

A week ago I was in Italy addressing a conference on eyesight. Not perhaps an obvious link to today's subject but, eyes tell you so much about the spirit of the person within. If you look into the eyes of someone with mental health problems, you see reflected back that confusion of emotions and thoughts. You see the fear and worry; you see the tears of frustration and despair; and you see the hope that we might listen and understand and that, if we do listen and understand, we will care, we will act, we will help and we will treat that person with dignity and respect. The tragedy is that most people never look into those eyes; they turn away; most people will prove to be part of the problem instead of being part of the solution.

If we feel like that, we should look into a mirror; try looking into our own eyes and imagine what it will be like when we develop a mental health problem, as one in four of us will assuredly do some time in our lives.

450 million people in our world live with a mental disorder
121 million of us have depression – 3 in every 100 of us every year.
58,000 of us in Europe die needlessly from suicide – more than die in road accidents or the AIDS epidemic - and half a million try to every year.

1 in 3 of people going to their GP have mental health problems – 1 in 6 diagnosed as such.
That does not mean that 2 in 3 of us will have good mental health; it means we may not yet need, or we may not seek, or we may not be offered, treatment or care.

It may mean we are given inappropriate treatment, with drugs and therapies and institutions and laws that at best may do no harm and at worst may lead to physical and psychological damage.

It almost certainly means that we are labelled, patronised, despised, feared and, to a greater or lesser extent, segregated – in society, within our family, at work, at play and even within our health and social services.

In a perverse reversal, we can hide but we cannot run; we cannot perform; we cannot contribute to society as we would wish; we cannot lead full and fulfilling lives as we would want.

In the countries of Europe we like to think we have moved on from the human rights abuses of mentally ill patients.

We still have debates about compulsory treatment; discharge or sectioning decisions are sometimes unsound; patient abuse is from time to time exposed in a residential home.

Arguments abound on vexed and conflicting rights of patients, families and communities.

But by and large we have fewer locks and bolts, more patient choice and consent, legal checks and balances to see the patient's civil rights are not abused.

We have not had the abuse of psychiatry for political purposes as under the Soviet system;

We do not acknowledge politically convenient diagnoses such as sluggish schizophrenia;

we do not pump healthy people full of drugs and turn them into zombies, because of their criminal or antisocial or political behaviour.

We have steadily improved so many areas of mental health policy and practice in recent years but we still tolerate the abuse of patients, which is stigma.

Stigma is rampant in all our countries and stigma is a human rights abuse – unintentional, born out of fear and ignorance, but just as damaging to the individual as any other form of abuse.

It ranges from an averting of the gaze, to a low priority in health and social care policy, to discrimination in housing allocation, to assumptions of inability at work or in leisure pursuits, and negative discrimination in prison, police and judicial systems.

We all contribute to the stigmatisation of people who, if they had a physical problem, would receive our sympathy and support.

Yet, with mental illness we so often turn away and hope someone else will cope.

Living with mental illness is tough enough, without having added to the burden of illness, the pain of rejection and stigma.

So how do we tackle it?

First we must confront stigma for what it is. It is prejudice.

Prejudice means literally pre-judging. It neither uses logic or facts.

It is based on ignorance mixed with assumption and emotion.
So: we could start by listening to and learning from service users.
After all, stigma is as much self inflicted as imposed by others. We need to know why.

We have legislated against discrimination for people with disabilities.
Perhaps we need to explore whether such laws could apply effectively, or more effectively, to people with mental illness.
We have charters of rights for patients in general; so why not for mental health patients?

We have mental health laws to give rights to patients in hospital; but are they adequate to cover rights in the community?

We need to educate and inform so we can break the vicious chain of prejudice and ignorance that links public, media, patient and government, but perhaps we need more carrots and sticks to push the anti-stigma agenda forward.

We need to listen to and learn from service users and involve them as partners and not just as patients.
We need to look within ourselves and within our society and acknowledge the institutionalised stigmatisation that infects our political, social and health systems.

When I was a Health Minister in Britain we 'benefited' if that is the right word, from the publicity surrounding one man jumping into the lion's den at London Zoo and another stabbing a stranger to death on the London Underground.

We 'benefited' because the shock horror media coverage led to public, parliament and NGOs demanding action.

Indeed in each case of violence we 'benefited' three times: the media gave dramatic coverage first to the event, then six months later to the trial and then another six months on to the Inquiry Report so that the public thought the number of cases was multiplying, increasingly thought it was not safe to go out on the streets and turned against care in the community.

The result was more money from Finance Ministers for better health and care services, but at a price – the terrible price of lost public confidence and a demand to reverse the policy of community treatment and care.

The price is stigma. Then when political and media attention moves on to carjacking or date-rape or knife crime, the pressure is off mental health services and so is the pressure to provide more money for them – until the next time.

All the thematic strands of this Pact must come together if we are to tackle stigma – child health and wellbeing, mental health at work policies, coping with the ageing population and suicide reduction – and the burdens, costs, outcomes, inclusiveness, respect and social justice. Knowledge spreads expertise but it also risks generating fear and suspicion if it is only half understood.

Economics show what we can afford and what we cannot afford not to do.

Evaluation shows the return on spending and equity and humanity add the social imperative for action.

We still of course struggle to agree formulae for comprehensive outcome measurements for mental illness and mental wellbeing. That makes it very difficult to estimate the cost of stigma and the cost of effective interventions to tackle it.

If stigma was there in the old institutionalised regimes and policies, it is multiplied a hundred times when you move to treatment and care in the community and attempt to integrate people with community, working and leisure life. So it becomes one hundred times more important to convince that the policy can work.

If you place people neatly into a hospital ward, politicians, press and public feel you have dealt with a health problem and will not enquire too closely what you are achieving behind the hospital gates.

If people are visible, and so is the nature of their health problem, questions are asked as to whether the policy is working, how much is being spent and what it is achieving – all wrapped up, of course, in terms of sympathy and concern for the patients who would: ‘surely be happier and better looked after’ in a nice and, preferably, remote, sanatorium.

We will not defeat stigma, if we cannot show that we have a policy that works and we are desperate for measurements.

So services need to be as visible as patients;
their regimes need to be as understood as the illnesses;

and the safety net needs to be accessible and confidence-building for patient and community alike.

An effective and comprehensive spectrum of services;
 outcome measurements that are more easily understood by the layman;
 visible and responsive local services, rehabilitation and retraining
 services, that bring people back, at a pace appropriate to each, to active
 and involved life, so that their friends, family and neighbours can see the
 progress;
 all will aid the defeat of stigma.

But the twin peaks are to convince the public to believe and to convince
 governments to spend. And with the public sit the media, with such
 power to influence in both directions.

And they are interdependent.

If the public believe, they will put pressure on the government to spend.

If the government spends they will make public belief possible.

If the media understands and promotes public and political understanding
 – and refrain from the negative stereotyping – they could move
 mountains.

The message to our doctors and scientists is:

In your hands are the skills of healing and treatment and care but you
 cannot remove that added burden of stigma on your own.

Carers and advocates can speak up and persuade by sharing their
 experience, but on their own they cannot abolish stigma.

The media can retail the reality and avoid the caricature.

Politicians can listen, learn, understand and then act to provide better
 services and to help first themselves and then others overcome fear and
 ignorance and prejudice.

None of us can do it alone.

But together we can make a difference.

And we must, because none of us are immune from mental illness – and
 none of us are protected from stigma.

In my Report for the Parliament in response to the Green Paper, I
 quoted the words of Stefan Heym in November 1989, addressing that
 vast crowd in East Berlin's Alexanderplatz; They had come together to
 oust a repressive regime.

'Wir haben in diesen letzten Wochen unsere Sprachlosigkeit
 ueberwunden und sind jetzt dabei, den Aufrechten Gang zu erlernen.'

'In these last weeks we have found our voice again and have learned once more to walk with our head held high.'

Stigma is just such a repressive regime.

Stigma stills our tongue and makes us hide our head.

Our Pact - and our individual and collective commitment – for Europe must be that people living with a mental health problem will, with our help, re-find their voice, their dignity, their self-respect and walk once more with their heads held high.

Unlike perhaps the big issues on today's European Union agenda – the global economy, global poverty, global warming, terrorism and bioterrorism, and so on, all of which are beyond our capacity to solve alone, we can here, now, within a timetable and as a Community, resolve to take action which could transform the lives of some of the most vulnerable of our fellow citizens.

As I enter the month which begins my final year as an elected politician, I am more conscious than ever of the good fortune I have had in my life and career.

It is pay-back time and where better to repay the debt I owe than in fighting for justice and to end the abuse that stigma personifies.

And I invite my fellow politicians to join me in opening our eyes, our ears, our minds and our imagination and to show we will not tolerate and we will not contribute to the cruel act and attitude which is stigma.

This paper was produced for a meeting organized by Health & Consumer Protection DG and represents the views of its author on the subject. These views have not been adopted or in any way approved by the Commission and should not be relied upon as a statement of the Commission's or Health & Consumer Protection DG's views. The European Commission does not guarantee the accuracy of the data included in this paper, nor does it accept responsibility for any use made thereof.