



Depression: asking the right questions

January 2016

PROJECT REPORT

Identifying priorities for depression research

www.depressionarq.org



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Transforming
mental health
through research

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- Sense about Science
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- Samaritans
- Sane
- Service User Research Enterprise, King's College London
- Stroke Association
- Young Minds



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Finally, we would like to thank everyone who responded to any and all of the public surveys. Your responses, time and consideration has the potential to make a real difference to the lives of people who experience depression and those who care for them. Thank you!



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Page 11 From left to right: theboone, 2007 and John Kirk 2013.
Page 13, 14,15,16 and 17 MQ, 2015.

Foreword

JENNIFER TUFT, PROJECT MANAGER,
MQ: Transforming Mental Health

I joined MQ in April 2015 to manage the Depression: Asking the Right Questions (D:ARQ) project because, through my own experience of depression, I knew how important the project is.



Although there is a wealth of information and support, and a large community available to those affected by the condition, I know I'm not alone when I say that despite these resources and the channels of professional intervention available there is still a great deal of unmet need.

Depression is complex and can affect virtually every aspect of someone's life, rendering people unable to work, impacting relationships and sometimes proving fatal. It's one of the highest causes of disability and absenteeism from work. But alongside all of this, it can be painful, exhausting and restricting. It can also be challenging for the people around us to know how to provide the best support.

That's where the Depression: ARQ project can give hope. By giving a voice to those with direct experience of depression, and gaining insight from those who care for them, we have been able to use a

systematic method to identify people's most important questions.

I, and MQ, believe that research is crucial for improving mental health and quality of life. But we need the help of individuals, politicians, charities, academics, policy-makers and healthcare providers in taking these priorities onboard and using them to inform real change.

So we call upon all of you to use this report in the mission to advance research and awareness about depression.

Executive Summary

INTRODUCTION AND BACKGROUND

Depression affects around 350 million people worldwide,¹ and roughly 1 in 10 people in the UK.² It is the leading cause of disability, greatly impacting people's daily lives, and can lead to suicide.³

Yet despite this, it is still seriously under-researched and prospects for research are under-funded. Just £1.55 per person affected by depression is allocated to depression research in the UK. This is a stark figure when compared with cancer, where research receives £1,571 per cancer patient.⁴ Whilst increased funding for depression and mental health more generally is necessary, it is vital that this is spent effectively, in areas that are of the greatest importance to those most directly affected by depression.

We know that there is often a mismatch between the things that patients, carers and healthcare professionals would like to have researched and what is actually researched (Crowe et al, 2015)⁵, and in general mental health research agenda is predominantly determined by academics and pharmaceutical companies.

This is why in 2013, MQ: Transforming Mental Health, a research-funding charity based in London, UK, approached the James Lind Alliance (JLA) to discuss working together to ensure that patient, carer and healthcare professionals voices are represented in setting research priorities for depression. This, to our knowledge, has never been done before in a systematic way.

The JLA method was originally designed to look only at questions that would result in clinical research. But mental health conditions, such as depression, have significant social factors and social interventions as well. Therefore, the Depression: ARQ project adapted the methodology to invite both clinical and social research questions and the results reveal an even spread of enthusiasm for research in both these areas.

THE PROCESS

The key stages of the JLA method were followed. An overview of the stages is detailed in Figure 1.

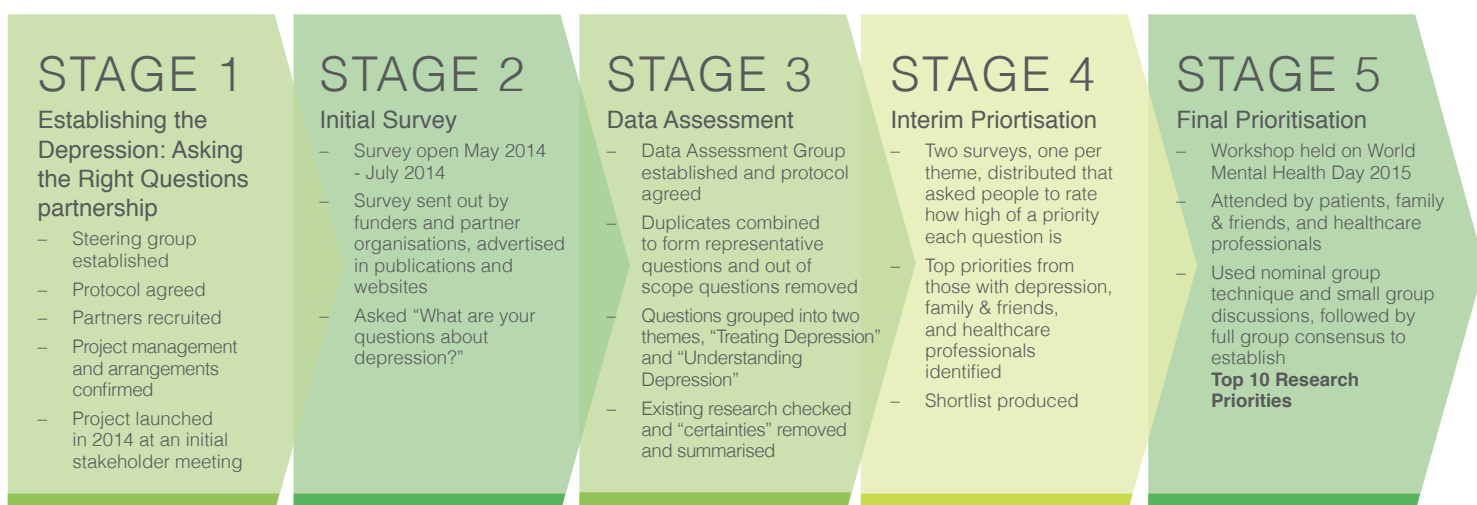


Figure 1

¹⁻³World Health Organization (2015). Retrieved 13 January 2016, from www.who.int/mediacentre/factsheets/fs369/en/

²McManus et al (2009). Adult psychiatric morbidity in England 2007. *Results of household survey*.

³MQ: Transforming Mental Health (2015). *Funding Landscape Report*. London: UK; Available at www.joinmq.org

⁴Crowe et al (2015). Patients', clinicians' and the research communities' priorities for treatment research: there is an important mismatch. *Research Involvement and Engagement*, 1:2; Available at <http://researchinvolvement.biomedcentral.com/articles/10.1186/s40900-015-0003-x>

TOP 10

RESEARCH PRIORITIES



In summary, the JLA method has five stages beginning with the establishment of partner organisations and a steering group that ensured the project met its objectives. The group was chaired by an independent JLA advisor.

An online survey then captured approximately 10,000 questions about depression from more than 3,000 people who identified as having experience of depression, being a family member or friend of someone who has, or a healthcare professional. These questions were then analysed, formatted and grouped into two themes: Treating Depression and Understanding Depression.

Two surveys, one per theme, were then distributed online asking people to rate each question according to how important they felt it was for research. This then produced a shortlist of the combined results of both themes, which was taken to a workshop attended by a group of people who had taken part in the surveys, where they reached a consensus on the top 10 priorities.

THERE HAS NEVER BEEN
A BETTER TIME, OR MORE
REASON, TO EXPLORE
RESEARCH PRIORITIES
FOR DEPRESSION.

1

What are the most effective ways to **prevent occurrence and recurrence** of depression?

2

What are the **best early interventions** (treatments and therapies) for depression? And **how early should they be used** in order to result in the best patient outcomes?

3

What are the best ways to **train healthcare professionals** to recognise and understand depression?

4

What is the **impact on a child** of having a parent with depression and can a parent **prevent their child** from also developing depression?

5

What are the best ways to inform people with depression about **treatment options** and their effectiveness in order to **empower** them and help them **self-manage**?

6

What are the **barriers and enablers for people accessing care/treatment** when they are depressed, including when feeling suicidal, and how can these be addressed?

7

Does depression impact employment?
How can **discrimination and stigma of depression** in the workplace be overcome, and how can employers and colleagues be informed about depression?

8

What are the best ways to **help friends and family members** to support people with depression?

9

Are **educational programmes** on depression effective in schools for reducing stigma?

10

What is the **impact of wait times** for services for people with depression?

Next Steps

A CALL TO ACTION

Use the Top 10

The Top 10 list covers a wide range of topics and therefore offers a wide range of potential activities. The partnership undertook the project with the main objective of the results used to inform **research projects**. But there are also other opportunities for **advocacy, stakeholder collaboration and influencing policy**.

Tell others about the Top 10

You can help by making sure that everyone who might be interested in these results is aware of them. There is a digital copy available online at www.depressionarq.org and you can request printed copies by emailing info@joinmq.org or calling **0300 030 8100**.

Tell us how you're using the Top 10

If we know how the results are being used and who is using them, we can better coordinate our efforts as a community of interested individuals and stakeholders. Please keep in touch by using the website, www.depressionarq.org or emailing info@joinmq.org

Additionally, the questions that were deemed "evidence certainties", or those adequately addressed by existing systematic reviews, will be made available at www.depressionarq.org. These can be used to help raise awareness of existing treatments, support, symptom awareness and for policy and advocacy work.

Please keep in touch by using the website
www.depressionarq.org

or by emailing
info@joinmq.org

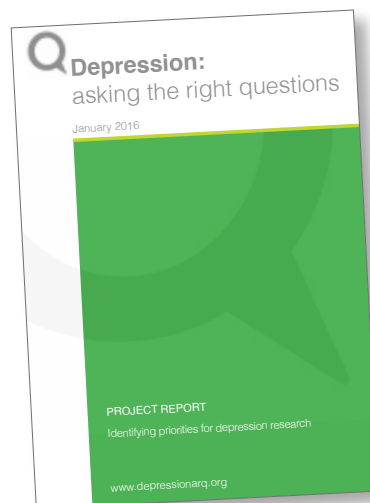
or call
0300 030 8100

How to get involved

We want to make sure that the results reach those who need to know about them – research funders, policy-makers, and service providers.

You can help by sharing the report and the project website (www.depressionarq.org) and continuing to show your support for the project.

If you are part of an organisation that would like to support this work, you can still join as a partner and help disseminate the results and help them deliver real change for people who experience depression, their friends and family members, and health and social care professionals.



For more information on how to get involved, visit www.depressionarq.org or email info@joinmq.org



Introduction and background

WHY DO WE NEED PRIORITIES FOR DEPRESSION RESEARCH?

Depression is an under-researched area. So, it is crucial that the limited resources available are spent on research that is most relevant to those directly affected: individuals with depression, their friends and family, and health and social care professionals. These are the people and groups who will benefit from the best and most relevant research.

We know that there is often a mismatch between the things that patients and carers would like to see researched, and what research is actually being done.⁶ It has also been suggested that when these priorities don't match the concerns of the end users, the research investment is potentially wasted.^{7,8}

Interestingly enough, the development of new and more effective treatments for depression has slowed considerably in recent years. This has been a frustration to psychologists and drug developers alike and suggests that there has never been a better time, or more reason, to explore research priorities from different perspectives. By expanding frames of reference, the research community is likely to uncover

figure when compared with cancer, where research receives £1,571 per cancer patient.⁹ Given these scarce resources, it is essential that we know what the priorities are for those most directly affected by depression so that research resources can be best allocated.

In light of this, in 2013 MQ: Transforming Mental Health approached the James Lind Alliance (JLA) to discuss working together to ensure that patient, carer and healthcare professional voices are represented in setting research priorities for depression.

The JLA is coordinated by the National Institute of Health Research (NIHR). Its aim is to provide a framework to help patients, carers and clinicians



new approaches to improving treatments and care. When compared with other areas of health research, mental health is woefully under-funded. Just £1.55 per person affected by depression is allocated to research into depression in the UK. This is a stark

work together to agree which are the most important evidence uncertainties affecting their particular interest, and to influence the prioritisation of future research in that area.

⁶ Crowe et al (2015). Patients', clinicians' and the research communities' priorities for treatment research: there is an important mismatch, *Research Involvement and Engagement*, 1:2; Available at <http://researchinvolvement.biomedcentral.com/articles/10.1186/s40900-015-0003-x>

⁷ Chalmers and Glaziou (2009). 'Avoidable waste in the production and reporting of research evidence', *The Lancet*, vol 374. (9683). pp 86–89

⁸ Chalmers et al (2014). 'Research: increasing value, reducing waste'. *The Lancet*, series papers. www.thelancet.com/series/research

⁹ MQ: Transforming Mental Health (2015). *Funding Landscape Report*. London: UK; Available at www.joinmq.org

Project Scope

The D:ARQ partnership is different from most previous Priority Setting Partnerships (PSPs) facilitated by the JLA because the scope is much wider.



Early on, the steering group decided to address questions not only about the treatment of depression, but about any aspect, including causes, diagnosis, outcomes, prevention and care.

The scope of the project was further defined to include questions from people aged 16 years old and above. Questions regarding self-harm and suicide were included where they clearly related to depression and questions regarding Bipolar were removed and shared with the Bipolar PSP (www.ouh.nhs.uk/research/patients/priority-setting-partnerships/bipolar/default.aspx).

STRENGTHS AND LIMITATIONS

While the D:ARQ project aimed to attract as representative a group of respondents as possible, it did not use population sampling. Information on demographics is self-reported and in most cases, limited.

Traditionally, the JLA method tends to limit scope to treatment-based research. However, due to the nature of depression and its social implications, support needs and triggers, the steering group decided to include all questions that could be addressed by clinical or social research that were in scope. This resulted in a significantly larger data set than previous priority-setting projects, therefore requiring some minor modifications in the ranking process.

Methodology

The partnership followed the methodology described in the JLA Guidebook, which can be found in full at www.jla.hihr.ac.uk

An overview of the process, as followed by the Depression: ARQ project can be found below.

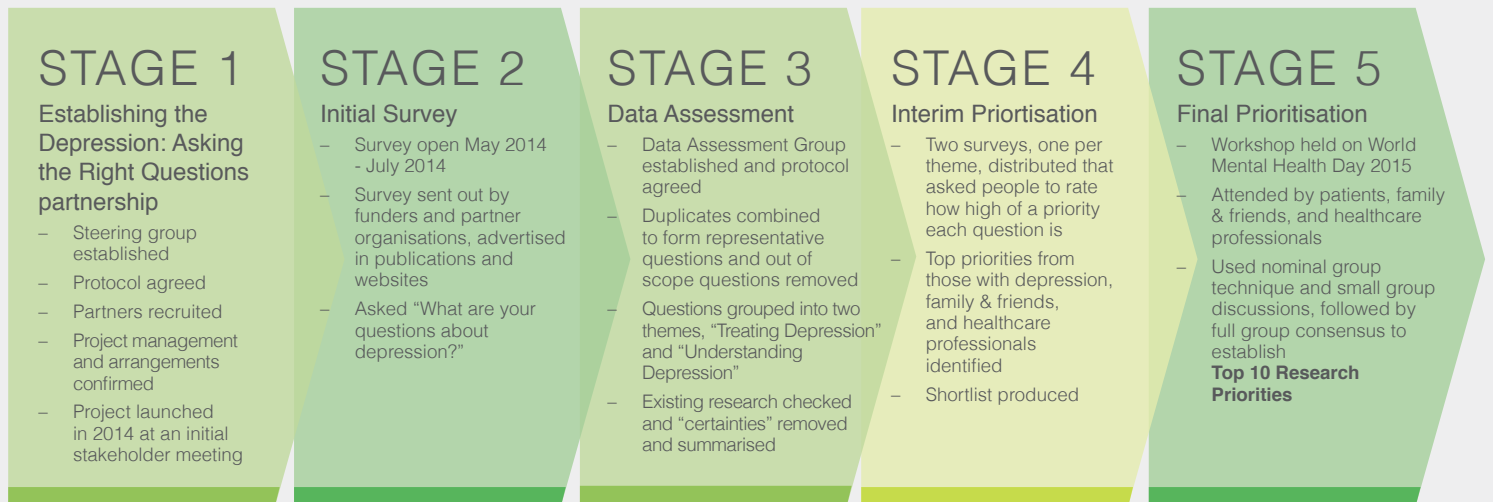


Figure 2



STAGE 1

Establishing the Depression: Asking the Right Questions partnership



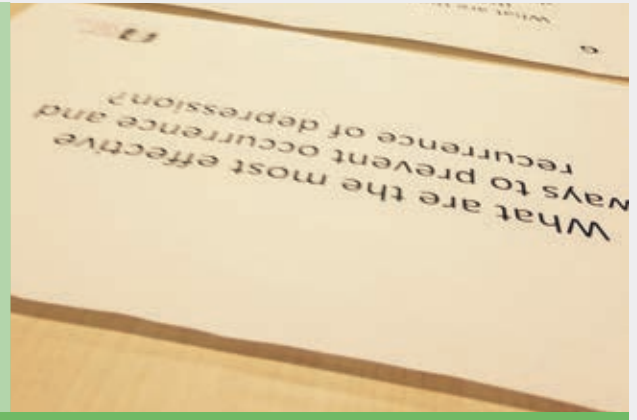
Key stakeholder organisations, academics, and service user representatives were identified and invited to be partners in the project, and a steering group was formed in order to ensure that the project met its objectives.

The partnership attracted support from a number of other organisations that want to see improvements in evidence-based care, support and treatments for depression and committed to co-funding the project along with MQ. Other organisations, representing a range of conditions and professional, patient and carer groups, signed up as stakeholders of the partnership, actively promoting the project and disseminating the surveys.

In early 2014, the partnership was officially launched, bringing together over 30 organisations, seeking to provide important input on areas most relevant to people with depression, carers and families, and health and social care professionals and with the intention of sharing the results with research funders to inform strategies.

STAGE 2

Initial Survey



We gathered questions from people with personal experience of depression, friends and family members, and health care professionals via a public survey. The survey was available online between May and July 2014 and asked:

What are your questions about depression?

Your question(s) can be about anything that you think is important to do with depression. We are interested in every aspect of depression – from diagnosis, to care, treatment and recovery. Questions about cause and prevention are welcome too.

The survey was available online at www.depressionarq.org. A paper version was also available on request.

To monitor who was responding, the survey asked respondents to identify themselves using the following categories:

- I have experienced symptoms of depression.
- I have been diagnosed with depression.
- I am a carer, family member, partner, friend or colleague of someone who has experienced depression.
- I am a health or social care professional working with people who have depression.
- I am a volunteer working with people experiencing depression.

In answer to the above, it was possible to tick multiple boxes, and indeed, many respondents identified as belonging to more than one category.

The survey was disseminated by supporting partners and individuals, and steering group members to their networks via email, newsletters, social media, web posts and blogs.

Over 3,000 people responded, approximately 80% of whom identified as having experience of depression. Responders provided approximately 10,000 individual questions.

STAGE 3

Data Assessment



Identifying Questions

A team at the University of Swansea led the analysis of the initial survey data. Their objective was to review each response, categorise it and identify each unique question. Where there were duplicates, these were combined into one representative question.

Theming Questions

Questions were grouped into two themes: Treating Depression and Understanding Depression. The Treating Depression questions related to the treatment of depression and tended to be more clinical in nature. The Understanding Depression theme contained questions around prevention, cause, social support, and social interventions.

Out of Scope Questions

Questions that were not directly related to depression were removed. These included questions about other mental health conditions when not coexisting with depression, such as Bipolar. Questions that were related to Bipolar were then passed to the Bipolar Priority Setting Partnership. Questions related to self-harm and suicide that were not directly related to depression were also considered out of scope.

Checking against Existing Evidence

Teams at the University of Swansea and the University of Bristol searched systematic reviews of existing evidence in order to check which questions had already been adequately answered by research. Questions that were deemed already answered, were categorised as “certainties” and removed.

Certainties

Summaries of the existing evidence for the questions identified as “certainties” were written and will be made publically available. Please check www.depressionarq.org for more information.

STAGE 4

Interim Prioritisation



Shortlisting Surveys

Two surveys, one for the Treating Depression theme and one for the Understanding Depression theme, were used to shortlist the questions, or “evidence uncertainties”. These were made available online and each ran consecutively for one month. Each survey received over 1,700 responses.

The surveys asked respondents to rate the importance of each question on a scale of:

- Very low priority
- Low priority
- High priority
- Very high priority
- No opinion/don't know

Respondents were asked again to self identify using the categories from the initial survey. However they were restricted to choosing one primary category, in order to aid the analysis.

Scores for the three overarching categories of respondents (1. those with experience of depression, 2. family and friends, 3. health and social care professionals and volunteers) were looked at separately, and the top ranking questions for each group were shortlisted, creating a list of 27 questions. This was done in order to ensure that each group's top priorities were included.

The full list of questions for each theme is in the Appendix to this report.

Workshop

The 27 shortlisted questions were then taken to a workshop on World Mental Health Day, 10th October 2015. The workshop was attended by 16 people who had participated in the initial and shortlisting surveys, and was observed by MQ staff and research funder representatives.

Following the standard JLA priority setting approach, which uses Nominal Group Technique, there were multiple sessions during the day in which participants worked in small groups in order to discuss and rank and re-rank the questions. These were facilitated by independent JLA advisors. The day finished with the whole group of participants reaching a consensus agreement for the full ranking of the questions, with a primary focus on the Top 10.

Results

RESULTS FROM DEPRESSION: ASKING THE RIGHT QUESTIONS FINAL WORKSHOP

10th October 2015

Participants at the workshop on 10th October 2015 discussed, ranked and re-ranked the 27 shortlisted questions before reaching consensus agreement on the order. The primary result of the project is a focus on the top 10 questions listed here.

1

What are the most effective ways to **prevent occurrence and recurrence** of depression?

6

What are the **barriers and enablers for people accessing care/treatment** when they are depressed, including when feeling suicidal, and how can these be addressed?

2

What are the **best early interventions** (treatments and therapies) for depression? And **how early should they be used** in order to result in the best patient outcomes?

7

Does depression impact employment?
How can **discrimination and stigma of depression** in the workplace be overcome, and how can employers and colleagues be informed about depression?

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What are the best ways to **train healthcare professionals** to recognise and understand depression?

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What is the **impact on a child** of having a parent with depression and can a parent **prevent their child** from also developing depression?

9

Are **educational programmes** on depression effective in schools for reducing stigma?

5

What are the best ways to inform people with depression about **treatment options** and their effectiveness in order to **empower** them and help them **self-manage**?

10

What is the **impact of wait times** for services for people with depression?



Listed here are the remaining shortlisted questions in ranked order.

11. What do people with depression feel works best in managing and treating depression?
12. What are the best ways to identify depression in children and teenagers?
13. What are the most effective ways of managing depression that doesn't respond to medication or talking therapies?
14. How can the way people with depression engage with mental health interventions/treatment be improved?
15. What is the effectiveness of school-based interventions/treatments for depression/wellbeing?
16. How can the stigma of depression be reduced and perceptions of people with depression improved within the general population?
17. To what extent does the stigma associated with depression affect people's treatment, symptoms and quality of life?
18. What are the most effective non-drug treatments for depression?
19. What are the long-term consequences of childhood depression?
20. How can depression be diagnosed and assessed in people with communication difficulties?
21. What is the best way to treat psychotic depression in young people?
22. What are the best ways to treat depression and anxiety together?
23. What events and factors can increase the likelihood of having another episode of depression?
24. What is the best way of helping young people with depression who are also diagnosed with another mental health condition?
25. What impact does long-term depression have on the brain?
26. What is the effect of social isolation on depression?

Note that while 27 questions went to the workshop, there are only 26 in the results. This is because priority 6 was originally two questions, one about depression and one about suicidal thoughts experienced by people with depression. The participants felt strongly that it was preferable to combine them into one priority.

The full list of priorities for depression that were identified from the initial survey after cleaning and analysis can be found in the Appendix.

Next Steps

A CALL TO ACTION

Use the Top 10

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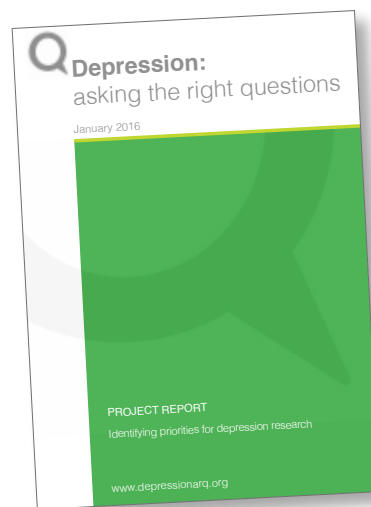
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Appendix: Full list of research priorities

TREATING DEPRESSION AND UNDERSTANDING DEPRESSION QUESTIONS

The questions in this appendix were identified after the initial survey questions were analysed, and those that were deemed to be out of scope questions removed or already answered by existing evidence were removed. (Please refer to the Methods section on page 12 - 16 for further information.)

The questions were divided into two themes, Treating Depression and Understanding Depression, and then put into two separate shortlisting surveys. (Please see the Methods section on page 17 for further information.)

TREATING DEPRESSION QUESTIONS

What are the most effective ways to prevent occurrence and recurrence of depression?

What are the best early interventions for depression?

What are the best ways to treat depression and anxiety together?

What are the most effective ways of managing treatment-resistant depression?

What is the best way to treat patients who do not respond to standard antidepressant medication treatment?

What do people with depression feel works best in managing and treating depression?

What are the most effective non-drug treatments for depression?

What are the long-term outcomes, recurrence rates and side-effects of taking antidepressant medication?

What is the impact of speed of access to services for people with depression?

What is the best way to identify depression in children and teenagers?

How can the way people with depression engage with mental health interventions/treatment be improved?

What are the best ways to inform people with depression about treatment options and their effectiveness in order to empower them and help them self-manage?

What are the barriers and enablers for people accessing care/treatment when they are depressed?

Is earlier intervention for depression associated with better patient outcomes?

Are GP training programmes for diagnosis and treatment of depression effective?

What is the best way of helping young people with depression who are also diagnosed with another mental health condition?

What is the best way for people with depression to support their partners and reduce the impact of their illness on them?

What is the best way to treat psychotic depression in young people?

What are the most effective school and work based interventions for people who are bullied and experience depression?

What are the most effective ways to ensure housebound people or those in care homes access appropriate treatment for depression?

What are the “withdrawal” effects of stopping antidepressant medication and how can they be managed?

What are the best sources to consult when looking for help with depression?

Is there a way to limit the side effects of current antidepressant treatments?

What are the best outcome measures to use when evaluating the effectiveness of interventions and services for depression?

Does taking antidepressant medication over a long period of time reduce its effectiveness?

What is the effectiveness of school based interventions for depression/wellbeing?

What antidepressants are safe to take during pregnancy?

What are the best ways for young people with depression to transition between services?

What is the effectiveness of providing information at GP surgeries on depression, such as on self-help groups available locally, websites and treatment options?

What interventions are most effective for poor school performance/refusal in young people with depression?

What are the best ways to help marginalised/seldom-heard groups access services?

What is the best way to treat people with communication difficulties for depression following a stroke?

Is a holistic approach (focusing on the whole person) in preventing and treating depression possible?

What is the best way to provide non-drug therapies for people with communication barriers, including deaf and deafblind people?

How effective is combining various non-drug treatments for depression?

What treatments are effective for people with Autistic Spectrum Disorder and depression?

How long should antidepressants be taken after symptoms have been relieved?

What criteria define “ill enough” for antidepressants?

How beneficial are support groups and peer-to-peer support in treating depression, including as an in-patient?

What are the best ways to treat people with depression who have cognitive impairment caused by injury or physical illness?

In what ways does a patient having choice and “shared-decision making” affect the treatment of depression?

How are treatment selection decisions made in psychiatric care?

How does the treatment environment (A&E, inpatient, office, home) affect the patient’s experience and the treatment’s effectiveness?

How effective is taking combinations of antidepressant medications?

What is the long-term effect of taking medications prescribed for other conditions (for example: treatment for hypertension, such as propranolol) on a person’s experience of depression?

How effective is “mindfulness” as a treatment for depression in the short and long-term?

What is the cost-effectiveness of early intervention for depression?

What treatments are effective for recurrent brief depression?

What are the reasons for talking therapy sessions being limited in duration when treating depression?

What are the best ways to improve sexual functioning when it is negatively affected by medication for depression?

What are the benefits of being outdoors in the management of depression?

How does drinking alcohol impact on the effectiveness of antidepressant medication?

Are occupational therapy programmes beneficial for the treatment of depression, including for psychiatric inpatients?

How long do antidepressants take to work?

What is the long-term impact of Electro-Convulsive Therapy (ECT) for treatment of depression, including causing other illnesses such as Motor Neurone Disease (MND)?

Does the time of day antidepressant medication is taken impact on its effectiveness or side-effects?

What are mental health professionals’ attitudes towards alternative treatments and how does that affect referral to and effectiveness of the treatment?

What is the effectiveness of neurofeedback therapy (using brain activity) in the treatment of depression?

What is the role of positive thinking in the treatment of depression?

What are the benefits of animal companionship in the treatment of depression?

What are the effectiveness and effect of psychedelic drugs, such as MDMA (or “ecstasy”), in treating depression?

What is the best way to treat and prevent seasonal affective disorder (SAD)?

How effective is assertiveness training in the treatment of depression?

What is the role of self-isolation or solitude, including going on a retreat, in managing depression and can it be beneficial?

Is art therapy an effective treatment for depression that does not respond to psychological therapy?

Is organisational skills training beneficial to treating depression?

What is the best way to stop receiving talking therapies?

How effective is hypnotherapy in the treatment of depression?

What is the role of reading and writing poetry in the treatment of depression?

What is the evidence for the effectiveness of alternative medicine (Eastern/Ayurvedic) in the treatment of depression?

What is the effectiveness of alternative therapies in the treatment of depression? (spiritual healing, Reiki, health kinesiology, bio-dance, massage, naturopathy, rebirth therapy)

UNDERSTANDING DEPRESSION QUESTIONS

What are the barriers to seeking help for people with depression when feeling suicidal, and how can these be addressed?

What are the best ways to train healthcare professionals to recognise and understand depression?

Does depression impact employment? How can discrimination and stigma of depression in the workplace be overcome, and how can employers and colleagues be informed about depression?

What are the best ways to help friends and family members to support people with depression?

How can the stigma of depression be reduced and perceptions of people with depression improved within the general population?

What are the best ways to identify depression in children and teenagers?

What events and factors can increase the likelihood of having another episode of depression?

What are the long-term consequences of childhood depression?

What is the impact on a child of having a parent with depression and can a parent prevent their child from also developing depression?

To what extent does the stigma associated with depression affect people's treatment, symptoms and quality of life?

What impact does long-term depression have on the brain?

What is the effect of social isolation on depression?

What factors increase the risk of self-harming in people with depression? Does having depression make you more likely to self-harm?

How can depression be diagnosed and assessed in people with communication difficulties?

How do a person's genes and their social and physical environments influence the onset of depression?

How frequently is depression incorrectly diagnosed and why does this happen?

What are the best ways to identify depression in older people?

What are the benefits and harms of being diagnosed as "depressed"?

Do people experience physical symptoms when they have depression? What kind of symptoms are they?

Can depression cause or worsen other conditions?

Are educational programmes on depression effective in schools?

What are the best methods to assess and diagnose depression in people with neurological conditions such as dementia and stroke?

How can someone know if they are depressed or just "low"?

Do people who are susceptible to negative thinking patterns have increased risk of depression?

What is the role of hormones in the occurrence of depression, and how are they linked?

What criteria must a person fulfil to be diagnosed with depression?

What are the causes of long-term but mild depression (dysthymia)?

What are the links between eating disorders and depression in young people?

What are the links between depression, post natal depression and the menopause?

Do certain personality traits increase the risk of depression?

Do men and women with depression experience suicidal thoughts differently?

Are there links between drug and alcohol abuse and depression amongst older adults?

What effects do websites and online forums have on depression in young people?

Does depression cause irrational behaviour in adults? What is the link between depression and so-called "mid-life crisis"?

Do children who experience serious physical illness have an increased risk of depression as teenagers/adults?

What is the relationship between depression and neurological conditions, such as Parkinson's disease and epilepsy?

Are the immune system and systematic inflammation a contributing factor to the onset of depression?

Are the symptoms of depression experienced differently by men and women?

Is there a link between Autism spectrum disorder/Asperger's disorder and depression?

What is the relationship between acquired brain injury and depression?

Does depression have an impact on how you experience pain?

What are the rates of depression among Black Minority Ethnic (BME) groups?

What are the rates of depression among the Lesbian Gay Bisexual Transsexual (LGBT) population?

Is there a link between depression and getting older?

Does depression have an evolutionary purpose? Do we learn something by going through depression?

Is there a link between viral/bacterial infections and the occurrence of depression?

Is there a link between being under- or over-weight and being depressed?

Is there a link between childhood hyperactivity and depression?

What is the interaction between depression and diabetes?

What is the impact of playing computer/video games on depression in young people?

Is there a link between dyslexia and depression?

Does IQ have an effect on depression?

Do people working in creative professions experience higher rates of depression?

Is there a link between childhood jaundice and depression?

What is the effect of religion on the occurrence of depression?

 **Depression:**
asking the right questions

Please keep in touch by using the website

www.depressionarq.org

or by emailing

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or call

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