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1 **TITLE**

2 Eleven top research questions asked by people with lived depression experience in
3 Alberta: A survey.

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41 substantial contributions to the conception, design, acquisition of data, analysis and
42 interpretation of data

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72 **DECLARATION OF AUTHORS COMPETING INTERESTS**

73 The authors have no competing interests to declare.

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4 75 **ABSTRACT**

5 76 **Background:** To support patient-oriented depression research priority setting in Alberta,
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8 77 Canada, the Patient Engagement Platform of the Alberta Strategy for Patient Oriented
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10 78 Research SUPPORT Unit and the Addiction and Mental Health Strategic Clinical
11
12 79 Network of Alberta Health Services, along with partners in addictions and mental health,
13
14 80 designed a depression research priority setting project. The research question guiding
15
16 81 this project was “What are the patient and clinician priorities for depression research in
17
18 82 Alberta?” The aim of the Alberta depression research priority setting project (the Project)
19
20 83 was to survey patients, caregivers and clinicians/researchers in Alberta about what they
21
22 84 considered were the most important unanswered questions about depression.
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26 85 **Methods:** The Project adapted the UK’s James Lind Alliance method into a six-step
27
28 86 survey to gather and prioritize questions about depression posed by people with lived
29
30 87 depression experience, which included patients, caregivers, clinicians and health care
31
32 88 practitioners.
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35 89 **Results:** A total of 445 Albertans with lived experience of depression participated in
36
37 90 ultimately identifying the 11 priority depression research questions, spanning the health
38
39 91 continuum, life stages, and both treatment and prevention opportunities.
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43 92 **Interpretation:** This Project is a fundamental step that has potential to positively
44
45 93 influence depression research. Including the voices of Albertans with lived experience
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47 94 will create advantages for depression research for Albertans, researchers and research
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49 95 funders, and the patient-engagement in research enterprise overall.
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98 INTRODUCTION

99 Depression is a major public health issue in Canada (1). Approximately 8% of adults
100 aged 25-64 years projected to experience major depression at some time in their lives, (2)
101 and estimated to account for at least \$32.3 billion of direct and indirect costs to this
102 nation annually. (3) Continued investment in research which explores prevention and
103 treatment is needed (4, 5) and in particular through engaging patients in this endeavor
104 (i.e., people living with depression, family members and informal caretakers) to better
105 ensure that research is relevant to their needs. Patient engagement occurs “when patients
106 meaningfully and actively collaborate in the governance, priority setting, and conduct of
107 research, as well as in summarizing, distributing, sharing, and applying its resulting
108 knowledge.” (6) Unfortunately, research findings suggest that medical research topics are
109 selected predominantly by researchers and funding agencies, with little input from
110 patients themselves, (7) and that even when patients are engaged in setting research
111 priorities, their opinions are sometimes overlooked. (8) Engaging people with lived
112 experience of a health situation in setting research priorities is one, structured way of
113 influencing researchers and research funders to consider their opinions.

114 The goal of the Alberta Depression Research Priority Setting project (the Project) was to
115 have patients and clinicians in Alberta, Canada, identify the most important unanswered
116 questions about depression by answering the Project research question, “What are the
117 patient and clinician priorities for depression research in Alberta?” The Project was co-
118 designed and co-implemented by the Patient Engagement Platform of the Alberta
119 Strategy for Patient Oriented Research (SPOR) Support for People and Patient-Oriented
120 Research and Trials (SUPPORT) Unit, the Addictions and Mental Health (AMH)

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3 121 Strategic Clinical Network (SCN) of Alberta Health Services, and the Alberta Hub of the
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5 122 Canadian Depression Research and Intervention Network (CDRIN). In this paper, we
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7 123 describe the process used to survey patients and clinicians on what they believe are
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9 124 unanswered questions about depression. We report our findings taking into account the
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11 125 GRIPP2 (Guidance for Reporting Involvement of Patients and Public) checklist criteria
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13 126 for patient and public involvement (9) and the Checklist for Reporting Results of Internet
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15 127 E-Surveys (CHERRIES) (10) . A separate paper discussing the patient engagement
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17 128 components of the Project is published elsewhere (11). Manuscripts on the knowledge
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19 129 synthesis and literature search strategies, including the identification of knowledge gaps,
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21 130 are in process.
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27 131 **METHODS**

30 132 *Setting and Recruitment of Persons with Lived Experience*

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34 133 The study, conducted in Alberta, Canada, focused on recruiting people who live within
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36 134 the geographic boundaries of this province. The previously-identified partner
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38 135 organizations recruited 14 members from their communities to form a Project Steering
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40 136 Committee consisting of six people living with depression, one caregiver, four clinicians,
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42 137 five researchers and two members of the project planning committee. As evidenced by
43
44 138 the total number of committee numbers, several members represented more than one
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46 139 category (i.e., a person living with depression who is also a clinician). A convenience
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48 140 sampling strategy was predominantly used to recruit people living with depression,
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50 141 people who care for those with depression, and health care professionals who treat
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3 143 Digital recruitment collateral for participants was advertised via social media platforms
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5 144 (Twitter and Facebook), through websites of partner organizations, and through network
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7 145 connections of Steering Committee members. To facilitate data collection, participants
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9 146 were asked to participate by giving them a specific URL to access the questionnaire. For
10
11 147 specific populations, including Métis and homeless populations, a purposive sampling
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13 148 technique was used, through engagement with established partnerships working with
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15 149 members of the population. A sampling frame was developed to address the study
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17 150 objectives by including people with lived experience with representation from a broad
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19 151 demographic spectrum (e.g., age, ethnicity, immigration status) who are justifiably
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21 152 considered ‘experts’ with depression (12). Paper copies of the questionnaire were
22
23 153 disseminated to these populations who may have more limited online access. Participants
24
25 154 were informed that their participation will help inform the research community on the
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27 155 direction of research focusing on questions that matter most to patients, families and
28
29 156 others who support Albertans with depression. The survey required 10-20 minutes for
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31 157 completion and all responses would be kept confidential and for the purpose of the study.
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33 158 Participants were not required to provide their name or contact information.
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43 160 *Study Methods and Design*

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46 161 The UK’s James Lind Alliance (JLA) Priority Setting Partnership method brings patient
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48 162 and clinician groups together on an “equal footing” to produce a jointly agreed list of
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50 163 research priorities that are recorded and made available to researchers and funders. (13)
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52 164 A “funnel approach” is used: a larger sample of people with lived experience first
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3 165 identifies research questions about a health issue, with a smaller sample ranking the
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5 166 questions, and a still smaller sample prioritizing the final questions. (12)
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8 167 The Patient Engagement Platform adapted the four-step JLA method into a six-step
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10 168 process to ensure that the voices of people with lived experience of depression were
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12 169 included throughout the Project. The Project used an egalitarian, consensus-building
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14 170 process, combining the perspectives of people with lived depression experience and
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16 171 clinicians. It is, therefore, classified on the “Collaborate” level of Patient and Researcher
17
18 172 Engagement in Health Research Schematic. (14). A complete description of the methods
19
20 173 used is given below. The implementation of the Project, from initial data collection to
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22 174 final priority setting, took 10 months. The Project was reviewed and received approval
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24 175 by Research Ethics Boards (REBs) at two universities, the University of Alberta and
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26 176 Athabasca University.

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32 177 **Step 1: Data gathering (Online and paper survey)**
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35 178 The Steering Committee co-designed the survey by consensus, with the goal of ensuring
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37 179 that people with lived experience of depression to identify their concerns and unanswered
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39 180 questions about depression. A copy of the survey can be found in Appendix 1. The two
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41 181 REBs identified above approved “implied consent”; that is, consent was implied by the
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43 182 positive act of completing the survey. The ISO 27001 compliant Snap Survey online
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45 183 platform was used and hosted by Alberta Innovates: Health Solutions, with data stored on
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47 184 secured internal systems. Access to the application was limited by site licenses, and only
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49 185 accessible from onsite/internal systems only. In addition, the web host function was
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51 186 password protected. No incentives were provided to complete the survey.
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3 187 In an effort to engage populations that have traditionally been voiceless in health
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5 188 research, a purposive sampling technique was used, utilizing established connections and
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7 189 relationships through partner organizations (e.g., leveraging positive connections at the
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9 190 Bissell Centre in Edmonton, AB). One hundred paper surveys were taken to a Métis
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11 191 settlement in Buffalo Lake (nine were returned), and 25 paper surveys were distributed to
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13 192 homeless individuals at the Bissell Centre in Edmonton (13 were returned, response rate
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15 193 of 52%). Survey responses were accepted for a four-month period.
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19 194 **Step 2: Question analysis and review**
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22 195 After excluding responses to the online survey from outside Alberta (n=192), Steering
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24 196 Committee members analyzed the data for diversity of representation . Diversity was
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26 197 analyzed periodically throughout the survey (on a weekly basis for the first three months;
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28 198 every other week for the last month) to inform the steering committee about
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30 199 representation across responses.
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35 200 Next, the open-ended questions submitted by people with lived experience were
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37 201 reviewed. Duplicate questions were removed, as were questions that two or more steering
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39 202 committee members agreed did not meet the purpose of the project. The remaining
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41 203 questions were reviewed by the entire committee to ensure that they were easy to
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43 204 understand, worded appropriately (without jargon or acronyms), and reflected the original
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45 205 intent of the questions submitted. In-person meetings allowed the Steering Committee to
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47 206 ensure the questions were being interpreted using a patient lens. (15) The aim was to
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49 207 fully capture the nuances in language on the list of prioritized questions. A smaller
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51 208 subset of questions was assigned to dyads within the steering committee (i.e., one person
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3 209 with lived experience and one clinician) to re-develop research the questions using a
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5 210 PICO (Population, Intervention, Comparator, Outcome) format, where possible.
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8 211 **Step 3: Question rating (Online survey)**

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11 212 An online rating survey was initiated and the URL shared on Twitter and through contact
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13 213 networks of the Steering Committee to rate the short-list of questions. Over a one-week
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15 214 period, survey respondents identified which questions were most important using a 5-
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17 215 point Likert scale: Not a priority, Low priority, Medium priority, High priority,
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19 216 Undecided. Data were collected and managed using REDCap electronic data capture
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21 217 tools (16), a secure and user friendly application, hosted at the University of Alberta.
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23 218 Similar to the Step 1 questionnaire, access to the application was limited by site licenses,
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25 219 is accessible from onsite/internal systems only and is password protected. Questions that
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27 220 were most frequently identified by as “high priority” were ranked higher than or equal to
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29 221 other questions to establish the order of question importance. This ultimately generated a
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31 222 list of research questions, rated in order of importance by those surveyed. No incentives
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33 223 were provided to complete the survey.
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40 224 **Step 4: Question prioritization (In-person workshop)**

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43 225 , Finally, participants attended a full day workshop to identify the top 10 questions
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45 226 submitted by Albertans. This was supported by, three facilitators, three Patient
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47 227 Engagement Platform members and two observers (one student and one evaluator)
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49 228 attended and supported the workshop, but did not participate in ranking. This sample fits
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51 229 within the JLA recommendation that prioritization workshops not exceed 30 participants
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53 230 (12). Prior to the workshop, participants were given a ranking tool listing the top-ranked
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3 231 25 questions from the rating survey, and asked to prioritize the questions from most
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5 232 important to least important. At the workshop, a Nominal Group Technique was used,
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7 233 where participants were divided into three groups to compare their personal rankings.
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9 234 Each group had a facilitator and recorder to manage the dialogue and guide the process
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11 235 towards group consensus. After two iterative rounds of dialogue and small-group work,
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13 236 the overall rankings of each question were brought back to the collective group for final
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15 237 ranking, and 11 questions were identified (versus the JLA suggestion of 10 questions as
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17 238 two questions had equal rating).
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22 239 **Step 5: Knowledge Synthesis**

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25 240 The Knowledge Translation Platform of the Alberta SPOR SUPPORT Unit searched the
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27 241 available literature to determine to what extent, if any, the top 11 questions had been
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29 242 addressed by previous research (to be reported in a forthcoming manuscript).
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33 243 **Step 6: Knowledge Translation**

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36 244 The Patient Engagement Platform developed a final report in conjunction with the
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38 245 Steering Committee and planned, implemented and hosted a media launch that resulted in
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40 246 TV, radio, and print news coverage, as well as attendance by researchers. The Platform
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42 247 is currently working with the identified partner organizations to facilitate dissemination
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44 248 and knowledge translation opportunities by developing a knowledge mobilization plan.
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48 249 **RESULTS**

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52 250 A total of 445 Albertans with lived depression experience participated in identifying
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54 251 depression research questions. Forty-nine Albertans rated the research questions to
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3 252 inform the 25 medium to high priority questions. During a full day workshop, 20 people
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5 253 (11 steering committee members and nine public members, including clinicians, health
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7 254 care professionals, and people with lived experience) attended an in-person workshop to
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9 255 identify the top 10 questions submitted by Albertans. A description of the participant
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11 256 sample is included in Table 1.

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15 257 The Project was successful in gaining representation from people with lived experience at
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17 258 every step. In Step 1 (data gathering), more than three quarters of respondents identified
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19 259 as people living with depression or as family members or caregivers of a person with
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21 260 depression (80.2%, $n = 357$). Within this population, 37.9% ($n = 159$) had more than five
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23 261 years' experience with depression, and a further 28.3% ($n = 119$) identified a lifetime of
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25 262 experience with depression. Nearly all participants in Step 3 (question rating) identified
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27 263 as having some experience with depression ($n = 44$, 90%), as did more than half of
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29 264 participants ($n = 12$, 60%) in Step 4 (question prioritization).

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35 265 The summary of outputs of the Project across each of the six steps is provided in Table 2.
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37 266 The final 11 priority research questions are identified in Figure 1.

38 39 40 267 **INTERPRETATION**

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44 268 In this study, we used a systematic and collaborative approach to identify 11 priority
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46 269 questions for depression research from the perspective of Albertans with lived
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48 270 experience. To our knowledge, this is the first time in Alberta that people with lived
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50 271 experience of depression and clinicians were involved in all steps of the research question
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52 272 identification and prioritization process. Aligning patient and clinician interests is
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54 273 challenging. The necessary “social conditions for dialogue” necessary for this alignment
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3 274 do not simply appear; therefore, an appropriate methodology should include strategies for
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5 275 developing mutual trust and commitment from otherwise disparate groups (17).
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9 276 This strategy presents many advantages for patients, clinicians and researchers, and the
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11 277 patient-engagement in research enterprise itself. First, as suggested by the IAP2
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13 278 spectrum, the higher the degree of participation within research priority setting activities,
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15 279 the more accurately the results reflect the community. (18) In this study, more than three
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17 280 quarters of the initial respondents identified as persons with lived experience of
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19 281 depression. The effects of this degree of participation may be illustrated by the extent to
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21 282 which the prioritized research questions span the health continuum, considering different
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23 283 life stages, treatments, and prevention opportunities. The comprehensiveness of the
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25 284 questions reflects the complexity of depression and the multiple ways in which it impacts
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27 285 the well-being of those affected. Second, this study presents an opportunity to address
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29 286 research priorities that are meaningful to Albertans. Researchers have suggested that
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31 287 priorities established by people with lived experience are better aligned with the complex
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33 288 experience of living with disease, and make it easier to gain broader collaboration from
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35 289 patients across the research activity spectrum. (17, 19) It recognizes patient contributions
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37 290 as valuable, acknowledging the expertise brought forward from patients' own experience
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39 291 (20, 21).
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46 292 Third, while the JLA method incorporates a simultaneous review of the literature to
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48 293 validate research uncertainties, the Project validated research questions through the
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50 294 creation of common themes that emerged from survey respondents, workshop
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52 295 participants, and Steering Committee members. Questions were not systematically
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54 296 filtered, based on existing research, before the prioritization process began; therefore, we
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3 297 believe that the results authentically reflect the voices and perspectives of Albertans,
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5 298 including people with lived experience. The patient engagement literature suggests
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7 299 several benefits from such meaningful representation, including improved quality of
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9 300 research design, increased participant enrolment and decreased attrition in research
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11 301 studies, wider application of research findings, and overall improved research
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13 302 effectiveness. (20, 22, 23) Therefore, we believe that employing the results from this
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15 303 study can assist in closing the knowledge-to-action gap (24) by mobilizing timely and
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17 304 relevant data to inform clinical care and research.
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22 305 Finally, recent research suggests that building collaborative relationships between the
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24 306 patient and researcher requires an informed and compassionate understanding of how to
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26 307 effectively and efficiently involve patients in a meaningful and feasible way (25) This
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28 308 study helps illustrate outcomes of meaningful patient and researcher engagement,
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30 309 building on other such work in Canada. (19, 26-34) It also contributes to the growth of
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32 310 evidence that people with lived experience are valuable research partners.
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37 311 **Limitations** At the same time, several important limitations should be considered when
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39 312 applying this study's findings. First, the convenience sampling strategy may have
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41 313 resulted in bias due to over- and under-representation of subgroups compared to the
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43 314 population of interest. This inherent limitation was addressed in part by the continuous
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45 315 review of demographic characteristics of participants who completed the online data
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47 316 collection and question ranking steps. While the survey had good reach, some groups
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49 317 were under represented, an ongoing challenge recognized in the patient engagement
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51 318 literature. (35) Committed efforts were made to reach these populations; however,
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53 319 recruitment from these groups were not very successful. Furthermore, a response rate
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3 320 cannot be calculated because the total sample number is unknown. To mitigate this in
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5 321 future research, a two-step process could be used where self-identified participants first
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7 322 agree to participate in the study; once this is documented, they are sent the questionnaire
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10 323 to complete, thereby allowing to calculate the response rate.
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15 325 Second, the possible subjective influences of steering committee members and of
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17 326 patients, particularly in the smaller group that completed the final prioritization of the
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19 327 research questions, should be considered in establishing research priorities, to ensure that
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21 328 decisions are not solely informed by one type of evidence.
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25 329 Third, a small sample ranked the 25 research questions (Step 3). While it is expected that
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27 330 the sampling frame narrows throughout the six steps, two factors may have decreased the
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29 331 number of persons who might have participated at this step: first, a limited time frame for
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31 332 completing the ranking (i.e., one week), and second, the ranking occurred during the
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33 333 summer months which may not have reached as wide of an available sample.
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37 334 Considering these limitations, the steering committee relied on the recurrence (i.e.,
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39 335 saturation) of themes as one indicator of representativeness, while continuously updating
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41 336 our strategies to solicit input from underrepresented populations. Future priority setting
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43 337 would focus on increasing representation from males, rural communities, immigrants,
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45 338 and ethnically diverse communities to ensure that priorities are representative of all
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47 339 Albertans living with depression. Alberta's specific demographic profile would need to
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49 340 be considered, with 15.8% of the population reporting an Aboriginal identity. (36)
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3 341 **Conclusions** The authors hope that the outcomes of the Project will better align research
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5 342 objectives with the needs of Albertans with lived experience, and will lead to funders
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7 343 identifying some or all of these top 11 research questions as qualifying for monetary
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9 344 resource allocation and as a result to research (20). Future studies can adapt this process
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11 345 to actively engage patients throughout the research cycle. It is expected that this strategy
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13 346 will promote greater understanding and insight into depression research, while
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15 347 continuously building rapport with people with lived depression experience as central to
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17 348 research processes. (37, 38)
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Table 1. Survey participant demographics (Step 1: Data gathering)

Variable	Result (n, (%))
<i>Respondent (n=445)</i>	
Person living with depression	283 (63.6%)
Family member or caregiver of person with depression	74 (16.6%)
Health care professional caring for people with depression	28 (6.3%)
Counsellor	3 (10.1%)
Nurse	7 (25.3%)
Psychiatrist	1 (3.8%)
Psychologist	4 (13.9%)
Social Group worker	1 (3.8%)
Other	12 (29.1%)
Clinician treating depression	14 (3.1%)
Other	46 (10.3%)
<i>Gender (n=445)</i>	
Male	88 (19.8%)
Female	354 (79.6%)
Did not report	3 (0.7%)
<i>Age range (n=445)</i>	
18-29	76 (17.1%)
30-39	108 (24.3%)
40-49	116 (26.1%)
50-59	95 (21.3%)
60-69	40 (9.0%)
70-79	8 (1.8%)
80 and older	2 (0.4%)
<i>Primary place of residence (n=445)</i>	
Edmonton	144 (32.4%)
Calgary	141 (31.7%)
Other	160 (36.0%)
<i>Immigration status (between 2011-2016) (n=445)</i>	
Yes	10 (2.0%)
No	435 (97.8%)
<i>Ethnic origin (n=445) *</i>	
Canadian	287 (64.5%)
European	150 (33.7%)

Variable	Result (n, (%))
East European	29 (6.5%)
Metis	25 (5.6%)
North American	16 (3.6%)
First Nation	13 (2.9%)
Asian	11 (2.5%)
South American	6 (1.3%)
African	5 (1.1%)
Middle Eastern	5 (1.1%)
Central American	3 (0.7%)
Inuit	2 (0.4%)
Other	6 (1.3%)
Prefer not to say	5 (1.1%)
<i>Experience with depression (n=420)</i>	
Lifetime experience with depression	119 (28.3%)
More than 5 years experience with depression	159 (37.9%)
3-5 years of experience with depression	39 (9.3%)
1 to 2 years experience with depression	28 (6.7%)
<1 year experience with depression	12 (2.9%)
New diagnosis of depression	4 (1.0%)
Other	15 (3.6%)
Recovered from depression	44 (10.5%)
<i>Number of months in past year with depression experience (n=352)</i>	
10-12	162 (46.1%)
7-9	32 (9.1%)
4-6	26 (7.5%)
0-3	64 (18.2%)

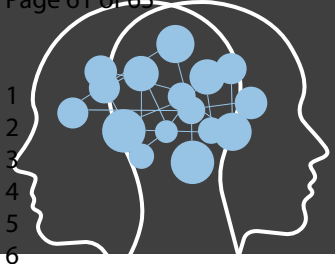
* Percentage equals over 100 as participants self-identified in one or more group of ethnic origin

Table 2. Summary of process and outputs of the Alberta Depression Research Priority Setting (DRPS) Project for determining top 11 Depression research questions

DRPS Process	OUTPUTS
<p>Step 1: Data Gathering</p> <p>(Participant online and paper survey)</p> <p>August – December 2016 (4 months)</p>	<ul style="list-style-type: none"> • 14-member steering committee formed • 445 respondents (from Alberta only) • 1270 questions and comments on depression received
<p>Step 2: Question analysis and review</p> <p>(Steering Committee)</p> <p>August – December 2016 (5 months)</p>	<ul style="list-style-type: none"> • 350 questions removed that were submitted by participants residing outside of the province of Alberta from how many respondents? • 724 questions removed due to duplication • 196 questions reformulated into PICO research question format and refined (e.g., removed jargon) • Short list of 66 research questions across 7 categories went forward for final priority setting (In order: Diagnosis and treatment; Society, culture and environment; Medication, biology and physiology; Child and youth; Access, service, funding and policy; Training and education; and Family and behaviour)
<p>Step 3: Question rating</p> <p>(Participant online survey)</p> <p>1-week in June 2017</p>	<ul style="list-style-type: none"> • 49 participants rated 66 research questions (through an online survey) • 25 medium to high priority questions (most commonly asked) were identified
<p>Step 4: Question prioritization</p> <p>(In-person participant workshop)</p> <p>1 day in June 2017</p>	<ul style="list-style-type: none"> • 20 participants prioritized 11 research questions (plus 4 PE staff members, 3 facilitators and 2 observers) • (14 remaining questions not selected in the top 11 were deemed worthy of consideration for future depression research)

<p>Step 5: Knowledge Synthesis</p> <p>(PE and KT Platform)</p> <p>July – October 2017</p> <p>(4 months)</p>	<ul style="list-style-type: none"> • 25 rapid reviews of depression research questions conducted
<p>Step 6: Knowledge Translation</p> <p>(PE and KT platform)</p> <p>November 2017- January 2018 and Ongoing</p>	<ul style="list-style-type: none"> • Dissemination and knowledge mobilization opportunities • Public report launched to media, January 2018

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Alberta's Top 11 Depression Research Priorities

Determined by Albertans with Lived Experience


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1 Which treatment therapy or method is more successful for long term remission or recovery?
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2 What are the long term physical implications of pharmacotherapy for treating depression?
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3 For various treatment options (eg. psychotherapy, individual vs. group psychotherapy and psychosocial support), what are the advantages in terms of cost, effectiveness, relapse prevention and safety?
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4 What are the prevention strategies/tactics for reducing self-harm and suicide in children, youth and adults with depression?
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5 What changes to the health care system will increase access to psychological services?
- 

6 What changes in the health care system will result in shortened wait times for depression services?
- 

7 Can diet or exercise affect the development of depression?
- 

8 What are the functional, social, intellectual, physical and psychological problems experienced by children and teens living with an immediate family member who has depression?
- 

9 What interventions are effective in preventing and treating workplace depression and reducing stigma associated with depression in the workplace?
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10 Are there structural or functional changes in the brain due to antidepressant therapy during brain development?
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11 What is the role of family in the treatment and trajectory of depression?

Alberta Depression Research Priority Setting Project (2017, August 10). [Alberta's Top 11 Depression Research Priorities: Determined by Albertans with Lived Experience] [Infographic]. Proceedings from the final workshop with the Alberta Depression Research steering committee and workshop participants, Edmonton AB June 12, 2017.

Appendix 1 – Data Gathering Survey (Step 1)

SECTION I	
1. Please identify which perspective you are answering or creating questions from. If more than one applies to you, please only select one and offer impressions from that perspective.	<input type="radio"/> As a person living with depression <input type="radio"/> As a family member or ‘carer’ of a person with depression <input type="radio"/> As a health care professional caring for people with depression <input type="radio"/> As a clinician treating depression <input type="radio"/> Other
2. If you are a <u>health professional</u> or <u>clinician</u> , specify the type (check all that apply). If this question does not apply to you, skip to question 3.	<input type="radio"/> Family physician <input type="radio"/> Psychologist <input type="radio"/> Counsellor <input type="radio"/> Social worker <input type="radio"/> Naturopath <input type="radio"/> Herbalist <input type="radio"/> Elder <input type="radio"/> Traditional healer <input type="radio"/> Support group worker <input type="radio"/> other
3. Select your gender:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Prefer not to say <input type="radio"/> Other
4. Select your age group	<input type="radio"/> 17 and younger <input type="radio"/> 18-29 <input type="radio"/> 30-39 <input type="radio"/> 40-49 <input type="radio"/> 50-59 <input type="radio"/> 60-69 <input type="radio"/> 70-79
5. Where do you currently live	<input type="radio"/> Alberta <input type="radio"/> First Nation Reserve <input type="radio"/> Northwest Territories <input type="radio"/> Outside Alberta
6. Where is your primary residence? Only specify the option applicable to you, leave the other blank	<input type="radio"/> City (specify) <input type="radio"/> Rural or remove (specify)

7. Are you a recent immigrant or refugee to Canada (between 2011-2016)?	<input type="radio"/> Yes <input type="radio"/> No
8. What is your ethnic origin? Check all that apply	<input type="radio"/> First Nation <input type="radio"/> Inuit <input type="radio"/> Métis <input type="radio"/> African <input type="radio"/> European <input type="radio"/> Eastern European <input type="radio"/> Middle Eastern <input type="radio"/> Asian <input type="radio"/> South American <input type="radio"/> Central American <input type="radio"/> Canadian <input type="radio"/> North American <input type="radio"/> Prefer not to say <input type="radio"/> Other
SECTION II	
9. Based on the perspective you chose earlier (living with, caring and or/treat) indicate your experience with depression (select only one option)	<input type="radio"/> New diagnosis of depression <input type="radio"/> Less than one years of experience with depression <input type="radio"/> 1 to 2 years of experience with depression <input type="radio"/> 3 to 5 years of experience with depression <input type="radio"/> More than 5 years experience with depression <input type="radio"/> Lifetime experience with depression <input type="radio"/> Recovered from depression <input type="radio"/> Other <input type="radio"/> Not applicable
10. Indicate the <u>number of months</u> in the past year where you experienced symptoms of depression (select only one option)	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10

	<input type="radio"/> 11 <input type="radio"/> 12 <input type="radio"/> Not Applicable
11. Indicate <u>your care or support experience</u> with depression (check all that apply):	<input type="radio"/> Family Physician <input type="radio"/> Psychiatrist <input type="radio"/> Psychologist <input type="radio"/> Counsellor <input type="radio"/> Social Worker <input type="radio"/> Naturopath <input type="radio"/> Herbalist <input type="radio"/> Elder <input type="radio"/> Traditional Healer <input type="radio"/> Support Group <input type="radio"/> Self-care (please describe using the space below) <input type="radio"/> Other (please describe using the space below) <input type="radio"/> Not Applicable
12. If you are willing to share, please describe your personal circumstances that may affect your experience with depression	
<p>SECTION III</p> <p>The following section is your opportunity to create questions about depression that you want answered. We have included specific topic areas to help guide you, but if your question(s) do not fit within these topic areas, there is additional space at the end of this survey to submit these questions. We have included age groupings as a guide, but it is not necessary to have questions for each age group.</p> <p>Here are examples of questions that some people have submitted:</p> <ul style="list-style-type: none"> • Can exercise improve symptoms of depression? • How safe is it for my baby if I am breastfeeding and taking antidepressant medication? 	
13. If you have questions about the development of depression in children (0-10), youth/teens (11-18), young adults (19-29), adults (19-64) and/or mature adults (65 plus) write them in the space below	
14. If you have questions about the treatment of depression in children (0-10), youth/teens (11-18), young adults (19-29), adults (19-64) and/or mature adults (65 plus) write them in the space below	
15. If you have questions about the influence	

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of depression in children (0-10), youth/teens (11-18), young adults (19-29), adults (19-64) and/or mature adults (65 plus) write them in the space below	
16. Do you have other questions about depression that you would like researchers to know?	

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