The World Journal of Biological Psychiatry, 2008; 9(1): 51–58

ORIGINAL ARTICLE

The 'European Alliance Against Depression (EAAD)': A multifaceted, community-based action programme against depression and suicidality

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Abstract

Action programmes fostering partnerships and bringing together regional and national authorities to promote the care of depressed patients are urgently needed. In 2001 the 'Nuremberg Alliance Against Depression' was initiated as a community-based model project within the large-scale 'German Research Network on Depression and Suicidality' (Kompetenznetz 'Depression, Suizidalität'). The 'Nuremberg Alliance Against Depression' was an action programme, conducted in the city of Nuremberg (500,000 inhabitants) in 2001/2002, addressing four intervention levels (Hegerl et al. Psychol Med 2006;36:1225). Based on the positive results of the Nuremberg project (a significant reduction of suicidal behaviour by more than 20%) 18 international partners representing 16 different European countries established the 'European Alliance Against Depression' (EAAD) in 2004. Based on the four-level approach of the Nuremberg project, all regional partners initiated respective regional intervention programmes addressing depression and suicidality. Evaluation of the activities takes place on regional and international levels. This paper gives a brief overview of the background for and experiences with the EAAD. It describes the components of the programme, provides the rationale for the intervention and outlines the current status of the project. The aim of the paper is to disseminate information about the programme's potential to reduce suicidal behaviour and to provide examples of how European community-based 'best practice' models for improving the care of depressed patients and suicidal persons can be implemented using a bottom-up approach. EAAD is mentioned by the European commission as a best practice example within the Green Paper 'Improving the mental health of the population: Towards a strategy on mental health for the European Union' (European Commission 2005).

Key words: *Depression, community-based intervention, suicidality, European network, suicide*

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(Received 7 November 2006; accepted 10 January 2007)

ISSN 1562-2975 print/ISSN 1814-1412 online
DOI: 10.1080/15622970701216681

Background

Major depression is a prevalent disorder with, in most cases, a recurrent or chronic course. According to results of the WHO global burden of disease study (Murray and Lopez 1997; Lopez et al. 2006) unipolar depression is projected to be placed as one of the top two leading causes of disability-adjusted life years in 2020. Depressive disorder is life threatening due to suicidality and other direct and indirect contributions to mortality (Bauer et al. 2002; Cuijpers and Smit 2002; Spießl et al. 2006). Psychological autopsy studies have shown that the vast majority of suicides are committed in the context of a psychiatric disorder, with affective disorders accounting for 30–88% of all cases (Lönnqvist and Koskenvuo 1988; Schneider et al. 2005).

Depression treatments with well-documented efficacy are available but are adequately provided to only a minority of depressed persons (Sartorius et al. 1993; Spitzer et al. 1995; Hylan et al. 1998; Lecrubier and Hergueta 1998; Dunn et al. 1999; Linden et al. 1999; Lawrenson et al. 2000; Wittchen and Pittrow 2002). This defines a large range for improvement and calls for action programmes to enhance the access to and the quality of care provided to depressed persons in the community.

Most published interventions have had a narrow focus on a certain measure with only mixed results (Rutz et al. 1989; Rutz et al. 1990; Callahan et al. 1994; Rahman et al. 1998; Lin et al. 2001; Bennewith et al. 2002; King et al. 2002; Simon 2002). Others had a broad approach but were lacking sufficient evidence of efficiency (Paykel et al. 1997; Hickie 2004; Jorm et al. 2005; Mann et al. 2005; for review see Althaus and Hegerl 2003). Compliance of the patients and adherence of the GPs to the guidelines are important factors (Schulberg 2001). Improved knowledge about symptoms and treatment possibilities are required not only for GPs but also other key groups in the community. Considering the complexity of the factors contributing to the under-diagnosis and under-treatment of depression, action programmes aiming at multiple levels, appear to be the most promising for this purpose (Gilbody et al. 2003).

Recently the Green Paper 'Improving the mental health of the population: Towards a strategy on mental health for the European Union on mental health' (European Commission 2005) has recommended multifaceted and community-based interventions for improving the care of depressed persons and has mentioned the 'European Alliance against Depression' (EAAD) as a best practice example. In the following the EAAD strategy and concrete interventions of this European project will be presented.

The strategy and the concrete measures running within EAAD are based in part on the 'Nuremberg Alliance against Depression' (NAAD) (Hegerl et al. 2006). This community based 2-year action programme against depression and suicidality in Nuremberg will also be presented because it provides evidence for the effectiveness of the EAAD approach.

The regional experience: 'Nuremberg Alliance against Depression' (NAAD)

The 'Nuremberg Alliance Against Depression' (NAAD) was carried out as a sub-project of the 'German Research Network on Depression and Suicidality' ('Kompetenznetz Depression und Suizidalität', funded by the German Federal Ministry of Education and Research) in the city of Nuremberg (500,000 inhabitants) during 2001–2002. The aim was to improve the care of depressed people and to prevent suicidality. The project has been evaluated both with respect to a 1-year baseline and a control region (city of Wuerzburg, 290,000 inhabitants). The intervention took place on four different levels complementary to each other (Figure 1; for details, see Hegerl et al. 2006).

Level 1: Co-operation with general practitioners

Interactive workshops using educational packages were developed and offered to GPs. Additionally screening tools were evaluated (Henkel et al. 2003) and handed over to GPs together with other material (e.g., leaflets and brochures). One of two professionally produced videotapes informed GPs about diagnosis and treatment of depression, the second

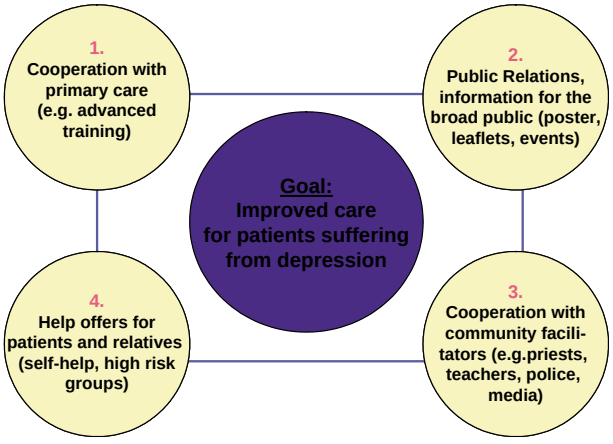

Figure 1. The four-level approach of the 'Nuremberg Alliance Against Depression' and the 'European Alliance Against Depresison'.

video was intended to support GPs in informing the individual patient about his disorder and its treatment. This second video should be handed out by the GP to their depressed patients who can then inform themselves at home together with their families about depression and its treatment.

Level 2: Public relations campaign

A professional public relations campaign was established including posters (Figure 2) at public places, leaflets, information brochures and several public events. Additionally a cinema spot was developed and two prominent patrons supported the campaign (German Federal Minister for Family Affairs, Senior Citizens, Women and Youth and the Bavarian Minister of the Interior).

Level 3: Community facilitators

To consider the important role of community facilitators educational workshops were arranged for teachers, counsellors, priests, geriatric nurses, policemen, pharmacists and others. These professionals might be influential in depressed and suicidal persons' decisions to access care. Special educational packages were developed for these community facilitators. Also a close co-operation with the media was established in order to avoid imitation suicides. A 12-point recommendation was handed out to local media in Nuremberg, providing information how to report and how not to report about suicides.

Level 4: High risk groups and self-help

An 'emergency card' (Morgan et al. 1993) was handed out to patients who have been treated after

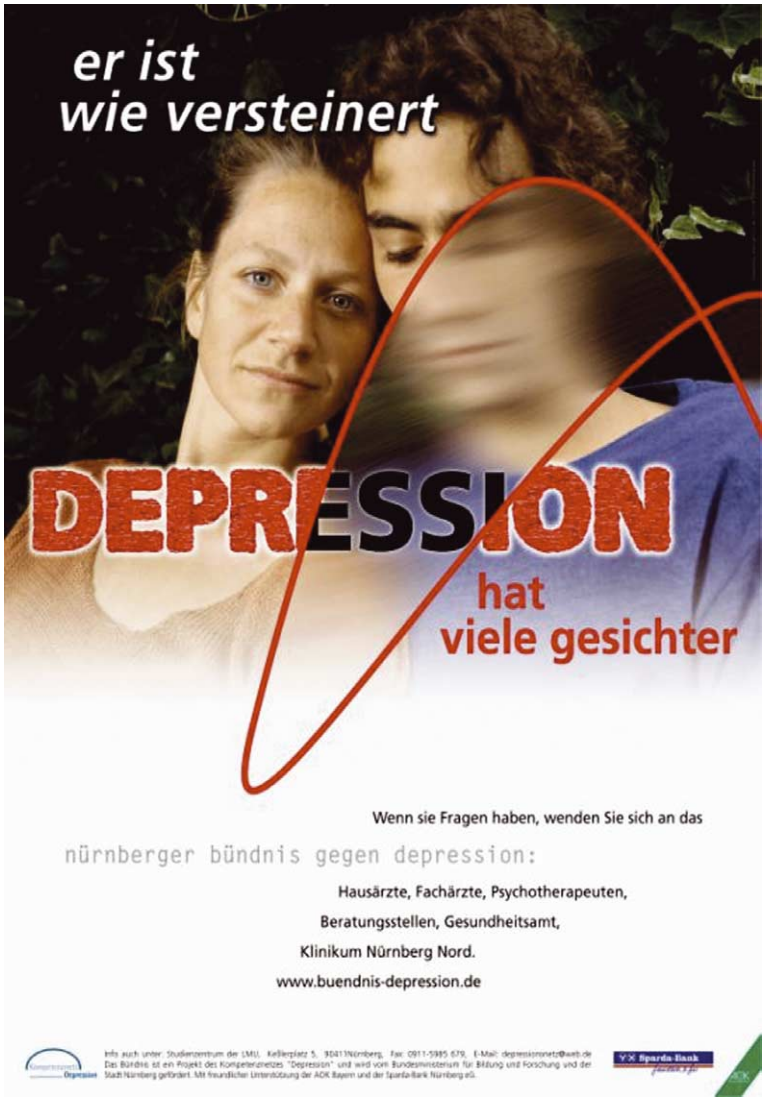

Figure 2. Poster at public places: 'Depression has many faces'.

suicide attempt, indicating a telephone number which allowed an easy and round the clock access to professional help offered by a specialist. Additionally several initiatives were taken to found self-help activities and support already existing self-help activities.

Evaluation of the NAAD

The predefined main outcome measure was the number of 'suicidal acts' (sum of suicide attempts + completed suicides). Completed suicides and suicide attempts are hard outcomes that can also be measured with limited resources. However, both are infrequent events with strong fluctuations, making it difficult to obtain sufficient statistical power to demonstrate an effect (Althaus and Hegerl 2003). Especially for completed suicides, the base rate is too low to detect even highly relevant reductions for a region such as Nuremberg. To decrease the risk of missing a clinically relevant effect and to increase the power of the Nuremberg study, the composite variable 'suicidal acts' was taken as the main outcome criterion, even though it combines two quite different aspects of suicidality. Compared to the control region, a significant reduction in frequency of suicidal acts was observed in Nuremberg during the 2-year intervention (2001 vs. 2000: −19.4%; $P<0.1$; 2002 vs. 2000: −24%, $P<0.005$) (Figure 3) (Hegerl et al. 2006). Considering suicide attempts only (secondary outcome criterion), the same effect was found (2001 vs. 2000: −18.3%, $P<0.05$; 2002 vs. 2000: −26.5%, $P<0.001$). The reduction was most noticeable for high-risk methods (e.g. hanging, jumping, shooting). The power of the study was not sufficient to draw conclusions concerning effects on completed suicides. Additional analyses of the year after the end of the intervention (2003) revealed a further reduction of the frequency of suicidal acts in Nuremberg (2003 vs. 2000; −32.2%; $P<0.001$). Further analyses (changes in media coverage, changes in prescription of antidepressants) supported the efficiency of the intervention programme, whereas no systematic effects on public attitude towards depression were detected (Hegerl et al. 2003). Data collection on suicide attempts is continued in Nuremberg and also data on completed suicides will be available in the future. This offers the possibility to analyse respective trends also in the future.

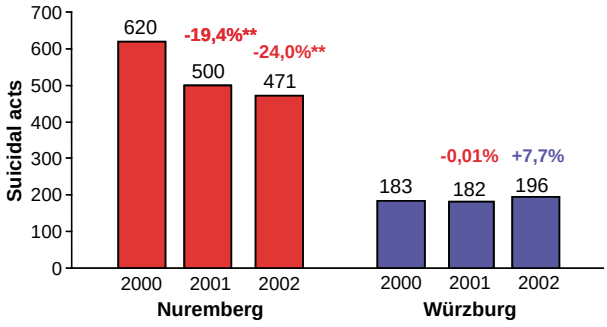

Figure 3. Suicidal acts in Nuremberg and Wuerzburg for baseline year (2000) and both intervention years (2001, 2002). A significant reduction was observed in Nuremberg compared to the control region Würzburg.

Foundation of the EAAD

Since 2003, the idea of the 'Nuremberg Alliance Against Depression' has spread all over Germany, and more than 40 German regions and communities have initiated their own intervention programmes under the umbrella of the German Alliance against Depression (www.buendnis-depression.de). In parallel to this development, regions from other countries have also expressed their interest in the NAAD concept. Iceland, South Tyrol in Italy and Switzerland have been the first international partners, who have started to implement similar programmes.

Because of this international interest, the 'European Alliance Against Depression' (EAAD), funded by the European Commission, was founded in 2004. The basic idea is again to implement regional community-based four-level intervention programmes with the aim of improving the care of depressed patients and to reduce suicidality. The interventions in the participating regions are oriented along the lines of the Nuremberg project, i.e. that the EAAD partners follow the four interventions levels as described above. To account for regional and cultural differences, some adaptations, like changes of poster motifs or length of training sessions, have been necessary. However, the majority of instruments used within the pilot project, including outlines and presentations for trainings, leaflets or posters, could easily be applied in the participating regions. Additionally these instruments have been completed by material already available in the respective regions (e.g., specific information leaflets or general information brochures about depressive disorders).

During the first phase of EAAD (2004–2005) such programmes have been set up in cooperating regions, and concepts and materials of the NAAD have been adapted to local needs. During the second phase (2006–2008), the activities are to be disseminated to other regions or nationwide in the different countries. In 2006, the EAAD comprised 20 international partners representing 18 different European countries (Figure 4).

A catalogue of 'best practice' materials for the four-level intervention programmes has been set up

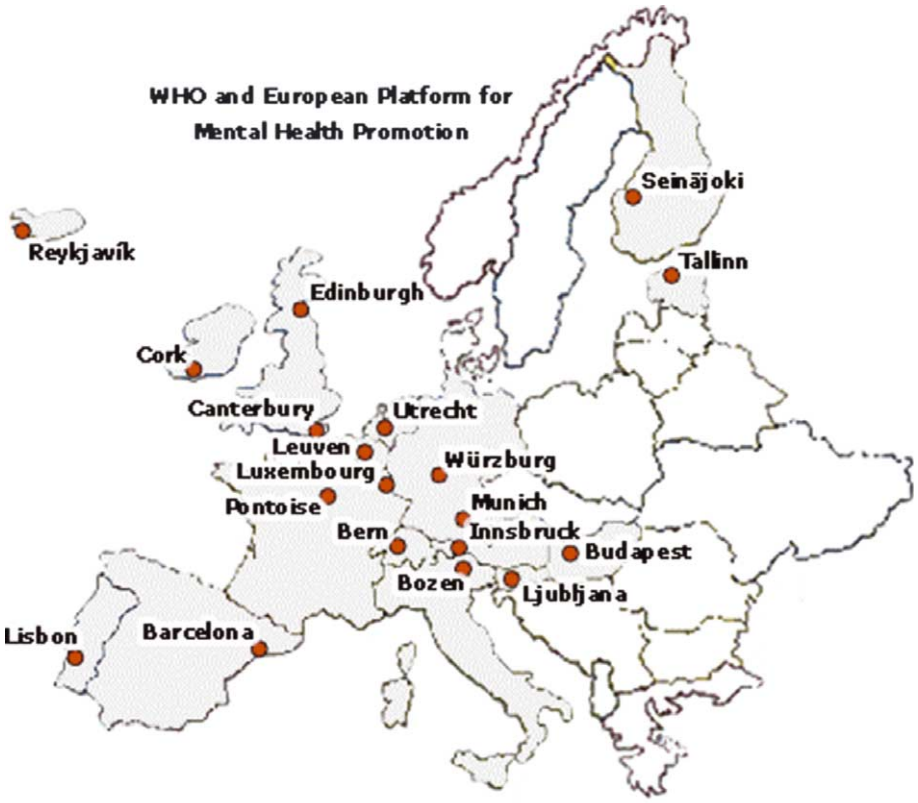

Figure 4. Partners within EAAD.

and is continuously updated. The catalogue comprises examples of

- posters used in various countries,
- leaflets addressing different target groups in different languages,
- screenshots of/links to regional EAAD websites,
- recommendations for media reporting about depression and suicide,
- several outlines of training modules for GPs and community facilitators,
- abstracts of videotapes,
- the outline of a train-the-trainer seminar,
- examples of offers for high-risk groups, and
- various additional material

Many of these materials are based on NAAD materials, but several regions have additionally contributed their own materials to this catalogue. The catalogue helps to identify examples of 'best practice' and to avoid unnecessary duplications.

A website (www.eaad.net), set up in summer 2004, informs the broad public about the project (see Figure 5) and allows an easy exchange of information and documents via an internal part for the EAAD project members.

Since 2004, information materials for large-scale public relations campaigns have been produced and disseminated. By summer 2005, nearly all partners officially started their campaign with the organisation of an opening event. A close co-operation with primary care physicians has been established by most partners by offering training courses addressing recognition and treatment of depression in the GP practice, and by providing information material to be handed over to depressed patients. Different groups of community facilitators, like, e.g., social service professionals, geriatric nurses, teachers, education counsellors, defence forces, clergy and police officers have been trained. Additionally, mental health experts have participated in train-the-trainer seminars to be prepared for their tasks as future trainers within EAAD. Special activities to support self-help and individuals at high risk (e.g., patients after suicide attempt) have also been organised by most EAAD partners. Table I provides an overview of measures taken on the four different intervention levels within EAAD.

Evaluation within EAAD

For evaluation, the network defined a set of core evaluation indicators:

- *suicides, suicide attempts/deliberate self harm (DSH);*

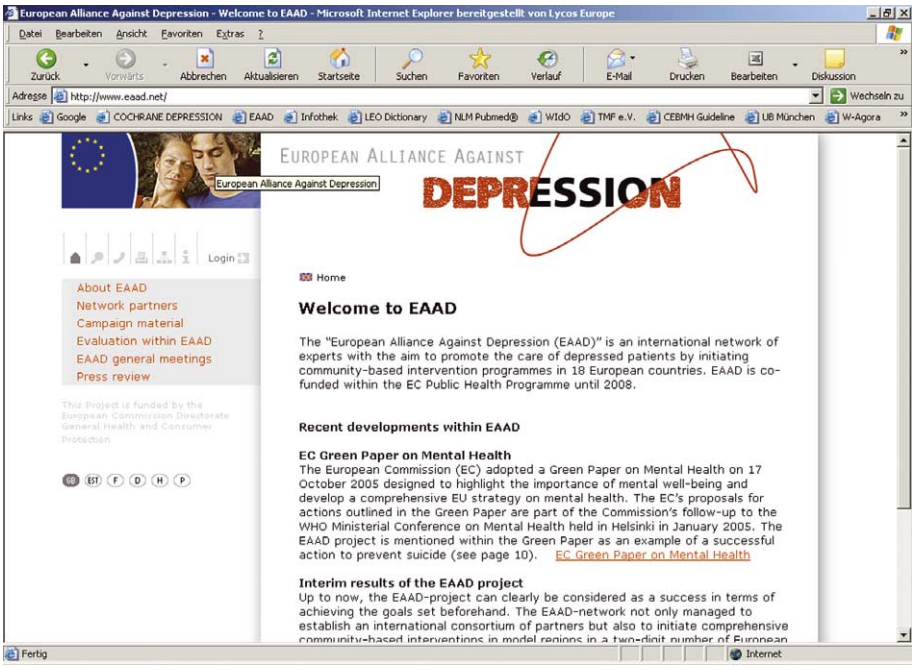

Figure 5. Screenshot of the EAAD homepage (www.EAAD.net).

- *prescription profiles concerning psycho-pharmaceutical drugs (mainly antidepressants);*
- *attitudes and knowledge towards depressive disorders and suicidality.*

A catalogue of official EAAD evaluation instruments has been established which lists all instruments recommended (questionnaires, evaluation tools, guidelines to register prescription profiles or suicides). This catalogue contains, e.g., concrete recommendations on item-level for surveys among different target groups, relevant ATC codes to study changes in prescriptions of antidepressants or ICD-10 X-codes to assess suicide attempts. Over and above that, additional instruments are recommended (e.g., the SIRI-II or the Depression Attitude Questionnaire, DAQ). The objective of the European Commission's public health programme is primarily dedicated to the implementation of concrete intervention activities rather than scientific evaluation of the respective programmes. Consequently, funding for evaluation activities within the EAAD is quite limited. However, numerous partners within the EAAD do evaluate their activities by conducting population surveys, by analysing prescription data or by systematic evaluation of training effects among GPs and community facilitators. Also, completed suicides and suicide attempts are objectives of evaluation activities. Based on the above mentioned core indicators, most partners started with their baseline assessment of data in 2004–2005 and collected first intervention data in 2006.

Table I. EAAD intervention activities during the first 2 years (2004–2006).

Intervention activities within EAAD (2004–2005)	
Posters, placards produced	>40,000
Information leaflets, brochures distributed	>370,000
Videotapes, CD-ROMs, DVDs distributed	~4,500
Cinema posts, TV spots produced	8
Regional websites set up	8
Press releases, radio and TV appearances	~250
Public information events	~250
Information events, workshops for GPs	~150
Train-the-trainer courses for gatekeepers	~20
Training courses for community facilitators	~200
Emergency cards distributed	32,000
Establishment of crisis help-lines, other counselling offers	11
Foundation of self-help groups	25

Perspective

Due to the heterogeneity in the structure of the health care systems as well as social service organisations amongst participating countries, there is not a single, uniform approach to initiating local networks and expanding them to a national level. Our experience, though, has been that the overall programme of the EAAD is flexible enough, so that it can be applied to a variety of systems and societal structures. In some countries the existing local networks are in the process of expansion from their regional activities to other regions or to the national

level (e.g., Switzerland, Austria, Italy, Estonia). In others, such as Iceland, the approach was a national one from the beginning. This process depends not only on the structure of the health care system in the different countries, but also on the integration of the EAAD activities to other national mental health initiatives. Switzerland, with its federalistic health care structures, may serve as an example to describe the former development: in the beginning a single region (Kanton Zug) adapted the original NAAD concept and implemented a respective programme. This activity was mainly driven by a cantonal health minister who gained support of several service providers in the field of mental health and other services. A second regional alliance against depression was initiated soon afterwards (Kanton Bern). On the basis of these local experiences and the ongoing mental health policy process, the Swiss Federal Office of Public Health decided to support the aim of spreading the EAAD initiative nationwide as an umbrella structure. The process of dissemination from regional to multi-regional or national activities against depression and suicidality has a strong bottom-up element or, in other words, is driven by the identification of the regional organisers and initiators with their regional alliance. This is the key for the success of EAAD as an extremely cost-effective European mental health programme.

Acknowledgement

The European Alliance Against Depression is funded by the European Commission, DG Sanco, Grant No 2005323. The Kompetenznetz 'Depression, Suizidalität' is funded by the German Federal Ministry on Education and Research.

Statement of interest

The authors have no conflict of interest with any commercial or other associations in connection with the submitted article.

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