Issued: 21 January 2020

Request for Proposal (RFP) for:

Insight analysis into "core components" underpinning interventions for youth depression or anxiety

Summary

We seek proposals to undertake a review and interpretation of the evidence ("insight analysis") in relation to "core components"[1], hypothesised to be the active ingredients in effective approaches to address anxiety and depression in young people (aged 14-24) worldwide.

Applicants should choose one core component as their "best bet" in relation to anxiety and/or depression as relevant to current 14-24 year olds globally, in relation to one or more of the following:

- Prevention
- Treatment
- Stopping relapse
- Ongoing management

They should outline how they propose to:

1. Review evidence in relation to their chosen core component across a wide range of research literatures
2. Hypothesise and draw inferences based on this review
3. Present the results in ways that are clear for non-specialists.

Applicants must commit to producing a report (4,500 words) that answers the following question: **"**Drawing inferences from the current evidence: in which ways and in which contexts and for whom does your chosen core component appear to work, and why, and in which ways and in which contexts and for whom does it appear not to work, and why?"

The choice of methodology is up to the applicant. We are looking for applicants to propose methodologies that combine rigour with opportunity for creative inference and hypothesising.

- Applicants can come from any sector e.g. universities, charities or commercial
- We encourage applications from a wide range of mental health science disciplines
- We encourage applications from early career researchers and diverse geographies

[1] By "core component" we mean those aspects of an approach to preventing or treating anxiety or depression most likely to contribute to positive impact. These can be conceived at any level thought most apt by applicants; from the cellular to societal, from biological to behavioural.

A full timetable can be found on p.13. **Key dates include:**

- An Intention to Respond (150 words max) submitted by email by **21 February 2020**[2]
- Full proposals (1,500 words max) submitted by email by **1 April 2020**
- Work to start on **1 June 2020**
- Final report submitted by **30 September 2020**

Please note due to the anticipated scale of response, we will not enter into individual discussions with potential applicants at this stage. Queries can be submitted as part of the Intention to Respond email and will be answered at a webinar on **28 February 2020.** The webinar will be recorded and made publicly available, along with any other clarifying material.

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[2] Appendix 1 provides examples of Intention to Respond emails. Submitting and Intention to Respond does not bind you to proceed to full proposal.

1. Background

The Wellcome Trust (the ‘Trust’, ‘Wellcome’) is the world’s second highest spending global charitable foundation. It is both politically and financially independent. Wellcome supports scientists and researchers, takes on big problems, fuels imaginations, and sparks debate.

Our funding supports over 14,000 people in more than 70 countries in exploring ideas, seeking solutions and improving the human condition through science, population health, medical innovation, the humanities and social sciences and public engagement. Further information on Wellcome can be found at www.wellcome.ac.uk.

As part of our mission, we are working proactively to tackle some of the world’s biggest health challenges. In 2019, we announced that Wellcome was making a five-year, £200 million commitment to transform how we understand, fund, prevent and treat anxiety and depression in young people (14-24) by creating a mental health priority area in order to ensure that no one is held back by mental health problems.

Our mental health programme strategy can be found on the website. All prospective suppliers are encouraged to read this in detail.

In our mental health strategy we are proposing to establish and promote a shared research agenda based on core components.

There is an ever-growing range of complex and commercially-branded approaches for preventing and treating mental health problems in young people. These range from large scale community prevention programmes to suggested self-care strategies to detailed clinical treatment protocols.

But what are their "core components”?

We believe that considering the core components that underpin effective approaches can best help us learn what works for whom, in what context, and why.

This request for proposals (RFP) seeks to commission an Insight Analysis on what suppliers choose as their “best bet” for the core component to address anxiety and depression in young people; whether via prevention, treatment, stopping relapse or managing ongoing difficulties.

Suppliers may select from the full gamut of possible approaches: from cellular change to self-care strategies, to therapist-led strategies, to societal structural change.

2. Definitions

Below are definitions as used in the context of this RFP.

“Insight Analysis”

We use the term “insight analysis” to convey that we want a combination of:

- Review of evidence in relation to one chosen core component, considering a wide range of research literatures
- Hypothesising and inferences based on this
- results presented so that are clear and accessible to non-specialist audiences.

The choice of methodology underpinning the insight analysis is up to the applicant. We are looking for applicants to propose methodologies that combine rigour with opportunity for creative inference and consideration of evidence from diverse research areas. This might include one or more of the following approaches or something entirely different:

- Narrative review
- Review of peer reviewed literature
- Review of commissioned reports ("grey" literature")
- Evidence synthesis
- Critical analysis
- Rigorous mapping
- Systematic mapping
- Review of PhDs
- Review of podcasts
- Review of presentations
- Review based on interviews with leading researchers from different fields
- Review based on interviews with early career researchers from different fields.

We are not necessarily seeking systematic reviews or meta-analyses- though these can be included as part of the approach.

Please note: we are NOT seeking primary research – this is out of scope**.**

"Prevention, treatment, stopping relapse, managing ongoing difficulties"

By "prevention" we mean: stopping 14-24 year olds developing depression or anxiety.

By "treatment" we mean: helping 14-24 year olds with depression or anxiety to recover.

By "stopping relapse" we mean: helping 14-24 year olds who have recovered from anxiety or depression to not develop these again.

By "managing ongoing difficulties" we mean: helping 14-24 year olds who have ongoing (chronic) depression or anxiety to live their best life.

"Helping 14-24 year olds"

By helping 14-24 year olds we mean: interventions directly targeted at this age group as currently constituted (i.e. out of scope are interventions targeted at younger age groups that may have repercussions once those people grow up, such as parenting interventions or early years interventions).

By "helping" (or "working" for an individual or group) we mean: contributing to a positive outcome as evidenced by some form of demonstrable impact on some relevant aspect of the individual's life. This can range from symptoms to functioning to subjective states, either currently or in the future.

It will be up to the supplier to specify what they are taking as indications of "helping" or "working" and at what time points.

“Anxiety and Depression”

We take anxiety and depression to be loose verbal descriptions of constellations of thoughts, feelings and behaviours that exist on a continuum, and have been classified as entities by historical consensus.

In scope are: any thoughts feelings and behaviour seen as “part of” anxiety and/or depression that impair function/hold people back - by consensus this generally involves several weeks of difficulties.

Out of scope are: every day emotional responses of low mood or anxiety that are part of life.

We start from the assumption that whilst the boundaries and categorisations may be unclear the thoughts, feelings and behaviours that hold people back in life are all too real. We remain committed to our vision of creating a world in which no one is held back by one or many of the following:

- Thoughts such as entrenched negative beliefs, intrusive thoughts of terrible things happening, suicidal ideation, attention to negative stimuli, difficulties concentrating
- Feelings such as sense of enduring sadness, hopelessness, sudden panic, disabling fear
- Behaviours such as ongoing trouble sleeping, enduring irritability, persistent avoidance of feared contexts.

These may be conceived or experienced differently in different parts of the world and by different populations

We are happy for the applicant to provide their own definition anxiety or depression as the focus for their proposal as long as it can be fitted within the above broader approach we are taking. Some applicants may choose to take a diagnostic framework some may not.

Moreover, applicants are free to focus on a particular subgrouping or aspect of anxiety or depression (e.g. social anxiety or major depression or feelings of ongoing sadness as part of depression).

“Core component”

By core component we mean those aspects of any intervention most likely to be contributing to making the difference i.e. the “active ingredients”.

In some instances, this is relatively clear cut. A core component of effective treatment of cancer is destruction of cancer cells, whether this is achieved by surgery, medication or other means.

Of course, there is much complexity about which other factors might constitute additional core components.

It is anything but clear-cut in mental health. Take effective treatment for depression: Is a core component challenging underlying negative beliefs? Or learning new positive behaviours which reinforce each other? Or developing more supportive relationships via modelling with the therapist? Or being labelled in a way that brings new societal support or status? Or directing attention towards more positive stimuli? Or changing a neural pathway? Are all equally “core” or are some more important than others? Are some necessary but not sufficient? Are some more core for some people than for others?

We do not think it likely there is a clear-cut answer and we are not looking for a silver bullet.

Table 1 below outlines some possible core components that have been suggested to address anxiety or depression (or both) in 14-24 year olds for each of prevention, treatment, stopping relapse, and management of ongoing difficulties.

This is by no means a comprehensive list.

We have divided them into four domains: biological, behavioural, relationships and societal for ease of viewing - others may prefer different categorisations, this is not intended to be prescriptive.

We have included Table 1 to stimulate applicants' thinking, not to create a prescribed pick list.

The examples in table 1 are chosen to illustrate the diversity of possibilities. They are not intended to be suggestions of what are the most important. Many could apply to several different points of intervention but have been noted in only one cell to aid readability.

Table 1: some possible core components

Prevention	Treatment
Biological e.g. good levels of physical activity, good nutrition, limited use of drugs or alcohol **Behaviour, Thoughts & Beliefs** e.g. learning to deal with negative emotions, engaging the imagination through reading or looking at pictures, learning now to regulate emotions, learning how to deal with drugs and alcohol **Relationships** e.g. structured, consistent and positive interactions with significant others, learning how to maintain good relationships **Societal** e.g. state protection from abuse or harm, equitable distribution of wealth, reducing air pollution, addressing bullying, neighbourhoods designed to support social cohesion	**Biological** e.g. reduction in serotonin re-uptake and/or inflammation (depression), stopping impact of adrenaline (anxiety) **Behaviour, Thoughts & Beliefs** e.g. expressing emotion, feeling hope for change, learning now to have a trusting relationship with another person, attending to more positive aspects of things (depression), undertaking a pleasurable activity each day (depression), preventing avoidance of feared situations (anxiety) learning to problem solve **Relationships** e.g. feeling heard, valued or loved **Societal** e.g. guaranteed economic security
Stopping Relapse	**Managing Ongoing Difficulties**
Biological e.g. management of bodily states as for prevention or treatment **Behaviour, Thoughts & Beliefs** e.g. tracking emotional states to identify patterns, avoiding triggers, self-compassion **Relationships** e.g. managing expectations, positive romantic relationship **Societal** e.g. additional economic support when in need	**Biological** e.g. management of bodily states as for prevention or treatment **Behaviour, Thoughts & Beliefs** e.g. practicing gratitude, sleep regulation, belief in higher purpose **Relationships** e.g. peer support, joining a choir **Societal** e.g. workplace/school policies supporting inclusion

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3. Rationale for this commission

As part of our mental health strategy we are seeking to identify best bets of what core components might be amongst the most impactful, for the most people, in the most contexts.

This is to build common foundations for future research and in time to help policy makers make their "best buy" decisions on a firmer, clearer basis. It will also enable young people with lived experience to develop a clearer, common understanding of what helps, why and how.

Investigating core components may be particularly challenging in mental health.

- It may be more complex to identify core components in mental health where there is no clear underlying biological mechanism
- Mental health research has not traditionally been organised in terms of thinking about core components across different research communities so we lack a common language or extensive existing literature
- There is a lot of confusion in terminology used by different researchers from different communities and even within the same community. Thus, the same word is sometimes used by different researchers to mean different things and sometimes different words are used to describe the same things (the “jingle-jangle” fallacy)
- A range of core components may need to be combined for effective interventions and different combinations may be needed for different people or in different contexts
- It may be challenging to tease apart the core components of existing complex interventions
- There may be a concern that attempting to look at core components indicates a lack of understanding that it is highly likely that there are complex interactions between core components

Despite the challenges we believe it is worth focusing on core components.

- We believe dis-aggregating current complex approaches is key if we are to identify building blocks for further research with a view to updating our focus as our learning grows.
- Given the confusing and overlapping multitude of terms being used to describe different things that may relate to the core components by different groups of researchers it is crucial we develop some common understanding and focusing on a small number of core components may help with this.
- We see this as an iterative process with potential for expanded and deepened review of a varied and wider range of core components as our knowledge grows over time.
- We recognise it is likely that constellations of core components will be necessary to bring about change in most instances, and that these may vary across different groups of people and contexts.
- By focusing on a limited number of core components, we can look in depth and develop our understanding over time.

We are committed to identifying and considering in-depth an initial selection of core components in the first year of our programme, with a view to this being an ongoing and iterative process. Different core components may be focused upon in future years. We are not seeking to agree a set of core components that are then set in stone or become the sole focus of interest.

4. Who is eligible to apply?

We encourage applications from anywhere in the world, provided the applicant can accept work that is contracted from the UK.

Applications can be made by individuals (either self-employed or contracting via a current employer) or small teams (a team of more than 3 people would need to be robustly justified).

Please note: where the proposal is made on behalf of a team, we will form a contractual relationship with only the lead applicant who will be responsible for delivery of the outputs on behalf of the whole team.

Applicants can come from any sector e.g. universities, charities, or commercial companies All relevant costs can be included in the application.

At least one member of the team must have relevant background (PhD or equivalent) in an area of mental health science with a focus on youth anxiety and/or depression. By mental health science we mean any discipline that uses evidence in rigorous and transparent ways, whether based on observation or experimentation, that can help us find answers to the best way to create a world in which no one is held back by mental health problems.

This could include Psychiatry, Psychology and Neuroscience, but also Population Health, Economics, Anthropology, Humanities, Social Sciences and Informatics (among others).

We are looking for applicants who can critically consider and synthesise diverse findings from across diverse research communities in order to develop new, or reinforce existing, hypotheses which they are able to convey in a clear and concise way to non-specialists.

We are thus looking for evidence of sufficient background expertise combined with the potential for creative thought, together with skills to present information in an accessible way.

Those working on this commission must have enough IT and other support available within their current work context to undertake the work, including ongoing access to relevant journal databases.

Please note that whilst all final outputs must be produced in English, the substantive work and literature reviewed can be in other languages. However, the supplier must translate the final outputs into English prior to submission and must have sufficient English to communicate with Wellcome and the wider network of organisations using English.

We are interested in applications from a wide range of mental health science disciplines and geographies. We encourage applications from early career researchers and from the global south.

The work must be able to be conducted between 1 June 2020 and 30 September 2020 with the final report submitted by 30 September 2020.

5. Governance

Successful suppliers will report to Dr Catherine Sebastian (Wellcome Mental Health Priority Area Evidence Lead) on a day-to-day basis and will ultimately be accountable to Professor Miranda Wolpert (Wellcome Head of Mental Health Priority Area).

Successful applicants will be required to come together virtually (via conference calls) as part of developing an international network to share learning and approaches, likely for around 1.5 hours on at least a monthly basis (i.e. at least three meetings over the course of the project). This will be coordinated by Wellcome.

All meetings between Wellcome and prospective suppliers will be conducted in English.

Wellcome will own the intellectual property created in this commission and Wellcome may wish to make the final outputs public itself (in whole or in part), either on its website or other media, and in doing so may apply a Creative Commons (CC-BY) licence to the outputs.

If the final outputs are of sufficient standard, Wellcome will encourage and work with applicants to look to publish the final outputs in suitable peer reviewed academic outlets.

6. Specification and Deliverables

We ask applicants to choose **ONE** promising candidate core component. Applicants can choose from one of the core components given as examples above or propose completely other core components.

The core component must be hypothesised by the applicants to be amongst the top likely core components to help 14-24 year olds in a variety of contexts worldwide[3] in terms of one or more of the following intervention periods:

- Prevention
- Intervention
- Stopping relapse
- Ongoing management

The core component must be hypothesised to be an active ingredient in approaches aimed at current 14-24 year olds (i.e. not primarily focussed on younger or older age groups).

The supplier is asked to produce an Insight Analysis report (and allied materials as detailed below) that answers the following question:

"Drawing inferences from the current evidence: in which ways and in which contexts and for whom does the chosen core component appear to work, and why, and in which ways and in which contexts and for whom does it appear not to work, and why?"

[3] Must be relevant to at least 10 million 14-24 year olds worldwide.

All selected suppliers will need to answer this by producing the following, which must be emailed to Wellcome by **Wednesday 30 September 2020**:

1. Insight Analysis Report formatted as an academic article. The exact specification for the style and format will be provide to suppliers at time of contract. It is likely to be of up to 4500 words and max 50 references
2. 1 page infographic summary
3. 1 page lay narrative summary
4. A video of up to 2 minutes explaining what you found and what you make of it
5. A presentation slide deck of up to 15 minutes summarising your Insight Analysis.

7. Application process

Intention to Respond

All potential applicants are asked to submit an intention to respond by email to mentalhealth@wellcome.ac.uk by **21 February 2020**.

The intention to respond must be **no more than 150 words** and include answers the following key questions:

1. **Names and professional backgrounds of all applicant(s) clearly stating who is the Lead applicant**
2. **Organisation**
3. **Core component proposed as focus for proposal**
4. **Time point(s) for intervention proposed as focus for this proposal**
5. **Definition of anxiety or depression or subcategory thereof proposed**
6. **Any clarifying questions about the RFP.**

The answers to 3-5 above are not intended to be binding. We are asking for this information to allow us to have a sense of the range of core components and foci being considered.

Example intention to respond emails can be found in Appendix 1 to aid your understanding of what we are looking for at this stage.

All queries raised will be collated and answered at the webinar on 28 February, at which time we may also issue FAQ responses or other material to address common queries.

Due to likely high levels of interest, we cannot commit to answer individual enquiries.

Written Proposal

There is no selection or filtering process between Intention to Respond and full proposal.

No feedback will be given to individual proposals at this stage, though general comments may be made at the webinar.

All applicants who submit an Intention to Respond are eligible to submit a full proposal.

Applicants may only submit full proposals in the absence of an Intention to Respond in exceptional circumstances (by prior agreement with Wellcome).

Full proposals of no **more than 1,500 words** must be submitted by email to mentalhealth@wellcome.ac.uk by **Wednesday 1 April** using the Response Template, available as a separate download.

This asks for the following details:

1. Proposed core component including the reason for your choice (200 words)
2. Definition of anxiety and/or depression (or subcategory) being used (200 words)
3. Proposed methodology to answer the question including timeline (max 700 words)
4. Details of applicant(s) expertise and approach to this project (400 words)
5. A cost proposal in Excel format which details and justifies the proposed costs. This should include details of the hourly rate and number of hours to be contributed by each member of the team, plus any proposed ad hoc consultancy fees. Any costs related to this work are in scope. The maximum cost permissible is £45,000 exclusive of VAT
6. The names and contact details of 2 referees who can comment on the applicants' past work, whom Wellcome can contact as part of this RFP process should you be shortlisted
7. A two-page CV for each team member should also be appended, along with a letter of institutional support e.g. head of department or organisation, as relevant

When providing the referees, please include their contact name, organisation, brief overview of work you had provided for them, email address & telephone number (including country code). Please see the Wellcome Privacy Statement for more on our commitment to safeguarding personal information in accordance with data protection law.

Assessment criteria

Proposals will be assessed using the following criteria:

- **Evidence of expertise, skill set and track record in** relation to the task as per the eligibility criteria laid out above, including evidence of; ability to undertake rigorous review, ability to consider information arising from different types of expertise, including the expertise of those with lived experience, ability to develop coherent inferences from review of literature and form new hypotheses; ability to present ideas in coherent and non-technical language; ability to complete projects on time and within budget, (35% weighting).

- **Strength of the proposed approach** to addressing the key research question including; good rationale for core component and definitions of anxiety and/or depression chosen, understanding of the question being asked in line with the rationale behind the commission; selection of an appropriate methodology and approach that combines rigour with opportunity for creative thought; evidence the approach will lead to consideration of evidence from across different expert communities and diverse

geographies; likelihood of the proposal being achievable within the budget and time allocated (50% weighting).

- **Justification and value for money** for the proposed costs (15% weighting).

Interviews

Shortlisted applicants may be invited to phone interview in late April 2020 (please find the full timetable on p.13).

8. RFP Documents

Below lists the documents provided to suppliers to support their response to this RFP.

Contractual Agreement

These documents represent the draft contractual agreements which are to be used with the successful supplier from this RFP exercise.

The long form consultancy agreement will be used where we are contracting with individuals and the general terms and conditions for when we are contracting organisations.

These documents are for information only.

Contract Feedback Sheet

This document allows suppliers to provide a response to the proposed contractual agreement specifically referencing any clauses which they desire to amend.

This document can be completed by suppliers who have been shortlisted for interview**.**

This is your opportunity to provide feedback on the contract and to raise any concerns or queries you may have.

These will be addressed at the interview or in writing as relevant.

9. Timetable

The timelines for this RFP exercise, including deadlines for suppliers, are detailed below. All times listed are in UK time.

#	Activity	Responsibility	Target Date (2020) (Please note that these may be subject to change)
1	Request for Proposals (RFP) issued to suppliers	Wellcome	Tuesday 21 January
2	Intention to Respond to RFP containing answers to key questions (outlined on p.10) by email	Supplier	Friday 21 February, **midday**
3	Response to queries raised in Intention to Respond emails communicated to suppliers via webinar. This will then be posted publicly with any other clarifying materials with links via the Wellcome website thereafter	Wellcome	Friday 28 February, **15.00**
4	Full response to Written Proposal using the Response to Proposals Template along with appended CVs (as outlined in Section 5)	Supplier	Wednesday 1 April, **midday**
5	Notification of shortlisted suppliers	Wellcome	Monday 20 April
6	Interviews via phone or online with shortlisted suppliers - times to be agreed between Wellcome and shortlisted suppliers	Supplier	Tuesday 28 April – Thursday 7 May
7	Notification of contract award to successful suppliers	Wellcome	Wednesday 13 May
8	Contract negotiation	Both	Wednesday 13 May – Wednesday 20 May
9	Proposed contract start date following agreement of contract	Both	Monday 1 June
11	Month 1 check in by provision of brief written update and group or individual phone call	Both	Friday 19 June
	Month 2 check in by in by provision of brief written update and group or individual phone call	Both	Friday 17 July
	Month 3 check in by provision of brief written update and group or individual phone call	Both	Friday 14 August
12	Draft final report submission date	Supplier	Monday 7 September, **midday**
13	Wellcome response to draft final report including phone calls as relevant	Wellcome	Thursday 17 September - Friday 18 September
14	Final report submission date, with any amendments	Supplier	Wednesday 30 September, **23:59**
15	Presentation to Wellcome by the supplier (can be via phone)	Supplier	Friday 2 October
16	Proposed contract end date	Both	Monday 7 October

The following section explains in further detail the process set out within the timetable, up to the contract start date for the successful supplier:

1. **RFP issue to suppliers:** The RFP document will be circulated to potential suppliers.

2. **Intention to respond to RFP & submission of key questions:** Suppliers will indicate their intention to respond to the RFP to Wellcome by email and submit any questions.

3. **Response to questions:** Wellcome will answer all questions submitted by all suppliers, anonymise any elements which require confidentiality and share all answered questions with all suppliers.

4. **Full Response:** Suppliers will submit in line with this RFP the following documents:
   - Written Proposal using the template provided
   - Appended CVs

5. **Notification of invitation to present proposal:** Wellcome will notify suppliers of whether they have been shortlisted to phone interview with the Evaluation panel. Dates and times of interviews will be agreed with shortlisted suppliers.

6. **Presentations:** Shortlisted suppliers will undertake remote interviews with the Evaluation panel.

7. **Notification of contract award:** Wellcome will notify suppliers of their outcome from the RFP process and agree next steps.

8. **Contract negotiation:** This stage sees the contract negotiated and finalised.

9. **Contract start date:** This stage sees the contract commence.

10. Non-Disclosure and Confidentiality

Prospective suppliers should be aware that inappropriate publicity could have a serious effect upon Wellcome's business. The information contained within this document or subsequently made available to prospective suppliers is deemed confidential and must not be disclosed without the prior written consent of Wellcome unless required by law.

11. Independent Proposal

By submission of a proposal, prospective suppliers warrant that the prices in the proposal have been arrived at independently, without consultation, communication, agreement or understanding for the purpose of restricting competition, as to any matter relating to such prices, with any other potential supplier or with any competitor.

12. Costs Incurred by Prospective Suppliers

It should be noted that this document relates to a Request for Proposal only and not a firm commitment from Wellcome to enter into a contractual agreement. In addition, Wellcome will not be held responsible for any costs associated with the production of a response to this Request for Proposal.

13. Wellcome Contact Details

We are unable to answer individual queries. All questions will be answered via a webinar and/or other posted materials such as FAQ. The single point of contact within this RFP exercise for all communications is as indicated below:

Name: Mental Health Priority Area Team
Email: mentalhealth@wellcome.ac.uk

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Appendix 1: Example intention to respond emails

To note these are for illustration only and not intended to give any steer as to content.
All intentions to respond must be less than 150 words long.

Example A

1. Names and professional backgrounds of applicant(s): **Dr Amira Khan (Lead, Historian) and Prof Jane Suggs (Neuroscientist**)
2. Organisational context: **University of X**
3. Suggested core component proposed as focus for proposal: **Social Inequality**
4. Suggested time point proposed as focus for this proposal: **Prevention**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **Broad definition as per your strategy, include both depression and anxiety**
6. Any clarifying questions about the RFP: I**s it OK to look at research about different periods of time e.g. Victorian Age or Moghul Period.**[4]

(Word count: 96)

Example B

1. Names and professional backgrounds of applicant(s): **Jo Francois (Clinical Psychologist)**
2. Organisational context: **Charity Y**
3. Suggested core component proposed as focus for proposal: **Serotonin re-uptake inhibition**
4. Suggested time point proposed as focus for this proposal: **Treatment and ongoing management**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **treatment resistant depression**
6. Any clarifying questions about the RFP: **None**

(Word count: 67)

Example C

1. Names and professional backgrounds of applicant(s): **Dr Ben McDonald (Lead) (Clinical Psychologist), Dr Tania Caruana (Cognitive Psychologist)**
2. Organisational context: **University Y**
3. Suggested core component proposed as focus for proposal: **Training positive attributional styles**
4. Suggested time point proposed as focus for this proposal: **Prevention and treatment**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **Negative attributions and thought processes across anxiety and depression**
6. any clarifying questions about the RFP: **Should our review focus on experimental studies?**[5]

(Word count: 86)

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[4] NB the answer for this would be yes.

[5] Answer: this should form part of the supporting evidence, but we would like to also see a broader context of applicability (both therapeutic and real world.

Example D

1. Names and professional backgrounds of applicant(s): **Dr Tina Emenayou (Sociologist)**
2. Organisational context: **Self-employed**
3. Suggested core component proposed as focus for proposal: **Social connection**
4. Suggested time point proposed as focus for this proposal: **All four**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **Generalized anxiety**
6. Any clarifying questions about the RFP: **Can I just focus on girls?**[6]

(Word count: 69)

Example E

1. Names and professional backgrounds of applicant(s):
   Dr Rhiannon Rayner (Lead, Immunologist), Mr Chris Reese (PhD candidate), Prof Amy Lo (Clinical Psychologist)
2. Organisational context: **MRC Research Institute**
3. Suggested core component proposed as focus for proposal**: Reduction in inflammatory markers**
4. Suggested time point proposed as focus for this proposal**: Prevention, Treatment**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **Depression**
6. Any clarifying questions about the RFP: **Can I supervise my PhD student (or postdoc) to complete this work?**[7]

(Word count: 87)

Example F

1. Names and professional backgrounds of applicant(s): **Dr Paul Howell (Lead, Sports Scientist, now in Policy),**
2. Organisational context: **NGO Z**
3. Suggested core component proposed as focus for proposal: **Exercise**
4. Suggested time point proposed as focus for this proposal: **All four**
5. Suggested definition of anxiety or depression or subcategory thereof proposed at this point: **Negative thoughts, sleep disturbance, restlessness**
6. Any clarifying questions about the RFP: **I have a network of 5-6 colleagues around the world and I would like to draw on their expertise for a cross-cultural perspective. Can I do so?**[8]

(Word count: 97)

[6] Answer to this would be no, but you can do sub analyses to look at this as a group of interest in terms of who works for and who doesn't.
[7] Answer: yes, and the project could potentially count as a paid secondment for the student or postdoc, subject to organisational approval.
[8] Answer: yes, in either a paid or unpaid (informal) capacity. If paid, this must be costed into the proposal, and administered via your organisation. Acknowledgement should be given as appropriate in the final report