European Alliance Against Depression

How to implement a 4-level community-based intervention targeting depression and suicidal behaviour

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Content

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1. INTRODUCTION

This manual is a guide for planning, implementing and evaluating a community-based suicide prevention programme.

Specifically, this handbook provides practical advice and explains the process of planning, implementing and evaluating the intervention, from the first ideas to the dissemination of results – step by step.

This manual is intended for use by researchers, health professionals and all others who intend to start community-based suicide preventive programmes.

This manual is distributed by the European Alliance against Depression (EAAD).

Specifically, the insights and suggestions provided in this handbook were gained through prior programmes: the Optimising Suicide Prevention Programmes and their Implementation in Europe (the OSPI-Europe study) and the Nuremberg Alliance against Depression. OSPI-Europe was a collaborative research project funded by the European Commission under the Seventh Framework Programme from 2008 - 2013. The result is an optimised and evidence based suicide intervention programme that focuses primarily on improving care for patients with depression.

The scientific background and the scientific results of OPSI-Europe are and will be presented elsewhere. The purpose of this manual is to share the practical lessons learnt and provide concrete implementation steps.

1.1 BASIC STRATEGY AND CONCEPT

- **To simultaneously target non-fatal suicidal acts (NFSA) and completed suicides**
  Suicide is a crucial public health problem worldwide. According to World Health Organization (WHO) estimates, 804,000 suicide deaths occurred worldwide in 2012. This represents an annual global age-standardized suicide rate of 11.4 per 100,000. Additionally, the rate of non-fatal suicidal acts (NFSA) is more than 20 times higher (World Health Organization 2014). In Europe, suicide is one of the ten leading causes of death (WHO/Europe, 2004).NFSA and suicide deaths have different demographic correlates.. For example, in most countries risk for NFSA is highest in younger females, whereas that for completed suicides in older males. However, both are also closely linked. Specifically, the risk for death by suicide after engaging in an act of NFSA is around 10% (Runeson et al. 2010). Prevention programmes that address both phenomena therefore have the potential to reduce not only non-fatal suicidal acts, but suicides (Hegerl et al. 2009). Therefore, the reduction of both NFSA and completed suicides should be the aim of the intervention.

- **To simultaneously address suicidal behaviour and the care of depression**
  Suicidal acts are strongly connected with psychiatric disorders, especially depression.

About 90% of all suicides occur in the context of psychiatric disorders, of which the majority are depressive disorders (Mann et al. 2005; Yoshimasu et al. 2008).

The lifetime prevalence of depressive disorders in the general population is 12-17%. However, only a minority of those affected receive evidence-based treatment. There is therefore a large range in the quality of care received. This can and should be addressed by suicide preventive interventions.

- Intervention focus can be adapted depending on the target group
  When addressing the general public with the public relations (PR)-campaign, the focus of the intervention should be shifted to depression. This is because campaigns focussing on suicide entail the incalculable risk of triggering in population subgroups unfavourable effects, such as increasing cognitive availability and Werther-effects. When addressing health professionals or community facilitators, a stronger focus can be given to suicidal behaviour and it´s prevention. This flexibility is considered to be a considerable advantage of combining suicide prevention with improved care of depression.

1.2 Evidence-based measures and multi-level suicide prevention programmes

Previous studies have provided evidence for the effectiveness of various individual suicide preventive interventions such as those listed below.

Raising public awareness of depression may help prevent suicide.

The most recent systematic review of suicide prevention strategies concluded that there is currently insufficient evidence to recommend public education campaigns for suicide prevention (Zalsman et al., 2016). However, several observational studies have shown that public awareness campaigns are linked to increases in calls to crisis helplines (Jenner et al., 2010; Till et al., 2013; Oliver et al., 2008), but not a decrease in suicide (Till et al., 2013).

Similarly, The Defeat Depression Campaign, implemented in Great Britain in the 1990s, led to small increases in public awareness about depression and treatment for depression (Rix et al., 1999). The program consisted of a public awareness campaign and knowledge-transfer about depression. However, since this study was uncontrolled, further evaluation is needed.

Training general practitioners (GPs) helps to improve the detection and treatment of depression.

Suicide decedents are more likely to make contact with general practitioners than with mental health care providers in the time preceding their death (Luoma et al., 2002). Up to 70-80% of the population are in regular contact with their GP (Althaus, Hegerl 2003) and in developed countries, primary care practitioners manage most cases of depression (Kovess-Mafesty et al., 2007; Vasiliadis et al., 2005). Training GPs to better detect and treat depression might therefore improve the care of depressive patients, either by the prescription of antidepressants or referrals to psychological or psychiatric care.

Indeed, pharmacological treatment of depression is currently a recommneded suicide prevention strategy (WHO, 2014; Zalsman et al., 2016). This is supported indirectly by

ecological data from 29 European countries showing clear inverse relationships between changes in the prescription of antidepressants and changes in suicide prevalence (Gusmao et al., 2013). Correspondingly, three quasi-experimental poplulation-wide studies in Sweden (Henriksson & Isacsson, 2006), Hungary (Szanto et al., 2007), and Slovenia (Roskar et al., 2010) also showed significant increases in antidepressant use alongside decreased suicide rates.

Current evidence does in fact support training general practitioners to detect and treat depression as an evidence-based suicide prevention strategy (Zalsman et al., 2016). There have been a number of studies since the so-called Gotland studies (Rihmer et al., 1995; Rutz et al. 1989) that provide evidence for this as a method for reducing rates of suicidal behaviors (Mann et al., 2005; Söderqvist & Mittendorfer-Rutz, 2009).

The strongest evidence comes from three quasi-experimental ecological studies (aside from the Nuremberg studies) that investigated the impact of training general practitioners to recognize and treat depression in lowering suicide rates in the general population (Henriksson & Isacsson, 2006; Roskar et al., 2010; Szanto et al., 2007). All three showed a significant increase in antidepressant use and two were associated with decreases in suicide rates (Henriksson & Isacsson, 2006; Szanto et al., 2007). One of the programs contained multiple components (Szanto et al., 2007), and therefore the effectiveness of general practitioner training could not be separated from the other elements of the intervention. In a more recent large-scale study of older adults in Japan, the use of depression screening and psychiatrist follow-up lowered the rate of suicide by 61% (Oyama et al., 2010).

It should be noted that the roles and outcomes of general practitioners in the suicide prevention literature vary, and not all approaches are currently recommend. For example, while GP training for detecting and treating depression is recommended, there is at present insufficient evidence to recommend a second primary care approach, which is screening directly for suicidal behaviors (LeFevre, 2014; Zalsman et al., 2016). Similarly, pharmaceutical therapy for depression is indicated for preventing suicide, but results from a recent Cochrane Collaboration systematic review indicate that more evidence is needed in order to recommend pharmacologic treatments for adults who have already engaged in self-harm (Hawton et al., 2015).

Focusing on high-risk groups helps to prevent repeat suicidal acts.

Individuals who have made a suicide attempt are at high-risk for further suicidal behaviour. At present, there are several promising strategies for preventing the repetition of suicidal behaviour. Conversely, there are some approaches that show no evidence of effectiveness.

The most promising strategies mostly involve provisions for follow-up care. For example, collaborative care with primary health-care services has been shown to be feasible, acceptable, and superior to standard care in reducing suicidal ideation (Comtois et al., 2011; Cooper et al., 2006; Nielsen et al., 2011). Following up and providing community support to people who have attempted suicide decreased the number of repeated attempts (Hvid et al., 2011; Bilen et al., 2014) and suicides (Fleischmann et al., 2008; Pan et al., 2013) in some but not all studies (Luxton et al., 2013; Morthorst et al., 2012; Johannessen et al., 2011).

For suicidal adolescents, family-based interventions have consistently shown decreases in suicidal ideation and suicide risk factors (Diamond et al., 2010; Hooven et al., 2010; Pineda et al., 2013; Warff et al., 2012) that are superior to routine care. However, one social support intervention for suicidal adolescents, the Youth-Nominated Support Team, showed very limited positive effects on repeated suicidal behaviors (King et al., 2006; King et al., 2009).

Patients who had attempted suicide and received a combination of three therapy sessions, regular follow-up contact, and personalized letters over a 24 month period were less likely than the control group to repeat suicide attempts (Gysin-Maillart et al., 2016).

On the other hand, there are several strategies that are not recommended or that need more evidence to support their effectiveness. For example, there is currently no evidence that emergency cards are superior to treatment as usual in reducing repetition of self-harm or suicide attempts (Hawton et al., 2016). Similarly, the most recent Cochrane Collaboration review concludes that there is little support for group-based psychotherapy for adolescents who have self-harmed (Hawton et al., 2015). Sending regular postcards is also ineffective in reducing repeat suicidal behaviour in high-income countries (Beautrais et al., 2010; Robinson et al., 2012).

Restricting the access to lethal means is an evidence-based measure to prevent suicidal behavior.

Restricting access to lethal means by installing physical barriers at hot spots leads to a reduction in suicides (Cox et al. 2013, Zalsman et al. 2016). In one study, structural interventions at suicide jumping sites led to a reduction in suicides by jumping (Pirkis et al. 2013). Restrictions of access to other common means of suicide such as firearm regulations, detoxification of domestic and motor vehicle gas as well as toxic pesticides have also been shown to contribute to lower suicide rates (Sarchiapone et al. 2011).

Combining different prevention strategies is recommended by research and policy makers

Reviews of evidence-based suicide prevention measures conclude that a combination of different strategies is most effective in reducing suicide rates (Hegerl et al. 2013, Zalsman et al. 2016). The combination of approaches may vary by region or in different communities. In support of such flexibility, the World Health Organization (2014) recommends national suicide prevention strategies that allow communities to focus on their own specific needs. The Office of the Surgeon General and National Action Alliance for Suicide Prevention also maintain that suicide prevention requires the cooperation of people in many sectors including government, health care, business, media, and education (U.S. Surgeon General and The National Action Alliance for Suicide Prevention 2012).

Combining different strategies is also effective and leads to synergistic effects

By combining several suicide prevention approaches in a multi-level intervention programme, synergetic effects can be expected (Althaus, Hegerl 2003; Hegerl et al. 2009; Hegerl et al. 2013; Harris et al. 2016). That is, the effect of the complete intervention programme exceeds the sum of the effects of the single intervention levels:

- A multi-level-study for suicide prevention, implemented in a region with a high suicide rate in Japan between 2001 and 2006, led to a remarkable reduction of the suicide rate (from 70.8/100,000 to 34.1/100,000 in test regions, from 47.8 to 49.1 in control regions) (Motohashi et al. 2007).
- The Nuremberg Alliance against Depression (NAD) was a four-level suicide prevention programme implemented in Germany between 2001 and 2002. The intervention focused on suicide deaths as well as non-fatal suicidal acts. The program led to a significant reduction in the numbers of suicidal acts (-24%), mostly because of the reduction of non-fatal suicidal acts (-26.5%). Compared to baseline rates in the year 2000, reductions were sustained in the follow-up year, 2003 (-32.4%) (Hegerl et al., 2010).
- In an augmented version of the NAD four-level approach, the OSPI-Europe project (Optimising Suicide Prevention Programmes and their Implementation in Europe), the focus was on exploring synergistic interactions between the four interventions. Results revealed synergies within and across the multiple levels of the programme (Harris et al., 2016).
- The European Alliance against Depression (EAAD) programme was implemented in the town of Szolnok in Hungary. Effectiveness was assessed by comparing changes in suicide rates before and after the intervention in the intervention versus the control region (Szeged). For the duration of the programme and the follow-up year, suicide rates in Szolnok were significantly lower than the average of the previous three years (Szekely et al., 2013). The suicide rate thus went down from 30.1 per 100,000 in 2004 to 13.2 per 100,000 in 2005 (−56.1 %)14.6 in 2006 (−51.4 %and 12.0 in 2007 (−60.1 %)This decrease of annual suicide rates in Szolnok after the onset of the intervention was significantly greater than that observed in the whole country and in the control region. The decrease in suicide rates was the same for men and women.

The 4-level approach of the European Alliance against Depression

The European Alliance against Depression (EAAD), first funded by the European Commission and now functioning as an independent non-profit organisation, was based on the findings of the Nuremberg Alliance against Depression. The insights and experiences from these projects

were then combined with those of the OSPI-Europe project. This resulting optimized 4-level approach which is displayed below, is disseminated by the EAAD across Europe.
The four levels of the EAAD-approach for suicide prevention are:

1. Cooperation with primary and mental health care practitioners: focusing on general practitioner training to identify and improve the treatment of depression
2. Public relations activities: education of the public with a depression awareness campaign
3. Cooperation with community facilitators and stakeholders: focusing on gatekeeper trainings for professional groups to improve the recognition and referrals of depressive persons to care, as well as restricting access to lethal means
4. Support for patients, high-risk groups and their relatives (low-threshold offers)

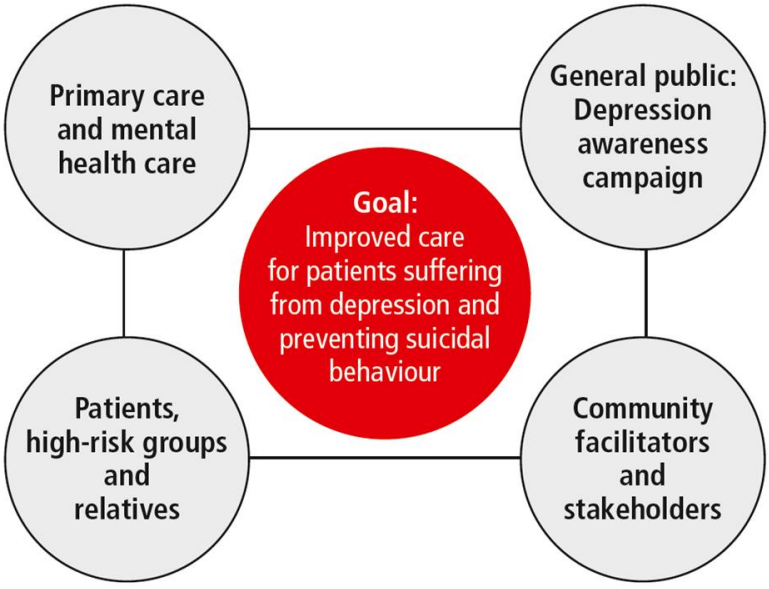

Figure 1: The four levels of intervention

- The EAAD 4-level intervention (Figure 1) can be adapted to the local context to include the measures most needed and feasible to a specific region.
- Local initiatives and actors should be invited to be part of the local alliance and form a network to target the common goal of suicide prevention (Figure 2).

Figure 2: Potential partners and actors in suicide prevention programmes

1.3 Membership in the European Alliance Against Depression (EAAD)

If you are thinking about implementing a multi-level suicide prevention programme, EAAD membership will help.

New EAAD members are always welcome and we look forward to sharing experiences, disseminating the 4-level approach as well as undertaking future research activities together. Listed below are the different opportunities for joining us.

The different opportunities of becoming an EAAD member are:

1. **Become a National Chapter**

   You can become the national chapter of your country if there is not already one established. This will allow you to act as the national leading centre. A national chapter acts as an umbrella organisation for regions that are interested in cooperating and implementing the 4-level-approach.

   EAAD membership includes:

   - Support with implementing the 4-level intervention programme in your region/country
   - Adaptation, use and implementation of the iFightDepression self-management programme for mild forms of depression
   - Assistance with adapting EAAD intervention materials to meet your specific regional requirements

- Opportunities to exchange experiences with other researchers and experts all over Europe via our established network
- Participation in international research projects targeting depression and suicidality
- Support with national and international grant applications
- An annual membership fee, which reflects countries' GDP level and varies between 1500 and 6000 Euro per year (as of April 2016)

If there is already a national chapter in your country and you would like to establish a regional alliance, please contact your national chapter or the coordination centre. Materials and support for the 4-level-approach will then be provided.

2. Become an Associate Member
   In addition to national membership, you can also become an individual or associate member.

3. Become a Supporter
   If you wish to support our ideas, work and national and international research on depression and suicide prevention, you can also support us with a financial contribution.

For further information, contact us via e-mail or phone or visit the homepages: www.eaad.net or www.ifightdepression.com.

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2. GUIDELINES FOR SUICIDE PREVENTION

2.1 Overview

The key principles of the EAAD intervention programme are:

- Depression can affect everybody.
- Depression has many faces.
- Depression can be treated.

The process of implementing 4-level suicide intervention programme can be broken down into the steps and tasks shown in Figure 3.

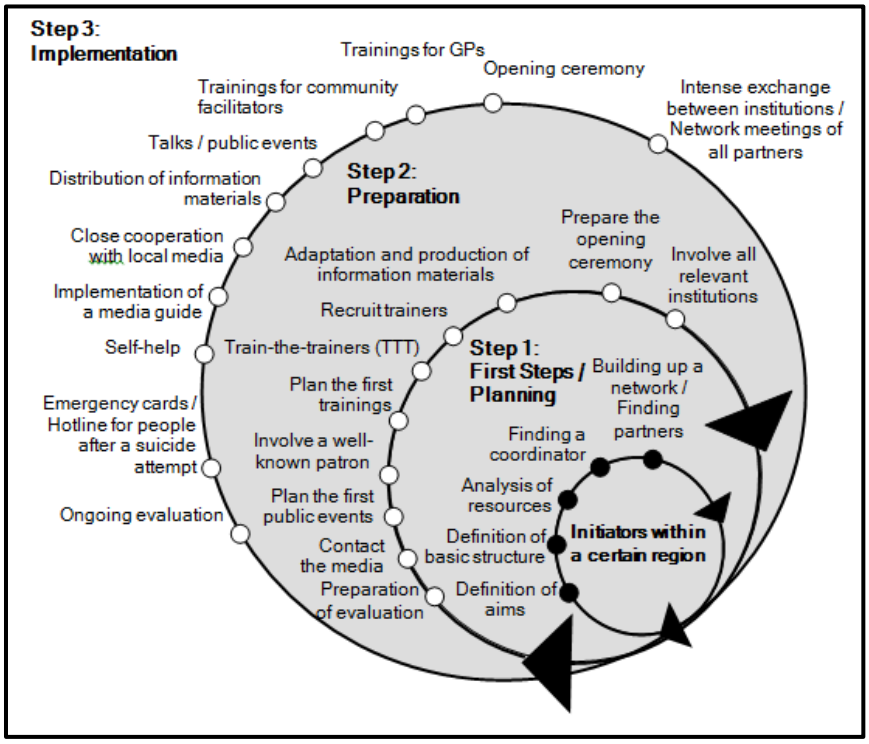

Figure 3: Stepwise approach to planning, preparing and implementing the 4-level intervention

The following chapters give detailed step-by-step suggestions for initiating and bringing to fruition a multi-level suicide intervention programme.

The checklists repeat and refine the information given in the text. These are meant to be lists of possibilities and recommendations.

This document is not meant as a static text, but will be continuously improved in the coming years to provide professional and up to date support.

General Advice

- Allow sufficient **time for planning**. Networking and recruiting collaborators may especially require time, but is well worth the investment.
- Determine whether there are **existing suicide and depression programmes.** The aim should not be to establish a competing programme. Rather, seek to develop activities which complement and are integrated into existing local programmes to form one large network.
- In many countries (e.g. Germany with over 75 regional alliances), a strong **bottom-up-approach** is important. New programs and members should identify themselves and collaborate with existing regional alliances against depression. Therefore, it should be avoided that one person or a single institution (e.g. a university hospital) dominates the alliance. This may trigger resistance in other stakeholders. Subtle signs such as the location of the organisational meetings take place are important. A bottom-up approach will enable the collaboration and buy-in from local care providers and help ensure their commitment.
- Emphasize that the common goals are **suicide prevention and improving the care of depression**. These aims can only be achieved through collaborative efforts. Make potential partners part of this effort by creating feelings of inclusion.
- If necessary, apply for additional funding, perhaps from multiple resources, in order to maximise the intensity of the intervention.
- Try to hold **network meetings** in community facilities (potentially alternating between different partners) to highlight the community-based nature of the intervention programme.
- Invite potential partners and stakeholders to meet on "neutral ground" (e.g. not in the leading department), to avoid conveying feelings of possession or power.
- Whenever possible, recruit **volunteers**. Some of these actors might be personally affected by depression, which will contribute a valuable patient perspective to the programme. Volunteers with different backgrounds and professional experience often show high levels of commitment and can assist with the workload in a cost-effective way.
- Find a **prominent patron** who is not necessarily affected by depression, but is supportive of the programme. This is especially important in the early stages of the intervention, as it will facilitate acquiring the cooperation of other important stakeholders.

2.2 Organisation of the project

2.2.1 First steps

Community members and stakeholders who want to initiate a suicide prevention programme should take the following first steps, which are elaborated below:

- Networking and finding partners (Checklist 1)
- Identifying a programme coordinator (Checklist 2)
- Analysing available financial and personal resources (Checklist 3)
- Defining programme aims: "As Is" and "To Be"-analysis (Checklist 4)
- Defining the basic programme structure, including the exact intervention region (e.g. postal codes) (Checklist 5)

Networking and finding partners (see also Checklist 1)

- Programme initiators can be single persons (e.g. a school director, health politician), small organisations (e.g. a self-help group) or institutions (e.g. a hospital).

- The initiators define the region in which they want to implement the programme.
- They also decide if they want to form an advisory board (i.e. a group of experts as external advisors without practical tasks in the project)
- Try to identify a wide network of stakeholders (i.e. decision makers / cooperation partners of the project region), which is very beneficial to the reach and effectiveness of the programme.
- Analyse the existing general health and mental health care systems to identify important actors in the region. Draw a map of the network of potential stakeholders.
- For efficient and satisfactory cooperation, the commitment of all involved is high. Previous personal links are of benefit to increase involvement.
- Existing initiatives of the local health care should be included in the preparation process as members of the advisory board or as stakeholders. This adds to the cooperative approach and helps to avoid the impression of a competing initiative that is build up in the region.
- Further important stakeholders or potential sponsors get involved in the preparation phase of the project. This leads to identification with the project. Other important groups are independent organisations for affected and their relatives. Have in mind that the involvement of key stakeholders and gatekeepers should not place too many demands on their time. When inviting them for participation it is helpful to outline the frequency of meetings or tasks.
- A small steering group (about 2 -5 people) for leadership of the project should be formed.

Organisation of the project – First steps – Checklist 1

Network and find partners	
• Define the target region of the project, e.g. a certain community, a city, a county	☐
• Point out important actors and draw a map of the potential network.	☐
• Identify and recruit potential actors in health care, e.g. see figure 3	
◦ Public health office	☐
◦ Hospitals (in- and outpatient treatment)	☐
◦ Associations of general practitioners / psychiatrists	☐
◦ Small non-governmental organisations (NGOs) in psychiatric health care (e.g. assisted living, counselling)	☐
• Identify and recruit other potential stakeholders, e.g.	
◦ Local politicians	☐
◦ Media representatives	☐
◦ Clergy	☐
◦ Police	☐
• Gain monetary and practical support from sponsors other than from pharmaceutical companies to ensure the credibility of the project:	
◦ Health Insurance companies and other institutions, possible those with an economic interest in suicide prevention	☐
◦ Public funding (e.g. health ministry)	☐
◦ Foundations and charity organisations	☐
◦ Private persons	☐
◦ Companies which can help with monetary resources, printing, meeting or training room provision	☐

• Check for good practice in the defined region for successful funding.	☐
• Do not cooperate directly or indirectly with the pharmaceutical industry; the EAAD consortium has decided to avoid such cooperation because they undermine the credibility of the EAAD as well as of the regional alliances against depression.	☐

• Identify and recruit representatives of other important groups / affected persons
  • Self-help groups
  • Small NGOs for affected people and their relatives
	
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• Contact these actors and invite them to individual meetings.
  • Present your project and propose concrete ideas for support per letter.
  • Explain the project to the potential partners, ideally in personal meetings.
  • Prepare digital presentations and printed materials for these meetings.
	
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• Include existing initiatives, important stakeholders and potential sponsors as members of the advisory board in the preparation process.	☐

• Organise a kick-off event and subsequent preparatory project meetings.
  • Find a date suitable for most of the actors (e.g. not in vacation time).
  • Find a suitable room (e.g. concerning size, location, accessibility).
  • Send out invitations including an agenda.
  • Prepare presentations for the meeting.
  • Prepare catering.
	
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• Invite key players to form the advisory board.
  • Form a steering group for leadership of the project.
  • Define initial responsibilities and tasks.
	
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Find a programme coordinator (see also Checklist 2)

A project coordinator will be needed to allow for a good flow of information, the integration and the concrete organisation of the multi-level activities. This can be a person already working within the health care system so that he or she can conduct the coordination tasks within their regular work. It might also be an option to carry out this task on a voluntarily basis. However, experience shows that a coordinator with good organisational and communication skills is crucial. The most feasible option might therefore be to employ a coordinator with at least a 50% part-time position. If there are several intervention sites, several local coordinators and one overall coordinator are recommended.

Find a programme patron (see also Checklist 13)

If possible, find the most prominent and broadly respected person in the region. He or she does not need to have any connection with depression or suicide, but should be willing to publicly support the programme. A prominent patron will facilitate gaining the support and cooperation from many partners. Therefore, a patron should be found early in the preparatory process.

Organisation of the project – First steps – Checklist 2

Find a programme coordinator	☐
• The task of the coordinator is the management of the 4-level-intervention programme. This involves processes of planning, implementation and monitoring / controlling. The main task is to assure that the defined aims are reached with the given resources	

(budget and staff) in the proposed time.	
• Concrete tasks of a coordinator can include: - Keeping constant contact with all internal partners - Keeping contact with external actors such as sponsors or media representatives - Setting up a suitable communication system, including a potential newsletter-databank - Planning and organising project meetings - Coordinating all activities in relation to the intervention levels - Planning and overseeing financial resources - Coordinating evaluation activities (preparation of questionnaires, data assessment/analyses) - Looking for sponsors	
• Helpful requirements for this position are: - Strong communicative, social and organisational skills - Background knowledge about depression and suicide prevention (ideally a health-care professional) - Experience with and knowledge of the local health care system - Professionalism so as to be taken seriously by the potential partners - Support from the project leaders (steering group) and the advisory board - Sufficient time, including a fixed consultation hour for network partners - A high level of commitment	
• Find a host institution: Try to cooperate with a bigger institution like a university or a hospital, which could release one of their personnel for the project. or • Find dedicated funding for remuneration of the coordinator.	□ □
• Best employed with at least 50% part-time position	□
• If the programme is to be implemented in several regions, find local coordinators and one overall coordinator.	□

Analyse financial and personal resources (see also Checklist 3)

The availability of financial resources will partly determine which intervention levels your suicide prevention programme is able to implement. There are also organisational issues related to finances. Specifically, the project should be connected to an existing institution, and if not, a separate project bank account should be established. The project leader should be responsible for managing the finances. If the project does not have a coordinator, a member of the steering group should be appointed to this role.

When calculating the programme budget, take into account personnel costs, expenses related to implementing the different programme levels, evaluation costs, and any fees for regular project meetings. These costs will depend on the local circumstances in the project region. EAAD can help with various aspects of cost planning, such as providing rough budget estimates.

Decide which intervention levels are to be implemented given the available financial resources. However, as explained in Chapter 2, it is highly recommended that the complete four-level-programme be implemented in order to achieve synergistic effects. The more actions that can be simultaneously implemented, the greater the chances are for achieving strong results.

Organisation of the project – First steps – Checklist 3

Analysis of financial and personal resources	
• Estimate the overall financial needs for the project.	☐
• Search for potential sponsors other than pharmaceutical companies. • Refer to Checklist 1	

• Opportunities for lowering costs
  • Recruit volunteers, especially among the partner-organisations of the project, affected people and students of psychology, social sciences etc.
  • Establish relationships with companies that can support the project with their services (e.g. printing or disseminating materials for the public campaign)
  • Try to find rooms for your meetings that are available free of charge, potentially through one of the partner-organisations
  • As the salary for the coordinator is a remarkable budgetary item, try to cooperate with a bigger institution like a university or a hospital that might be willing to release one of their personnel for the project.
  • Explore the possibility of volunteer trainers for train-the-trainer (TTT)-workshops.
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• Organise a project bank account.	☐
• Identify a person responsible for managing the finances.	☐
Decide which levels are to be implemented on basis of the financial resources. Include concrete aims of checklist 4 in this decision.	☐

• Estimate personnel costs
  • Project coordinator: at least 50% part-time position
  • Assistants for implementation and evaluation
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• Estimate the costs for implementing levels 1 and 3:
  • Adapting and printing training materials
  • Producing educational DVDs
  • Developing invitations for training events (printing, mailing)
  • Remunerations for trainers of TTT-workshops
  • Costs for reducing the access to lethal means
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• Estimate the costs for implementing level 2:
  • Adaptation, printing and distribution costs for materials (e.g. flyers, posters)
  • Costs for give-aways
  • Production costs for further informational material (e.g. CDs, DVDs)
  • Distribution costs for awareness spot(s) (in cinemas, TV or radio)
  • Costs for website design, programming and webhosting
  • Costs for the opening ceremony and subsequent public events
  • Costs for advertising the campaign as well as the distribution of the campaign material
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• Estimate the costs for implementing level 4:
  • Production and distribution of emergency card
  • Founding or support of existing self-help initiatives
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• Offers for high-risk groups	☐
• Estimate the costs for evaluation (see also Checklist 18):	☐
• Adaptation and printing costs for questionnaires	☐
• Costs for general population survey	☐
• Costs for media evaluation (subscription, archives)	☐
• Costs for population suicide data	☐
• Costs for assessment of suicide attempt data	☐
• Estimate the costs for regular project meetings	
• Define the frequency of the meetings.	☐
• Estimate the costs for rooms and catering.	☐
• Estimate the costs for hotels for the participants.	☐
• Estimate the travel costs	
• Travels to project and network meetings, conferences etc.	☐

Program aims, structure, and timeline (see also Checklist 4)

Define programme aims

The general objective is to prevent non-fatal and fatal suicidal acts and to improve the care of patients with depression. When further developing these aims, it is important to gather current information (the "As Is" state) such as the number of suicide deaths that that will help determine project goals (the "To Be" state). Specific objectives can be derived by comparing the "As Is"-state with the "To Be"-state. The programme goals should be concrete specific statements that describe what the intervention objectives as well as how those aims will be achieved. The SMART acronym (Specific, Measureable, and Acceptable for the Target Group, Realistic, and Time-Bound) can be used as a tool for formulating your goals. For example, one aim might be to reduce the number of non-fatal and fatal suicidal acts by 15% within the next three years.

Define the basic programme structure

Explore the possibility of joining existing organisations such as a department of psychiatry or a self-help organization. If no suitable partner is found, forming an NGO (non-governmental organisation, no-profit association) might be useful. This will create a bit of new administrative work, but has also advantages. Specifically, the project will then have a defined legal form, which will facilitate applying for additional programme funding and obtaining donations. The EAAD can assist you with this as well. When it is possible to form an institutional collaboration, a new local Alliance against Depression can be established with the signing of a formal cooperation agreement.

Create a programme timeline

The timeline for the intervention can be divided into the planning/preparation and the implementation phases. The proposed time allowances listed below are based on the experiences of existing local Alliances against Depression.

- Networking / finding partners

… up to 6 months

- Preparation including finding sponsors, recruiting / training speakers and trainers, planning events, preparing materials

… up to 9 months

- Time from the very first steps to the opening ceremony and start of the intervention

… up to 1 – 1.5 year(s)

Consider the duration of the project. Your programme can either be with or without a defined start and end point. When considering project duration, be sure to include the suggested time periods for each of the project phases and levels. For help with estimating these time frames, refer to each programme phase's respective chapter. Also, carefully consider the best time to begin implementing programme activities.

It is important to start the intervention with a big public opening ceremony at the most prominent public place in your region (e.g. city hall). The mayor and all other important regional stakeholders such as politicians should be invited. There should also be a press conference. These details and attendees will help draw considerable public attention. At the time of the opening ceremony, the first programme activities should already be planned. This will maximize the potential for the synergistic effects of raising awareness with the opening ceremony and the start of the campaign.

Organisation of the project – First steps – Checklist 4

Definition of aims	

• Define the "As Is"-state
  • Point out the state of things that need to be changed.
  • Examples: numbers on suicides and suicide attempts, data on depression and its possibilities of treatment, e.g. numbers of antidepressant prescriptions, waiting time for treatment
	☐
	☐

• Define the "To Be"-state
  • Point out the aspects that need improvement.
  • Examples: a reduction of the numbers of suicidal acts, an increase of antidepressant prescriptions, a reduction of waiting time for treatment
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• Formulate the specific objectives.
  • … concretely, SMART (see text)
  • … as if it already was true
  • Example: "The numbers of suicidal acts dropped by at least 12% in the last 5 years."
	☐
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Definition of basic structure	

• Explore the following possibilities to join in the structure of existing organisations.
  • Include the suicide prevention project in an existing public initiative, NGO or institution of the defined region.
  • Found an own NGO.
  • Join the EAAD, set up a cooperation treaty and found a new local Alliance against Depression.
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Timeline	
• Define the duration of the project. • Plan a sustainable organisation without any given end-point of the activities.	☐ ☐

• OR • Establish a project with a given duration and defined start and end point.	☐
• Define the time spans needed for the project phases and levels. • Refer to the respective chapters. • Define milestones.	 ☐ ☐
• Define the start point of the project. • Make sure you can reach the target groups. • Example: Avoid vacation times. • Try to reach the target groups for intervention activities at a convenient point in time. • Example: Avoid months with potentially a lot of ill people to reach GPs. Avoid end-term periods to reach teachers.	 ☐ ☐
• Start the intervention with a public opening ceremony and a press conference. • Refer to checklist 5	 ☐

2.2.2 Preparation

Involve all relevant institutions (see also Checklist 5)

All project members should come together for a kick-off meeting. This meeting should take place during the preparation phase and as soon as the network is established. As in the networking process, it is important to emphasize that the planned intervention is complementary to existing initiatives in the defined region. During the preparation and planning phase, regular project meetings are crucial, as most questions and fundamental decisions will occur during this phase. In these meetings, concrete tasks for the different actors should be developed and the respective work packages or teams defined. If necessary, interventions at several different intervention sites should be synchronised.

Involving a well-known patron is crucial for programme success and public awareness (see chapter 2.4.2, Checklist 13).

Organisation of the project – Preparation – Checklist 5

Involve all relevant institutions	
• Set up a newsletter system or a mailing list for internal use.	☐
• Organise a kick-off meeting to symbolise the start of the programme. • Find a date suitable for most of the actors. • Find a room and organise the catering. • Prepare and send out invitations to all partners of the project. • Prepare presentations and information materials (e.g. handouts) on the status quo. • Prepare name tags and an agenda. • Introduce all partners so that they get to know each other. • Introduce the advisory board, steering group members and the coordinator. • Motivate the group to collaborate closely. • Present and discuss the first ideas to split up the tasks as developed according to Checklist 1.	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
• Explain the added value of the programme beyond existing initiatives.	☐

• Introduce the programme as a joint-action of many involved with the common goal of suicide prevention and improvement of the care of depression. • Present the project as a complementary offer for the defined region. • Emphasise the value of existing local services to avoid competition. Decide commonly on intervention measures most needed and define those that are fulfilled by existing initiatives. • Identify other available community measures that link in with suicide prevention and are not (yet) part of the 4-level-intervention concept and discuss their inclusion.	☐ ☐ ☐
• Organise regular and frequent project meetings. • Decide about the frequency and structure of the meetings (involvement of all vs. sub-groups for different levels and other activities, e.g. finances, evaluation) • Find suitable dates on a regular basis depending on the needs of the sub-task like "every first and third Monday of the month for the public relations team". • Find a room and, if needed, organise the catering. • For overall meetings: Prepare and send out invitations to all partners of the advisory board, the steering group, stakeholders and volunteers. • Prepare presentations and information materials on the status quo.	☐ ☐ ☐ ☐ ☐
• Define teams / work packages. • Define concrete tasks for the different actors and a related timeline for organisation, the different levels (see respective chapters), and evaluation. • Formulate respective work packages and their concrete contents. • Specify the steps leading to the intermediate and final goals.	☐ ☐ ☐
• If necessary, synchronise interventions at several intervention sites. • Ensure comparability of the intervention across the sites when defining the respective tasks, work packages and timelines. • If evaluation is wanted, ensure comparability of data assessment across the sites and try to keep similar timelines.	☐ ☐

Prepare the opening ceremony (see also Checklist 6)

A large public opening ceremony is an opportunity to present your project to the public, the media and potential further partners and sponsors. The ceremony can easily be connected with a preceding press conference. Most materials for the opening ceremony can be obtained from the EAAD and have already been translated into several languages. Ideally, initial suicide prevention actions have already been planned and can be announced during the ceremony. This will help generate interest and increase the possibility for synergistic effects so that the project is effectively started.

Organisation of the project – Preparation – Checklist 6

Prepare the opening ceremony	
• Find a suitable date and location and organise the catering.	☐
• Decide on the format of the opening ceremony, for example	☐

• Scientific conference • Penal discussion • Cultural event	

• Set up an agenda.
  • Keynotes or greetings from well-known patrons or stakeholders
  • Scientific presentations or contributions
  • Further contributions (music, statements from a patient or relative, a representative of the EAAD…)
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• Prepare the press conference.	☐
• Set up a newsletter system or a mailing list for external use.	☐
• Prepare a list (preferably an excel-table so that you can send serial letters) of the important media including print, TV and radio, especially local media, and their contact persons.	☐
• Adapt / prepare the media guidelines for the journalists concerning suitable reporting on suicides. For details, refer to checklist 13 (level 2).	☐
• If resources allow, prepare give-aways with project logo, if applicable (e.g. ball-pens, key-rings). • Prepare handouts / cards with project coordinator's contact information.	☐

• Prepare and send out invitations including the agenda.
  • Invite all partners of the project.
  • Invite the journalists, also to the press conference.
  • Invite potential further partners and sponsors.
  • Invite members from the institutions that shall be trained in levels 1 & 3.
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• Adapt / prepare materials for the event.
  • Prepare your own presentations on the project.
  • Adapt / prepare the information materials (flyers, posters, brochures).
  • For details, refer to checklist 12 (level 2).
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• Prepare press-kits for the journalists to be handed out at the press conference.
  • Include press releases, if applicable.
  • Include a package of information materials.
  • Include the media guidelines.
  • Include give-aways.
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• Prepare signing lists.
  • Prepare signing lists for the project's newsletter.
  • Prepare signing lists for potential volunteers.
  • Prepare signing lists for participants to training sessions (levels 1 & 3).
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• Prepare a press release and send it out shortly before the event.	☐
• Prepare name tags for speakers and project partners.	☐

Evaluation planning

Steps taken to develop plans for evaluating your programme are presented in chapter 2.6.2. An important task during the overall preparation phase is to create a documentation system for all

programme activities. This will help ensure transparency and the giving of feedback to partners and sponsors.

The steps needed to prepare and plan for the different intervention levels are described in the following chapters.

2.2.3 Implementation

Communication between institutions and network partners

It is important to maintain effective and frequent channels of communication with all programme partners. Cooperating initiatives and institutions which are not formal project partners should also be contacted regularly, but less frequently. If there are several intervention sites, regular communication is even more important to maintain the efficient flow of information and to avoid potential misunderstandings. Regular project meetings are essential for maintaining cooperation. Project coordination is even more essential for larger projects, and in some cases, external project coordination may be required. During these meetings, evaluate the current status of all work and determine the important next steps. Allow room for discussion of ideas and problems. Plan the next steps together and find solutions for obstacles during the implementation process. Also, monitor the financial resources and compliance with the timeline.

Organisation of the project – Implementation – Checklist 7

Intense exchange between institutions / Network meetings of all partners	

• Maintaining effective channels of communication with all partners.
  • Send out regular news via internal newsletter or mailing list.
  • … especially when planning events, so that everyone knows what is happening when and whether their input might be required.
  • Encourage the partners to work pro-actively and if necessary, send friendly reminders of their responsibilities during implementation to enhance participation and the network capacity.
  • Give feedback on the partners' activities during implementation to ensure the motivation and work quality.
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• Maintaining less frequent, but regular contact with cooperating initiatives and institutions (e.g. stakeholders, sponsors).
  • Send out regular news via external newsletter or mailing list.
  • Maintain contact with one permanent contact person.
  • Give feedback on the activities the initiatives or institutions are involved in.
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• Maintaining regular contact and intense communication in the case of several intervention sites to assure a good flow of information.
  • Should problems or conflicts arise, the project coordinator can function as a mediator.
  • Use personal meetings as an opportunity to resolve difficulties.
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• Organising regular project meetings.
  • Find a suitable date and room and organise the catering.
  • Develop an agenda.
  • Prepare and send out invitations that include the agenda to all partners of the
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advisory board, the steering group, stakeholders and volunteers. • Prepare presentations and materials on the status quo.	☐ ☐
• Monitoring and coordinating the partners' activities and conduct regular meetings. • Encourage regular short reports from the partners on the status quo of their activities. • Keep a list of questions and difficulties related to the programme for common discussion during the next meeting. • During the meeting, ask them to report on the completed tasks and ongoing activities and report about the activities done by the coordinator • Go through the list of difficulties, identify solutions, and formulate corrective actions together. • At the end of a meeting, give information on the next steps and tasks.	☐ ☐ ☐ ☐ ☐
• Continuously monitoring financial resources. • Keep an overview of the money spent and how much is still needed. • As said above, maintain regular contact with sponsors and give feedback on the ongoing activities. • Invite them to project meetings and smaller personal meetings to ensure further funding.	 ☐ ☐ ☐

2.3 Cooperation with primary care and mental health care (Level 1) and community facilitators and stakeholders (Level 3)

In intervention Level 1, the goal of the trainings is to provide knowledge on depression and suicidal behaviour, particularly for depressed patients who present to primary and mental health care. The primary aim of Level 3 is to provide gatekeepers with knowledge and basic intervention skills for depression and suicidal behaviour. Journalists should also be trained on media guidelines. Finally, cooperation with various stakeholders should be sought in order to discuss efforts to restrict access to lethal means.

2.3.1 First steps

Define the professional groups that will receive the intervention Levels 1 and 3 (see Table 1 for possibilities). The number and type of professional group used by the Nuremberg Alliance against Depression (NAD) groups can be found in the annex.

Table 1: Possible professional groups for intervention Levels 1 and 3 (**core** & optional)

	Level 1	Level 3

Target group	Trainings for primary care providers
	- General practitioners (GPs)
	- Other primary care professionals, if applicable in project region: e.g.
	  - Primary care nurses
	  - Paediatricians
		Gatekeeper trainings for community facilitators, e.g.
		- Pharmacists
		- Priests (main religion)
		- Police
		- Teachers for the youth

	- Primary care psychologists - Primary care social workers **Trainings for mental health care professionals, e.g.** - **Psychiatrists** - **Psychotherapists**	- Carers for the young / elderly - Social / counselling centre workers - Hotline professionals - Prison professionals - Alternative practitioner - Enterprises health care professionals - Medical secretary - Undertaker - Taxi driver - Midwives - Paediatric and obstetric nurses **Media guidelines trainings for journalists** **Cooperation with stakeholders (restriction of access to lethal means)**

Prepare the content of the trainings. Prepare separate trainings for each of the respective target groups based on their special knowledge and needs. Start by defining the topics and key messages for each of the respective trainings. Professional groups requiring similar training contents can be combined into one training group. Another option is to have multi-disciplinary trainings involving participants from different target groups. Although considering their different respective needs might be a balancing act, multi-professional groups can enhance networking and improve care pathways, referrals and advice seeking. For greater acceptance of the trainings, consider applying for Continuing Medical Education (CME) accreditation (see also Checklist 8). Depending on local circumstances, this process may require several weeks or months.

Contact important stakeholders in the project region to begin collaborative efforts for restricting access to lethal means.

Level 1 & 3 – First Steps – Checklist 8

Define the target professional groups for trainings	
• Identify the professional groups to be trained during the project • Obtain information on each groups´ availability for trainings, for instance by random interviews before starting the project. • Gather information on the local needs in the defined region, perhaps by brainstorming with the project partners. • Find other important health care groups in the defined region.	☐ ☐ ☐ ☐
• Determine the best time for trainings for each respective group, for example *not* during: • Months with a lot of ill people for GPs • Vacation time for teachers • Big events in the defined region for police	☐ ☐ ☐ ☐
• If a systematic implementation involving evaluation is planned, define the minimal intensity (e.g. minimal number of trainings to be conducted) • Obtain the number of professionals for each target group in the defined region. • Calculate the minimal number of professionals to be trained using the formula	 ☐ ☐

provided in the annex	
Prepare the content for the trainings	
• Decide on the overall topics and key messages of the trainings, such as: • Epidemiology of depression, diagnosis and treatment, pathogenesis • Improving diagnosis and treatment of depression • Enhancing skills for treating depressed patients • Facilitating primary care and mental health care pathways and networks • Improving gatekeepers' skills and referrals into primary care • Media guidelines for journalists (see Checklist 10) to improve the quality of media reporting on depression and suicidal behaviour to prevent copycat suicides	☐ ☐ ☐ ☐ ☐ ☐ ☐
• Consider separate trainings for different target groups, taking into account their special knowledge and needs: • Considering GPs' diagnostic skills • Pharmacists' knowledge on antidepressants • Legal aspects of compulsory hospitalisation for policemen	☐ ☐ ☐ ☐
• Define the topics and key messages for each of the respective trainings. • Obtain and document information on the knowledge and needs of each professional group, via input from local partners or by interviews with professionals. • Compare the findings from the step above with the overall topics and key messages of your programme. • Prepare agendas for the different trainings. • Consider placing different professional groups with similar needs into one training group.	☐ ☐ ☐ ☐
• Consider the number of training sessions and the length of each session. • Potentially also prepare shorter versions (1-2 hours) of the trainings.	☐ ☐
• Ensure multi-professionalism by providing opportunities for networking such as: • An overall opening or closing event during the trainings. • With workshops or special networking events.	☐ ☐
• Apply for CME accreditation (consider the time needed for this): • Request the highest possible number of CME credit points. • Consider using the following arguments: 1. the trainings have already been accredited for CME in several countries; and 2. emphasize the trainings´ interactive elements such as the usage of diverse media and, if possible, evaluation of the trainings account for a number above the average of credit points.	☐ ☐
Contact important stakeholders to collaborate on restricting access to lethal means	☐
• Contact individuals in the public (e.g. a psychiatric coordinator) private sectors, as well as your project partners. Possibilities include: • Construction offices for assistance with barriers at bridges and buildings • Local politicians to support your means restriction plans	☐

• When contacting potential collaborators, send information on your project and if applicable, ask for help in defining the most commonly used lethal means as well as the location of suicide hot-spots. Clearly request assistance with restricting them.	□

2.3.2 Preparation

Adapt and produce informational materials. Prepare the training slides to reflect the earlier defined core topics and key messages. When doing so, consider professionals' special knowledge and needs, the latest research and make training modules practical. Any supplementary materials for the trainings should also be prepared.

Recruit trainers. Consider using a train-the-trainer (TTT) model to maximise capacity building and ensure longer term sustainability of your project. In this model, clinical experts are recruited as trainers and with minimal effort, a great number of participants can be reached (see Figure 4).

Figure 4: Characteristics of local trainers

Train-the-trainers (TTT). Organise the first TTT-sessions and train the trainers before the opening ceremony.

In line with the EU-funded research project PREDI-Nu(Preventing Depression and Improving Awareness through Networking in the EU"), a TTT including the referral of patients to the iFightDepression tool has been developed and is available in the EAAD Material Catalogue.

Levels 1 & 3 – Preparation – Checklist 9

Adapt and produce the training materials	
• Prepare the training slides for the different professionals' trainings.	□
• Include the core topics and key messages for each professional group according to Checklist 7, considering special knowledge and needs.	□
• Make reference to the latest research knowledge.	□

• Include practical training modules (e.g. role plays, group discussions) to increase the likelihood that skills will be used in daily work. • Share the training materials in advance with members of the target groups to ensure the relevance to their daily work.	☐
• Prepare supplementary materials. • Prepare information packages for professionals and patients (e.g. informational videos/DVDs for patients, educational videos/DVDs for GPs. EAAD members can derive these from EAAD materials. • Write and print a manuscript with the contents of the training. • Adapt and print the public campaign materials (refer to Checklist 12). • Prepare promotional gifts with the project logo (refer to Checklist 5).	☐ ☐ ☐ ☐
• Prepare the presentations for the TTT-sessions. • The TTT-sessions should focus on the training material, educational techniques and the transfer of information to the trainees.	☐
• Prepare and produce a general informational flyer on the trainings that includes: • A general description of the project. • An explanation of the importance of the trainings. • The basic content and aims as well as a short version of the curriculum. • State that the participants will receive practical materials for themselves as well as their patients.	☐ ☐ ☐ ☐
Recruit trainers	
• Identify clinical experts with the following skills and characteristics to serve as trainers: • Experience with depression and suicidal behaviour • Experience with training • A peer relation to the target group • Credibility	☐ ☐ ☐ ☐
• If experts external to the project are identified, contact them and invite them to become a trainer. • Send a personal invitation letter along with the training flyer. • Invite all interested potential trainers to a personal meeting. • Prepare digital presentations and printed materials for these meetings.	☐ ☐ ☐ ☐
Train-the-trainers (TTT)	
• Organise the first TTT-sessions. • Find a date suitable for most of the trainers (e.g. not during vacation time). • Find a room, ideally in the community setting. • Organise catering, if your budget allows. • Send out invitations to the TTT-sessions that include a short version of the curriculum. Invite them all together or if there are more than 20 trainers-to-be, group them according to their profession. • Plan networking events such as an overall closing event for the trainings.	☐ ☐ ☐ ☐ ☐
• Train the trainers before the opening ceremony, so that the first trainings of the target group can take place shortly after the event.	☐

Plan the first trainings. While training the trainers, find participants for the first trainings and organise the first sessions. The number of training sessions will depend on the size of the project region. Use a "top-down"-strategy for this: contact the institutions, not single persons. In the case of GPs, try to contact them personally or via their medical association. Prepare a documentation system for the registration of the participants. As mentioned in Checklist 3, there may be times to avoid for project-related events and training sessions of certain professional groups.

Cooperate with stakeholders. Hold a meeting with the identified stakeholders to identify the local hot-spots in the whole group and to define measures to restrict their access.

Prepare evaluations for the training sessions. Prepare questionnaires to evaluate the training sessions (refer to Chapter 2.6).

Levels 1 & 3 – Preparation – Checklist 10

Plan the first trainings	

• Find participants for the first ten trainings.
  • If possible, contact the potential participants via their institutions (top-down).
  • Try to contact GPs personally via the phone or an in-person visit or via their medical association.
  • Send an invitation letter along with the training flyer.
  • To enhance the likelihood of participation, consider simultaneously disseminating all project flyers, posters or newspaper ads.
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• Organise the training sessions.
  • Find a date that is suitable for most of the participants (e.g. not during vacation time).
  • Find a room, ideally in the community, and organise the catering (if budget allows).
  • Send out invitations for the trainings which include the respective curriculum.
  • Plan networking events such as an overall closing ceremony for the trainings.
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• Prepare a documentation system for the registration of participants.
  • Include information on already contacted persons and institutions.
  • Include information on which communication channels were used.
  • Include the number of participants per training (not more than 15 per training).
  • Leave space for additional comments that might facilitate future communication.
  • Prepare a mechanism for sending reminders to participants (e.g. an internet-based registration system with automatic reminders or newsletter)
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• Prepare media guidelines.
  • Adapt EAAD´s media guidelines for the responsible reporting of suicide to meet your needs, or formulate your own guidelines.
  • Prepare an emergency plan for cases of celebrity suicide.
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• Plan the journalist workshop.
  • Select a date and location, organise the catering (if budget allows) and send out invitations that include an agenda to media contact persons.
  • Prepare the workshop presentations and the press kits (see Checklist 6).
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Cooperate with stakeholders for restricting access to lethal means	
• Within an overall project meeting, address the topic of means restrictions by trying to identify local suicide hot-spots along with potential measures to restrict their access.	☐
• Potentially hold a smaller means restriction meeting with related stakeholders (e.g. those involved in local security, politicians). Otherwise, approach them for individual appointments.	☐
• If applicable, involve local responsible staff to inspect existing hot-spots such as cliffs and railway tracks	☐ ☐
• Develop a common model for the restriction of access to the identified hot-spots and if necessary, apply for specific funding	☐
Prepare evaluations for trainings (see also Checklist 18)	
• Prepare the questionnaires for the pre and post-training evaluation.	☐
• If conducted as a scientific study, informed consent with a lay description of the project should be provided to each participant before administering questionnaires.	☐
• Set up an anonymous coding system to keep track of each participants´ questionnaires.	
• Consider a follow-up-evaluation 6 and/or 12 months after the training.	☐
• Be sure to allow extra time for the questionnaires when planning the training sessions.	☐
• If a follow-up survey is planned, online questionnaires might be a practical way to increase participation	☐ ☐

2.3.3 Implementation

Conduct ongoing trainings (Checklist 11). During the implementation phase of the suicide prevention programme, recruiting participants should be the main task. Due to high work load, motivating GPs to attend the trainings may require special effort. Use and keep up-to-date the established documentation system to monitor recruitment efforts (see Checklist 9).

Conduct media workshops and implement the media guide. Monitor the local print and online press for non-beneficial reporting about suicide. When such reporting occurs from a media member who has already attended one of your media workshops, send a friendly reminder to all journalists who attended, potentially including the media guidelines. In the case of non-beneficial reporting from a journalist that has not yet attended a workshop, take the opportunity to provide the media guidelines and invite them to a workshop session.

Using the train-the-trainer model can maximise capacity building and help ensure the sustainability of your programme. Additional refresher courses and de-briefing sessions may be required to ensure that the skills and confidence of the trainers is maintained.

Restrict access to lethal means by continuing cooperation with stakeholders and responsible persons (see also chapter 2.5 for sign-posts at hot-spots).

Levels 1 & 3 – Implementation – Checklist 11

Conduct ongoing trainings	
• Repeat the process outlined in Checklist 9 throughout the entirety of the	☐

implementation phase. • Collect recommendations through the project partners' network. • Remain alert to individuals or institutions not yet contacted. • Ask training participants to distribute information and flyers. • Coordinate the timing of the trainings with the public awareness campaign.	☐ ☐ ☐
• Motivate GPs to attend the trainings: • Include GPs and their stakeholders as project partners (e.g. on the advisory board). • Try to contact GPs personally via the phone, a personal visit, or via their medical association. • Prepare short versions (1-2 hours) of the trainings for very busy participants. • Apply for the highest possible number of CME credit points. • Choose suitable times/dates and a room in the community setting for the trainings. • Emphasize that the participants will receive practical materials for themselves as well as their patients. • Encourage local and/or regional medical associations to include depression as a topic on their agenda, perhaps even as the core topic of the year. This will further increase awareness of the problem. • Offer incentives such as posters or training certificates for doctors´ offices. • If there are special events that involve GP training or education, try to embed one of your project´s training sessions within. • Special days like "World Suicide Prevention Day" (September 10th), "European Depression Day" (October 1st), and "World Mental Health Day" (October 10th) can facilitate communication and gain further credibility. • Point out that the training session will also be a good networking opportunity. • Explain that the training will provide insight and knowledge about existing local care pathways for depressed patients beyond primary care.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
• Send out friendly reminders to media contact persons when non-suitable reporting on suicides occurs • If necessary, include the media guidelines.	☐ ☐
• Use the established documentation system and keep it up-to-date.	☐
• After some time has passed, organise refresher courses for trainers.	☐
Restricting access to lethal means	
• Remain in contact with the relevant stakeholders and try to implement the measures identified (Checklist 10).	☐

2.4 General public: depression awareness campaign (Level 2)

2.4.1 First steps

Define public awareness campaign activities according to available finances and regional needs. Table 2 provides an overview of possible actions along with their associated estimated costs. The images/motifs for the informative materials and the cinema location can be obtained from EAAD. Table 2 displays cost estimations for various Level 2 measures.

Table 2: Cost estimates for Level 2 intervention measures (relevant for interventions taking place in Germany)

Possible interventions	Material	Costs in Euros (€)
Flyers	10 pages, folded, 15,000 pcs.	700
Posters	DIN A3, paper: 135g/m^2, 5 motives, 500 pcs. each	500
	DIN A1, 1 motive, 1,000 pcs.	500
	DIN A0, 1 motive, 500 pcs.	400
Cinema location	26 sec., copy on film	70
	26 sec., copy on DVD	40
	Regional adaptation (final picture)	125
	Plus costs for screening	Variable, at least 200
Brochures	Incl. regional addresses and information, 1 pc.	1,30
DVDs	Information for GPs, patients and relatives, 1 pc.	2

Further recommended activities are:

- Opening ceremony (refer to chapter 2.2.2)
- Press conference (refer to chapter 2.2.2)
- Involving a well-known patron (refer to chapter 2.4.2)
- Talks and other public events (refer to chapter 2.4.3)
- Website and/or a newsletter (refer to chapter 2.2.2, Checklist 6)

Promoting the iFightDepression Website

The iFightDepression website (www.ifightdepression.com) aims to provide evidence-based information about depression and suicidal behaviour not only for the general public, but also for young people, family and friends, community professionals (e.g. media, teachers, religious leaders, police), and health care professionals (general practitioners, pharmacists).

The website was launched in April of 2014 and as of January 2016 is available in 12 European languages, with more languages to come in the near future. The website consists of various subpages on different depression topics such as information on the causes and symptoms as well as different treatment options.

Visitors can take a depression self-test, provide website feedback, and find contact information for local help services. There is also a glossary, a download section with region-specific material, as well as other useful links.

Level 2 – First steps – Checklist 12

Define public awareness activities according to the needs of the defined region.	☐
• Always keep in mind the general aims: • Enhancing knowledge about depression	

• Reducing depression stigma • Communicating the key messages (see chapter 2.1) • Enhancing help-seeking • Promoting positive mental health	
• Estimate the costs for the different activities and materials. • Try to obtain offers for free or reduced price printing services from local printing and distribution from companies. • Try to get these services in the form of a sponsorship and offer their logos being integrated in the design of the visual materials. • Try to find a cinema screening location that can be used free of charge.	☐ ☐ ☐
• Design the free gifts, if they cannot be obtained by the EAAD. • Include the logo of the project. • Include the key messages of the project. • Design the gifts to reflect the key messages (e.g. faces of different gender and ethnicity for "Depression can affect everybody.") • If a well-known patron has already been found, integrate his or her picture.	☐ ☐ ☐ ☐
• Decide which posters will used if they can be obtained by the EAAD. • The smaller the budget, the fewer posters/displays should be selected. • Include the contact information and addresses of regional actors/partners. • Include the logos of the sponsors and partners.	☐ ☐ ☐
• Find places for distribution. • Prepare a list (preferably an Excel table so that you can send ongoing letters) of contact persons for potential locations for displaying your materials (e.g. public spaces, hospitals, insurance companies, local transportation companies). • Look for advertising spaces that can be used for free (e.g. medical practices, pharmacies, advisory centres, and religious centres). • Send letters to these organisations and ask for their support in the form of free help with distribution or free advertising space. • Also consider virtual distribution: prepare a banner to promote the project homepage and find websites willing to include it in their online offers.	☐ ☐ ☐ ☐
• Begin these tasks several months before the opening ceremony.	☐
• Define the minimal intensity of the public awareness campaign, if a systematic implementation involving evaluation is planned. • … following the numbers of the Nuremberg Alliance against Depression: approximately 9,000 flyers, 1,500 brochures, 2-3 public information events per 100,000 inhabitants • … or try to find out how many posters, flyers etc. are needed for the desired impact (e.g. by analysing good practice examples)	☐ ☐

2.4.2 Preparation

Involve a well-known patron to raise awareness and to increase the credibility of the campaign.

Example from the German Depression Foundation: Harald Schmidt, a well-known entertainer and late night host, has been the patron of the German Depression Foundation for several years. He appears in most of the public relations material and has also moderated the bi-annual Patient Congress on Depression.

Plan the first public events before the opening ceremony so that they can be effectively promoted. This is likely to benefit the overall campaign. A lot of different public events are possible, and variation is best suited to maximise contact with the target group. The key messages of the project should always be the focus programme events. Effective advertising will help to raise awareness of your program.

Contact the media. This is closely related to the media workshops and journalist training activities outlined in Level 3 (see chapter 2.3.2, Checklist 10). Reach out to contacts that you might have made during trainings, the opening ceremony, or the press conference to help with advertising programme events in the local media. Also consider approaching contacts made through networking and public relations to participate in workshops. Press work can be done actively by publishing press releases on events and depression-related topics. You might offer interviews or depression-related information to journalists. Journalists may also approach you for depression-related statements and information, once it is known to them that there is a local alliance against depression.

Get involved in Social media (as an example, see the Facebook page for the German Depression Foundation). It makes sense to set up social media channels in order to easily reach a wider target group. Furthermore, we recommend installing a person responsible for all social media activities and "marketing" of the campaign.

Level 2 – Preparation – Checklist 13

Involve a well-known patron	

• Find a well-known patron such as a famous sportsperson or entertainer.
  • Contact several potential personalities, most likely through their managers.
  • Briefly present the project, provide informative materials and explain why cooperation could be appealing for them.
  • Give concrete information on the efforts needed (e.g. be present with a picture on informative materials, be present at one annual meeting, or a radio spot).
	☐
	
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Plan the first public events	
• Decide on the type of the events (e.g. public talks, podium discussions, theme nights, information booths, school projects, art exhibitions, religious services)	☐
• Find suitable dates that do not compete with important local events.	☐

• Find suitable locations.
  • Try to estimate the number of guests and identify a suitable location.
  • Try to obtain sponsorship in the form of rooms and/or catering for free.
  • Cooperate with other initiatives in the community.
	
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• Contact potential actors such as: • Specialists who are willing to speak at informational events and workshops.	☐

• Other organisations and initiatives in the defined region and invite them to present their projects. • Involve contributors from the entertainment industry (e.g. music, lecture).	☐ ☐
• Set up a timeframe or an agenda, if needed. • Send it to all actors and keep them updated on any changes in the timeline.	☐ ☐
• Advertise your activities. • Print flyers and distribute them to project partners and via the mail. • Distribute posters about the event (if larger-scale) • Update your website (and social media) accordingly. • Inform the general public through local press releases and your alliance-newsletter	 ☐ ☐ ☐ ☐
Contact the media	
• Issue press releases. • According to Checklist 6, a list of media contacts should already exist. Keep this list updated throughout the duration of the project. • Inform the media about the opening ceremony as well as the press conference (refer to Checklist 6). • Consider using the press offices of larger partner institutions for press releases.	 ☐ ☐ ☐
• Offer Q&A-sessions via telephone or online chat. • Find a specialist willing to host the session. • Promote the session through newspapers and magazines.	 ☐ ☐

2.4.3 Implementation

Talks and public events should take place continuously during the intervention period. The project should be presented as often as possible in various settings: during project events for the general public, at network meetings and during professional, and if applicable scientific, congresses. This not only benefits the dissemination of project activities, but indirectly raises awareness about depression as a health problem.

Regarding the content of the events, there are many possibilities. While penal discussions and medical or more serious presentations serve to increase the knowledge of depression as a treatable disease, other existing channels might be useful for increasing overall project acceptance. Patients and relatives should be included as speakers at the events, as this will strengthen programme-public partnerships and fight stigma. Cultural events, benefit concerts, film nights and other public events such as exhibitions or art projects can also help to address different target groups and to raise awareness in various settings.

Distributing informative materials is a crucial aspect of the public awareness campaign. Stay in contact with the responsible partners, even if one wave of the intervention has ended, as the next will come. Document all actions carefully, as it may be helpful in obtaining further funding.

Maintain close cooperation with the media. Stay in contact with the media via press releases and event announcements.

Talks and public events	
• Continuously plan program events for the public. • Refer to Checklist 13 to plan the events.	

• Include project presentations at professional events
  • Search for suitable conferences and seek recommendations from the project partners.
  • Prepare a short description of the project for the funding applications.
  • Calculate the budget before applying.
  • Send in the abstract and wait for the invitation.
  • Prepare a presentation of the project suitable for the respective audience.
  • Take information materials to the conference.
	☐
	☐
	☐
	☐
	☐
	☐

Distribute informative materials	
• If applicable and needed, find a professional company to assist with the distribution of materials, for example to hang the posters in public spaces or send flyers in the mail • Regularly send information materials to community-based primary and mental health care providers, partners and other institutions willing to help with distribution. • After a certain time (e.g. two weeks), call the institutions to verify that they have received the package to inquire about whether they find the materials helpful and if they need anything else	☐ ☐ ☐
• Stay in contact with the responsible partners. • Even if a partner is "inactive" at the moment, stay in contact (e.g. via an internal or external newsletter) (refer to Checklists 5 & 6).	☐

• Document the process of distribution.
  • If a company is involved, ask for a report of the distribution.
  • Take exemplary photos of posters and other awareness materials for public relation purposes and documentation.
	☐
	☐

Maintain close cooperation with the media and implement the media guide	
• Keep the list of media contacts updated throughout the duration of the project.	☐
• Issue press releases. • … regularly, for special events, on certain days (e.g. World Suicide Prevention day, 10th of September), on new statistics on suicide/depression, and in cases of emergency (e.g. a celebrity's suicide).	☐ ☐

• Offer regular Q&A sessions via telephone or online chat, possibly in cooperation with newspapers, magazines or radio programmes.
  • Find a specialist willing to host the session.
  • Promote the session through newspapers and magazines.
	☐
	☐

2.5 SUPPORT FOR PATIENTS, HIGH-RISK GROUPS AND RELATIVE (LEVEL 4)

2.5.1 First steps

Define the target groups, which should be patients and their relatives, but the target group may be defined more precisely as a high risk group (e.g. young adults).

Define the intervention measures taking into account existing care provisions in the project region (refer to chapter 2.2.1).

Table 3: Possible target groups and interventions in Level 4

Target group	Patients and their relatives	High-risk groups
Possible interventions	- Support of self-help groups and activities - Self-management offers (such as the iFightDepression tool, see below) - Psychoeducational groups - Peer-to-Peer projects - Leisure time activities (creative and sport activities) - Symposia and lectures especially designed for patients and relatives - Information materials (brochures, videos, DVDs, literature list etc.) - Information and Screening at health days - Measures for families bereaved by suicide	- Emergency card for patients after a suicide attempt - Follow-up care measures - Information materials (e.g. flyers, DVDs) for high risk groups - Sign postings at hotspots

The iFightDepression® tool is an internet-based self-management programme for individuals experiencing mild to moderate and sub-clinical forms of depression. It is free of charge and is intended to facilitate self-management of depression symptoms and to promote recovery. The tool is used with the support of a trained guiding health professional such as general practitioners, psychotherapists and clinical psychologists.
It is, as well as the accompanying iFightDepression.com website, coordinated and disseminated by the European Alliance against Depression (www.EAAD.net). More information about the tool and website can be found in the EAAD catalogue of intervention materials.

Prepare the information material for the target groups. Print it before contacting and meeting the potential partners.

Level 4 – First steps – Checklist 15

Define the target groups	
• Patients and their relatives	

• If suitable for the project region, include social status, age and other variables in the definition of the target groups.	☐
• High-risk groups • e.g. persons after a suicide attempt and their relatives • e.g. persons bereaved by suicide	 ☐ ☐
Define the intervention measures	
• Define what activities are needed in the project region based upon the analysis according to checklist 4.	☐
• Find out if similar offers already exist in the project region (e.g. self-help groups).	☐
• Offer cooperation to these or choose complementary activities to avoid competition and plan your actions accordingly.	☐
• Get into contact with community stakeholders to put up sign posts at hot-spots (see also checklists 8-11).	☐
Prepare the educational materials	
• Decide which materials will be distributed (e.g. flyers, brochures, DVDs).	☐
• Include the project logo, contact information of the project coordinator and cooperating counselling centres in the informative materials.	☐
• Include professional information on depression, its possible causes and treatment options.	☐

2.5.2 Preparation

Cooperate with potential partners in relevant institutions. Obtain an overview of existing services for depressed patients, high-risk groups and their relatives. Offer them (partners) to hold a network meeting and to cooperate in disseminating information about their offers to the patients and the general public. Send them information materials on depression and suicidal behaviour for patients.

Self-help. Focus on self-help groups, which are a good example of mutual benefit and cooperation.

Emergency cards / Hotline for people after a suicide attempt. Prepare the issue of an emergency card by designing the card itself and set up collaboration with an existing institution or establish a hotline for crisis intervention. The card could be designed in a credit card format, to allow for easy keeping and handling. It could be distributed via the other information materials, project flyer(s) or personal contact by counsellors or medical staff (e.g. given to all patients in psychiatric wards or emergency departments after a suicide attempt).

Level 4 – Preparation – Checklist 16

Print the information material	☐
• Try to find sponsors especially for this or companies printing the materials for free.	☐
Cooperate with potential partners	
• Prepare a list (preferably an excel-table so that you can send serial letters) of contact persons in institutions that offer support for the defined target group or work with them otherwise.	☐ ☐

• e.g. hospitals, counselling centres, self-help groups	
• Offer, and if applicable plan, a network meeting. • Find a date suitable for the participants. • Find a room, ideally in the community setting, and organise the catering. • Send out invitations to the meetings including an agenda.	 □ □ □
• Allow all involved to explain their project and discuss potential patient needs.	□
• If feasible, plan new offers for patients and relatives and define responsibilities.	□
• Get into personal contact with community stakeholders; perhaps by holding a meeting to organize putting up sign posts at hot-spots (see also checklists 8-11).	□
• Design the sign-post including the project logo, contact information for the project coordinator, cooperating counselling centres, as well as the hotline number (see below).	□
Self-help	
• Cooperate with existing self-help groups by including them in your activities and providing them with information materials that they can disseminate in their own networks.	□
• Cooperate with existing groups for relatives from mentally ill / depressed patients • Include them in your activities • Potentially offer psycho-educational groups or events	□ □ □
• If necessary, initiate new self-help groups	□
• Invite self-help representatives, patients or relatives to volunteer in your local alliance against depression to enhance the project's perceived congruence with participants' special experiences and needs. • … especially concerning the transition between inpatient and outpatient treatment, e.g. by counselling in the hospital, regular phone calls	□ □

Emergency cards / Hotline for people after a suicide attempt	
• Design the card to include the corporate design (e.g. logo) of the project, contact information of the project coordinator and the number of a crisis hotline.	☐
• If there is no existing crisis hotline, one can be established. When doing this, it is important to take into account the needed personnel and financial resources. Potentially involve volunteers. A peer-to-peer help or mentoring system might be an option for this. • Train the personnel and define service hours (ideally 24/7)	☐ ☐
• Print the emergency cards. • To control costs, try to find sponsors or companies which may be willing to print the materials free of cost.	☐ ☐

2.5.3 Implementation

Send out the information material to suitable institutions, self-help groups and volunteers and monitor the distribution.

Set up the sign-posts at hot-spots / Find new hot-spots.

Emergency cards / Hotline for people after a suicide attempt. Send out the emergency cards for distribution and ask for documentation of the number of distributed cards.

Level 4 – Implementation – Checklist 17

Send out the information materials to…	
• … institutions that offer support to or work with the defined target group • Send the cards directly to the contact person.	☐ ☐
• … self-help groups.	☐
• … volunteers.	☐
• Encourage them to regularly distribute the materials (e.g. by a project newsletter, at regular meetings or by phone calls, or by asking if they need additional supplies).	☐ ☐
Set up the sign-posts at hot-spots / Find new hot-spots	
• Include other potential spots that have been used to commit suicide - Stay attentive to identify new hot-spots.	☐
Emergency cards / Hotline for people after a suicide attempt	
• Send out the emergency cards together with information material on the project to suitable institutions in the project region, e.g. hospitals, crisis intervention centres. • Ask the contact persons in the institutions to document the distribution of the cards, at least the number of distributed cards.	☐ ☐
• If feasible, the emergency cards should be distributed in the emergency department and psychiatric wards of hospitals.	☐
• Ask the crisis hotline personnel to document the incoming calls; at a minimum the number of calls and general content, and if possible caller sex and age.	☐

2.6 Evaluation

2.6.1 First steps

Whether or not an evaluation will be conducted depends on the character of the intervention programme, the local context as well as the needs and professional background of the project partners. The concrete measures depend on the specific objectives of the project (see chapter 2.2.1, checklist 4) and require exact definitions. When selecting evaluation outcomes, take into consideration the additional resources needed.

Figure 5 shows different potential levels of evaluation that could be implemented when evaluating a multi-level suicide prevention programme: primary outcome (according to the aim), intermediate outcomes, process evaluation and health economic evaluation.

For more detailed information on evaluation, please refer to the annex.

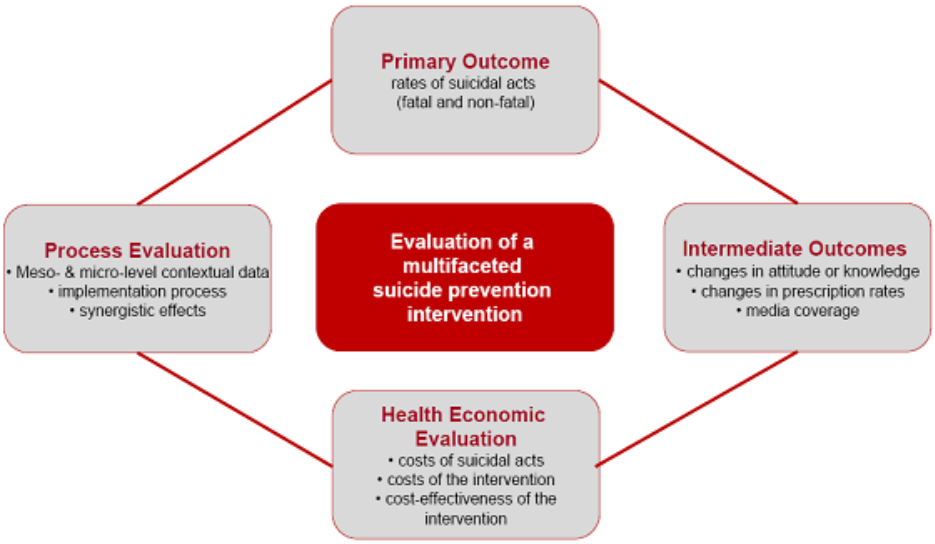

Figure 5: Possible levels of evaluation

Evaluation – First steps – Checklist 18

Decide whether evaluation is necessary.	

• Check with the partner institutions, stakeholders and sponsors if evaluation is required.
  • If the project is connected to a scientific institution, the results will most likely be published.
  • The stakeholders and sponsors may request numbers reflecting the success of the intervention. (A health economic evaluation might be especially well-suited for certain actors, e.g. politicians, health insurance companies.)
	☐
	☐

Concrete the measures for evaluation. / Define the outcomes.	
• Primary Outcome: according to the project aims (see checklist 4). • … e.g. when the aim is a reduction of the suicide rate, the number of completed	☐

suicides (and attempted suicides, ideally) and population numbers are assessed to calculate the rate. • In case of official statistics, consider the time needed by the official offices to process the data (up to two years) and the costs for data provision	☐ ☐
• Intermediate outcome: proximal or short-term effect indicators of single interventions directly linked to the contents of the interventions • … e.g. effectiveness of training activities (levels 1 & 3) • … e.g. impact of awareness campaign on the general public (level 2) • … e.g. impact of media guidelines on the media (level 3) • … e.g. numbers of direct referrals or experiences of patients for follow-up care offers after inpatient treatment (level 4)	 ☐ ☐ ☐ ☐
• Process evaluation to set the primary / intermediate outcome into context of local conditions • … e.g. actions easy / hard to implement due to certain local circumstances • … e.g. quality of cooperation / communication among project partners	☐ ☐ ☐
Find project partners responsible for the different levels of evaluation.	☐
Check for data availability.	☐
• e.g. contact statistics offices for availability and costs of official data. • e.g. contact hospitals for possibilities to assess suicide attempts. • e.g. contact hospitals or insurance companies for availability on the costs of suicide and suicide attempts.	☐ ☐ ☐
Calculate the additional resources needed for evaluation.	
• Calculate the additional budget, staff and time needed for evaluation. It might be necessary to outsource some steps of the evaluation (e.g. population survey). • Integrating evaluation activities into routine project work will be easier and more cost-effective • … e.g. evaluation of training sessions directly before and after the trainings • … e.g. workshops / focus groups on networking during project meetings	☐ ☐ ☐ ☐

2.6.2 Preparation

Prepare the evaluation materials. Gather the needed questionnaires and prepare the data assessment by setting up a codebook and a data entry system.

For scientific evaluation activities, ethical approval is necessary. Prepare the application for this. It can be used in front of other committees as well. Further, prepare the information sheets and informed consent sheets for the participants as well as trainings for the persons responsible for data assessment (see also chapter 2.3.2, checklist 10).

2.6.3 Implementation

Supervise the process of data collection. Fill in the data continuously to facilitate future analyses.

Evaluation – Preparation and implementation – Checklist 19

Prepare evaluation materials.	
• For a list of validated assessments, refer to the annex.	☐
• The questionnaires are available in English, German, Hungarian, and Portuguese.	☐
• Set up a codebook and a data entry system for each evaluation measure including all variables and their values	☐
Prepare an exact outline of the planned evaluation as a proposal.	
• … including the concrete project aim, the evaluation measures and the evaluation materials	☐
• … e.g. for hospital committees, coroner's offices, national ethics committees, data protection offices	☐
• … for ethical approval in case of scientific evaluation	☐
Prepare the information sheets and informed consent for the participants.	
• Refer to checklist 10	
◦ Prepare the questionnaires needed for the pre-post-training evaluation.	☐
◦ Provide each participant with the information sheet and obtain informed consent.	☐
◦ Set up an anonymous code to match the questionnaires of each person.	☐
◦ Consider also a follow-up-evaluation after 6 and/or 12 months.	☐
◦ Make sure to allow extra time for the questionnaires during the trainings.	☐
Prepare trainings for the persons responsible for data assessment.	
• Explain the meaning of the questionnaire and variables and how to fill the questionnaires in.	☐
• Explain the importance of transparency and documentation, e.g. ensuring that you have as many consent forms as questionnaires.	☐

Evaluation – Implementation – Checklist 20

Collect the data.	
• Supervise the data collection process.	
◦ Continuously provide the staff with materials.	☐
◦ Bring enough copies of materials to the trainings.	☐
• Document and archive the assessed data (data entry).	
◦ … e.g. derive the official data once a year (if the project will take place over several years), keep the database up to date and maintain contact with the office	☐
◦ … e.g. document which training sessions were evaluated and the number of completed questionnaires	☐
◦ … e.g. plan regular workshops / focus groups to ensure process quality	☐
◦ … e.g. treatment costs for cases of attempted suicide in hospitals	☐

2.7 Dissemination and sustainability

There is considerable overlap between dissemination activities and public relations. The activities of level 2 should be used to promote the project in the scientific community as well as with the general public. It is therefore important to address scientific journals and the media. Another possibility is to present the project at professional conferences and congresses (which might incur travel costs and admission fees). It might be useful to prepare detailed presentations in a corporate design, especially if several people take turns presenting.

The question of intervention sustainability depends on whether the project has a set or an open time frame. In case of the former, more actions need to be taken, especially when the project has to be detached from an existing institution. Most steps of chapter 2.2.1 will need to be retaken.

Ask the project partners whether or not they wish to continue the work. Shifting to a lower level of involvement with fewer activities and less staff and costs is also a possibility. The aims of the project should be reformulated (as continuous evaluation takes place). The legal aspects of the project also need to be assessed. New funding, as well as rooms and staff might also need to be obtained.

Maintain regular contact with the sponsors who are not members of your team. Keep them updated on your activities, ideally with evaluation results. Explain why you want to continue the project and point out the economic and psychosocial benefits of such an intervention.

Ways to optimise the intervention are still being discovered. The evaluation process will reveal necessary changes. Intervention results can be used to apply for additional funding and to ensure the continuing interest of the project partners as well as the public.

3. EAAD: Lessons learned

- There are still many opportunities for improvement in the treatment of depression
- Evidence for preventive effects on suicidal behaviour is available from regions in Germany, Hungary and Portugal
- Targeting both depression and suicidal behaviour in prevention seems important
- Combining intervention measures (multifaceted and multilevel intervention) leads to synergistic & catalytic effects
- Generalizing effects (destigmatisation) from depression to other mental disorders

…Start with a *model* project

- Adapt and supplement EAAD intervention materials
- Make use of the catalogue of EAAD evaluation materials including iFightDepression
- Document implementation experiences

…Support other interested regions

- National coordination: advice, support, counselling
- Conduct Train-the-Trainer Sessions

… Establish a national network of regional alliances

- A learning network for the exchange of experiences and intervention materials

= balance between bottom-up and top-down elements

4. SUMMARY AND PROSPECTS

The purpose of this manual is to provide actors interested in initiating suicide prevention with a comprehensive and practical guide for implementing a 4-level depression and suicide intervention programme.

It represents an adapted and optimised version of the OSPI-Europe intervention programme, where the restriction of access to lethal means was identified as an evidence-based approach to suicide prevention, but which was not included in the original EAAD intervention. During the implementation phase of the OSPI-Europe intervention, effectively restricting the access to lethal means within a community-based intervention was found to be challenging. However, restricting access to lethal means is an effective way of preventing suicide. Therefore, various aspects of the original concept have been integrated in the revised version of the framework.

Nevertheless, this manual does not represent a final and fixed intervention concept.

Despite the evidence for this in about 100 established regional alliances in Germany, throughout the rest of Europe, Chile and Canada, it remains difficult to provide immediate and complete care to all people in need. The experiences from our projects, particularly the public awareness campaign, show that patients are motivated to seek help. At the same time, patients are often confronted with the difficulty of limited access to psychotherapy and pharmacotherapy. The structural constraints of many existing health care systems therefore underscore the need for alternative ways of providing help and care.

Millions of people access the internet each year for health-related information, with searches for information on depression exceeding those for any other condition. However, the availability of online self-help interventions and support from health care professionals is currently limited in many countries. It is our task and a future challenge to explore and make use of the opportunities offered by the World Wide Web and social media. Providing information, helpful contacts and guided self-management programmes via these methods have the potential to close part of the gap in care provision. Online and social media programmes could be a practical way of providing ready access to effective psychosocial interventions for mild to moderate depression and have potential to impact on suicidal thoughts and behaviours. The project “Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU; GA no.20101214)”, a guided internet-based self-management programme and a multilingual European awareness website on depression has been developed and will be tested. Those measures are thought to be effective methods to further improve the impact of community based interventions and are already integrated in the 4-level intervention concept of EAAD.

Another new aspect of PREDI-NU was the creation of material for adolescents and young adults (aged 15 – 24). Up to now, many of the intervention materials used within EAAD did not adequately address adolescents and children. Networks providing care for these groups with depression and possibly suicidal behaviour are not well established. It is therefore a key priority to increase depression awareness and implement innovative interventions for treatment of depression that match young people’s needs.

Along these lines, the 4-level intervention concept will be continuously improved upon to already represents an evidence-based model which has proven to be flexible as well as easily adaptable to different settings and contexts.

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