FROM: Bob Anthony: President, Rotary Club of Wellesley, Massachusetts USA
103 Old Colony Road, Wellesley MA 02481 USA
(781) 727-8617
BobAnthony@AdolescentWellness.org

SUBJECT: Invitation for schools in Nigeria to participate in Rotary Interact *Peer Leadership & Depression Prevention* project

The *Peer Leadership & Depression Prevention* project has been launched with schools in the United States, Puerto Rico and India. This invitation is to join a project in planning with Rotarians in the Rotary Club of Ibadan Idi-Ishin.

There is no cost for schools to participate. The initial funding of $15,000 is donated by Rotary clubs and this amount is more than tripled by the Rotary District and Rotary International. The curriculum content used in the project is free to all through the Boston Children's Hospital web page: www.BreakFreeFromDepression.org/ The Rotary funding helps:

- identify and communicate a referral protocol to a mental health provider as needed
- provide routine interaction with a local psychologist
- augment the train-the-trainer for adults and peer leaders
- ensure suitable supplies and equipment are available in participating schools
- ensure sustainability without additional funding in the future

Outcomes by Country from PEER LEADERSHIP & DEPRESSION PREVENTION

Pre-to Post Survey improvement:

LOCATION	KNOWLEDGE (at least 80%)	CONFIDENCE IN HELP SEEKING (Strongly Agree or Agree)	ATTITUDE (Strongly Agree or Agree)
USA	77%	97%	9%
Puerto Rico	146%	32%	10%
India	665%	42%	49%

In order to participate in the project, there is a form to be completed by the school leader, a Memorandum of Understanding. The key points are a commitment to:

A. Identify a person to participate in train-the-trainer sessions and be the lead contact for each school

B. Identify that person or another to be the person implementing the curriculum in the school, communicating the implementation schedule, collecting and communicating the outcomes information.

C. Knowing the schedule for routine consultation with the clinician and the protocol how to refer a student for treatment with a mental health care provider

D. Committing to replicating the curriculum for a second year and communicating ideas for sustaining the program beyond year two

Adolescent Emotional Health: The Need

Depression in Youth

As Maugham, Collishaw, and Stringaris (2013) indicate, less than three decades ago depression was seen as a predominantly adult disorder. Children were considered too developmentally immature to develop such a disorder, without personalities sufficiently developed to support the diagnosis of a depressive disorder. Adolescent low mood was considered part of the normal teenage experience, characterized by mood swings and irritability. Current research highlights that children and adolescents can, and do, experience depressive disorders. Not only do youth experience depression, but this experience is a world-wide phenomenon. The World Health Organization declared depression as the leading cause of disability and the fourth leading cause of premature death worldwide for people ages 5 and older (WHO; Owens et al 2012). Depression, therefore, stands out as a major public health problem given the disorder's often chronic, recurrent, and increasingly harmful nature (Guerry &Hastings, 2011). Increased chronicity, severity, impairment, high risk of relapse, and medical morbidity are particularly associated with childhood and adolescent onset depression (Beardslee, Gladstone & O'Connor, 2012; Brent & Maalouf, 2009; Cummings & Fristad, 2011; Eckshtain & Gaynor, 2011). Children and adolescents with depressive disorders are also at high risk of substance abuse, legal problems, negative life events, early pregnancy, and poor work functioning (AACAP, 2007).

Below are significant facts related to depression in children and adolescents:

- A family history of depression and exposure to stressful life events are the most robust risk factors for depression (Maughan, Collishaw & Stringaris, 2013)

- By the age of 18 approximately 15–25% of adolescents will have experienced a major depressive episode (Garber & Weersing, 2010; Lewinsohn and Essau 2002 in Auerbach et al 2011)

- Average age of onset of major depression is between 11 and 14 years, with rising rates in the early teens with a near doubling of rates from 13–14 years (8.4%) to 17–18 years (15.4%) (Goldman, 2012; Maughan, Collishaw & Stringaris, 2013; Merikangas et al 2010)
- Twelve percent of children will relapse within 1 year, 40% will relapse within 2 years, and 75% will experience a second episode within 5 years (AACAP, 2007; Beardslee, Gladstone & O'Connor, 2012; Maughan, Collishaw & Stringaris, 2013)

Risk for Suicide

Depressive disorders in adolescence are the largest single contributor to suicide risk during this period (Van Voorhees et al., 2008). As with depression, suicidal behavior among children and adolescents is a serious public health concern, not just in the United States (US), but world-wide (Cummings, Caporino & Kendall, 2013; World Health Organization, 2000). Suicidal behavior increases as children grow older, with adolescents at higher risk than school age children. In the US, suicide is the fifth leading cause of death among children ages 5-14 and the third leading cause of death for adolescents between the ages of 15 and 24, behind only accidents and homicides (Guerry, Reilly & Prinstein, 2011). During the period between 2003 and 2004, suicide rates for females ages 10–19 and males ages 15–19 increased significantly (Centers for Disease Control and Prevention, 2007). The number of children ages 10–14 dying by suicide has been particularly alarming, with suicide rates increasing by 51% between 1981 and 2004 among children in this age group (American Association of Suicidology, 2006; Miller & Eckert, 2009).

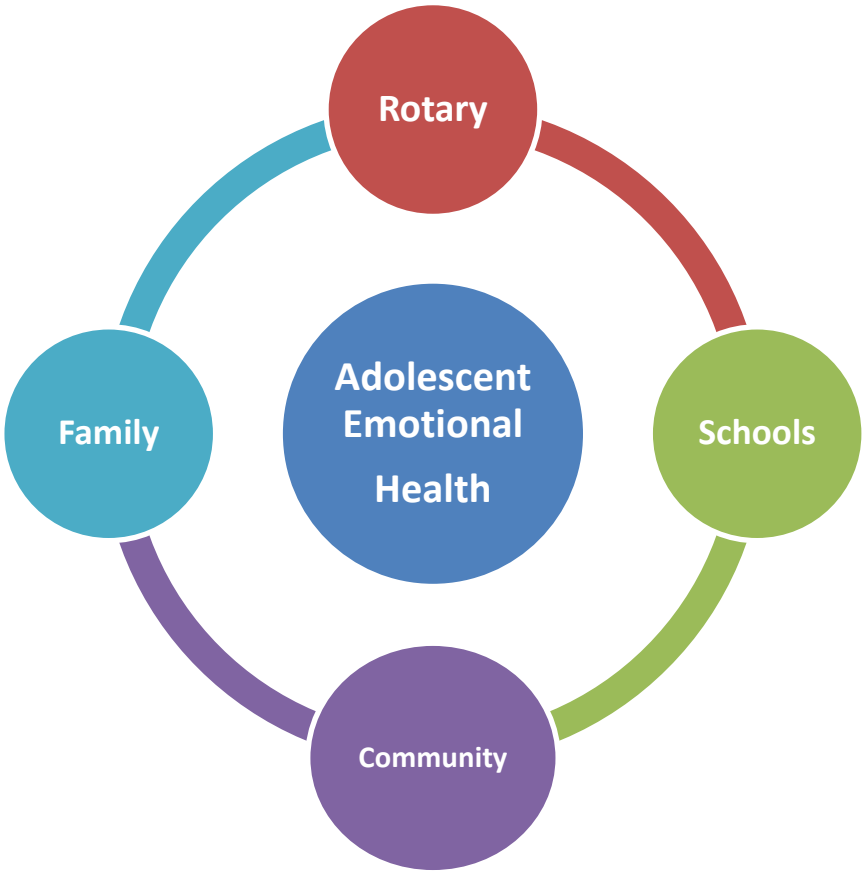
Despite these noteworthy statistics, among adolescents suffering from depression, only about 25% receive treatment (Garber et al., 2009). Research clearly indicates that a diagnosis of depression is a risk factor for suicidal behavior. In fact, review studies have found that between 49% and 64% of adolescent suicide victims had a depressive disorder (Beardslee et al 2012). Therefore, it is absolutely imperative that we address this public health crisis via innovative ways that engage youth and their communities of support before crises occur. Prevention of depressive symptoms and early intervention once symptoms begin to emerge are critical ways of addressing depression among youth.

Ecological Approach

Children's development can best be understood from a human ecological systems theory, which posits that development is influenced by the interaction of the contexts in which children live, study, and play (Atkins, Hoagwood, Kutash, & Seidman, 2010; Bronfenbrenner, 1977). The child is at the center of this series of nested systems, contributing individual factors that include temperamental qualities and cognitive abilities (Bronfenbrenner, 1977). The interactions between individual child factors; the quality of the child's relationships with family, teachers, and peers; and broader ecological factors (e.g., school quality, neighborhood safety) collectively have a significant impact on children's emotional wellbeing (Greenberg, 2006). The ecological approach further accounts for the impact that broader organizations, policies, and culture have on child mental health outcomes (e.g., mental health disparities, lack of access to services due to lack of insurance; Espelage, Hong, Rao, & Low, 2013). Finally, this approach

seeks to promote youth emotional wellness by addressing multiple systems within a youth's life, by promoting positive and long-standing relationships, and by offering practical strategies that resonate with the youth's culture and community. The outcome hope of this approach is to promote resilience and emotional wellbeing.

Rotary Clubs: Addressing Adolescent Emotional Health through School, Family, and Community Partnerships



The mission of The Rotary Foundation is to enable Rotarians to advance world understanding, goodwill, and peace through the improvement of health, the support of education, and the alleviation of poverty (www.rotary.org/myrotary/en/learning-reference/about-rotary/rotary-foundation). The Rotary Foundation followed this mission by funding a visionary program that truly advanced understanding, goodwill, and peace by focusing on the improvement of mental health. This acknowledgement of the need to support emotional health is significant, as often emotional health is seen as separate from physical health and therefore neglected from health prevention programs. The Rotary Foundation's funding of this program represents support of the notion that focusing on youth mental health is a worthwhile and important endeavor, as well as a critical component of health programming.

Conceptual Overview: Peer Leadership and Depression Prevention project

Focus on Prevention and Mental Health Promotion

The Peer Leadership and Depression Prevention (PLDP) project focuses on prevention and mental health promotion. Given the significant number of children struggling emotionally, approaches that address mental health issues before they develop into diagnosable disorders are critical. Prevention science is a "multidisciplinary field devoted to the scientific study of the theory, research, and practice related to the prevention of social, physical, and mental health problems" (O'Connell, Boat, & Warner, 2009, p. xxvii). There are two main concepts of prevention science that are highly relevant to children's emotional health and well-being: prevention and mental health promotion.

Prevention refers to "interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder" (O'Connell et al., 2009, p. xxvii). Prevention happens at three different levels, each defined by the degree of risk in the population (Domitrovich et al., 2010).

- *Universal prevention* strategies target the general public or an entire population that has not been identified on the basis of individual risk. For example, a universal prevention program can be used with an entire class or grade without requiring identification of children who may be struggling.

- *Selected prevention* strategies target individuals or subgroups that are identified as being at elevated risk for a disorder. The individuals or groups are chosen not because they are demonstrating symptoms of a disorder, but because their circumstances place them at higher risk for disorders—for example, children of recently divorced parents, children with chronic illnesses, or children who recently emigrated from another country.

- *Indicated prevention* strategies target individuals who are identified as having some initial symptom presentation related to mental disorders but who do not yet meet full criteria for a diagnosis.

Mental health promotion refers to strategies that "focus on well-being rather than prevention of illness and disorder, although it may also decrease the likelihood of disorder" (O'Connell et al., 2009, p. 65). Mental health promotion strategies aim to enhance individuals' ability to achieve developmentally appropriate tasks; aid them in acquiring a positive sense of self-esteem, mastery, and well-being; and strengthen their ability to cope with adversity (O'Connell et al., 2009). Mental health promotions strategies are typically used with a whole population (e.g., an entire class, the whole grade), so they are particularly well suited for use in schools.

Integration of New Resources with Existing Infrastructures

The PLDP project relies on the joining of new resources with the strength of existing infrastructures to promote success and long term sustainability. An important part of the project involves training leaders at various levels within the community, including school staff, students, and community members The project offers a program and structure for implementation, but it is the integration of this program with the existing relationships and expertise of community members that leads to positive change.

Peer Leadership Model

Johnson, Simon, and Mun (2014) report that effective peer leadership programs do the following: carefully assess and select peer/cross-age leaders; allow for adult support and supervision for peer leaders in the structure of the program; make training materials developmentally appropriate and engaging; and set high expectations for peer leaders and provide them with the supports to reach them. The PLDP project follows these best practices, and in addition encourages teen leaders to do the following:

- Promote not only awareness of depression, but also pro-social behaviors related to mental health and wellness, such as how to help others.
- Challenge stigma related to mental illness and promote non-judgmental attitudes and language.
- Inspire a shared vision toward open communication and mental health and wellness.
- Commit to be positive role models and advocates for mental health and wellness.
- Encourage and support peers' initiatives around mental health and wellness.

Promoting Long-Term Conversations and Interventions

Although the core of the PLDP project is a curriculum, the philosophy of the program is that conversations and interventions around mental health and wellness should be an integral part of the fabric of a community. One-shot workshops, or conversations limited to single programs are not as effective as promoting safety within a community to continue long-term conversations and interventions around mental health and wellness. Communities participating in the current school year plan program replication and expansion in the following school year.