Age discrimination across the lifespan

Many of Anderson’s observations\(^1\) on unjustified age discrimination at the later stages of the lifespan apply also to children and adolescents with mental health problems. They receive a disproportionately low level of funding, are excluded from much research, are subject to often inappropriate extrapolation of treatment guidelines for adults, and until recently have been excluded from formal mental health strategic thinking (both the National Service Framework\(^2\) and New Horizons\(^3\) specifically excluded child and adolescent mental health services (CAMHS) from their remits).

Anderson states that the Royal College of Psychiatrists’ position statement on age discrimination in mental health\(^4\) incorporated contributions from all of its constituent faculties and sections. It is unclear to me where the contribution from the Child and Adolescent Psychiatry Faculty is to be found. In this regard, the government’s new mental health strategy\(^5\) is to be welcomed as it adopts an all-age approach to mental health by explicitly including CAMHS within it. Strategies aimed at addressing age discrimination need to consider the whole of the lifespan if they are not unwittingly to recreate it.

No physical health, only mental health

In the canteen of our psychiatric hospital I found myself standing behind an in-patient who had been escorted by a nurse from the ward. I was rather concerned to witness the patient request, and be sold, three hot dinners, three sandwiches, four packets of crisps and four bottles of an energy drink. The nurse escorting the patient confirmed that all the food was indeed for the patient himself and that he did this every day, which was also confirmed by the patient’s obesity. I expressed my concern that the patient was putting his health at risk by being allowed to buy and eat so much food in the hospital. The reply given by the nurse was that the treatment team were all aware of the situation but were of the opinion that ‘Well, what can we do, the patient has rights to eat what he wants, who are we to stop him?’ Those responsible for the care and treatment of the patient (detained under the Mental Health Act) were aware of his extreme overeating but they were merely observing such behaviour, believing themselves to be attending to his mental health needs in isolation, even to the extent of escorting the patient on his bingeing trips.


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We are all aware of the possible risks of metabolic syndrome associated with many of the physical interventions we prescribe, but awareness alone is of little help to our patients. The motto of the Royal College of Psychiatrist is ‘No health without mental health’, but we appear to be at risk of following an alternative motto, ‘No physical health, only mental health’. I would welcome some advice from the College or the thoughts of other members who have been able to implement a more useful response to the observed problem in their own clinical institutions.

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Bored and stressed in-patients smoke more
Similarly to Thakkar et al,1 we carried out a survey enquiring about the smoking habits of in-patients on the general adult wards of a psychiatric hospital (in York) before the hospital closed each ward’s smoking room.2 We too were concerned to discover that the majority of patients (56%) smoked and that the majority of these (63%) reported smoking more after admission than in the week before. In keeping with Thakkar et al’s findings, we discovered that the main reason given for smoking more was boredom, with other key reasons being stress and the wish to socialise.

Rather more heartening was our finding that 17% of the smokers surveyed reported smoking less after admission, citing improvement in mental state and a dislike of the smoking areas as the main reasons. Unlike in Thakkar et al’s survey, our in-patients did not think their smoking habits had changed because of medication side-effects.

We also felt that the issue of in-patient boredom should be addressed through active management of the ward environment and that our services should be better advocates of smoking cessation. There is the hope that the recent smoke-free legislation will lead to substantially lowered tobacco consumption in the general population. If so, it will become more important than ever for psychiatric wards to be activity-focused places. Some hospitals have improved the ward environment through hard work and investment. If such change for the better is not widespread then the physical health of people with mental illness who require hospital care – but experience it in a tedious, activity-free ward environment that finds them increasing their smoking habit – will drift further than ever from that of the rest of the population.


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