

in comparative studies. Also, stigma by definition excludes 'positive aspects of mental illness'. This is why the authors decided to reverse the scores of the 'positive aspects of mental illness' factor. For this reason, they should have also called the factor 'negative aspects of mental illness', as a high score on this new factor then represents stigmatisation and its negative influence on the person.

In brief, a scale which partly measures people's mental state and partly objective social reality is neither valid nor standardisable because it cannot measure what it is supposed to measure (i.e. it cannot satisfy the fundamental condition of validity).

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**King, M., Dinos, S., Shaw, J., et al (2007)** The Stigma Scale: development of a standardised measure of the stigma of mental illness. *British Journal of Psychiatry*, **190**, 248–254.

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**Authors' reply** We were puzzled by Dr Haghghat's criticism of our development of a stigma scale and would like to respond to his points. First, ours is a self-report measure of perceived stigma and we do not claim otherwise. Perceived stigma is a valuable construct that may have a greater impact on mental and social well-being (including relationships and occupation) than so-called objective acts of discrimination. This is also true of social support. Second, we agree that the relationship between perceived stigma and low self-esteem is potentially confounded by low mood. However, our sample contained a heterogeneous group of participants from a range of settings and thus it is unlikely that a sizeable proportion were depressed at the time

of the study. In addition, Dr Haghghat overlooks the complexity of any putative association between stigma and depressive symptoms. Perceived stigma may cause or maintain depressive episodes.

Third, it is important to avoid invalidating reports of perceived stigma by dismissing them as depressive or paranoid epiphenomena. Fourth, Dr Haghghat claims that our instrument has no validity. In fact, as we made clear in our paper, it is based firmly on the views and experiences of people with mental illness who were interviewed in depth in a previous study (Dinos *et al*, 2004), and thus it has greater validity than many scales used in the field of mental health. Fifth, we do not understand Dr Haghghat's reference to randomisation, which has no role here. If he means random selection of people to participate, then our method closely approximates to this in that potential participants were not selected on any pre-determined basis. Naturally, participation depends to some degree on participants' abilities and personal inclinations but that is true whether selected randomly or not.

Finally, participants in our earlier qualitative study (Dinos *et al*, 2004) emphasised that positive outcomes may arise from experiencing mental illness and thus such items were included in our scale. We reversed their scores to indicate that stigma might be greater when such positive aspects were lacking. This is not the same thing as assuming mental illness has only negative aspects. In parallel fashion the opposite of risk is not protection, it is lack of risk.

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## Metabolic syndrome and intellectual disability

Mackin *et al* (2007) highlight the importance of screening and management of metabolic syndrome in patients with severe mental illness. This is particularly important in patients with intellectual disability as they have high rates of both physical and psychiatric comorbidities compared with the general population (Welsh Office, 1996). In addition, considerable evidence points to a disparity between the health of people with learning disability and the general population, and this was also highlighted in two Mencap reports (Mencap, 2004, 2007).

Suggested causes for this disparity include specific patterns of complex health needs associated with the aetiology of their intellectual disability, sensory and communication difficulties, reliance on carers to communicate their health needs, and barriers to healthcare accessibility due to poor professional knowledge and attitudes.

The Government White Paper *Valuing People* (Department of Health, 2001) acknowledges this disparity and identifies the improved healthcare of people with intellectual disability as a key outcome. However, the document is a little unclear on how these aims will be achieved.

As Mackin *et al* point out few studies specifically examine the impact of different models of care on physical well-being and comorbidities in people with severe mental illness, and this is also the case for people with intellectual disability. There is a pressing need for evidence-based integrated models of care for delivering high standards of care for this patient group.

**Department of Health (2001)** *Valuing People: A New Strategy for Learning Disability for the 21st Century*. TSO (The Stationery Office).

**Mackin, P., Bishop, D., Watkinson, H., et al (2007)** Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *British Journal of Psychiatry*, **191**, 23–29.

**Mencap (2004)** *Treat Me Right*. Mencap.

**Mencap (2007)** *Death by Indifference*. Mencap.

**Welsh Office (1996)** *Welsh Health Survey 1995*. Welsh Office.

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