smoke free is not easy. Although the high-security arrangements at Rampton make it difficult for inpatients to obtain cigarettes, the situation in typical inpatient units, where cigarettes are freely available, is different. Implementing and

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PA Photos

Rampton Hospital

maintaining smoke-free policies in these circumstances is a major challenge that needs substantial investment and sustained commitment to train and support staff, and provision of cessation and temporary abstinence treatments for smokers.[9,10] However, health benefits to staff and to this vulnerable group of patients, who are frequently excluded from mainstream health provision, are substantial.

Had the appeal succeeded, the whole process of making mental health units smoke free would have been undermined, perhaps fatally so. Instead, this judgment clears the way for full implementation of smoke-free law across mental health units in England from July, 2008. Whether the trusts involved rise to the challenge by showing the commitment, leadership, and investment necessary to ensure success remains to be seen.

Elena Ratschen, Ann McNeill, Gillian A Doody, John Britton
UK Centre for Tobacco Control Studies, University of Nottingham, Clinical Sciences Building, City Hospital, Nottingham NG5 1PB, UK (ER, AMN, JB); and University of Nottingham, Division of Psychiatry, Duncan McMillan House, Nottingham, UK (GAD)
mcxer2@nottingham.ac.uk

AM co-authored the national guidance for smokefree hospital trusts. This guidance was profiled in a letter that Louis Appleby, the National Clinical Director for Mental Health, wrote to all Mental Health Trusts in February, 2007. ER, GAD, and JB declare that they have no conflict of interest.

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HIV/AIDS estimates and the quest for universal access

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Recent debates about trends in HIV infections have overshadowed genuine achievements in addressing the pandemic.[1] WHO, UNAIDS, and UNICEF have recently issued a series of reports that assess progress towards universal access to HIV prevention, treatment, and care.[2,3] Leaders of the G8 countries had committed to this ambitious goal in Gleneagles, UK, in 2005 and in the political declaration made at the UN General Assembly.[4,5] On the basis of data from 143 countries, by the end of 2007, almost 3 million people in low-income and middle-income countries were being maintained on antiretroviral therapy—1 million more than the previous year. Almost three-quarters of the individuals on therapy lived in sub-Saharan Africa, where measurable reductions in AIDS mortality are occurring, and 200 000 were children. Treatment coverage globally was estimated at 31%; the total estimated need for therapy under current treatment recommendations[6] is 9·7 million people.

Coverage for antiretrovirals in HIV-positive pregnant women for prevention of mother-to-child transmission in low-income and middle-income countries increased from 9% in 2004 to 34% in 2007. In such countries, the percentage of young people having sex before age 15 years is decreasing in all regions, a continuation of trends detected earlier this decade.[3]

Despite these gains, huge gaps in access remain. Only 20% of people with HIV in low-income and middle-income countries are aware of their infection status. Surveys indicate that 40% of men and 38% of women at ages 15–24 years had accurate and comprehensive knowledge about HIV and about how to avoid transmission. In countries with epidemics that are concentrated within the populations most at risk, HIV prevention programmes fail to reach many people at risk of acquiring HIV, including most men who have sex with men and injecting drug users.[3]

Focusing scale-up of services where they are needed requires "knowing your epidemic", globally and locally.[7] According to the 2007 UNAIDS/WHO AIDS epidemic update,[8] at the end of 2007, 33·2 million people (range 30·6–36·1) were living with HIV. Some 2·5 million people became newly infected that year, and 2·1 million