
Commentary

Janey Antoniou

I have a diagnosis of schizophrenia and am very committed to breaking down the stigma attached to having a mental health problem in our society. I think that Smith (2002, this issue) has done an admirable job in defining this stigma and putting forward some excellent and very practical strategies for combating it. However, I would like to add some comments from the perspective of someone who has to deal with it as a mental health service user. First, however, I would like to say that there is no such thing as 'the' service user: we are all individuals with our own needs and ways of coping with our problems. What is written here is a personal opinion.

Smith gives some principles that he feels can be used in the fight against stigma. I agree with all of them, but would like to comment on the first, the 'acceptance of difference'. The British have the reputation of being a very tolerant people, but I wonder how much difference should be accepted and who dictates this. Personally, I have no problem with people talking out loud to their voices in the street, neither do I care particularly if someone has no clothes on in public (a crime); however, I do object to anyone sticking his hand up my skirt on a London underground's escalator. Other members of society may draw their acceptance line differently and we should probably have some public debate on this subject.

There are several anti-stigma campaigns running at present and they approach the problem from a variety of different ways, all of which are very commendable. However, at the same time statutory services are having to implement the National Service Framework (NSF) for mental health, with its key aims of 'safe, sound and supportive services' (Department of Health, 1999). In the course of this, what seems to be happening is that the public are receiving mixed, and to some extent subliminal, messages of the perceived dangerousness of people with a mental health problem.

For example, as part of the information strategy to ensure that all practitioners have the information they need to implement the NSF, local health and social service teams are being asked to set up a database which would share details of the diagnosis, care plan and risk factors of their clients. There is the possibility that this information-sharing may be expanded (at least in part) to include housing services and the police. The NSF says of this:

[At present] there is no systematic information collected on the implementation of care planning and delivery, yet this is the central pillar that supports care management of individuals with severe mental illness, *protecting the public* [my italics] and delivering safe, sound and supportive services' (Department of Health, 1999).

I recently went to a one-day conference on electronic care plans where this safety aspect was never mentioned. Service users were told that a database would improve services, and practitioners that the data collected would lead to more resources. Of course I agree that the public should be protected from violent people and that there is a small increase in violence among those who have mental health problems. But we should be openly acknowledging this. The doubts of service users about the erosion of their civil liberties should also be discussed.

Another example of the same sort of thing occurred in my locality. The community clinic is shared between mental health services and other services such as chiropody, dental care and the baby clinic. There used to be one open-plan reception for everyone and several consulting rooms. Last year the whole area was re-planned: the reception desk was put behind glass windows (as in a post office) and all the consulting rooms were moved behind a locked door requiring a code to enter. Clients are never allowed unescorted in that area. I understand the need of the staff to feel safe in their work but it does give the unspoken impression to everyone

Janey Antoniou is a mental health service user and freelance trainer and writer on mental health issues. Correspondence c/o Gillian Blease, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.

using the clinic that mental health service users are not to be trusted.

It is normal, part of the fight or flight response, for people to be wary or frightened of someone who is behaving in an unpredictable way, and dialogue with the public should acknowledge this. Although I would not want to ask anyone to mistrust the way they feel or think, I would like a chance to discuss it with them. I work as a trainer trying to facilitate understanding of mental health problems within statutory services such as the police, and also in my own circle of associates I have always been very open about what is wrong with me. As a result of this, friends start discussions with me about films they have seen and articles they have read about mental illness, which in turn gives them knowledge and allows me to be accepted as I am. Occasionally this approach has backfired on me but mostly I am happy with it.

If I were to pick one thing that I think would make a difference in challenging the stigma of having a mental health problem I would choose dialogue between mental health service users and the people who are in contact with them. I would also like dialogue between service users, psychiatrists and general practitioners. Yes, there will probably be a lot of anger on both sides but if the wider public see users helping to structure services and being respected by the mental health professionals, it will have a positive effect. After all, no one really has the moral high ground here.

References

- Department of Health (1999) *A National Service Framework for Mental Health*. London: Stationery Office.
 Smith, M. (2002) Stigma. *Advances in Psychiatric Treatment*, **8**, 317–323.

Parent-Training Programmes for the Management of Young Children with Conduct Disorders: Findings from research



By Joanna Richardson and Carol Joughin

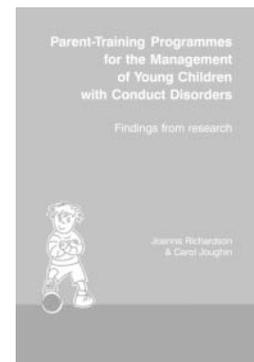
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Contact: Book Sales, The Royal College of Psychiatrists,
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