

ANNEX I
DESCRIPTION OF THE ACTION

1. OVERVIEW

1.1. Title

Anti Stigma Programme: European Network (ASPEN)

1.2. Priority area and action

3. Health determinants, 3.2 Integrative approaches on lifestyles

1.3. Summary (objectives, methods, expected results)

In Europe 20 million people experience depression and its associated personal distress, while the total cost is estimated at 105,666 million Euros each year.

The general objective of the Anti Stigma Programme: European Network (ASPEN) is to make an important contribution to the reduction of stigma and discrimination against people with depression in the 27 EU member states. The methods and means to be used to achieve this will be: (i) produce scales to assess stigma and discrimination with people with depression; (ii) interview 500 people with depression in 19 sites; (iii) collate best-practice to reduce stigma and discrimination; (iv) assess if anti-discrimination policies are applied in practice; (v) recommend how to include people with mental illness for policy formation; and (vi) for generic disability discrimination laws.

The key outcomes are: (1) EU information sharing via best practice toolkit; (2) Availability of a high quality assessment tool from the development of the stigma /discrimination scale development; (3) Knowledge transfer on the nature and severity of discrimination experienced across Europe by people with depression from the stigma and discrimination survey; (4) Availability of better knowledge for policy makers on practical measures able to improve social inclusion for people with depression form the toolkit for policy makers on how to involve civil society in mental health policies; (5) Transfer of practical and useable information to policy makers on increasing work opportunities for people with depression form report on legal and social barriers to employment; and (6) Improved information availability throughout the EU (and for policy makers and key stakeholders in particular) of information on best practice in stigma and discrimination reduction, service user and carer involvement in policy formation, and required policy initiatives to promote the social and work inclusion of people with depression via the ASPEN webpage and the summary reports.

The project is a 3 year project linking 19 sites in Europe.

2. OBJECTIVES

2.1. General objectives

The overall primary strategic objective of this proposal is to contribute to reducing stigma and discrimination against people with mental illness across the 27 EU member states, and to communicate this knowledge to all relevant stakeholders. To achieve this, ASPEN will assess and understand the extent of stigma and discrimination against people with depression (both adolescent and adults) and gather and disseminate information on best practice (at the policy and at the operational levels) to reduce stigma and discrimination against people with mental illness to relevant stakeholders in all 27 member states. Best practice is understood here as a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success.

2.2. Specific objectives

2.2.1 Collate and distribute across Europe high quality information on what research and best practice show to be effective interventions at the national and local levels to inform relevant stakeholder groups and policy makers in all 27 member states

2.2.2 Create a set of stigma and discrimination scales for use in all EU member states to assess self-stigma, self-esteem, empowerment, actual and anticipated discrimination

2.2.3 Create a detailed analytical European profile of stigma and discrimination as experienced by young people and adults with depression, including both anticipated and expected discrimination, and self-stigma.

2.2.4 Understand the nature and degree of legal and policy barriers which contribute to social exclusion and stigma. Investigate if service users and civil society take part in forming a policy related to mental health, with dedicated evidence-based policy briefs to assist policy-makers at all levels to set policies to combat stigma and measure the effectiveness of those policies.

2.2.5. Establish across sites an understanding of the barriers and facilitators to employment, implementation of EU legal standards, and best practice on work entry and job retention. Enriched processes will result in better laws and policies, and their ownership.

2.3. Indicators chosen

2.3.1 Collection of best anti-stigma practices (WP 4) will be monitored for collection of data on EU-wide anti-stigma campaigns. The indicator of achievement will be availability of one paper and one web publication by month 36, and the relevant indicator is how far this has been achieved.

2.3.2 Development of stigma-related assessment scales (WP 5) will be monitored for percentage progress in development of new scales and for number of local language translations of scales. The indicator of achievement will be existence of local language versions of the scales in the 19 participating sites, or percentage completion. A quality indicator will be the acceptance of the scales by the relevant government health ministry in each recipient member state.

2.3.3 Work to produce a European profile of stigma and discrimination against people with depression (WP 6) will be monitored for collection of data across the 19 sites. The indicator of achievement will be existence of a project database with quantitative data on stigma and

discrimination from 19 sites. The key indicator is a variable showing percentage completion.

2.3.4 Analysis of social exclusion in mental illness (WP 7) will be monitored for collection of data across participating sites. The indicator of achievement is the percentage completion of a set of 16 country profiles on the nature and degree of social exclusion experienced by people with mental illness.

2.4. Rationale and relative merits of the project

The results of assessing stigma and discrimination in Europe have produced generally consistent findings. First, there are few countries, societies or cultures in which people with mental illness are considered to have the same value as people who do not have mental illness, as shown for example in lower rates of financial investment in mental health services. Second, the quality of information that we have is relatively poor, with few comparative studies between countries or over time. Third, there are clear links between popular understandings of mental illness and whether people in mental distress seek help or feel able to disclose their problems. The core experiences of shame (to oneself or to one's family) and blame (from others) are common, although they vary to some extent between cultures. Where comparisons with other conditions have been made, mental illnesses are usually more stigmatised, and indeed this has been called the 'ultimate stigma'. Finally, the behavioural consequences of stigma (rejection and avoidance) appear to be universal phenomena. Nevertheless, this literature says little about a core issue: how such processes affect the everyday lives of people with mental illness. In terms of the effects of discrimination upon people with depression, it can lead to low rates of help seeking, lack of access to care, under-treatment, material poverty, and to social marginalisation.

This is a 3 year project linking 19 sites in Europe. The scope of the project will focus on the impact of stigma and discrimination upon the everyday lives of people with depression, and identify proven strategies to reverse such forms of social exclusion. We have chosen depression because: (i) it is common, affecting up to 8% of the population each year; (ii) it is often untreated; (iii) it has a major impact on the economy (in the UK, the loss of productivity is £12 billion a year).

We include actions both at the national and policy level and at the local level because the emerging evidence from anti-stigma campaigns in Australia, New Zealand and Scotland is that they are effective if they carefully co-ordinate multi-level interventions.

We shall include participants aged 16 and over as we wish to include a special focus on young people because most young people who are mentally ill do not seek help. Yet mental illnesses affect about 10% of young people. The rates for mental disorders, including suicide, are increasing. Indeed teenagers seek help less often than adults. Stigma against mental illness is a powerful (and potentially reversible) contributory factor to the reluctance of many young people to seek help for mental illness. For these reasons we shall analyse our results, both of discriminatory experiences and of best practice in successful interventions, to specifically highlight these issues in relation to young people.

We also include in ASPEN a particular emphasis on gender issues. Women have an increased vulnerability to depressive disorders during their childbearing years. Worldwide, major depression is at least twice as common in women as men and this is not explained by diagnostic bias, greater help seeking or symptom reporting. Moreover, women are more likely to have parenting responsibilities than men and there is evidence that maternal depression has adverse consequences for children's emotional, behavioural and cognitive development.

About a tenth of the adult population in Europe suffer from mental disorders at any one time. They now account for about 12.3% of the global impact of disease, and this will rise

to 15% by the year 2020. Considering disability alone, the impact of neuro-psychiatric conditions is starker still, as they account for 31% of all Years Lived with Disability. In Europe these conditions now contribute towards almost half (43%) of the total impact of disability.

The stigma and discrimination associated with mental illness often are significant factors in reluctance to seek treatment and care. The WHO World Health Report underlined the importance of promoting social inclusion. The 2005 WHO/EC Helsinki Inter-Ministerial Conference launched a pan-European Declaration and Action Plan on mental health, and one of the 5 key priorities is to reduce stigma and discrimination.

There is strong evidence that many people with mental illness suffer unjustified restrictions in finding and keeping work. The National Labour Force Survey in England found that the proportion of the adult population who were employed was about 75%, while for people with physical health problems the figure was about 65% yet for people with more severe mental health problems only about 20% were employed. Even for people with the more common types of mental illness, such as depression, only about half are competitively employed.

Mental illness can impede the social participation and life chances of those living with the condition, through loss of self-esteem, whilst public images and social reactions add a dimension of suffering which have been described as a 'second illness'. Yet there is very little evidence about which interventions actually reduce discrimination against people with depression.

Mental healthcare is underprovided in Europe. 48% of people with mental illnesses in Europe receive no treatment, compared with 8% of people with diabetes (Alonso J, et al. BJP 2007; 190:299-306.) Mental health also has a weak policy framework in Europe. Only 55% of States have a national mental health policy. ASPEN therefore supports: 'Promoting the mental health of the population. Towards a strategy on mental health for the EU' (COM (2005) 484 final of 14 October 2005).

The nature of discrimination against people is not well understood, and we do not yet have strong evidence on how to counteract such stigmatisation. Stigma includes three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination). Stigma and discrimination add a dimension of suffering to people with mental illness which has been described by service users as a 'second illness', and often results in social exclusion and human rights violations. To date research on stigma has been particularly unhelpful for people with mental illness because: (i) research on stigma has made relatively few connections with clinical practice or disability rights policy; (ii) there have been notably few direct contributions to this literature by service users (those with mental illnesses or disabilities themselves), and (iii) there has been no attention to how stigma contributes to social exclusion.

The most important knowledge gaps in this field are:

- (i) the nature and extent of social exclusion of people with depression in different EU Member States;
- (ii) the target groups identified by people with mental illness and carers as most adversely discriminating against them;
- (iii) effective interventions against stigma and discrimination at national and at local levels in Europe;
- (iv) measures to improve access to employment for people with mental illness;

(v) strategies most effective at including civil society in policy and legislative developments concerning mental health.

3. EXPECTED RESULTS

3.1. Outcomes

3.1.1 A pragmatic and widely usable Anti-Stigma Best-Practice Toolkit will be developed and utilised to describe and assess EU-wide anti-stigma projects and to collate information on best practice. Key stigma and discrimination contacts across EU; evidence base for effective interventions for stigma and discrimination; and availability of existing programmes across EU and key activities at regional, national and supra-national levels will be available by M36 distributed to key stakeholders in all 27 member states. The expected outcome is that the relevant government health ministry in each recipient member state will be better equipped to collect information on stigma and discrimination and to support best practices to address stigma and discrimination.

3.1.2 Stigma /discrimination scale development: Scales will be created for use in languages of all sites, to measure self-stigma, self-esteem, empowerment, actual and anticipated discrimination experienced by young people and adults with depression, by M12. The main discrimination scale will be published in a peer-reviewed scientific journal. The intended outcome is that the scale will be readily accessible and available for future use in all EU Member States.

3.1.3 A stigma and discrimination survey will be conducted across all 19 sites on the nature and extent of stigma and discrimination against people with depression across Europe by M36. Reports will be produced for service user, family member, NGO, staff and scientific publications in all 27 member states. The results of the survey will be published in peer-reviewed scientific journals, and disseminated to the relevant governmental and non-governmental groups in each member state. The intended outcome is that awareness of the impact discrimination in the everyday lives of people with depression will be raised.

3.1.4 Policy briefs will be written with practice guidance for policy-makers on how to include civil society into policy and legal developments. Enriched processes will result in better laws and policies, and their ownership. Intended outcome is to make widely available in all EU member states detailed and practical information about how to meaningfully include service user and carer groups in mental health policy formation.

3.1.5 A report on legal and social barriers to employment will analyse legal barriers to employment for people with mental illness in employment. The report will be in English and summaries in local languages. The intended outcomes are to make available to key policy makers a rich set of information on (i) the actual barriers to social participation which have been identified by people with depression, and (ii) to give specific guidance on what practical measures have been experienced as of direct assistance to people with depression which can be the consequences of governmental action, such as workplace based adjustments to employment conditions.

3.1.6 The ASPEN webpage will be hosted by the Mental Disability Advocacy Center (MDAC) on its own website. It will contain relevant details about the ASPEN project, its work, its products and deliverables. Intended outcome: to provide a well designed, easily accessible and practically useful resource on stigma and discrimination to everyone active in the field of mental health in Europe. The website will be created after a detailed consultation with the site leads and with service user and related advocacy groups in the 19 study sites. This will take the form of a Stakeholder Analysis process, in which the form,

content, and ease of use will be consulted upon, taking into account current best practice in terms of web design. This will include analyses of: key audiences, page wire grid and layout, browser compatibility, navigation, colour and graphics, multimedia, content presentation, functionality and accessibility.

3.1.7 An executive summary will be written for policy makers and parliamentarians at the EU level and in member states, and a project summary version suitable for service users and family members. The intended outcome is to provide a concise précis of the key findings of the project as a whole and so to raise awareness among EU policy makers of: (i) the nature and extent of discrimination against people with depression across Europe; (ii) how this contributes to social exclusion; (iii) positive examples of best practice, and (iv) specific recommendations on the policy support required at the EU level to reduce such discrimination in future.

3.2. Deliverables

<i>Deliverable No</i>	<i>Deliverable title</i>	<i>Delivery date</i>	<i>Nature</i>	<i>Confidentiality level</i>	<i>Dissemination</i>
D 1	Report on the Stigma /discrimination scale development	M12	Report	Confidential while under development and to be published openly when completed	Design and completion of assessment schedules
D 2	ASPEN webpage report	M12	Report	Public	As webpages containing information in all project language versions
D 3	ASPEN interim report	M12+2	Report	Confidential in the first instance	Paper and PDF reports for project partners and PHEA
D 4	ASPEN interim report	M24+2	Report	Confidential in the first instance	Paper and PDF reports for project partners and PHEA
D 5	Best practice report	M36	Report	Public	1 paper & 1 web publications on: key stigma & discrimination contacts across 27 EU member states; evidence base for effective interventions for stigma & discrimination using outputs from WP 7; availability of existing programmes across EU & key activities at all levels
D 6	Stigma and discrimination survey report	M36	Report	Public	Reports for service user, family member, NGO, staff and scientific publications.

D 7	Report for policy makers on how to involve civil society in mental health policies	M36	Report	Public	Policy briefs disseminated to policy makers at the EU and national-(all members states) level by email and websites via NGOs to educate and influence legislators and ministry officials
D 8	Report on legal and social barriers to employment	M36	Report	Public	Printed copies for primary decision-makers (eg. MEPs). Other stakeholders via email, and media in all countries. Local language summaries to all relevant in-country stakeholders
D 9	Summary reports for policy makers and stakeholders	M36	Report	Public	Scientific journals, in professional, vocational and NGO press, at relevant congresses to policy, staff, and service user and carer audiences, and press releases, discussion and debate of the main findings
D 10	Final evaluation report on ASPEN	M36	Report	Public	Paper and PDF reports for project partners and PHEA
D 11	ASPEN final report	M38	Report	Confidential in the first instance	Paper and PDF reports for project partners and PHEA

4. METHODOLOGY

4.1. Methods used, references, significances

The programme of work as a whole will be separated into the following seven workpackages:

- WP 1. Coordination of the project
- WP 2. Dissemination of the results
- WP 3. Evaluation of the project
- WP 4. Best practice toolkits
- WP 5. Stigma /discrimination scale development
- WP 6. Stigma & discrimination survey
- WP 7. Analysis of mental health policy and legislation

The rationale for the division of the core tasks in this way is: (i) it separates out distinct functional elements of the programme; (ii) it builds upon an established track record of strengths at each Workpackage lead site; (iii) it allows for many of the Workpackages concurrent work to be undertaken during the 3 year project duration; (iv) it allows sites across all parts of Europe to be actively involved both during the developmental phases of the project (such as scale development) and in the substantive data collection (eg in WPs 4, 6, and 7).

Methods and Means for Objective 1

Create and use Anti-Stigma Best-Practice Toolkit. Develop toolkit, collect information on best practice, summarise in paper and on web by month 36. This will be summarised in one paper and one web publications relating to young people and to adults, by the end of month 36.

Methods and Means for Objective 2

Specific objective 2. Create a set of stigma and discrimination scales for European use. Use scales in languages of 19 sites, for self-stigma, self-esteem, empowerment, actual and anticipated discrimination using the following scales:

- Discrimination and Stigma Scale (DISC)
- Internalised Stigma of Mental Illness (ISMI)
- Boston University Empowerment Scale (BUES)
- The Rosenberg Self-Esteem Scale (SES)

Methods and Means for Objective 3

Specific objective 3. Create a European profile of stigma and discrimination against young people and adults with depression. Assess anticipated and expected discrimination, and self-stigma of 500 young people and adults with depression.

Survey methodology. Each site will conduct face-to-face interviews with 25 people with depression, of which 5 will be tape-recorded.

Administration of the scales: BUES, ISMI and SES by self-administration of participants at the meeting with the interviewer, and DISC by interview of interviewer and participant.

Method and Means for Objective 4

Specific objective 4. Understand the nature and degree of legal and policy barriers which contribute to social exclusion and stigma. Investigate if service users and civil society take part in forming policy related to mental health with dedicated toolkit.

4.2. Analysis of the risks and contingency planning

Risk identified: poor project co-ordination. Risk management strategy: Project Management Team to manage legal, contractual, ethical, financial and administrative elements; overseeing the promotion of gender equality in the project.

Risk identified: lack of consensus in identification of project aims / methods. Risk management strategy: clear lines of responsibility, accountability and governance, through Project Management Team with full responsibility for financial, administration, management, monitoring, evaluating, and control of intellectual property rights.

Risk identified: lack of clear communication between all stakeholders. Risk management strategy: clear project communication strategy including information exchange via a project website; schedule for meetings; clarifying that each of the participants is responsible for its own WP; monthly teleconferences for all WP leads; annual meetings of all site leads rotating between sites.

Risk identified: poor collaboration from service user groups. Need to ensure that there will be successful collaboration from service user groups at all sites. Plans are already agreed for a service user with extensive experience of pan-European work via ENUSP to lead on this.

4.3. Work package overview

<i>Work-package (WP) No</i>	<i>Work package title</i>	<i>Lead partner</i>	<i>Number of person days</i>	<i>Global cost (€)</i>	<i>Starting date</i>	<i>Ending date</i>	<i>Deliverable No</i>
WP 1	Coordination of the project	KCL	446	216,712	M1	M36	D 3, 4, 11
WP 2	Dissemination of the results	MDAC	370	92,981	M13	M36	D 2, 9
WP 3	Evaluation of the project	STAKES	275	90,464	M1	M36	D 10
WP 4	Best practice toolkits	MHF	1163	245,554	M1	M36	D 5
WP 5	Stigma /discrimination scale development	KCL	338	153,818	M1	M12	D 1
WP 6	Stigma & discrimination survey	UNIVR	1663	473,694	M13	M36	D 6
WP 7	Analysis of mental health policy and legislation	MDAC	1200	226,606	M1	M36	D 7, 8
WP 8							
WP 9							
WP 10							
TOTAL			5455	1,499,829			

4.4. Time schedule

Work package	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21	M22	M23	M24	M25	M26	M27	M28	M29	M30	M31	M32	M33	M34	M35	M36
WP 1	Establish network and publication protocol									M1			D3		On-going coordination of all aspects of ASPEN						M2			D4						M3. D11.						
WP 2													D2			Prepare dissemination strategy						Prepare dissemination materials						D9								
WP 3	Prepare evaluation strategy						Establish evaluation plans, and milestones for each partner.						On-going evaluation of project and progress monitoring.																		D10					
WP 4	Overview of existing programmes across EU												Development of database of key contacts. Summary of evidence base of best practice						Development and pilot testing of toolkit												D5					
WP 5	D1																																			
WP 6													Data collection at sites												Collaboration in data analysis						D6					
WP 7	Establish NGO contacts						Completion of a summary for employers						Research on legal policy barriers to employment						Set up stakeholder network						Development of practical policy briefs for policy makers						D7, D8					

Key: M1 – first meeting with site leads; M2 – second meeting with site leads; M3 – third meeting with site leads.

5. WORK PACKAGES DESCRIPTION

5.1. Work package n° 1: Coordination of the project

5.1.1. List of partners involved

King's College London (KCL) (estimated work days: 446)

5.1.2. Description of the work

(i) Establish the ASPEN Office based in London with administrative responsibility for co-ordinating all actions and organising the allocation of finance to all associated partners. Funds will be distributed according to the agreed work plan and the necessary actual expenditure incurred at each study site in the proper pursuit of the agreed work plan.

(ii) Create and manage the ASPEN Project Management Team (PMT) consisting of the Leads for all 7 WPs with the Project Co-ordinator/ Senior Researcher, with monthly phone conferences at which progress to agreed targets will be monitored. Overall project major decisions will be made by this group. Day to day and week to week operational decisions will be made by the Project Co-ordinator/ Senior Researcher in association with the Project Director (Professor Thornicroft). Overall approval for the budget will be with the Head of Finance at the Institute of Psychiatry, King's College London, while operational budget issues will be taken by the Senior Administrator and Finance Officer at the Health Service and Population Research Department at the Institute of Psychiatry, KCL, accountable to the PMT, in liaison with the project site leads (Supervisors/Managers) and their associated nominated budget officers.

(iii) Create and manage ASPEN Heads of Sites Team (HST) for heads of all 19 sites, to meet each year in London, Budapest and Helsinki to discuss progress and risks, and agree targets and decisions. Heads of Sites (Supervisors/Managers) have the overall responsibilities of the management of all operations in individual sites in relation to the Workpackages they are involved in, and the management and supervision of administrative and research staff (Researchers) to ensure that they carry out day-to-day tasks to assist in achieving the milestones and deliverables in Workpackages 5 - 7.

(iv) Support the involvement of junior project staff and their mentoring to gain experience to assist their career development, and so build capacity in this field of European activity for the future.

(v) Regular email communication to seek consensus decisions within the network co-ordinated for administrative matters.

(vi) Coordinate a 5-day writing-up week to discuss publications

(vii) Invite collaborating partners and the Commission to establish the Expert Advisory Group to attend two annual meetings in London and Helsinki to offer regular advice on the methods, aims and operations of the project; how best practice and results of the study are disseminated; and related developments in the field of mental health internationally

(viii) organise and lead the annual project meetings to oversee and coordinate all aspects of the project including: progress of workpackages to timetable and

to budget, staff and participant recruitment, data entry, co-ordination and analysis, production of web and paper reports and other knowledge transfer materials, formulate and action the project publication plan, and to organise and complete the necessary interim and final reports in a timely manner.

We shall also:

- Bring all ethical issues for discussion to all partners
- Insist the proper national and local ethical approvals are gained
- Ensure ASPEN meets the relevant legislation, regulations and guidelines
- Act in accordance with the relevant international conventions and declarations
- Pay particular attention to proper informed consent of all participants
- Give full relevant information about the project to those invited to participate
- Take all proper steps to ensure the safeguarding of confidentiality of data

5.1.3. *Milestones*

<i>Date</i>	<i>Milestone</i>
At M9	Establish network and publication protocol
At M10	First annual meeting of site leads
At M22	Second annual meeting of site leads
At M34	Coordination of data, statistical analyses and assessment schedules produced by Work packages 4, 5, 6 and 7
At M34	Third annual meeting of site leads and writing up

5.1.4. *Deliverables*

Interim report (D3) at M14, interim report (D4) at M26 and final report (D11) at M38 to PHEA

5.2. Work package n° 2: Dissemination of the results

5.2.1. List of Partners involved

Mental Disability Advocacy Center (MDAC) (estimated work days: 370)

5.2.2. Objectives

To disseminate the findings via:

- advising the EU/EC, WHO-Copenhagen and WHO-Geneva
- advising all respective governments on national mental health policy
- publishing in peer reviewed scientific journals
- organising international conferences
- giving invited lectures at international meetings
- contributing to European Union, European Commission, WHO, Association of European Psychiatry and World Psychiatric Association meetings and working parties, and have written policy and discussion papers for these organisations
- liaising closely with national user and carer groups and NGO's close involvement of the operators and national institutions and authorities

5.2.3. Overall strategy and methods

For dissemination and knowledge transfer of ASPEN results we have set the following targets as we establish the European Stakeholder Network. The targets specifically have been chosen to assist in broad but focused dissemination and in dissemination to countries not represented in the consortium. They therefore include international inter-governmental, professional, academic, and non-governmental organisations with high profiles that work on an EU level. The materials will be designed in a way to optimise their relevance beyond the life of the project and to offer the best possible sustainability for the information presented. The following stakeholder groups will be offered materials from ASPEN, both through access the web-based materials, and by directly send papers summaries, which will include links to the internet materials. These knowledge transfer channels will be established and maintained by ASPEN staff, and will be organised in terms of the contents of the main workpackage areas. They will present information which will be organised in ways that reflect the priorities that emerge from our stakeholder analysis, which we anticipate will be to offer the information in ways relevant to the main intended beneficiaries including policy makers, service users, carers, service providers and NGOs.

- **INTERGOVERNMENTAL BODIES:** Relevant officials at EC (including DG-RTD, DG-JLS), MEPs, Council of Europe (DG Social Cohesion, Commissioner for Human Rights), WHO, UN (High Commissioner for Human Rights, Special Rapporteur on Disability, Special Rapporteur on the Right to Health, Special Rapporteur on Education, as well as to the to-be-established Committee of the Rights of Persons with Disabilities), UNICEF, UNDP.
- **GOVERNMENTS OF CONSORTIUM STATES:** Ministries of Health, Education, Social Affairs, Justice where relevant in the 27 member states.
- **NATIONAL QUASI-GOVERNMENTAL BODIES:** eg ombudsman offices, human rights institutions, children's rights commissioners, health care boards, inspectorates of mental health and social care institutions in all member states.

- LOCAL AUTHORITIES: especially services which contribute to or cause social exclusion, such as education authorities, social services, employment agencies.
- INTERNATIONAL NGOs: Target umbrella and membership groups to ensure “snowball effect”, eg. European Disability Forum, European Network of Users and Survivors of Psychiatry, World Network of Survivors of Psychiatry, Inclusion Europe, Save the Children, World Institute on Disability.
- NATIONAL AND LOCAL NGOs: Groups of people with mental illness, children, relatives and carers, as well as NGOs which advocate on their behalf in member states.
- INTERNATIONAL PROFESSIONAL ORGANISATIONS: Such as Association of European Association of Psychiatry, World Psychiatric Association
- NATIONAL PROFESSIONAL ORGANISATIONS: Psychiatric and other specialist professional bodies, as well as trade unions of teachers, nurses, social workers, doctors.
- UNIVERSITIES: within and beyond consortium countries which carry out relevant research.
- MEDIA: Electronic and printed press will be targeted in all consortium countries, and specific international media outlets, to convey key messages to the public both within and beyond consortium countries, via press releases and press conferences, with prominent experts.

Internet will be used to enhance the communication strategy in the following ways:

- use our webpage to include specific links to source materials related to stigma and discrimination and mental illness
- include in our webpage information and links to groups active in Europe in working to reduce stigma and discrimination, and evidence of effective interventions
- post materials from the project, along with information about the results of this project, for service user, policy makers and research audiences
- have a focal point at which we hold a launch event to communicate the main findings of the project in terms of successful methods to reduce stigma

5.2.4. *Description of the dissemination work*

Each of the project Partners has an established record of:

- advising the EU/EC, WHO-Copenhagen and WHO-Geneva
- advising our respective governments on national mental health policy
- publishing in peer reviewed scientific journals
- organising international conferences
- giving invited lectures at international meetings
- contributing to European Union, European Commission, WHO, Association of European Psychiatry and World Psychiatric Association meetings and working parties, and have written policy and discussion papers for these organisations
- taking part in international project to produce standardised outcome measures of mental health treatment and service interventions
- liaising closely with user and carer groups and NGO’s in our respective countries

- close involvement of the operators and national institutions and authorities.

MDAC will analyse legal barriers to employment in the different Member States. This would include investigating guardianship (legal capacity) issues, and practices such as compulsory health checks before employment (with employers simply rejecting people if they have a mental health diagnosis). The output will be a report of legal barriers for people with mental illness to employment, highlighting best practices from various countries. This will then be disseminated to reach policy-makers, and NGOs.

Further, the WP lead will draw up a dissemination and publication plan in collaboration with other WP leads, specifying the number of publications, conference presentations, press releases etc envisaged and the timing.

5.2.5. *Milestones and deliverables*

Date	Milestones and deliverables
At M12	Create an ASPEN webpage with relevant details about the ASPEN work and its products and deliverables (D2)
At M36	Executive Summary for policy makers and parliamentarians at the EU level and in member states, and a project summary version suitable for service users and family members (D9)

5.2.6. *List of stakeholders*

EU/EC, WHO, WHO-EURO, governments, policy makers, professional organisations such as Association of European Psychiatry and World Psychiatric Association, national and international user groups, carer groups, NGO's.

5.3. Work package n° 3: Evaluation of the project

5.3.1. List of parties involved

National Research and Development Centre for Welfare and Health (STAKES)
(Estimated work days: 275)

5.3.2. Description of the work and methodologies

ASPEN will be systematically evaluated by STAKES, a partner with extensive experience from DG SANCO projects. The ASPEN project evaluation will consist of a process evaluation, performed regularly by e-mail and at Management Team meetings, and by an electronic monitoring of achievement of milestones using e-monitoring methods. Results of process evaluation will be used to identify barriers and success factors, which will be fed back to the project coordinator. The electronic monitoring will enable continuous monitoring of progress and early identification of delays and problems - a software solution is the web-based application *milliarium* (<http://www.gabomi.com/1024x768/ENU/milliarium.php>) which will be actively considered.

The evaluation will assess: (i) the project implementation process; (ii) the quality of the deliverables; and (iii) the outcomes achieved. The methods used will be a combination of direct assessments of project participants, target group members, service user group members and stakeholder groups, including use of internet completed questionnaires.

Evaluation is an integrated part of the project at all its phases (see Time schedule at 4.4 for key timepoints), consisting of:

- to establish an evaluation plan and participate in project meetings to ensure continuous quality improvement and evaluation
- evaluator will continuously monitor the achievement of milestones
- evaluator will alert the project coordinator in any case of non-achievement
- evaluator will assess achievement of stated general and specific objectives by 1) monitoring progress, and 2) comparing progress with pre-stated indicators of success:
- collection of best anti-stigma practices (WP 4) will be monitored for collection of data on EU-wide anti-stigma campaigns. The indicator of achievement will be availability of one paper and one web publications by month 36.
- development of stigma-related assessment scales (WP 5) will be monitored for progress in development of new scales and for number of local language translations of scales. The indicator of achievement will be existence of local language versions of the scales at month 36 in the 19 participating sites.
- work to produce a European profile of stigma and discrimination against people with depression (WP 6) will be monitored for collection of data across the 19 sites. The indicator of achievement will be existence of a project database with quantitative data on stigma and discrimination from 19 sites.

- analysis of social exclusion in mental illness (WP 7) will be monitored for collection of data across participating sites. The indicator of achievement is existence of a set of 16 country profiles on the nature and degree of social exclusion experienced by people with mental illness.
- evaluator will collect qualitative data from the associated partners for a process evaluation by a web-based survey
- to allow for corrective actions, the emphasis will be on early collection of evaluation data, by web-based surveys of all partners at months 6, 12 and 18.
- evaluator will analyse the collected survey data to identify barriers and success factors in the project and report the results of the surveys without delay to the Coordinator
- evaluator will produce an evaluation report for the Final Report

Links with other Workpackages:

WP 4: Monitoring of WP progress and achievement of pre-stated success indicator

WP 5: Monitoring of WP progress and achievement of pre-stated success indicator

WP 6: Monitoring of WP progress and achievement of pre-stated success indicator

WP 7: Monitoring of WP progress and achievement of pre-stated success indicator

5.3.3. Indicators

1 Best anti-stigma practices (WP 4)

Description: Develop toolkit, collect information on best practice, summarise in paper and on web by month 36. The indicator of achievement will be % completion of one paper and one web publications by month 36. Method: indicator operationalized by scrutiny of the relevant publications.

2 Development of stigma-related assessment scales (WP 5)

Description: use scales in languages of 19 sites, for self-stigma, self-esteem, empowerment, actual and anticipated discrimination. Indicator will be % completion of local language versions of the scales at month 12 in 19 participating sites. Method: indicator operationalized by assessment/counting the relevant language versions of the scale.

3 European profile of stigma and discrimination against people with depression (WP 6)

Description: assess anticipated and expected discrimination, and self-stigma of 500 young people and adults with depression. The indicator of achievement will be % completion of a project database with quantitative data on stigma and discrimination from 19 sites. Method: indicator operationalized by assessment of the project database, and its quality and completeness.

4 Analysis of social exclusion in mental illness (WP 7)

Description: investigate if service users and civil society take part in forming policy related to mental health with dedicated toolkit. Indicator of achievement is % completion for the set of 16 country profiles on nature and degree of social exclusion experienced by people with mental illness. Method: indicator operationalized by analysis of the country-specific reports on experiences of social exclusion.

5.3.4. *Milestones and deliverables*

Date	Milestones and deliverables
At M6	Evaluation strategy completed
At M6	First cycle of e-mail survey to map partners' experiences of project.
At M7	Report of first evaluation cycle delivered to co-ordinator
At M12	Second cycle of e-mail survey to map partners' experiences of project and consolidated report to co-ordinator.
At M13	Synthesis report of second evaluation cycle delivered to co-ordinator.
At M18	Third cycle of e-mail survey to map partners' experiences of the project and synthesis for consolidated report to co-ordinator.
At M19	Synthesis report of third evaluation cycle delivered to co-ordinator.
At M24	Midpoint evaluation report delivered to co-ordinator.
At M36	Evaluation report completed (D10)

5.4. Work package n° 4: Best practice toolkits

5.4.1. List of partners involved

Lead: Mental Health Foundation (MHF) (estimated work days: 440).

Other partners:

King's College London (KCL) (estimated work days: 43),

Global Initiative on Psychiatry – Sofia (GIP-Sofia) (estimated work days: 40),

National Research and Development Welfare and Health (STAKES) (estimated work days: 40),

Heinrich-Heine-Universität Dusseldorf, Rheinische Kliniken Dusseldorf (RKD) (estimated work days: 40),

University Mental Health Institute (UMHRI (EIPSI)) (estimated work days: 40),

Awakenings Foundation (AWF) (estimated work days: 40),

Provincia Lombardo Veneta Ordine Ospedaliero di San Giovanni di Dio – Fatebenefratelli (IRCCS) (estimated work days: 40),

University of Verona (UNIVR) (estimated work days: 40),

Stichting Kenniscentrum Rehabilitatie (KcR) (estimated work days: 40),

Associação para o Estudo e Integração Psicossocial (AEIPS) (estimated work days: 40),

Mental Disability Advocacy Center (MDAC) (estimated work days: 40),

Asociația din România de Psihiatrie Comunitară (A.R.P.C.) (estimated work days: 40),

Association for Mental Health INTEGRA, o. z. (Integra o.z.) (estimated work days: 40),

University Psychiatric Hospital (PKL) (estimated work days: 40),

Foundation of Psychiatry Clinic of Medical Faculty of Istanbul (PAP) (estimated work days: 40),

Vilnius University (VU) (estimated work days: 40),

Etablissement Public Santé Mentale Lille-Métropole (EPSM/C.C.OMS) (estimated work days: 40),

Katholieke Universiteit Leuven (K.U. Leuven) (estimated work days: 40)

5.4.2. Objectives

Create and use Anti-Stigma Best-Practice Toolkit. Develop, finalise and widely disseminate a pragmatic Anti Stigma Toolkit to describe and assess EU-wide anti-stigma projects and to collate information on best practice, to be summarised in one

paper and one web publications relating to adults and to and young people by the end of month 36. Best practice is understood here to mean a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success.

5.4.3. *Description of the work*

We shall develop, finalise and disseminate a pragmatic and widely usable Anti Stigma Toolkit to describe and assess EU-wide anti-stigma projects and to collate information on best practice, to be summarised in one paper and one web publications relating to adults and to young people by the end of month 36. This will include:

- The development of a database of key stigma and discrimination contacts across the EU
- A summary of the evidence base and pointers for promising practice for effective interventions to tackle stigma and discrimination in relation to mental health problems/mental illness, informed by the systematic literature review to be undertaken in Year 1 under WP7 and drawing on other recent relevant initiatives such as the work of the WHO Collaborating Centre on Stigma
- A thorough review of the peer-review and the report literature to identify best practice, with a sample of the material doubly rated by two assessors to ensure high inter-rater reliability of selection of material, along with a consensus-based method developed by all WP site staff to establish criteria for selecting best practice case examples.
- An overview of the availability of existing programmes, initiatives, resources across the EU aimed at tackling stigma and discrimination
- The development of a database of key activities across the WHO European region including at regional/devolved administration, national and supra-national levels
- The development and application of a Toolkit to support the dissemination, co-ordination and implementation of effective initiatives for addressing stigma and discrimination in relation to depression with a particular focus on young people. The development of the Toolkit will use the above resources and be informed by outputs from other WPs.

5.4.4. *Milestones and deliverables and links with other work packages*

<i>Date</i>	<i>Milestones and deliverables</i>
M12	Overview of existing programmes across EU.
M18	Summary of evidence base of best practice
M18	Development of database of key contacts
M30	Development and pilot testing of toolkit
M36	Completion of toolkit and summary reports on the development, and finalisation of a pragmatic and widely usable Anti-Stigma Best-Practice to describe and assess EU-wide anti-stigma projects and to

	collate information on best practice. 1 paper and web publications (D5) on: key stigma and discrimination contacts across EU; evidence base for effective interventions for stigma and discrimination using outputs from WP 7; availability of existing programmes across EU
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5.5. Work package n° 5: Stigma /discrimination scale development

5.5.1. List of partners involved

Lead partner: King's College London (KCL) (estimated work days: 158).

Other partners:

Global Initiative on Psychiatry – Sofia (GIP-Sofia) (estimated work days: 10),

National Research and Development Welfare and Health (STAKES) (estimated work days: 10),

Heinrich-Heine-Universität Dusseldorf, Rheinische Kliniken Dusseldorf (RKD) (estimated work days: 10),

University Mental Health Institute (UMHRI (EPIPSI)) (estimated work days: 10),

Awakenings Foundation (AWF) (estimated work days: 10),

Provincia Lombardo Veneta Ordine Ospedaliero di San Giovanni di Dio – Fatebenefratelli (IRCCS) (estimated work days: 10),

University of Verona (UNIVR) (estimated work days: 10),

Stichting Kenniscentrum Rehabilitatie (KcR) (estimated work days: 10),

Associação para o Estudo e Integração Psicossocial (AEIPS) (estimated work days: 10),

Mental Disability Advocacy Center (MDAC) (estimated work days: 10),

Asociația din România de Psihiatrie Comunitară (A.R.P.C.) (estimated work days: 10),

Association for Mental Health INTEGRA, o. z. (Integra o.z.) (estimated work days: 10),

University Psychiatric Hospital (PKL) (estimated work days: 10),

Foundation of Psychiatry Clinic of Medical Faculty of Istanbul (PAP) (estimated work days: 10),

Vilnius University (VU) (estimated work days: 10),

Etablissement Public Santé Mentale Lille-Métropole (EPSM/C.C.OMS) (estimated work days: 10),

Katholieke Universiteit Leuven (K.U. Leuven) (estimated work days: 10)

Mental Health Foundation (MHF) (estimated work days: 10)

5.5.2. Objectives

Create a set of stigma and discrimination scales for European use. Create stigma-related assessment scales for use in local languages of 19 participating sites, measuring

self-stigma, self-esteem, empowerment, and actual and anticipated discrimination experienced by young people and adults with depression, by the end of month 12.

5.5.3. *Description of the work*

- Discrimination and Stigma Scale (DISC). This is the core scale to be developed in relation to people with depression during the ASPEN project. The interviewer will ask the participants for a series of domains whether they have experienced such discrimination because of their mental illness, the direction (positive or negative) of such discrimination and its severity. The domains will address work, marriage, parenting, housing, leisure, and religious activities. The structure of each question will be in the form ‘Have you been treated differently from other people in [eg finding a job] because of your diagnosis of mental illness?’. The scale will also consider how far participants limit their own involvement in important aspects of everyday life, e.g. work and intimate relationships. These items will form the ‘anticipated discrimination’ subscale.
- The development of this scale will also include the translation and cross-cultural adaptation of the scale in to all the site languages. The consistent procedure to be adopted for the translation and cross-cultural adaptation of DISC will be to ensure that language-equivalent versions of the scale are readily understood by people with depression and by the interviewers in all sites, taking into account the influence of local cultural factors. The scale will be translated from English into the local (target) language using a forward and back translation approach. A reconciliation focus group with 6-10 local people with a clinical diagnosis of depression will be conducted in each site before the final version is established to ensure that all the key terms are translated into local language equivalents. (see reference: Sartorius N, Kuyken J. Translation of Health Status Instruments. In: Orley J, Kuyken J, editors. Quality of Life Assessment in Health Care Settings. Volume 1. Berlin: Springer-Verlag; 1994.)
- Internalised Stigma of Mental Illness (ISMI). This existing 29-item measure assesses the experience of stigma. It has 5 subscales: Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal and Stigma Resistance. The initial validation study (N=127) showed that the ISMI has a high internal consistency ($\alpha = 0.90$) and test-retest reliability ($r=0.92$).
- Boston University Empowerment Scale (BUES). This existing scale was developed with strong service user involvement. A 17-item version of the scale consisting of factor 1 “Self-esteem-self-efficacy” and factor 2 “power-powerlessness” is used in this study. Each scale item is rated on a four-point Likert scale anchored at 1=strongly disagree and 4=strongly agree.
- The Rosenberg Self-Esteem Scale (SES) is an existing 10-item self-report measure of global self-esteem. It consists of 10 statements related to overall feelings of self-worth or self-acceptance. The SES has also been administered as an interview measure. It has demonstrated good reliability and validity across a large number of different sample groups. The scale has been validated for use with both male and female adolescent, adult and elderly populations.

The ISMI, and BUES scales have been selected because they will assess important aspects of stigma and discrimination, namely how far they relate to internalised stigmatisation, and how far experienced of stigmatisation are negatively associated with

empowerment from the point of view of service users. These scales have recently and successfully been used in the 21 country GAMIAN study of self-stigma, across a wide range of diagnostic groups, and been found to be comprehensible and feasible. The SES will take understanding in this field a step further by allowing analysis of stigma-related experiences to measurement of lowered self-esteem.

5.5.4. *Milestones and Deliverables and links with other work packages*

<i>Date</i>	<i>Milestones and deliverables</i>
M6	Translation of DISC into local languages completed
M8	Focus groups and training for scales and inter-rater reliability exercise
M12	Completion of scales for use in languages of all sites, which measure self-stigma, self-esteem, empowerment, actual and anticipated discrimination experienced by young people and adults with depression (D1)

5.6. Work package n° 6: Stigma and discrimination survey

5.6.1. List of partners involved

Lead partner: University of Verona (UNIVR) (estimated work days: 223).

Other partners:

King's College London (KCL) (estimated work days: 80),

Global Initiative on Psychiatry – Sofia (GIP-Sofia) (estimated work days: 80),

National Research and Development Welfare and Health (STAKES) (estimated work days: 80),

Heinrich-Heine-Universität Dusseldorf, Rheinische Kliniken Dusseldorf (RKD) (estimated work days: 80),

University Mental Health Institute (UMHRI (EIPSI)) (estimated work days: 80),

Awakenings Foundation (AWF) (estimated work days: 80),

Provincia Lombardo Veneta Ordine Ospedaliero di San Giovanni di Dio – Fatebenefratelli (IRCCS) (estimated work days: 80),

University of Verona (UNIVR) (estimated work days: 80),

Stichting Kenniscentrum Rehabilitatie (KcR) (estimated work days: 80),

Associação para o Estudo e Integração Psicossocial (AEIPS) (estimated work days: 80),

Mental Disability Advocacy Center (MDAC) (estimated work days: 80),

Asociația din România de Psihiatrie Comunitară (A.R.P.C.) (estimated work days: 80),

Association for Mental Health INTEGRA, o. z. (Integra o.z.) (estimated work days: 80),

University Psychiatric Hospital (PKL) (estimated work days: 80),

Foundation of Psychiatry Clinic of Medical Faculty of Istanbul (PAP) (estimated work days: 80),

Vilnius University (VU) (estimated work days: 80),

Etablissement Public Santé Mentale Lille-Métropole (EPSM/C.C.OMS) (estimated work days: 80),

Katholieke Universiteit Leuven (K.U. Leuven) (estimated work days: 80)

Mental Health Foundation (MHF) (estimated work days: 80)

5.6.2. Objectives

Create a European profile of stigma and discrimination against people with depression and to interpret these data for their implications for the necessary EU and national level policy changes

5.6.3. Description of the work

Survey methodology.

Use the measures developed in Specific Objective 2 to assess the nature and extent of stigmatisation, along with anticipated and expected discrimination assess self-stigma, actual and anticipated discrimination among (a) young people and (b) adults with depression in the 19 ASPEN sites.

Each site will conduct face-to-face interviews with 25 people with depression, of which 5 will be tape-recorded, transcribed into English for detailed qualitative evaluation. Entry criteria will be: (i) aged 16 or over, (ii) in contact with local mental health services, (iii) clinical diagnosis of major depression, (iv) able to complete the self-administered questionnaire, and (v) giving written informed consent to participate. Exclusion criterion is: current in-patients. We shall identify members of the ‘target groups’ (ie participants in the survey who are people with depression) within the local area of each participating site. We shall identify people with depression from working closely with staff in the local mental health services, local non-governmental agencies advocating for or providing services to people with depression (for example via the EU wide GAMIAN mental health network with whom we have strong existing links), and by making contact with local service user and self-groups in the field of mental health.

Administration of the scales: BUES, ISMI and SES by self-administration of participants at the meeting with the interviewer, and DISC by interview between interviewer and participant. These data will also be used as a baseline for future work to assess if stigma and discrimination against people with mental illness is changing across Europe, reporting the results by month 36.

5.6.4. Milestones and deliverables and links with other work packages

<i>Date</i>	<i>Milestones and deliverables</i>
M24	Data collection completed
M36	Data analysis completed. Report of results suitable for publication from across all 19 sites on the nature and extent of stigma and discrimination against people with depression across Europe. Reports for service user, family member, NGO, staff and scientific publications (month 36) (D6).

5.7. Work package n° 7: Analysis of mental health policy and legislation

5.7.1. List of partners involved

Lead partner: Mental Disability Advocacy Center (MDAC) (estimated work days: 570).

Other partners:

King’s College London (KCL) (estimated work days: 35),

Global Initiative on Psychiatry – Sofia (GIP-Sofia) (estimated work days: 35),

National Research and Development Welfare and Health (STAKES) (estimated work days: 35),

Heinrich-Heine-Universität Dusseldorf, Rheinische Kliniken Dusseldorf (RKD) (estimated work days: 35),

University Mental Health Institute (UMHRI (EIPSI)) (estimated work days: 35),

Awakenings Foundation (AWF) (estimated work days: 35),

Provincia Lombardo Veneta Ordine Ospedaliero di San Giovanni di Dio – Fatebenefratelli (IRCCS) (estimated work days: 35),

University of Verona (UNIVR) (estimated work days: 35),

Stichting Kenniscentrum Rehabilitatie (KcR) (estimated work days: 35),

Associação para o Estudo e Integração Psicossocial (AEIPS) (estimated work days: 35),

Mental Disability Advocacy Center (MDAC) (estimated work days: 35),

Asociația din România de Psihiatrie Comunitară (A.R.P.C.) (estimated work days: 35),

Association for Mental Health INTEGRA, o. z. (Integra o.z.) (estimated work days: 35),

University Psychiatric Hospital (PKL) (estimated work days: 35),

Foundation of Psychiatry Clinic of Medical Faculty of Istanbul (PAP) (estimated work days: 35),

Vilnius University (VU) (estimated work days: 35),

Etablissement Public Santé Mentale Lille-Métropole (EPSM/C.C.OMS) (estimated work days: 35),

Katholieke Universiteit Leuven (K.U. Leuven) (estimated work days: 35)

Mental Health Foundation (MHF) (estimated work days: 35)

5.7.2. Objectives

To investigate the extent to which users and civil society are currently involved in the development of policy/legislation related to mental health issues. Create policy briefs with practice guidance for policy-makers on how to include civil society into policy and legal developments. Enriched processes will result in better laws and policies, and their ownership

5.7.3. Description of the work

- (i) Liaise with other ASPEN partners to carry out a review of existing best practices at combating stigma/discrimination in the workplace
- (ii) Produce a summary for employers which would reflect research findings, and best practices in reducing discrimination and stigma

(iii) Produce a training module for employment agencies on reducing discrimination.

(iv) Work with partners to contact NGOs from all project countries to assess the level of civil society engagement in policy and legal reforms. This will include comparing if possible, other disability groups. Production of practical policy briefs for policy-makers on how to involve civil society.

(v) Conduct desk research of the legal and policy barriers to employment in the Member States, using existing research, and analysing its relevance to mental illness. Recommendations to Member States to reduce employment discrimination.

(vi) The key stakeholder groups to be addressed by the social inclusion and civil society workpackage are as follows (see section 5.2.3 for further details)

- intergovernmental bodies:
- governments of consortium states
- national quasi-governmental bodies
- local authorities
- international ngos
- national and local ngos
- international professional organisations
- national professional organisations.
- universities:
- media:

5.7.4. *Milestones and deliverables and links with other work packages*

<i>Date</i>	<i>Milestones and deliverables</i>
M6	Establish NGO contacts
M12	Completion of a summary for employers which would reflect research findings, and best practices in reducing discrimination and stigma, and a training module for employment agencies on reducing discrimination.
M18	Desk research on legal policy barriers to employment
M24	Set up stakeholder network
M36	Report on the policy briefs practice guidance for policy-makers on how to include civil society into policy and legal developments.

	Enriched processes will result in better laws and policies, and their ownership (D7)
M36	Report on legal and social barriers to employment. Report in English and summaries in local languages (D8)

6. MEASURES TO ENSURE VISIBILITY OF COMMUNITY CO-FUNDING

We consider it good practice to fully acknowledge the funding organisations which support ASPEN. We shall therefore give full credit to the European Commission at every opportunity in our knowledge transfer and dissemination activities. These will include:

- Naming the EU as the commissioner of this work in published papers and reports
- Where appropriate using the EU logo to denote the EU support we have received for presentations at local, national and international levels
- Stressing EU funding when giving interviews to the mass media
- Including clear mention of EU support in our institutions webpages and newsletters
- Emphasising in our dissemination work to policy, professional, service user, family member and other audiences that the work took place by virtue of EU support.

Managing sponsor acknowledgments. As contractors we shall submit at, or before, the end of the Project, a technology implementation plan acceptable to the Commission. It will include a summary of the project, the forecast of the intentions of each contractor and description of achievements regarding use of the knowledge (including timetable). The coordinator shall provide, a one-page publishable summary of the project which can be easily disseminated and distributed to the public. In addition, no later than the first report, the coordinator shall provide to the Commission a publishable poster targeted to a non-specialist audience and summarising the main features of the entire project. Each of these knowledge transfer actions will fully acknowledge the EU as the source of funding.

Examples of our knowledge transfer activities in which high EU visibility will be ensured:

- The WPA Global Stigma Programme has well established programmes in 20 countries across the world with professional input to assist with transfer of knowledge. The web site www.openthedoors.com will be used by ASPEN to host: evaluation discussion boards, training materials, lecture notes, research summaries, consumer perspectives on ASPEN.
- Bi-annual ENMESH congresses bringing together colleagues from across the whole of Europe to discuss mental health service improvement and evaluation
- Regular, high visibility and high-impact press releases and media campaigns by Mental Disability Advocacy Centre on reports highlighting the need to improve (i) mental incapacity and (ii) guardianship arrangements across many countries in Europe.
- Regular, targeted newsletters summarising key findings from our recent completed projects, such as the IoP Health Service and Population Research newsletter Towards Mental Health published annually in printed and electronic formats.
- Show EU support in the spread of the project results through our partners organisations such as the European family member mental health organisation EUFAMI via: <http://www.eufami.org>.

7. LIST OF COLLABORATING PARTNERS

<i>Collaborating organisation</i>			<i>Contact person</i>			
<i>Organisation</i>	<i>Town / City</i>	<i>Country</i>	<i>Title / Function</i>	<i>Family name and First name</i>	<i>Telephone No</i>	<i>E-mail</i>
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