

# The European Alliance Against Depression approach: an evidence-based program to reduce depression and suicidal behavior

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The Global Burden of Disease studies have consistently highlighted the persisting burden of mental disorders worldwide. Public health emergencies such as the COVID-19 pandemic, war and conflict, and climate change have exacerbated many determinants of poor mental health, resulting in an increased prevalence of anxiety and depression worldwide. Despite substantial advancements in intervention and prevention programs, treatment gaps in depression and suicidal behavior persist. Addressing these gaps requires a multi-level approach involving both community and health services. This Perspective addresses the urgent need to strengthen mental health systems globally. The primary purpose of this Perspective is to discuss the four-level community-based approaches of the European Alliance Against Depression program, including evidence in support of its four-level intervention as a sustainable model for community-based mental health care that can be effectively adapted to various contexts, including current and future public health emergencies.

The global burden of disease studies have consistently reported mental disorders as remaining among the top ten leading causes of burden worldwide, with no evidence of a global reduction since 1990 (ref. 1). Between 1990 and 2019, the global number of disability-adjusted life years due to mental disorders increased from 80.8 million to 125.3 million, and the proportion of global disability-adjusted life years attributed to mental disorders increased from 3.1% to 4.9% (ref. 1). Depression is a common illness worldwide, and approximately

280 million people globally are reported to have depression<sup>2</sup>. Depression is associated with a reduction of life expectancy of approximately 10 or more years<sup>3</sup>. In recent years, it has been recognized as the single major cause of years lived with disability worldwide and the leading contributor to the global burden of disease<sup>3</sup>.

Suicidal behavior is another major public health problem, with over 700,000 deaths by suicide worldwide every year<sup>4</sup>. Suicide is often under-reported due to social stigma, cultural or legal concerns<sup>5</sup>.

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Suicide occurs across the lifespan and was the third leading cause of death among 15–29 year olds globally in 2021 (ref. 4). One in every 100 deaths globally is by suicide<sup>4</sup>, highlighting the urgent need to prioritize this issue. Suicide is recognized as a critical public health problem by the World Health Organization in its Comprehensive Mental Health Action Plan 2013–2030. This plan strongly emphasizes developing and implementing comprehensive national strategies for the prevention of suicide, with special attention to groups associated with increased risk of suicide. Depression and suicidal behavior are closely linked, but only partly overlapping, mental health problems. Depressive disorders represent a major risk factor for suicidal ideation<sup>6</sup>, suicide attempts<sup>7</sup> and suicide deaths<sup>8,9</sup>. This Perspective explores how the European Alliance Against Depression (EAAD) four-level approach serves as a community-based intervention for addressing treatment gaps in depression and suicide prevention. The model's adaptability to various health system contexts ensures its applicability beyond specific public health emergencies and crisis scenarios, making it a valuable strategy for long-term mental health-care improvement.

The COVID-19 pandemic exacerbated several determinants of poor mental health, contributing to an increased prevalence of major depressive disorder and anxiety disorders—both major risk factors for suicide<sup>10,11</sup>. Many individuals with depression experience relapse episodes, worsening symptoms and heightened suicidal ideation, which is often linked to changes in routine, reduced physical activity and disrupted sleep patterns<sup>12</sup>. The increased prevalence of mental health conditions during the COVID-19 pandemic has coincided with severe disruptions to mental health services, leaving major gaps in the care for those who need it most<sup>11</sup>. A high proportion of patients reported a reduced quality of care due to the measures against COVID-19 (ref. 12). For much of the pandemic, services for mental, neurological and substance-use conditions were most disrupted among all essential health services. The pandemic substantially disrupted mental health services, limiting access to essential care for many individuals<sup>11,13</sup>. Suicide-prevention services were also affected, although global suicide rates remained largely unchanged during this period, according to data from 21 countries<sup>14</sup>. However, systematic reviews indicate a modest increase in suicidal ideation<sup>15,16</sup> and self-harm<sup>16,17</sup>. While the pandemic highlighted the urgency of strengthening mental health systems, treatment gaps have long existed, requiring sustainable, community-based interventions beyond crisis periods<sup>10,18</sup>.

The 2017 World Health Organization Strategic Framework defined emergency preparedness as the knowledge, capacity and organizational systems that governments, response and recovery organizations, communities, and individuals develop to anticipate, respond to or recover from emergencies<sup>19</sup>. To reduce the burden of mental disorders and to address both current and future mental health challenges associated with public health emergencies, preparedness and coordinated delivery of effective prevention and treatment programs by governments and the global health community are imperative<sup>1</sup>.

Public health emergencies take on many forms, such as pandemics, natural disasters or other mass-casualty events<sup>20</sup>. The pandemic- and climate-related distress were linked to greater depression and anxiety and reduced health-related quality of life<sup>21</sup>. War-related distress was associated with greater anxiety<sup>21</sup>. In terms of other recent public health emergencies with wide-ranging mental health impacts, there are a growing number of countries involved in war and conflict<sup>22</sup>.

As a result of the heterogeneity of factors contributing to depression and suicidal behavior, including those at the individual level, in health-care systems and in culture and society, as well as diagnostic and therapeutic deficits concerning depression, multifaceted interventions are considered to be most effective for the prevention of suicidal behavior<sup>23</sup>. The community-based, four-level intervention concept developed and implemented in an increasing number of countries by the EAAD provides a multifaceted intervention, simultaneously addressing depression and suicidal behavior<sup>24–26</sup>. The EAAD is

an international, non-profit organization that arose from previously EU-funded projects with the central aim of supporting the implementation of a community-based, four-level intervention program targeting depression and suicidal behavior in European countries and beyond. The core dual objectives of the EAAD are to achieve improved care and treatment for patients with depressive disorders and to prevent suicidal behavior. So far, the four-level intervention has been implemented in more than 130 regions in 16 countries within and outside Europe. EAAD also offers the iFightDepression (iFD) tool as part of its level 1 and level 4 interventions, which involves an internet-based self-management tool for people with milder forms of depression.

The primary purpose of this Perspective is to discuss the EAAD approach and provide evidence that supports its role as a community-based mental health-care model. Its structured, four-level framework offers an effective strategy for reducing depression and suicidal behavior across different health-care systems and populations.

The EAAD four-level model was named as a best practice example of suicide prevention in the 2005 Green Paper on Mental Health and the 2014 Suicide Prevention Report by the World Health Organization. The iFD tool and EAAD four-level model were voted as mental health best practices by states' representatives at the European Commission's Joint Research Centre in Ispra in May 2019. According to a recent systematic review<sup>27</sup>, the four-level intervention approach is the only community-based intervention demonstrating preventive effects on suicidal behavior. The decision made in Ispra resulted in the formation of a consortium for the multinational parallel intervention EAAD-Best. This acronymizes 'Adapting and Implementing EAAD's Best Practice Model to Improve Depression Care and Prevent Suicidal Behaviour in Europe'. The project had a duration of 3 years, commencing in April 2021 and ending in March 2024, involving institutes from 10 countries.

## Core components of EAAD models

'EAAD-Best' refers to an innovative project, funded by the European Union's 3rd Health Programme, that had two aims: to improve care for patients with depression and to prevent suicidal behavior in Europe by facilitating the implementation and transfer of the evidence- and community-based EAAD four-level intervention concept, as well as introducing the iFD tool to new regions and countries in Europe and exploring the factors of its uptake (2021–2024)<sup>28</sup>. The four-level concept embraced seven countries, some for implementation (new) and some for transfer (repeating the intervention, which had been previously known), whereas the iFD tool was introduced to eight EU countries (in two of which it was previously unknown). Here we outline the supporting evidence of the EAAD four-level approach and its potential to strengthen mental health services, in particular during public health emergencies.

### EAAD-Best four-level community intervention model

The EAAD's four-level intervention is a community-based intervention that targets both depression and prevention of suicidal behavior, wherein activities are simultaneously run at four intervention levels. The four separate levels of the approach are designed to work together to influence community attitudes about depression, improve treatment of depression at the primary care level, encourage help-seeking and directly address high-risk members of the community<sup>29</sup>.

The four levels, presented in Table 1, involve the following activities<sup>29</sup>:

Level 1: training sessions and practice support for primary care physicians and mental health-care professionals, including an e-mental health intervention, referred to as the iFD tool, for those who want to offer the tool to their patients

Level 2: public awareness activities, kick-off event and media campaigns

Level 3: training sessions for community facilitators and gatekeepers in contact with people with depression and suicidal behavior in the

**Table 1 | The EAAD-Best four-level intervention concept**

Goal: improve care for depression and prevent suicidal behavior	
Level 1	Primary and mental health care
Level 2	General public depression and awareness campaign
Level 3	Community facilitators and stakeholders
Level 4	Patients, high-risk groups and relatives

community (for example, geriatric care givers, priests, pharmacists, health-care staffs, police, journalists), cooperation with journalists based on a media guide with the aim to reduce copycat suicides

Level 4: support for patients with depression and suicide risk, as well as relatives, including the iFD tool

**Outcomes of the EAAD four-level intervention on depression and suicidal behavior**

The Nuremberg Alliance Against Depression, a 2-year 4-level community intervention, substantially reduced suicidality compared with baseline and the control region of Würzburg. Suicidal acts (suicide attempts plus completed suicides) declined by 19.4% in the first year and 24.0% in the second year ( $P = 0.004$ ), with suicide attempts alone falling by 18.3% and 26.5%, respectively<sup>24</sup>. The intervention also reduced the use of high-risk methods (hanging, jumping, shooting) by 47%, compared with a 15% reduction in low-risk methods ( $P = 0.005$ )<sup>24</sup>. In the follow-up year (2003), after the end of the intervention, effects were sustained and even more pronounced: suicidal acts decreased by 32.4% compared with baseline, greater than the -5.5% change in Würzburg ( $P = 0.0065$ )<sup>30</sup>. Attempted suicides fell by 36.2% overall, with high-risk methods showing the steepest decline (62.5%)<sup>30</sup>. Although completed suicides fluctuated annually without significant differences, overall findings confirm the sustained preventive impact of the four-level intervention<sup>24,30</sup>.

The Optimizing Suicide Prevention Programs and their Implementation in Europe (OSPI-Europe) trial extended the four-level community-based intervention to Germany, Hungary, Ireland and Portugal and found some variation in the overall reductions in suicidal acts between intervention and control regions. In Portugal, a significant 16% reduction in suicidal acts was reported, while Germany showed a numerically notable but statistically non-significant decrease (5.3% decrease in the intervention region compared with 8.8% increase in the control region). Conversely, Ireland experienced an increase in suicidal acts in the intervention area, which the authors suggest may have been linked to the effects of the economic recession during the study period<sup>31</sup>. Additional positive benefits of the four-level intervention were identified, including synergistic interactions between intervention levels and catalytic interactions generating external activities sharing similar suicide prevention goals. Synergistic interactions between different levels of the intervention enhanced the benefits or impacts between them. Catalytic impacts were observed where the program or single levels within the program stimulated related activity in those external to the intervention teams<sup>32</sup>. An example of the synergistic interactions is the public awareness campaign at level 2 of the intervention, in which members of the media were invited to the launch. This increased media reporting of the activities from an early stage, establishing a good relationship with journalists, which enhanced press coverage especially in Ireland and Germany. The relationship established with the journalists facilitated coverage of the ongoing activities and encouraged the journalists to attend training in media reporting of suicide. In relation to the catalytic impacts in Portugal, the team discovered that initiating training activity stimulated other professionals to initiate complementary activities outside of the intervention<sup>32</sup>. A process evaluation of the four-level intervention explored the role of advisory groups as a key mechanism

in the ease of implementation of the intervention. It found their composition and the meaning of participation for them was important to strengthen network capacity in reach and implementation<sup>33</sup>.

Overall, the four-level intervention has reported positive results in terms of reducing suicidal acts in the intervention sites, which were found to be sustained at follow-up compared with the control sites and across different countries. This provides evidence supporting the potential use of the EAAD four-level intervention approach in the context of global public health emergencies (Table 2).

**Community-based interventions in other countries and regions**

Community-based interventions have been implemented in many regions worldwide with varying effects. A systematic review by Linskens et al.<sup>27</sup> reported effects from community-based, multi-strategy programs for suicide prevention in other regions, including Asia, New Zealand and Australia. This review reported uncertain effects on suicide deaths or suicide attempts across eight observational studies in Asia. While the evidence of community-based interventions to prevent suicide was found to be inconsistent, EAAD was concluded to be most promising<sup>27</sup>. Furthermore, only two community intervention models, EAAD and LifeSpan<sup>34</sup>, include community-based interventions at the population level and involve convening the multi-stakeholder teams at the local level<sup>34</sup>.

**iFD tool and website**

In EAAD-Best, a core component of the four-level intervention concept is the promotion and availability of the iFD tool and the associated iFD awareness website, in particular offered by levels 1 and 4. The iFD tool is a guided, online self-management program for people experiencing mild to moderate forms of depression. It is based on the principles of cognitive behavioral therapy. The tool is ‘guided’, meaning that it is used with support from a health or mental health professional. Access and guidance to the tool are provided by a health or mental health professional (general practitioner, psychiatrist or psychotherapist) who has been trained to be a guide. An e-learning tool has been developed for health professionals offering the iFD tool to patients. The iFD tool is free of charge and is intended to help individuals self-manage their symptoms of depression and promote recovery. There are two versions of the iFD tool: one for adults (25 years of age and older), and one for young people (15–24 years of age). The adult version is available in 16 languages, and the youth version is available in 12 languages.

The iFD awareness website aims to promote and increase awareness of depression and suicidal behavior by providing comprehensive information about depression and its consequences. The website is currently in 21 languages (Albanian, Bulgarian, Catalan, Chinese, Dutch, English, Estonian, French, German, Greek, Hungarian, Italian, Mandinka, Norwegian, Polish, Portuguese, Russian, Spanish, Turkish, Ukrainian and Wolof). It contains information for different target groups, including the broad general public, young people, family and friends, community professionals (media, teachers, religious leaders, police) and health-care professionals (general practitioners, pharmacists). In addition, it provides a self-test, national helplines and various downloadable materials. More details can be accessed via <https://ifightdepression.com/en/>.

**Effectiveness of the iFD tool in depression and suicidal behavior**

The effectiveness of the iFD tool for depression and suicidal behavior is supported by consistently positive results according to independent evaluations in different countries (Table 3).

Oehler et al.<sup>35</sup> conducted a randomized controlled trial with 348 participants, comparing iFD with progressive muscle relaxation (PMR). The results showed a significant reduction in depressive symptoms

**Table 2 | Studies reporting process and outcomes of EAAD interventions for depression and suicidal behavior in Europe**

Reference and location	Sample (n)	Design	Description of the interventions	Outcome measures	Major outcomes/results
Hegerl et al. (2006) <sup>24</sup> , Nuremberg, Germany	Nuremberg: 488,400 (intervention) Würzburg: 286,885 (control)	Controlled before–after design with control region	2-year, four-level intervention: general practitioner training, public relations, cooperation with community facilitators, support for self-help and high-risk groups	(1) Number of suicidal acts (suicide attempts + completed suicides), and (2) suicide attempts only	Suicidal acts decreased by 19.4% in year 1 and 24.0% in year 2 in Nuremberg, compared with baseline (620 → 500 → 471); control region showed no meaningful change (183 → 182 → 196); confirmatory $\chi^2=8.28$ , $p=0.004$ ; effects most pronounced for high-risk methods
Hegerl et al. (2010) <sup>30</sup> , Nuremberg, Germany (follow-up)	Nuremberg: 490,000 Würzburg: ~290,000	Follow-up study (1 year after intervention)	Continuation assessment after 2-year four-level intervention, with limited ongoing activities	Number of suicidal acts (primary)	Effects were sustained 1 year post-intervention: suicidal acts decreased 32.4% compared with baseline (620 → 419); reduction significantly larger than control region (–5.5%; $P=0.0065$ ).
Hegerl et al. (2019) <sup>31</sup> , OSPI-Europe, Germany, Hungary, Ireland, Portugal	Germany (Leipzig: 515,469; Magdeburg: 230,047) Hungary (Miskolc: 170,234; Szeged: 169,030) Ireland (Limerick: 188,299; Galway: 237,898) Portugal (Amadora: 172,110; Almada: 166,103)	Controlled before–after design across four intervention and four matched control regions	OSPI-Europe: four-level interventions + added element restricting access to lethal means	(1) Number of suicidal acts, and (2) changes in knowledge, attitudes and awareness (general practitioners, public, community facilitators)	Overall, no significant effect on suicidal acts (–3.3% intervention versus –1.4% control, $\chi^2=0.13$ , $P=0.72$ ); country-level differences: significant reduction in Portugal (–16%, $\chi^2=4.82$ , $P=0.03$ ); Germany showed non-significant trend (–5.3% versus +8.8%); Ireland showed increase, possibly linked to recession
Harris et al. (2013) <sup>33</sup> , Germany, Hungary, Ireland, Portugal	Germany: 14 interviews, 1 focus group Hungary: 10 interviews, 2 focus groups Ireland: 13 interviews, 1 focus group Portugal: 10 interviews	Longitudinal case study with realist evaluation	Process evaluation of early OSPI-Europe implementation (five-level model, with control and intervention sites)	(1) Organizational and partnership structures, and (2) engagement and collaboration mechanisms	Advisory groups were crucial to implementation; strong partnerships facilitated active participation and collaboration in early OSPI roll-out
Harris et al. (2016) <sup>32</sup> , Germany, Hungary, Ireland, Portugal	Germany: 14 interviews, 4 focus groups Hungary: 10 interviews, 4 focus groups Ireland: 13 interviews, 3 focus groups Portugal: 10 interviews, 1 focus group	Longitudinal mixed-method case study with realist evaluation	In-depth process evaluation of OSPI-Europe, using interviews, focus groups, workshops, observations and questionnaires	(1) Synergistic interactions (2) Catalytic effects	Synergistic effects across intervention levels observed in all countries; OSPI acted as a catalyst for additional suicide-prevention activities beyond project funding
Székel et al. (2013) <sup>35</sup> , Szolnok, Hungary	Szolnok: 76,311 (intervention) Control: Szeged	Controlled before–after design	EAAD four-level community intervention implemented in Szolnok, compared with control region and national rates	Suicide rates	Suicide rates declined from 30.1 per 100,000 in 2004 to 13.2 in 2005, 14.6 in 2006, and 12.0 in 2007 (–56%, –51%, –60%); reductions significantly greater than control region ( $P=0.0015$ ) and national trends ( $P=0.017$ ); benefits observed in both men and women

and improved quality of life for the iFD group, with notable effects at the 3-month follow-up. However, effects were less pronounced after 6 weeks and beyond. The iFD group also reported higher user satisfaction compared with the control group<sup>35</sup>. Schwarz et al.<sup>36</sup> evaluated iFD in in-patient settings, wherein participants showed moderate to high expectations and above-average satisfaction with the tool; 67% of active users expressed the intention to continue using iFD after discharge. Despite some participants not engaging due to short hospital stays or digital literacy issues, the findings highlight the tool's long-term potential and adaptability in in-patient environments<sup>36</sup>. Varga et al.<sup>37</sup> compared iFD with treatment as usual (TAU) and found that iFD, particularly when combined with telephone support, resulted in a greater reduction in depressive symptoms. Both iFD groups showed significantly higher odds of reliable improvement compared with the TAU group, indicating the iFD tool's effectiveness across diverse settings<sup>37</sup> (Table 3).

The reductions and satisfaction were most prominent at the 3-month follow-up and were sustained at the 12-month follow-up<sup>35</sup>. Furthermore, a study examining the symptom changes in a guided versus unguided sample using the iFD tool demonstrated greater symptom reduction in the guided sample. This indicates that guidance is an important factor to facilitate adherence and improve outcomes in internet-based interventions such as the iFD<sup>38</sup>. Greater adherence was associated with greater symptom reduction for depression in patients guided by licensed psychotherapists compared with those guided by general practitioners and medical doctors trained in mental health. Patients guided by psychotherapists spent more time logged into the

iFD tool and completed more modules than those guided by the other mental health professionals<sup>39</sup>. In addition, a recent study discovered that the iFD tool effectively reduced symptoms in patients with mild, moderate and severe depression. This reduction was observed with low-intensity guidance from mental health professionals, both when using the intervention alone and in conjunction with weekly phone guidance<sup>37</sup> (Table 3).

## Discussion

The global gap in treatment coverage for depression has been consistent, indicating that only 33% of those diagnosed in high-income locations and 8% of patients in low- and lower-middle-income countries received mental health treatment in the past 12 months<sup>40</sup>. This means that there is a treatment gap of 67% in high-income countries and 92% in lower- and middle-income countries for depression<sup>40</sup>. Moreover, the rates of minimally adequate treatment for depression ranged from 23% in high-income countries to 3% in low- and lower-middle-income countries<sup>40</sup>. Another study that utilized community surveys from 21 countries concluded that only 1 in 5 people from high-income countries and 1 in 27 people from low- and middle-income countries have received minimally adequate treatment<sup>41</sup>. Even in high-income countries where treatment rates are comparatively higher, the majority of individuals receiving care for depression failed to receive a level of care that is consistent with practice guideline recommendations<sup>40</sup>. Only a small minority of individuals with depression accessed treatment in the specialized mental health-care system<sup>40</sup>. In addition, it is important to note that these

**Table 3 | Studies that report the outcome of the iFD tool for depression and suicidal behavior**

Reference, location and setting	Sample (n)	Design	Description of the interventions	Outcome measures	Major outcomes/results
Oehler et al. (2020) <sup>35</sup> , Germany, web-based intervention	348 total 174 PMR 173 iFD 1 withdrew consent	Randomized controlled trial assessing the efficacy and usability of a guided web-based self-management intervention (iFD) compared with an active control condition (PMR); patients recruited online and randomly assigned to one of two intervention arms; followed up at 6 weeks, 3, 6 and 12 months	A 6-week, guided, web-based self-management intervention building on the principles of cognitive behavioral therapy (iFD tool) compared with web-based PMR	(1) Compare changes in self-rated symptom severity occurring during the trial period up to 12 months for patients with mild to moderate depression who used either a cognitive behavioral therapy-based or web-based self-management tool (iFD) or took part in an active control condition (PMR)	A greater reduction in symptoms of depression and a greater improvement of life quality was found in the intervention group compared with the active control group; significant effects on depressive symptoms at the 3-month follow-up but not after 6 weeks and 6 and 12 months; the intervention was significantly superior to the control condition with respect to user satisfaction.
Schwarz et al. (2022) <sup>36</sup> , Germany, in-patient (paper in German)	78	Clinical study to implement and evaluate iFD tool to assess benefit for in-patient use	The web-based, therapist-guided self-management tool iFD	(1) Symptom severity, and (2) intervention expectations and experience	Out of 78 participating in-patients, 42 used the iFD tool at least once; moderate to high levels of expectation regarding the iFD tool and mildly above-average level of satisfaction after the intervention were observed; of the active users, 67% indicated they would continue to use the iFD tool after discharge; the main reasons for not using the iFD tool were short duration of stay, severity of disease and lack of digital literacy.
Varga et al. (2022) <sup>37</sup> , psychiatric out-patients and primary care in Hungary	163	Pre-test and post-test study with three groups. Post-test after 6 weeks	Three intervention groups, as follows: (1) TAU, (2) TAU combined with access to the iFD tool (TAU+iFD), (3) TAU combined with iFD and weekly telephone support (TAU+iFD+telephone)	(1) Primary outcome depression severity on PHQ-9 (a patient health questionnaire widely used for assessing the severity of depression), and (2) secondary outcomes number of completed iFD modules, association of effects with telephone support	There was a significantly greater decrease of depressive symptoms in both iFD groups compared with the TAU group; the odds of reliable improvement were significantly higher in both iFD groups compared with the TAU group.

treatment gap estimates were made before the COVID-19 pandemic, and it is expected that the current mental health treatment gap has worsened due to the increase in depression and anxiety disorders following the pandemic<sup>42</sup>. Considering that depression is one of the leading causes of disability worldwide<sup>43,44</sup>, the low treatment coverage rate is highly concerning.

One of the major concerns in treating suicidal behavior is the low rate of help-seeking among those affected<sup>45–47</sup>. A substantial portion of individuals experiencing suicidality do not reach out for assistance<sup>48,49</sup>. In addition, the mental health-care needs of many patients presenting to emergency departments following self-harm or suicide attempts are often inadequately addressed, with some not receiving referrals to mental health services<sup>50</sup>. Despite their emergency department visits, there remains a 30% gap in mental health-care coverage for these individuals<sup>50</sup>, representing a missed opportunity. This gap highlights the need for enhanced mental health awareness and training for emergency department staff to improve referral and treatment services for self-harm patients. Notably, these care gaps are particularly pronounced among self-harm patients without a diagnosed psychiatric disorder<sup>50</sup>.

The treatment gap is influenced by multiple factors. Therefore, we advocate that a multi-component intervention such as the EAAD approach is more promising than individual intervention approaches. For example, the barriers to mental health treatment could be attributed to individual factors, such as stigma<sup>51–54</sup>, complex service user needs<sup>55</sup>, poor mental health literacy<sup>51,52,54</sup>, self-reliance<sup>52</sup>, a preference for informal mental health help over professional help<sup>53</sup> or negative beliefs about mental health professional services<sup>49,53–56</sup>, as well as financial difficulties in meeting treatment expenses<sup>53,57,58</sup>. In addition, system-related and structural factors, such as the lack of availability

and accessibility of specialized mental health services<sup>57,58</sup>, inadequate mental health manpower and services<sup>40</sup>, poor services and delays in availing appointments and treatment<sup>54</sup>, and insufficient referrals to mental health services by hospital staff<sup>50</sup>, contribute to the treatment gap. As described earlier, the EAAD four-level community-based intervention works toward improvements and impact on multiple levels (Box 1). For example, the lack of mental health resources may be improved by training general practitioners in primary care through the level 1 approaches of the EAAD. Early identification of mental disorders and community participation are enhanced through level 2 and level 3 approaches, which involve training community facilitators and non-specialist health-care workers. Stigma and poor mental health knowledge are tackled through public mental health awareness programs (level 2). Lack of accessibility and availability of mental health services is addressed by training general practitioners and providing online self-help training tools such as the iFD tool, as well as through EAAD level 1 training.

### The potential of the online iFD tool in mental health treatment and its role during lockdowns

The increased prevalence of mental health conditions during the COVID-19 pandemic<sup>4</sup> coincided with severe disruptions to mental health services, leaving major gaps in care for those who need it most<sup>13,59</sup>. Throughout the pandemic, services for mental, neurological and substance-use conditions were among the most disrupted of all essential health services. Many countries also reported notable disruptions in life-saving mental health services, including suicide-prevention services<sup>13,60</sup>. In addition, there was a reduction in mental health-care utilization by many patients with suicidal behaviors during the pandemic<sup>15,16</sup>. However, this reduction in health-care

## BOX 1

## Key lessons from EAAD's four-level approach

EAAD has learned incrementally from implementing its four-level model to target depression and suicidality across Europe. The evidence and learnings offer potential for improving mental health promotion and suicide-prevention programs worldwide. Here are the main takeaways:

**Intervening at multiple levels simultaneously.** Tackling depression at all four levels (public, doctors, community and individuals) at the same time creates intensified and incremental effects and benefits. For example, public awareness campaigns reduce stigma, making it easier for doctors to diagnose depression. Working together regionally also helps mental health professionals connect and share ideas.

**Adapting to local needs.** Mental health programs work best when they balance local community efforts with government support. In areas where people are very involved, local leadership keeps programs going. In places with less community involvement, stronger government support may be needed.

**Staying independent.** To keep people's trust, mental health promotion and suicide-prevention programs should not be influenced by pharmaceutical companies. While medication is important, staying independent ensures the program stays fair and focused on helping people via a wide range of evidence-based treatments.

**Growing through networks.** When a program works well in one area, it can spread to others. To do this, materials should be adjusted to fit different health systems, and regions should work together. A national coordinator can help share knowledge, raise funds and push for supportive policies.

**Keeping a clear focus.** Programs should have clear goals, such as focusing on a specific area or issue (for example, depression). Diverting too much can weaken the program impacts. Staying focused on depression, rather than all mental health conditions, makes the program more effective.

**Caution when disseminating suicide-prevention messages.** Anti-suicide campaigns can encourage people to seek help, but they can also have unintended effects, such as making suicide seem more common. EAAD's integrative approach combines depression awareness with targeted suicide prevention to reduce these risks.

**Keeping costs low and sustainable.** Using local resources and partnering with community groups or governments, and increasing capacity via Train-the-Trainer programs, can save money. Getting support from well-known figures or officials can help secure funding. Diversifying funding sources (such as grants or sponsorships) ensures the program can continue without relying on pharmaceutical companies.

**Taking EAAD's model to other countries and regions—challenges and opportunities.** EAAD's model can be adapted to other countries and regions, especially low- and middle-income countries. However, challenges such as lack of mental health workers, stigma and poor health-care systems need to be addressed. Solutions include building capacity via training community health workers via Train-the-Trainer programs and using digital tools such as the iFD program. EAAD's success shows that similar models can work in areas with high rates of depression and suicide. However, challenges, including funding requirements, political resistance and logistical problems, must be carefully managed.

utilization may have been a result of public health measures to protect health services, reduced access to public transport, anxieties about contracting the virus or limited access to services<sup>61–63</sup>. Given the individual and system-related barriers to accessing face-to-face mental health services during a pandemic, it is important to promote evidence-based online mental health services. A meta-analysis evaluating the outcomes of internet-based CBT interventions concluded that self-guided iCBT is effective in treating depressive symptoms<sup>64</sup>. Digital mental health interventions can be effective for improving depression, anxiety and psychological well-being<sup>65,66</sup>. The COVID-19 pandemic created a particular opportunity for greater utilization of digital technologies in mental health improvements<sup>67–71</sup>. EAAD's online iFD tool is a promising option and provides an evidence-based approach for patients suffering from mild to moderate depressive symptoms. The iFD tool provides a potential complement to existing treatment methods for depression and suicidal behavior; where treatment may not be readily available, this is especially relevant during public health emergencies.

However, there are also challenges and drawbacks associated with digital therapies, particularly for individuals who may need them the most. These challenges include limited access to necessary technology and the skills to use it, unreliable internet connections, data costs, and concerns about privacy and data security<sup>72</sup>. Digital therapies would be beneficial for patients with relatively straightforward, low-risk diagnoses, strong motivation and engagement, high computer literacy and access, and low need for tailored content<sup>73</sup>.

### Coordinating with stakeholders: enhancing the impact of mental health initiatives in the community

To implement successful and sustainable programs in mental health, stakeholder involvement has been identified as a key element<sup>74–77</sup>. Engaging key stakeholders is an integral component of the EAAD four-level approach and is embedded across each level of the intervention. At level 1, involvement of stakeholders includes professionals from primary care and the mental health services. As many people with depression are managed and treated in the primary care setting, engagement with general practitioners and other key primary health professionals is a key element at this level of the intervention<sup>78,79</sup>. The engagement of the mental health services in each of the areas where the intervention is implemented is also important. Engaging the community at level 2 through awareness campaigns is a key aspect of the four-level intervention and again at level 3 through training in those in the community to act as gatekeepers for those who may be at risk of mild to moderate depression or display signs of suicidal behaviors. These coordinated efforts to engage key stakeholders are fundamental to the implementation of the program. The engagement of key stakeholders will in turn enhance the impacts within the community.

The role of advisory groups is important for strengthening network capacity and to effectively facilitate implementation of the intervention. This was highlighted during a process evaluation of the four-level intervention wherein the advisory group was also found to bring stakeholders together, and this in turn enhanced local capacity

## BOX 2

# Addressing mental health treatment and suicide-prevention gaps via the EAAD four-level approach

The EAAD four-level community-based model offers a structured, multi-component response to the dual challenges of depression and suicidal behavior. It addresses critical gaps in access, awareness, care quality and community engagement through coordinated action at four levels:

- (1) Bridging the mental health and suicide-prevention gaps
  - Reaching individuals who often face multiple challenges—those with undiagnosed depression, untreated suicidal ideation or limited access to specialized care
  - Enhancing early identification and intervention across multiple settings, including primary care, community and emergency services
  - Responding to the widespread issue of low help-seeking among people experiencing suicidal thoughts or behaviors
- (2) Tackling barriers to care
  - Reducing stigma and myths around depression and suicide through targeted public awareness campaigns
  - Improving mental health literacy and promotes help-seeking behavior in the general population
  - Addressing systemic limitations, such as fragmented care, poor referral systems, workforce shortages and service inaccessibility
- (3) Building local capacity and sustained community action
  - Training general practitioners and front-line professionals to recognize and manage depression and suicide risk (level 1)
  - Engaging and educating community gatekeepers—such as educators, pharmacists, police and clergy—to identify at-risk individuals and provide timely support (level 3)
  - Using advisory groups and a Train-the-Trainer model to strengthen community networks and ensure long-term sustainability—even during public health emergencies
- (4) Integrating digital tools and catalytic system change
  - Incorporating digital self-management tools (for example, iFD) as a complement to face-to-face support, especially in low-resource or crisis settings
  - Encouraging synergistic and catalytic interactions across intervention levels, generating momentum and new activities beyond the program's scope
  - Demonstrating adaptability in both high- and low-resource settings and during public health emergencies

building and sustainability regarding intervention activities<sup>33</sup>. Active local stakeholders are key to providing future sustainability of the built network.

## Complementary, not conflicting: integrating new treatment models with existing approaches

The four-level model demonstrates how new programs can be complementarily integrated into existing care structures. During the COVID-19 pandemic, systematic reviews of digital mental health tools showed that, while uptake was often driven by necessity, practitioners still reported unexpectedly positive experiences and enhanced

digital proficiency<sup>80,81</sup>. This aligns well with how the iFD tool complements usual care.

Another area in which the four-level intervention complements existing models of care is in relation to catalytic interactions that have the benefit of stimulating activity in other areas outside of the intervention site. Catalytic interactions were found to generate two different types of impacts. The enhanced planned activities by generating something new also facilitated additional external activity relating to a shared goal of suicide prevention<sup>32</sup>. This can be beneficial in integrating new methods into existing models of care as catalytic interaction can increase additional activity and enhance systemic capacities, especially during public health emergencies (Box 2).

For those aiming to increase preparedness for mental health support during crises and beyond, the EAAD model offers a practical, community-focused strategy. By training general practitioners, engaging community stakeholders and promoting online tools, such as the iFD, communities can create a responsive mental health system that is both proactive and resilient. This approach can be integrated into local public health planning, providing a tested blueprint for rapid mental health support deployment when traditional services are disrupted. During public health emergencies, staff redeployment can hinder capacity building. The EAAD Train-the-Trainer model ensures ongoing preparedness.

## Conclusion

The EAAD four-level community-based approach offers a comprehensive and adaptable model for addressing depression and suicidal behavior. By engaging primary care, the public, community gatekeepers and individuals at risk, the intervention creates a coordinated response that strengthens mental health systems and reduces stigma. As demonstrated across diverse settings, the EAAD model bridges critical care gaps and supports sustainable, community-driven solutions. This perspective highlights an actionable framework that can be adapted globally, expanding mental health preparedness and response in both routine care and public health emergencies.

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## Competing interests

The authors declare no competing interests.

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