EFFECT OF A MENTAL HEALTH TRAINING PROGRAMME ON THE MENTAL HEALTH KNOWLEDGE, ATTITUDES AND INTENDED HELP-SEEKING BEHAVIOUR OF YOUNG PEOPLE IN KOGI STATE POLYTECHNIC

BY

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A PROJECT SUBMITTED TO THE CENTRE FOR CHILD AND ADOLESCENT MENTAL HEALTH, IN PARTIAL FULFILMENT FOR THE DEGREE OF MASTER OF SCIENCE IN CHILD AND ADOLESCENT MENTAL HEALTH (MSC CAMH) OF THE UNIVERSITY OF IBADAN

MAY, 2016.

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DECLARATION

This dissertation is submitted in partial fulfilment of the award of the Master of Science in Child and Adolescent Mental Health of the University of Ibadan.

I hereby declare that this study or part of it has not been and will not be submitted for any other diploma, fellowship, degree or any other examination.

Lydia Audu Ibrahim

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DEDICATION

I dedicate this work to Professor O.O Omigbodun for being so passionate about Child and Adolescent Mental Health in Nigeria.

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ACKNOWLEDGEMENTS

I acknowledge God for his love, care, protection and sustenance over me and my family to this day.

I appreciate my husband, children, siblings, in-laws and parents for their love, understanding and support throughout the duration of this course- thanks to all of you.

My sincere appreciation goes to my supervisors, Dr C. Ani for being a teacher every student will love to have, Dr Bella-Awusah for being so accessible, helpful and supportive, Dr Adedokun for his time despite his busy schedule and to Miss Adeola Oduguwa for her humility, hard work and diligence.

I am grateful to Matron R. Dogwo for releasing me to go to school when all hands were needed in the clinic-Matron I celebrate you.

To my lecturers in CCAMH, classmate and all who contributed to the success of this work – I say thanks to you all.

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LIST OF ACRONYMS

ANCOVA	Analysis of co-variance
CCAMH	Centre for Child and Adolescent Mental Health
GHSQ	General Help Seeking Questionnaire
KASDS	Knowledge Attitude and Social Distance Scale
PTSD	Post -Traumatic Stress Disorder
SEF	Student Evaluation Form
SHQ	School Health Questionnaire
W H O	World Health Organisation

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ABSTRACT

Introduction

Despite the high prevalence of mental illness among young people, several studies report that the knowledge of mental illness is generally low among the general population and young people rarely seek help for emotional problems. Poor knowledge of mental illness accounts for stigmatisation and low usage of mental health services.

The adolescent period is an opportune time where knowledge of mental illness can be impacted, negative attitudes changed and help seeking behaviour for emotional problem promoted.

This present study evaluated the effect of a mental health training programme on the mental health knowledge, attitude and intended help seeking behaviour among young people in Kogi State Polytechnic, Nigeria.

Methodology

The study utilised a quasi- experimental design with an intervention and a control group and used a pre and post - test design. Two of the campuses of Kogi state Polytechnic located about 50 kilometre apart from each other were allocated into control and intervention arm respectively. A total of 90 college students were recruited by simple random sampling for the study, 45 students per group. At baseline both groups completed the Socio-demographic section of the School Health Questionnaire (SHQ), Knowledge, Attitude and Social distance Questionnaire (KASD) and the General Help Seeking Questionnaire (GHSQ). The intervention group received a 5 hour training programme on mental health spread over 3 days. The intervention included the use of multiple teaching methods, such as lectures, video, question and answer, drama and group discussion sessions. At immediate Post - test, the intervention group first completed the KASD and GHSQ questionnaires, the control group did same after 2 hours. The Student Evaluation Form was filled by the intervention group alone. Data analysis

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was done by the use of Statistical Package for Social Sciences (SPSS) Version 20 based on the different variables. Qualitative variables were presented as percentages while continuous variables were presented with means and standard deviations. Cross tabulations and Chi-square were used to explore relationship between categorical variables. The impact of the intervention was determined as follow; Comparison of socio-demographic characteristics and scores on outcome measures (Scales) at baseline, was done using independent sample t tests, correlations for continuous measures and Chi square for categorical variables. Comparison of baseline and post test scores on outcome measures among the intervention group, paired sample t-tests was used. To compare baseline and post test scores on the outcome measures among the control group, paired sample t - test was used. To compare the post test scores of the intervention group with the post test scores of the control group on knowledge of mental illness, attitudes towards persons with mental illness, and intended help seeking behaviour, independent sample t test was used. Treatment effect was determined by Analysis of Covariance (ANCOVA) using post test scores on outcome variables while controlling for the baseline scores.

The level of significance was set at $P < 0.05$, two-tailed and 95% confidence interval.

Results

The mean age of the respondents was 21.05 (SD ± 2.17) years with an age range of 18-24 years, Majority were males (84.4%) and Christians (68.9%). There were no significant differences between the sociodemographic characteristics of the study participants in the control and intervention group. However, there was a significant positive change in participants knowledge of mental health at immediate post- test, mean knowledge score (baseline - 20.5, SD - 3.1, immediate post –test - 22.6, SD - 4.1, p = 0.001). Similarly there was a significant change in respondents' intended help seeking behaviour for emotional problems at immediate post

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intervention, mean General Help Seeking score (baseline - 8.2, SD - 6.2. immediate post-test - 12.8, SD -5.6 p = 0.001) compared to baseline. However there was no significant change in the mean attitudes and social distance scores at immediate post-test. The effect size of the intervention on knowledge (Cohen's d = 0.75) and intended help seeking behaviour for emotional problems (Cohen's d = 0.77) was moderate. The evaluation of the programme by the participants showed that the training was useful to them. However, they learnt most from lecture (48.9%), followed by group discussion (28.8%), video (20.0%) and least from question and answer (2.2%).

Conclusions

The present study shows that the use of multiple teaching methods and multiple training sessions can change young people's knowledge of mental illness and intended help seeking behaviour for emotional problems. The intervention did not have any effect on negative attitudes and social distance towards persons with mental illness. This suggests that there is need for other methods besides education to combat negative attitudes and social distance. This may include contact with persons living with a mental illness and more accurate portrayal through the media.

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CHAPTER ONE

Introduction

1.0 Background to the study.

Mental health is an essential part of health and wellbeing (WHO 2013). It refers to an individual's ability to realise his or her potentials, cope with the normal stresses of life, be productive, fruitful and contribute to his or her society (Sadock and Sadock, 2007). According to World Health Organisation (WHO) 2001, mental health is determined by biological, psychological and social factors such as genetic inheritance, severe psychological trauma (abuse), bereavement, poverty and others. Poor mental health is associated with exposure to violence, chronic physical illness, social exclusion and stress (Bovier et al., 2004, Wilkinson and Marmot, 2003). Physical health and mental health are inseparable, there is no health without mental health (Prince et al., 2007).

Mental illnesses on the other hand are a leading cause of disability world-wide and are characterised by changes in an individual's thinking, mood and behaviour, distress and or deficiency in daily functions (Stein et al., 2011, WHO, 2014,). Mental illness accounts for14% of the global burden of disease (WHO, 2008), with 75% of people affected with mental illness found in low income countries (Whiteford et al., 2013, Amuyunzu-Nyamongo (), 2013). According to Kessler et al, 50% of all psychiatric illness begin by age 14 and 75% by age 24. Moreover, most of the severe mental disorders seen in adult, started in childhood as a less severe disorders [which was not given due clinical attention] (Kessler et al., 2007a). Furthermore, untreated mental disorders in youth, interferes with establishment of peer relations, career and educational development (Patel et al, 2007). Up to 20% of adolescents

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experience mental illness at some point in their lives (Kieling et al., 2011) and these mental illnesses persist into adulthood increasing the mortality and morbidity burden in young people.

Despite the high prevalence of mental illness among young people, several studies report that the knowledge of mental illness is generally low among the general population (Rahman et al., 1998, Crisp et al., 2000, Gureje et al., 2005). Besides, young people rarely seek help for mental illness (Gulliver et al., 2010, Gonzalez et al., 2011). Poor knowledge of mental illness also accounts for stigmatisation and low usage of mental health services (Kelly et al., 2007). Studies also describe the stigma attached to mental illness and to persons with mental illness (Alexander and Link, 2003, Pinto-Foltz and Logsdon, 2009). Stigma is defined as a mark of shame, disgrace or disapproval which results in the affected individual being ill-treated and rejected (Watson et al., 2004, Corrigan and Watson, 2002). Stigma according to Thornicroft (2007) comprises of three constructs namely - knowledge (ignorance), attitude (prejudice) and behaviour [discrimination] (Thornicroft et al., 2007, Li et al., 2014).

Stigma is often negative and based on false myths and beliefs, it is frequently pervasive and held across several cultures and societies, Nigeria inclusive (Crisp et al., 2000, Gureje et al., 2005). Stigma leads to rejection of persons with mental illness by families, friends, and community leading to loneliness and exclusion (Moses, 2010, Gureje et al., 2005). At other times, the affected individual is denied employment, housing and equal participation in society. This results in low quality of life, refusal to seek professional help, starting or staying in treatment (Kessler et al., 2001, Corrigan et al., 2004, Rickwood et al., 2005). Other effects of stigma include; low self-esteem, self-blame, negative emotions and attempt to hide the disease instead of seeking help (Link et al., 2014). Stigma has been identified as a foremost reason for the rejection of formal sources of care. It also increases the use of informal sources of care,

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such as prayer houses and herbal homes (Coton et al., 2008, Abdulmalik and Sale 2012). Delay in seeking professional help may lead to the onset of complications and poor prognosis (Prince et al., 2007).

To combat this stigma, mental health training, mental health literacy, and face to face contact with persons who have recovered from a mental illness have been recommended (Corrigan et al., 2001). According to studies, education can produce significant changes in student's knowledge and perception of mental illness (Corrigan et al., 2001, Pinfold et al., 2003, Alexander, 2003, Bella-Awusah et al., 2014). Moreover, the adolescent period is an opportune time to encourage positive attitudes, reduce stigma related to mental disorders and reduce the burden of mental illness across the life span (Pinto-Foltz et al., 2011).

Mental health training programme carried out on college campus among young persons have several advantages such as the ability to reach more students (Sartorius, 2005) as well as positively changing student's perception of mental illness (Watson et al., 2004, Stuart, 2006b). Training young people have also been equated with training the community (Rahman et al., 1998), because young people belong to families and communities. Thus they return to their communities after graduation to live and work (Gudmundsdottir, 2002) thereby transferring the knowledge and the attitude acquired into the community.

Several studies carried out to improve knowledge of mental illness recorded varied results. An intervention study in the United Kingdom among secondary school students using an hour short educational workshop over 2 days, produced only positive changes in attitudes toward people with mental illness but not in social distance (Pinfold et al., 2003). Another intervention study carried out among secondary school adolescents in rural and urban areas in southern Nigeria,

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by Bella- Awusah et al, 2014, used a 3 hour educational strategy to deliver an intervention. They reported improvement in knowledge of mental illness but no improvement in attitude and social distance. A more recent study carried out among adolescent secondary school students in south west Nigeria (Oduguwa, 2015) added the use of drama to a purely educational method and recorded improvements in knowledge of mental illness and attitude but not in social distance. Another Study on mental health knowledge and attitude in young adults students in West Indies campuses in Jamaica, Barbados, Trinidad and Tobago also reported low scores on knowledge of mental illness and stigmatising attitudes towards persons with mental illness (Youssef et al., 2012). A randomised control trial by Papish et al, (2013) in Canada among undergraduates medical students recorded changes in knowledge of mental illness but not in attitude and social distance (Papish et al., 2013).The variations in the results obtained, probably occurred due to the different methods, duration of training, period of assessment between training and assessment time used by the different researchers for assessment of knowledge, attitude and social distance.

Studies on help seeking for mental illness by young adults reports that despite the high prevalence of mental illness among young people, they feel reluctant to seek professional help (Rickwood et al., 2005, Gulliver et al., 2010). In a study by Gonzalez and Prihoda in the University of Texas, to investigate attitudes toward seeking mental health treatment in a National Epidemiological Survey, young adults reported the most negative attitudes, as compared to older adults. This was due to their ignorance of the symptoms of mental illness, and benefits of seeking professional mental health treatment (Gonzalez et al., 2005 citing Dubow et al., 1990). Males reported more negative attitudes, as compared to females, a consistent finding in young adults (Gonzalez et al., 2005). The reason for this difference being ascribed to the effect of gender socialization, and internal feelings of dependency (Gonzalez et

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al., 2005 citing Ortega and Alegria, 2002). Females are socialised to be more accepting of help seeking roles whereas males are socialised to suppress their emotions. A systemic review of help seeking for mental illness by Gulliver et al., (2010) reported that adolescents experience mental illness but tend not to seek help. Stigma, inability to identify symptoms of mental illness and preference for self-reliance were identified as the main barriers to help seeking while past positive experience, social support and encouragement from others facilitate help seeking for mental illness (WHO, 2005, Gulliver et al., 2010). It has been advocated that in promoting help seeking for mental illness in young persons, focus should be on stigma reduction, improving mental health literacy and taking into account young people's desire for self-reliance (Gudmundsdottir, 2002, Gulliver et al., 2010)

1.2. Justification for the study

Studies have shown that mental health training programmes among young people can produce changes in their attitudes due to the fact that young people are quick to learn and adapt to changes (Pinto-Foltz and Logsdon, 2009, Pinto-Foltz et al., 2011). Hence various strategies can be used to improve mental health knowledge and attitudes among them. Corrigan et al., (2001) described three strategies for handling psychiatric stigma namely; education, contact with someone or persons with mental illness and protest (Corrigan et al., 2001, Corrigan and Watson, 2002, Watson et al., 2004).

Kogi State Polytechnic have no provision for mental health services. Persons seen are often referred unattended to and sent to the Federal Medical Centre, hence the need for mental health training programme.

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Most Nigerian Studies on knowledge and attitudes, were carried out among secondary school students in the Southern part of the country. These studies described stigmatising attitudes towards persons with mental illness. There is therefore a need for studies among older adolescents and younger adults and for studies from the northern part of Nigeria.

Previous Studies on mental health knowledge and attitudes in Nigeria used a 3 hour (in one day) educational intervention and recorded improvements in the participant's knowledge of mental illness only (Bella-Awusah et al., 2014). Oduguwa, 2015, used education and drama and increased the training time from 3 hours to 5hours over 3 days and recorded improvements in participant's knowledge and attitude of mental illness. This study aims to add video show (video of famous people with psychiatric illness) as a form of contact, in addition to education and drama to train young persons in Kogi State Polytechnic. The addition of video and time is to allow for improved knowledge of mental health, reduce stigmatising attitudes towards persons with mental illness, and teach appropriate help seeking behaviour.

1.2.1. Relevance of the study to Child and Adolescent Mental Health (CAMH) in Africa

This study will contribute to the body of knowledge on mental health as well as, provide appropriate choice of interventions for mental illness that are effective for young people in CAMH. The study could also change young person's perspective about mental illness, change their attitudes to persons with mental illness positively through the provision of adequate knowledge about mental illness and help seeking sources.

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1.3. Aim

The overall aim of this study is to evaluate the effect of mental health training programme on the mental health knowledge, attitudes and intended help seeking behaviour of young persons in Kogi State Polytechnic, Lokoja.

1.4. Specific objectives

The specific objectives of this study are:

1. To assess the baseline knowledge, attitudes and social distance towards people living with a mental illness and intended help seeking behaviour for emotional problems among young people in Kogi State Polytechnic

2. To determine the Socio-demographic factors associated with knowledge, attitudes, social distance and intended help seeking behaviour for emotional problems among young people in Kogi State Polytechnic.

3. To evaluate the effects of an intervention on knowledge, attitude, social distance and intended help seeking behaviour and compare with a control group who did not receive the intervention

1.5. Null hypothesis

1. There is no significant difference between the knowledge of mental illness, attitudes, intended help seeking behaviour and social distance towards persons with mental illness among young persons at Kogi State Polytechnic at baseline and post intervention between intervention and control group

2. There is no significant relationship between the socio –demographic factors of young polytechnic students and their baseline knowledge of mental illness, attitude, intended help seeking behaviour and social distance towards persons with mental illness.

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1.6. Primary outcome measures.

1. Changes in knowledge of mental illness derived from participants score on the knowledge item of the KASD scale.

2. Changes in attitude and social distance as derived from the participant's score on the attitude and social distance of the KSAD scale.

3. Changes in intended help seeking behaviour as derived from the participants score on the help seeking scale.

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CHAPTER TWO

Literature review

2.0. Introduction

This section reviews literature relevant to the study and is divided into eight sections. The first five (5) section includes; definitions of mental health and mental illness, epidemiology of mental illness, types of mental illness experienced by young people, Risks, protective factors and Consequences of mental illness. The 6th and 7th Section reviews knowledge, attitudes and help seeking behaviour for mental health problems among College students and factors that affect them. The last section (8th) describes Literacy programmes for College students and its effects on mental health knowledge, attitudes and help seeking behaviour for mental health problems of College students in Nigeria, Africa and the rest of the world.

2.1. Definitions of mental health and mental illness

Mental health is the successful performance of mental functions in terms of thought, mood and behaviour resulting in productive activity, fulfilling relationships with others and an ability to adapt to changes and cope with adversity (Sadock and Sadock, 2007). On the other hand mental illness is a condition that impacts on an individual's thinking, mood, ability to function and relate well with people and function effectively at home, school, work or community (WHO, 2014). Child and adolescent mental health is the ability of a child to attain and remain in optimal psychological functioning and wellbeing, which is related to level reached and the competences achieved by a child, in psychological and social functioning (Dawes et al., 1997, WHO, 2007). The WHO defines young people as persons aged between 10-24 years of age. Children and adolescents form a third of the world's population(Kieling et al., 2011) and they are not exempt from experiencing mental illness (Unicef, 2011).

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2.2. Epidemiology of mental disorders among college students.

The WHO 2001 report indicates that child and adolescent mental illness occupies a large and disproportionate percentage of the burdens of disease (WHO, 2001). Belfer et al., 2008, in a global report of World Health Organisations Child and Adolescent Resource Atlas Project, reported that the current global epidemiological data regularly reports that up to 20% of children and adolescents suffer from a disabling mental illness. In addition, suicide is the 3rd leading cause of death among adolescents and up to 50 % of mental illness starts in the adolescent age group (Belfer, 2008).

In 2005, Kessler et al carried out a National comorbidity survey to estimate the life time prevalence and age onset distribution of DSM-IV disorders in America. The lifetime prevalence estimate reported 28.8% for anxiety disorders, 20.8% for mood disorders, 24.8% for impulse control disorders, 14.6% for substance use disorders and 46.4% for any disorder. The median age of onset for anxiety and impulse control disorders was estimated at 11years, substance use disorders, 20years and mood disorders, 30years. 50% of mental illness started by the age of 14, and three fourths by the age 24 (Kessler et al, 2005).

In New Zealand. The lifetime prevalence of any mental illness was 39.5%, for anxiety disorders, 24.9%, mood disorders, 20.2%, substance use disorders, 12.3% and eating disorders, 1.7%. The prevalence of all mental illness were higher in the younger age groups. Females had higher prevalence of anxiety, mood and eating disorders compared with males. Males had higher prevalence of substance use disorders. The estimated projected lifetime risk of any disorder at age 75 years was 46.6%. Median age of onset being 18 years (Oakley et al, 2006)

In sub Saharan Africa, evidence suggests that considerable levels of mental health problem exists among children and adolescents (Kleintjes et al., 2006, Cortina et al., 2012). Approximately 1 in 7 children and Adolescents have significant difficulties, with 1in 10 (9.5%)

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having a specific psychiatric disorders(Cortina et al., 2012). In South Africa, Kleintjes et al, 2006, reported that the overall prevalence for mental illness in Western Cape Town, South Africa was 17.0% for children and adolescents. Common disorders found were generalised anxiety disorders, 11.0%, while PTSD and major depressive disorder had a prevalence rate of 8.0% (Kleintjes et al., 2006).

In Nigeria, community studies carried out in primary health care settings estimates that up to 20% children and adolescents experience mental illness but most of these children and adolescents are not recognised and treated (Gureje et al, 1994, Omigbodun et al, 2007). In Lagos State, Lasebikan et al, 2012 using the Primary Care (PC) version of mental disorder checklist and International Statistical Classification of Diseases [ICD10] Primary Care version reported unexplained somatic disorder (57.5%) as the most prevalent mental illness among primary health care attendees in Lagos Island. In Kwara State, reported prevalence rate in children and adolescents attending a primary health care centre for mental illness was 11.4%. Common disorders were enuresis (13.4%), conduct disorder (3.8%), Attention Deficit Hyperactivity Disorder [ADHD] (3.3%), Anxiety disorders (2.5%), depression (1.3%) and mental retardation (1.3%).(Tunde-Ayinmode et al., 2012)

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2.3. Types of mental illness experienced by young people

Mental illnesses are generally more prevalent among young people (Kessler et al., 2007b, Belfer and Nurcombe, 2007). Common mental illness of young males and females include but are not limited to; depression (Adewuya and Ologun, 2006), substance abuse (Omigbodun and Babalola, 2004), suicide and self-harm (WHO, 2012), Post-Traumatic Stress Disorder (PTSD) and psychosis (Busari et al., 2014, Gureje et al., 2010).

2.3.1 Substance Abuse

Substance abuse is the excessive use of a substance leading to a significant impairment in functioning (American Psychiatric Association, 2013). Substance abuse is characterized by pathological use of non-medically indicated drugs or toxins. There are several kinds of drugs that people abuse; namely alcohol, tobacco, cannabis, marijuana, cocaine, hallucinogens, inhalants and heroine (Blow et al., 2002). Nevertheless, of all these, alcohols, tobacco, and cannabis are the most abused due to their availability and social acceptability (Kandel et al., 1992, Omigbodun and Babalola, 2004).

Globally, substance abuse is a major problem among the general population (Degenhardt et al., 2008, Whiteford et al., 2013). The United Nations Office on Drugs and Crimes (UNDOC) gave a global estimate of 155-250 (3.5-5.7%) million for illicit drug use in the past one year among 15-64 years old in the population (UNDOC 2014). More males (8.1%) compared to females (4.5%) are more likely to abuse drugs first time. Male are 2.2 times more likely to use drugs and 1.9 times more likely to become dependent (Etten et al., 1999). Mamman et al., 2004, reported the age of onset of substance abuse at 11-25 years.

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In Africa, substance abuse is also a problem among young people. Several studies estimate different rates. According to the United Nations statistics, Africa is the second largest in trafficking and consumption of illegal drugs (UN 2014). About 28 million Africans use drugs compared to Canada and USA combined which is 32 million (UN 2014). Anti-Drug Alliance of South Africa's (ADASE) estimate for substance abuse in South Africa -1 in 3 South African adults use drugs on regular basis.

In Nigeria the trend is not different, adolescents in secondary schools and in the university abuse drugs (Makanjuola et al., 2007, Oshodi et al., 2010). Alcohol, tobacco and cannabis being the most abused (Omigbodun and Babalola, 2004). According to Mamman et al, Northern Nigeria has a 37.47% of drug victims, south 17.32% with more males (94.2%) compared to female (5.8%) abusing drugs. Multiple drug use account for 78.8%. Among the Almajiris (religious street kids) aged 5 to 16years in North east Nigeria, prevalence of substance abuse was 66.2%. Drugs most frequently abused being stimulants 49.7%, volatile solvent 21.5%, cigarrette19.1% and cannabis 18.5% (Van Etten and Anthony, 1999, Abdulmalik et al., 2009). Substance abuse put a great burden on the individual and the nation (Volkow and Li, 2005). These burdens include but are not limited to; loss of functioning, inability to continue in school, business and other productive activities, onset of mental disorders, gangster formation, cultism, social violence, loss of lives, properties and other vices too numerous to count.(Abasiubong et al., 2008)

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2.3.2. Depression

Depression is a major cause of morbidity and mortality among adolescents (Chisholm et al., 2004). It is an internalizing disorder that is characterized by persistently low moods, reduced energy and aversion to previously enjoyed activities (Peterson et al., 1993).

Globally more than 300 million people of all ages suffer from depression, it is a contributor to the global disease burden and premature death by suicide (WHO, 2012). Depression is currently estimated to be the 3rd leading cause of death in young persons but projected to be the 2nd by the year 2020 (Michaud et al., 2001). Depression has a 4-5% per year prevalence rate in adolescents with more cases seen in low and middle income countries (Thapar et al., .2012). It occurs more in females compared to males (ratio 2:1) and rises sharply after puberty to 20%, by the end of adolescent its prevalence rate is 4% (Kessler et al., 1993, Thapar et al., 2012).

In Africa, 2002-2004 statistics for depression from South Africa puts the lifetime prevalence at 9.7% to 14.9% per year (Mynors-Wallis et al., 1995), in Nigeria Adewuya recorded 9% among adolescents (Adewuya and Ologun, 2006), while 23.3% was recorded among undergraduate medical students in Enugu (Aniebue and Onyema, 2008).

Adolescents with depression are at a higher risk for substance abuse, risky sexual behaviour and other psychiatric comorbidities (Birmaher et al., 1996). Depression produces significant impairment in functions across social, academic and occupational domains leading to low quality of life (Simon, 2003). To reduce this burden recognition and prompt treatment for depression have been advocated.

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2.3.3. Suicide and Self Harm.

Suicide is the act of taking one's own life while self-harm is deliberate injury inflicted by someone on his or herself (Silverman, 2006). According to WHO 2012 report, Suicide and self-harm may be a manifestation of psychological or psychiatric disorder. Suicide is a major problem with about a million cases recorded annually and the 2nd leading cause of death among 15-29 years worldwide (WHO, 2012). A suicide occurs in every 40 seconds in the world and 75% of these suicides occur in low and middle income countries (WHO, 2012).

Globally, suicide is more common in males compared to females (Schrijvers et al., 2012). More females self-harm compared to males (Thompson et al., 2011). More males use violent methods compared to females. Popular methods used for committing suicide include; hanging, poisoning and the use of firearm (Callanan and Davis, 2012). The reason for the gender differences in suicide, was attributed to the different traditional gender roles (Schrijvers et al., 2012). More cases of suicide are recorded in mid-adolescent. Self-harm increase the risk of suicide by about 100 times and is 20 times more frequent than completed suicide. In 2008 prevalence rate for suicide attempt was 1.9-8.7 (Nock et al., 2006).

In Africa, Sudan has the highest suicide rates of 23 men to 11 women per 100,000. The high rate was attributed to the war (since 1955), which made weapons readily available to unleash trauma on the general populace. The effect of trauma and abuse triggers depression and Post-Traumatic Stress Disorder (PTSD), which progresses to hopelessness and suicide in those affected. Nigeria ranks 102 in the world and has a suicide rate of 6.5 for both sexes in 2011 (WHO report, 2012).

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Adolescent suicide places some difficulty on family functioning. The difficulties include but are not limited to, decreases in emotional bonding, coping with the after effect of suicide and changes in family roles (Lohan, 2002). Suicide also produces significant loss to the family and nations (Cerel et al., 2008). Family members are faced with the challenge of carrying on with their lives and mourning the loss of their loved ones.

2.3.4. Psychosis

Psychosis is a severe mental disorder that is characterized by impairment in thought and emotions leading to a loss of contact with reality (APA, 1994). Psychosis presents with symptoms of delusion (unusual beliefs that are not true), hallucinations (false perceptions), a disordered and a slowed rate of thinking (Gelder et al., 2005). The 2 most common mental illness where psychotic symptoms are a predominant features are schizophrenia and bipolar disorder (Starling and Feijo, 2012).

Psychosis is among the ten top causes of disability and it results in suicide in approximately 10% of its sufferers (WHO, 2010). About 24 million people are living with psychosis globally (WHO, 2001).The lifetime prevalence of psychosis ranges from 0.5% to 1.5% for 18years and over. It has equal male to female ratio but earlier onset in males (Gureje et al., 2010) . The incidence of psychotic disorders vary by age, sex, place, migration status and ethnicity. With variation being ascribed to increased social adversity and psychological factors such as poverty and smaller proportion in a larger population (Harrison et al., 1997). Psychosis is more prevalent in urban communities compared to rural communities, more in developed countries compared to developing countries and is higher among the low socioeconomic class. Freeman, 1994, reported overcrowding, exposure to toxins, infection and poverty among others as the cause of the increase in prevalence.

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In Africa rates of psychosis recorded in 15-59 years old in an urban Tanzania study was 3.9% (Jenkins et al 2010). In Nigeria, the life time prevalence of psychosis was 2.1% and a 12month estimate of 1.1%. Age of onset for psychosis was in 6-18 years, (Gureje et al., 2010, Adeosun et al., 2015).

2.3.5. Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that develops after an exposure to a traumatic or terrifying event in which severe physical harm occurred or the person's life and safety was threatened (APA, 2013). Such events include violent personal assaults, natural or unnatural disasters, accidents, or military combat. Anyone who has gone through a life-threatening event can develop PTSD (Perkonigg et al., 2000). This include; rescue workers for catastrophes like bombing; survivors of accidents, earthquakes, Boko Haram, floods, rape and physical or sexual abuse (Zoladz and Phillip, 2013). PTSD, occurs at any age and women are more likely to develop PTSD compared to men. PTSD is frequently comorbid with depression, substance abuse and other types of anxiety disorders (Clark et al., 1994).

The global burden of PTSD in year 2000 by WHO was 0.6%, the lifetime prevalence of PTSD vary from country to country. Reported Prevalence rates ranges from 0.3% in China to 6.1 % in New Zealand. Prevalence among direct victims of disaster is between 30%-40% (Javidi and Yadollahie, 2011). Reported prevalence rate for adolescents; 1% for females and 3% for males (Cuffe et al., 1998).

In Africa, in a survey carried out by Seedat et al in 2004, among 2041 adolescents aged 12 -18 in Cape Town and Nairobi PTSD prevalence recorded was 22.2% in South Africa and 5% in

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Nairobi. In south Arica more males than females met the PTSD symptom criteria (Seedat et al., 2004).

In Nigeria Busari et al., 2014 recorded 16% in adolescent females following assaultive violence in Lagos State Nigeria. With the increase in violence occurring in Nigeria, PTSD rate will be higher if studied closely (Busari, 2014). PTSD has a significant adverse effects on young people's physical, psychological, and social functioning and adversely influences their Quality of life [QOL] (Clark and Kirisci, 1996).

2.4 Risk and protective factors of mental illness

Several risk and protective factors for mental health have been identified among young persons (Wille et al., 2008). A mental health risk factor is any factor that increases the likelihood of the development of a mental health problem and when present perpetuates the course (Tunde-Ayinmode et al., 2012). Examples include; abandonment, psychiatric illness in a parent, physical and sexual abuse, different types of family conflicts among others (Omigbodun, 2004). On the other hand, mental health protective factors mitigate against the development of mental health problems and also promote resilience (WHO, 2012). Examples include; good health, good social support system, intelligence among others (WHO, 2012). There is no single risk or single protective factor that can predict or protect against the development of mental illness. Mental health and well-being is influenced by individual attributes, the social circumstances in which a person finds his or herself and the environment in which he or she lives (WHO, 2012). These determinants interact with each other dynamically, and may threaten or protect an individual's mental health state (WHO, 2012).

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Risks to mental health manifest themselves at all stages in life. Taking a life-course approach shows how risk exposures in the developmental stages of life such as substance use in pregnancy, family violence in childhood and insecure attachment in infancy can affect mental health or predispose towards mental disorder later in life (WHO, 2012). Households living in poverty, people with chronic health conditions, minority groups, and persons exposed to riots, displaced by war or conflict are at increased risk of experiencing a mental illness (WHO, 2012). Studies in Low and Middle Income Countries, identify poor living condition, maternal mental illness, school failure, infection, joblessness, urbanisation and poverty as risk factors for mental illness (Gureje and Omigbodun, 1995). High Self-esteem, social and problem solving Skills (Opler et al., 2010), secure and sensitive parenting, good physical health, getting along with others, being a good student and participation in activities (Rae-Grant et al., 1989, Patel et al., 2007) were identified as protective factors against mental illness. Risk and protective factors could be biological, psychological and social or a combination. The promotion of positive mental health equips young people with the necessary life skills, resources and supports to fulfil their potential and overcome adversity.

2.5 Consequences of mental health disorders in young persons.

Poor mental health in children and adolescents is associated with social problems such as delinquency, substance abuse, family conflicts, justice involvement, and school failure in adulthood (Jenkin et al., 2011, Kieling et al., 2011). Kessler et al., 1995 report that individuals with mental illness are less likely to complete high school, enter college or earn a degree compared to their peers without mental illness (Kessler et al, 1995).

Young people with mental illness are reported to have an increased likelihood of experiencing disability, premature mortality and low quality of life compared to their peers without mental

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illness (WHO, 2012). Other adverse consequences include; the suffering from the distressing symptoms of mental illness, loss of functioning and productivity due to the chronic and disabling nature of mental illness (Russel et al, 2008). People suffering from a mental illness find it difficult to learn new things, secure employment, (Östman et al., 2005, Greenberg et al., 2003), and experience social exclusion, poverty, stigma and discrimination (Corrigan et al., 2001).

Link and Phelan citing Goffman, referred to stigma as a "spoilt identity", which denotes affixed labels that associate a person to undesirable characteristics that form a stereotype (Link and Phelan, 2001). The spoilt identity may be public, relating to negative perceptions or behaviours of others or private, concerning internalized feelings about oneself (Link and Phelan, 2001).
Mental illness stigma encompasses three constructs; stereotypes, prejudice, and discrimination (Corrigan, 2004). Stereotypes represent society's shared beliefs about members of a group. They are not subject to personal control (Devine and Sharp, 2009). Such beliefs include beliefs about persons with mental illness and the causes of mental illness such as the belief that, persons with mental illness are violent and dangerous, mental illness is caused by a person's action or inaction and mental illness cannot be treated (Corrigan et al., 2002, Pescosolido et al., 2010). Prejudice on the other hand, is a preconceived opinion that is not based on reason or experience. Prejudice promotes negative attitude toward a person or group leading to avoidance and social exclusion. Prejudice is expressed by willingness to engage in varying interpersonal interactions with persons with mental illness for example become friends, neighbours or working with persons suffering from mental illness (Goffman, 1986, Pescosolido et al., 2010). Discrimination is the behavioural aspect of stigmatization resulting from prejudice or stereotypes. It embraces social exclusion and negative social interactions and also encompasses laws, policies, and practices that treat persons with mental illness unfairly such as restrictions

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on their voting rights, parenting rights and their rights to hold office (Hemmens et al., 2002, Angermeyer and Dietrich, 2006)

2.6 College student's knowledge of mental health problems

Knowledge according dictionary.com is acquaintance with facts, truths or principles as from study or investigation; while attitude is an established way of responding to people and situations which is learned, based on belief (Williamson, 2002).

Globally studies report poor knowledge of mental illness among young persons (Dogra et al., 2011,Pinfold et al., 2003, Henderson and Thornicroft, 2009). A study carried out by Watson of more than 1500 middle schooler's knowledge and attitude towards mental illness in the United States, revealed that the students had some knowledge of the causation of mental illness as a problem of the brain but had no knowledge about the treatment. Overall they were not sure about many aspects of mental illness(Watson et al., 2004, Dogra et al., 2011).

In Africa, a systematic empirical study of knowledge and attitude of mental illness among University undergraduates in Cameron, suggests gaps in students' knowledge of mental illness with particular reference to the causation of specific disorders (Nguedo, 2015).

In a study of Nigerian school children, the children displayed stigma towards mental illness (Dogra et at., 2005) this was similar to what has been found among adults in Nigeria and young people in other countries. The displayed negative attitude was attributed to a lack of Knowledge regarding mental health problems (Gureje et al.,2005., Dogra et al., 2011, Bella-Awusah et al., 2014).

Factors affecting young people's knowledge of mental illness is based on their beliefs about the causation of mental illness (Crisp et al., 2000, Gureje et al., 2006). In a community study

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of 18 years and older in Nigeria, mental illness was believed by the study participants to be caused by the misuse of drugs hence the view that substance abusers afflict themselves with mental illness. Others believed in the supernatural causation of mental illness such as being possessed by evil spirits (Gureje et al., 2005, Gureje et al., 2006).

A study of adolescents in secondary school in southern Nigeria reported that, the study participants believed that mentally ill people were weak, unpredictable and were to be blamed for their illness. They were also ignorant about prevalence and causes of mental illness and they could not identify the symptoms of depression (Dogra et al., 2011).

The media depiction of mental illness is another factor that affects young person's knowledge of mental illness (Ampadu, 2012). The popular Nigerian home movie industry (Nollywood) often presents people with mental illness as being psychotic or schizophrenic, squalid, disorganised, unpredictable, violent, should not be helped, interacted with, but best avoided (Harwood, 2006, Atilola, 2015, Atilola and Olayiwola, 2012).

A study carried out in Leeds reported that the causes and treatment of mental illness as depicted by the Nigerian and Ghanaian home movies were due to witchcraft attack, a result of a curse or the consequences of sin committed. Therefore mental illness cannot cured or treated by orthodox means but by spiritual means through the use of unorthodox or non-professional means (Ampadu, 2012). These stereotyped media depictions of mental illness forms the public's perception of mental illness, to correct these wrong notions, there is a need to supply correct factual information about mental illness to change the stigma and attitudes directed by people towards young persons with mental illness.

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2.7. College student's attitude towards mental illness.

Attitude refers to an emotional tendency that is expressed by evaluating a particular person or object with some degree of favour or disfavour (Eagly and Chaiken, 2007). They are sets of belief, emotions and behaviour displayed towards a person or an object. Attitudes are formed through experience, upbringing, observation and conditioning. Attitudes influence behaviour and they can be changed (Watson et al., 2004, Wahl et al., 2014). Studies describe young people's negative attitude towards mental illness (Wahl et al., 2014) and negative attitudes are reported to be formed as early as five years and becomes more advanced as people age. Negative attitudes toward people with mental illness manifest as stigma, social distance and discrimination and they stem from ignorance about mental illness, especially in situations where mental illness is not talked about openly leading to the maintenance of misconceptions about mental illness.(Alexander and Link, 2003).

In a study of students' attitudes by Wahl in United States of America, Attitudes toward persons with a mental illness were generally positive, but a significant numbers of the students had less favourable attitudes. (Wahl et al., 2014). Social distance scores revealed considerable reluctance to interact closely with a person with mental illness. The results also reflected a frequent finding by studies that measure social distance. The more intimate the relationship, the less willing is an individual to interact with someone with a mental illness. This result points that a student with mental illness experiences substantial rejection and exclusion by peers (Wahl et al., 2014).

Youssef et al., 2006 in their study of knowledge and attitude among college students in English speaking Caribbean, reported poor attitudes and stigmatisation towards persons with mental illness. Adewuya and Makanjuola, 2005 also reported that students in a Nigerian university

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displayed negative attitudes and high social distance towards persons with mental illness. Furthermore the social distance scores increased with the level of intimacy required for the relationship.

Factor that affect young person's attitude to mental illness include, poor knowledge of mental illness, myths and perceptions surrounding the causes and treatment of mental illness (Crisp et al., 2000), media depiction of mental illness and stigma (Atilola and Olayiwola, 2012). Consequently, addressing negative attitudes early is a right step in changing such attitudes. Moreover, Interventions aimed at reducing negative attitudes promote help-seeking behaviour among young people experiencing a mental illnesses (Rickwood et al., 2005, Pinfold et al., 2003).

2.8.0 Help seeking of college students for mental illness and factors affecting it.

Help seeking behaviour is the behaviour of actively seeking help from other people through communication to obtain advice, information, treatment and general support to a problem especially at a time of illness or distress (Rickwood et al., 2005). Help seeking could be formal, from healthcare professionals or informal, from family, friends and from other sources such as internet.

Prevalence of mental disorders is highest among young people aged 16-24 years (Kessler et al., 2007b) which is more than at any other stage of the lifespan. Despite this high prevalence of mental illness, young people, feel reluctant to seek professional help (Rickwood et al., 2005, Gulliver et al., 2010).Only a minority of young people with mental health problems seek help from professionals and when they do they would have first sought for help from informal sources before turning to the formal (Boldero and Fallon, 1995). Help seeking increases with

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age and females are more likely to seek help for a mental illness compared to their male counterparts. This was attributed to better knowledge of mental illness by older adolescents and gender role socialization of females. Similarly younger children seek help more than older adolescents, due to the fact that they depend on adults for care while the older adolescents do not, as they are more self-reliant (Gudmundsdottir, 2002, Gulliver et al., 2010).

Help-seeking is also determined by the kind of problem at hand and the nature of the problem, if is an emergency situation, people tend to seek help faster as they view the situation as life threatening (Mojtabai et al., 2002). Where young people seek help is also determined by the problem. A patient suffering from schizophrenia will most likely seek help from a psychiatrist (Boldero and Fallon, 1995) unlike a patient suffering from fever.

Despite the high prevalence and burden of mental illness, a lot of young people still refuse professional help (Wang et al., 2007) (Kessler et al., 2007b) due to the Stigma attached to mental illness (Alexander and Link, 2003, Pinto-Foltz and Logsdon, 2009). Rejection of professional help by young people is a challenge to successful early intervention approaches. Early treatment and prevention are important for young people aged 10-24 due the high prevalence and burden of mental health problems at this stage of life (Kessler et al., 2007b).

When young people seek help for their mental health needs, it is generally from someone they are familiar with and have confidence and trust in. Evidence from research shows that adolescents often seek help from their family, friends, the Internet, from doctors, teachers, school counsellors and school nurses. However, some adolescents still report they would not seek help from anyone (Wang et al., 2007)

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2.8.1 Factors affecting help seeking behaviour

Griffins in her review reported that young people show greater help-seeking intentions towards trusted sources due to the concern for privacy and trust relating to stigma (Gulliver et al., 2010). Young people are afraid of being humiliated should peers and family find out that they had sought help for mental illness (Wilson, 2007, Wang et al., 2007, Gulliver et al., 2010).

Knowledge of mental illness and difficulty identifying the symptoms of mental illness was another factor identified that affects how young people seek help (Rickwood, 2005). In cross-sectional correlational studies and reviews of studies of young people with mental distress by Biddle et al 2004, participants were aware of their distress, but continuously changed the meaning they attached to this distress in order to avoid seeking help. Young peoples' lack of knowledge about mental health services also affects help-seeking, a finding which is consistent with prior reviews (Jorm, 1997, Wilson, 2007, Kelly, 2007).

Lack of accessibility coupled with lack of mental health professionals makes it difficult for young people to seek help in rural areas. In a study conducted in rural Canada, Stigma, travelling long distances to get help, ignorance of the awareness of mental services, lack of finance and personnel for mental health were reported as factors affecting help seeking (Boydell et al., 2006, Reid et al., 2011).

According to the Griffiths' study, adolescents and young adults prefer to rely on themselves rather than to seek external help for their problems (Gulliver et al, 2010). Some of the studies reviewed found that concerns about the characteristics of potential provider such as age (older age), race (racial disparity), and culture (cultural differences) are factors that affect help seeking. Lindsey and kalafat reported the qualities of potential providers in schools that young

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people perceived as barriers to help-seeking. These were active pessimism, breach of privacy, double roles, negative attitude or tendency to show preference, uncooperative responses, being out of touch with adolescents [provider do not know much about adolescent behaviours] (Lindsey and Kalafat, 1998).

Many young people reported that they were fearful about the act of seeking help, or the source of help itself. Evidence suggests that young people who have established relationships with health professionals and had past positive experiences are more likely to seek help in the future (Rickwood et al., 2005). Past experience with sources of help may reduce fears about the unknown, and encourage young people to seek further help. Other factors include, emotional capability, understanding, positive attitudes towards seeking professional help and social encouragement (Rickwood et al., 2005).

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2.9 Literacy programmes for college students and its effect on mental health knowledge, attitude and help seeking intention.

Corrigan et al., 2012 in their effort to identify the most effective anti-stigma approaches, conducted a meta-analysis of data from 72 outcome studies in 14 countries of overall anti-stigma strategies. The strategies include; education about mental illness, contact with persons with mental illness and protest. The overall result showed that, both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults. For adolescents, the opposite pattern was found; education was more effective for reducing mental illness stigma. Overall, face-to-face contact was more effective for reducing mental illness stigma compared to contact by video (Corrigan et al, 2012)

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In Nigeria, Bella et al,.(2012) carried out an intervention study among secondary school students using lectures, group discussions and reported significant changes in students' knowledge of mental illness at immediate and 6months post intervention. More recently, a study among secondary schools using multiple teaching method including the use of drama showed sustained change in both students' knowledge and attitude to mental illness at 3weeks post intervention (Oduguwa, 2015).

Other methods found useful for increasing knowledge of mental illness and improving attitude of young person to mental illness is the use of mass media. The mass media is a means of communication that reach large audience simultaneously. Examples of mass media include radio, newspaper, television, internet, social media to mention a few (Stuart, 2006a).The use of media is important in challenging public prejudices to positively tilt the image of mental health and mental illness by passing accurate information across to the public using the different kinds of media that are available in the country. Interesting media stories about people who live with mental illness is a way of speaking out for patients who may not be able to speak out for themselves, a means of improving public education and awareness. (Stuart, 2006b, Wakefield et al., 2010, Austin and Husted, 2014).

Presently, the media portrayals of mental illness, persons with mental illness and mental health interventions, depict distorted images of mental illness that stresses on dangerousness, wrong doing and unpredictability (Allen and Nairn, 1997, Wahl, 2003). These media portrayals model negative attitude, fear, rejection, disdain and mockery of mental illness and persons experiencing mental illness (Wakefield et al., 2010).

The consequences of negative media images for people who have a mental illness could be profound. They impair medication adherence, self-esteem, help-seeking behaviours, and general recovery (Stuart, 2006a). The use of media to counter these wrong information is an essential step in combating stigma and improving help seeking (Wakefield et al., 2010).

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In assessing the efficacy of help seeking interventions, Battaglia et al., 1990, carried out a Week long Mental Illness Awareness program in United States (an intervention study) to increase help-seeking intentions and improve attitudes toward psychiatrists among secondary school students. The programme involved Psychiatry residents visiting secondary schools and speaking to classes of students about help-seeking for depression, professional help, substance abuse, and suicide. The students who were involved in the classroom sessions showed modest improvements in intention to speak to a counsellor or a psychiatrist. Besides the students enjoying the talks and it also stirred interest in them to learn other sensitive topics (Battaglia et al., 1990, Kelly et al., 2007).

In another study, William et al., 2006, carried out an evaluation of a classroom based strategy to modify help seeking intentions for mental illness among college students in Mississippi. The study involved a 40minute intervention focused on dismissing myths and stigmas associated with mental illness, modifying psychotherapy expectations and its effectiveness. The programme provided students with information regarding treatment options, at same time assessing the impact of a brief psychoeducational intervention on participants' attitudes toward seeking professional psychological help. Participants in the classroom group showed significant improvements in attitudes toward seeking professional psychological help and in some of their opinions about mental illness, for up to a month following the intervention when compared with the control group. These finding suggest that the use of a brief, classroom-based mental health education program is a promising method to modify help-seeking attitudes and negative opinions of the mentally ill (William et al, 2006).

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CHAPTER THREE

Methodology

3.1. Study location

Kogi state known as the confluence state is located in the North Central region of Nigeria, with Lokoja as the capital. It has a total land mass of 29,833 km2, and was created out of Benue and Kwara States on the 27th of August 1991. It has an estimated population of 3,596,796 as at 2005 (National Demographic health survey, 2013).The ethnic groups in Kogi state consist of Igala, Ebira, and Okun. The main occupation of the inhabitants of Kogi State indigene is farming. Kogi state connects the Federal Capital Territory to 22 southern states. Kogi state has 21 Local Government areas (www.mamaye.org (Babatimehin et al., 2011).

The study was conducted in Kogi State Polytechnic. Kogi State Polytechnic was established in 1992 by the 1st governor of Kogi State, Prince Abubakar Audu through an amended edict no. 6 of 1994. The polytechnic started operations in 1993 at the then Government Science Secondary School (www.kogistatepolytchnic.edu.ng). Kogi State Polytechnic is located in Lokoja the capital of Kogi State and has two main campuses in Lokoja and Osara. The polytechnic has a student population of about 10,000 and offers both Art and Science courses at Pre- National Diploma (Pre-ND), National Diploma (ND) and Higher National Diploma (HND) levels. The Lokoja campus runs the Pre- National diploma, National Diploma and Higher national Diploma programmes (Pre- ND programmes lasts a year, while the ND and HND programmes last for 2years each). The Osara campus is located at about 50 kilometre along Okene road, a distance of about 50 kilometers from Lokoja. It runs the Interim Joint Matriculation Board (a year pre- degree programme which is equivalent to the Pre-ND programme) and engineering programmes (ND and HND). Both campuses are funded by the Kogi state Government.

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There are 7 schools comprising of 16 departments. The 7 schools are: School of Management Studies, School of Applied Sciences, School of Arts, Design and Printing, School of Engineering and Technology, School of Environmental Technology, School of General Studies and the School of preliminary Studies (IJMB). Osara campus runs the school of preliminary studies and engineering courses.

The Kogi State Polytechnic has a medical centre in both campuses that attends to general health problems of the students and staff of the Polytechnic but has no provision for mental health services. Persons with mental illness seen are referred unattended to and often sent to the Federal Medical Centre or Kogi State Specialist Hospital. When there is ongoing hospitals industrial action, parents are called upon to come and pick their wards to anywhere they can get them treated.

3.2. Study design

The study utilised a quasi-experimental design with an intervention and a control group

3.3. Study population

The study subjects were made up of young Kogi State Polytechnic students aged 18-24 years.

3.3.1. Inclusion criteria

Young person aged 18-24 years who gave voluntary consent to participate and were either in the Pre- Diploma (School of General Studies) or Pre- Degree programmes (IJMB). These two groups were chosen because of the similarity in their programmes, levels of availability (have the least holiday) and to reduce loss to follow up.

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3.3.2. Exclusion criteria

1. Young persons who are in ND or HND in both campuses. Osara campus and Lokoja campus run parallel ND or HND academic programme. Furthermore, some of the students were on Industrial Attachment (IT), rounding up their programmes and writing examinations and projects at about the time the study was conducted, hence the reason for their exclusion and to reduce loss to follow up.
2. Young persons who refused to give voluntary consent.

3.4. Sample size calculation

The total minimum sample size (n) was calculated using the formula for the minimum sample size for two proportions as follows:

$n = 2F (\sigma/d)^2$ (Wade 1997)

Where:

n = is the minimum sample for the group,

F = is 7.85 - a factor based on 80% power and 5% level of significance

σ = is the standard deviation for the outcome measure (knowledge score).

d = is the difference expected to be found between the pre and post-intervention outcome measures.

Assuming that the intervention will result in 0.75 standard deviation difference between the intervention and control groups then, the sample size will be

$n = 2F (\sigma/d)^2$

$n = 2x\ 7.85(1/0.75)^2$

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n= 33 per group

Calculating loss to follow up n=n/1-L

Where L=10%

33 x 10/9

= 330/9

n =36.6 but rounded up to 45

n = 45 per group, giving a total of 90 participants for this study.

3.5. Sampling techniques

Sampling technique was a 3 stage sampling method.

1st stage: selection of school [Kogi State Polytechnic] was purposive. The purposive sampling was used for the study to fulfil the Centre for Child and Adolescent Mental Health (CCAMH), University of Ibadan requirement. Selection of campuses into an intervention arm and a control arm was by random sampling through balloting. The decision to use a different campus for the intervention and control was to avoid cross over and contamination of the control group through interaction with the intervention group. Furthermore, the two campuses are about 50 kilometre apart from each other.

Schools were categorised within the Polytechnic into similar groups based on courses offered. All schools offering Art courses constituted a group while all schools offering science courses constituted another group.

2nd stage: selection of a school from a science and an art group. This was done through simple random sampling by balloting. The school of pre-degree was selected for the control group. The school of pre- diploma was selected for intervention

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3rd stage: was the recruitment of study participants from the selected departments within the selected schools. The department of pre- degree science and pre-degree arts were selected for the control group while the department of pre- diploma science and pre- diploma art were selected for the intervention group. The list of students that made up the selected departments were obtained from the Office of the Director Student Affairs. The list was used for the sample frame and the study participants were recruited by simple random sampling by balloting for the study.

3.6. Study instruments

All recruited study participants who met the inclusion criteria were administered the questionnaires listed below-

1. Socio Demographic Health Questionnaire.
2. Knowledge ,Attitude and Social distance scale(KASD)
3. School Evaluation form (SEF)
4. General help seeking questionnaire (GHSQ)

3.6.1. The Socio- Demographic Health Questionnaire

The Socio-Demographic section of the School Health Questionnaire was used for the study. It was an instrument designed by Omigbodun and Omigbodun (2004). The questionnaire Contained 40 Item, written in English and Yoruba. It assesses information about a respondent's personal, family and school life. The instrument was validated among secondary school students in South west Nigeria by (Bella- Awusah et al., 2014, Oduguwa et al., 2014). Only the English version of the questionnaire was used for this study. It is expected that being in higher institution of learning the students should understand English language. Besides English

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language is the general means of communication and learning within the campuses. (Omigbodun et al, 2008, Oduguwa, 2014) [See appendix I].

3.6.2. Knowledge, Attitude and Social Distance Scale (KASD)

The questionnaire was designed to elicit information from respondents on knowledge of mental illness, attitude and social distance toward persons with mental illness. It was designed based on the World Psychiatric Associations and Stigma Schools Project in Canada for use among secondary school students in the United Kingdom (Pinfold et al., 2003).

The instrument was validated and modified for use in Nigeria (Bella - Awusah, 2014 and Oduguwa, 2014).There are 29 items on the KASD questionnaire divided into 3 sections as follows:

Knowledge items -There are 15 knowledge items in the questionnaire, with 12 items positively-worded and 3 items negatively-worded. For the positively worded items, 'agree' remained a category while 'disagree' and 'not sure' were merged together. For the negatively worded items, 'disagree' remained a category while 'agree' and 'not sure' were merged together (Bella et al., 2014).

In order to develop a knowledge subscale score, for each of the positively-worded item, a score of 2 was assigned to every 'agree' response, 0 for 'disagree' responses and 1 for 'not sure' responses. For negatively worded items, a score of 2 was assigned to 'disagree', 0 for 'agree' and 1 for 'not sure (Bella *et al*., 2014). The total obtainable score for the knowledge subscale was 30. Participants who scored on the mean and 2 Standard Deviation (SD) from it were regarded as having 'average knowledge' about mental illness. Participants who scored 2 SD below the mean were categorized as having knowledge that is' below average'. Participants

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who scored 2 SD above the mean were categorized as having knowledge that is 'above average'.

Attitude items

There are 8 attitude items in the questionnaire, all items are negatively worded. Responses on these items were re-coded into two categories such that 'disagree' remained a category while 'agree' and 'not sure' were merged together.

Furthermore, in order to generate an attitude subscale, a score of 2 was assigned to 'disagree', 0 for 'agree' and 1 for 'not sure (Bella –Awusah, 2014). The total obtainable score was therefore 16.

Participants who scored 2 SD below the mean were categorized as having 'negative attitude' towards persons with mental illness. Participants who scored 2 SD above the mean were categorized as having 'positive attitude' towards persons with mental illness while participants who scored on the mean and 2SD from were regarded as having 'indifferent attitude' towards people with mental illness (Bella – Awusah, 2014).

Social distance items

The questionnaire contains 4 positively-worded social distance items, each with 5 responses on a Likert scale. These responses were re-coded into 2 categories such that 'don't know' responses and responses that implied unfavourable disposition towards persons with mental illness were merged into one category while responses that implied favourable disposition towards persons with mental illness were merged into another category. Additionally, in order to create a social distance subscale, a score of 2 was assigned to every correct response, 0 for

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incorrect responses and 1 for 'don't know' responses (Bella et al., 2014). The total obtainable score was 8.

Participants who scored on the mean and 2SD from it were regarded as being 'indifferent' towards persons with mental illness. Participants who scored 2 SD above the mean were regarded as being 'favourably disposed' towards persons with mental illness while participants who scored 2 SD below the mean were regarded as being 'unfavourably disposed' towards persons with mental illness (Bella-Awusah et al., 2014) (see Appendix II)

3.6.2. General Help Seeking Questionnaire (GHSQ).

The General Help Seeking Questionnaire (GHSQ) was developed by Wilson, Deane and Ciarrochi (2005) in Australia to elicit information from respondent's intentions to seek help from different sources for psychological distress, suicidal intentions and previous quality and quantity of professional psychological helping episodes. (Wilson, Deane and Ciarrochi, 2005a).The instrument was validated for use in Australia, further adaptation and validation of the questionnaire was among Filipino college students in Philippines. However, to the best of author's knowledge the questionnaire have not been used or validated in Nigeria. The Help seeking questionnaire scale is divided into 2 parts namely;

A. General Help Seeking Questionnaire (GHSQ) for emotional problems which was designed to assess future help seeking intentions. The help seeking intentions are reported at 3 subsets, as level of intention to seek formal help, informal help and seeking help from nobody. The questionnaire has 10 listed potential sources of help. Participants were asked to choose from the listed options their choice source of seeking help on a 7 point Likert scale of extremely unlikely (1) to seek help to extremely likely (7) to seek help for emotional problems.

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The General Help Seeking Questionnaire was modified for the purpose of this study. The Likert based responses were modified to yes and no format and each correct response was assigned a score of (2) and every incorrect response was assigned a score of zero (0). The total obtainable score was 20. Higher mean scores of 10 and above indicate higher intentions while 9 and below indicate poor help seeking intentions.

B. Actual Help Seeking Questionnaire (AHSQ) this portion of the questionnaire assesses past help seeking experiences. This portion of the questionnaire was not used (See appendix III).

3.6.3. School Evaluation form (SEF)

The evaluation form that was used for this study was designed by Oduguwa et al., 2014. It contains 9 questions that elicits information from respondents about the relevance and effectiveness of the intervention (see appendix IV).

3.7. Study procedure

The study procedure was designed to be carried out in four phases- baseline, intervention, immediate post intervention and at 3rd week. However, the 3rd week post intervention test was not administered due to an indefinite closure of the school after a student riot. As at the time of compiling this result, the students have not resumed.

Each campus was visited prior to the commencement of the study to:

- Promote familiarity with the campus
- Explain the content of the research project to the school authority
- Systematically select students into the study
- Distribute the consent forms for the students to sign.

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- Structure the course of data collection and training as it applied to each campus.

The school lecture theatre was used, this made simultaneous addressing of all the participants in each campus easy.

At baseline, participants in both control and intervention groups completed the Socio-Demographic Health Questionnaire, the Knowledge, Attitude, Social Distance (KASD) and the General Help Seeking Questionnaires (GHSQ) for emotional problems. Time estimated for completing the questionnaires was about 40-50 minutes.

At intervention, participants in the intervention group received the mental health-training programme, after which both groups filled the KASD and Help seeking questionnaire again. The study procedure is shown below (Table 3.70)

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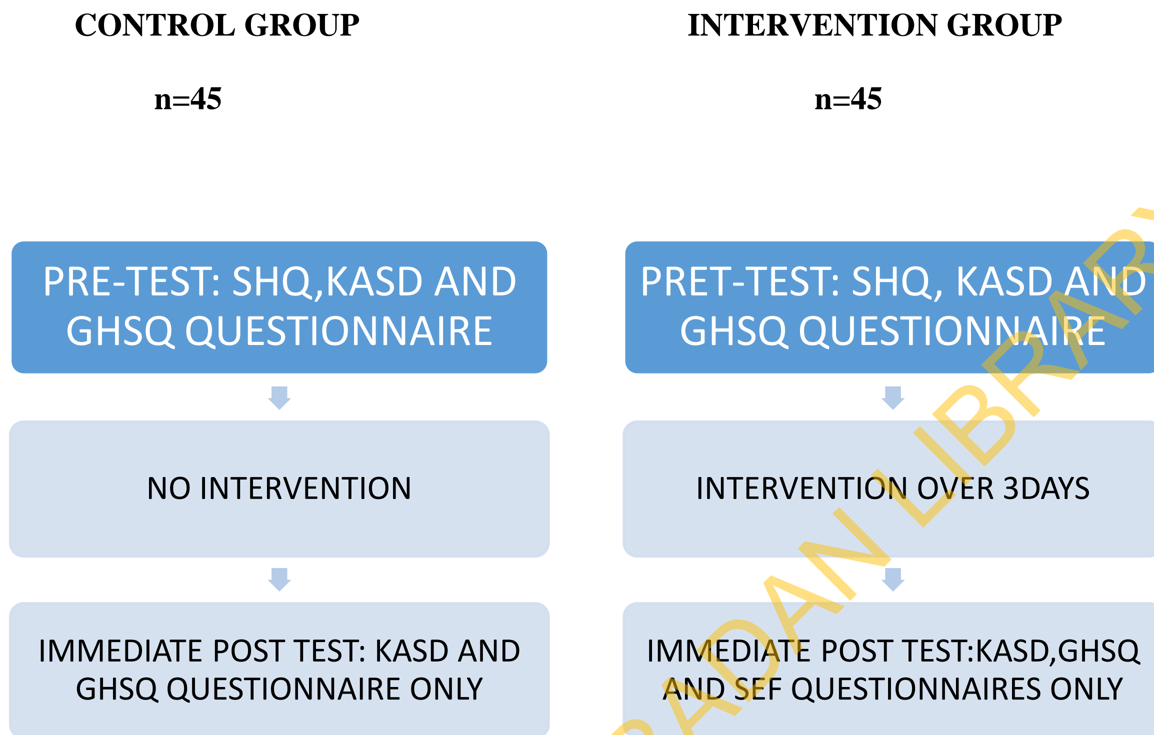
Table 3.70: study procedure

STUDY PROCEDURE



3.7.1 The Pilot Study.

Preceding the commencement of the study, the study instruments were pre-tested among 10 students aged within 18-24years, randomly selected for the pre-test study from the Federal University of Lokoja. Males made up 70.0%, females 30% and 80% live in monogamous family settings. The study Participants noted that the questions were clear and that the training manuals were easy to read and understand.

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3.7.2. The interventions

This consisted of the video of famous people with mental illness and the training material for multipurpose care workers in developing countries developed by Omigbodun and Adejumo (2012). The video contains pictures and stories of famous people such as actors, actresses, famous people in government, business men, among others with mental illness that have recovered. The manual contains case vignettes that describe the presentations, causes of mental illness, myths, appropriate places to seek for mental health care and appropriate behaviour towards persons with mental illness and treatments of mental illness in a clear and simple language that the respondents could understand. This material was adapted to suit the age of the study participants and the area of research focus as described earlier (Psychosis, Depression, Suicide and Self harm, PTSD and Substance Abuse). The entire training programme was delivered in a 3-4 hour session run over two (2) – three (3) days as permitted by the school. An hour and 30 minutes was used for each training session per day. Teaching aids included Power-points and Flip Charts, video show, interactive sessions, lecture, small group discussions with questions and answers.

The description of the case vignettes.

A total of 7 case vignettes were used, namely

a. Five case vignettes and questionnaires highlighting the symptoms and causes of mental illness were selected from the manual.

b. Two case vignettes highlighting myths associated with mental illness, appropriate places to seek for mental health care and appropriate behaviour towards persons with mental illness were used.

c. A drama sketch titled 'It is Possible', based on one of the 2 case vignettes was used for the training.

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The case vignettes making up the training materials were provided for each participant in the intervention arm of the study. The drama was acted out by student volunteers among the participants while the others watched.

3.8. Data analysis

Data analysis was done by the use of Statistical Packages for Social Sciences (SPSS) version 20 based on the different variables.

Qualitative variables were presented as percentages while continuous variables were presented with Means and Standard Deviations. Cross tabulations and Chi-square were used to explore relationships between categorical variables

The impact of the intervention, was determined by the following data analyses:

Comparison of socio-demographic characteristics and scores on outcome measures (Scales) at baseline, was done using independent sample t-tests and correlations for continuous measures and Chi square for categorical variables were used.

Comparison of baseline and post test scores on outcome measures among the intervention and control group, paired sample t-tests was used. To compare the post test scores of the intervention group with the post test scores of the control group on knowledge of mental illness, attitudes towards persons with mental illness, and intended help seeking behaviour, independent sample t-test was used. Treatment effect was determined by Analysis of Covariance (ANCOVA) using post test scores on outcome variables while controlling for the baseline scores.

The level of significance was set at $p < 0.05$, two-tailed and 95% confidence interval

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3.9. Ethical approval and considerations

Ethical approval for the study was given by the Federal Medical Centre, Lokoja's Ethical Committee.

3.9.1 Informed consent

Written informed voluntary consent was obtained from individual study participants, after appropriate explanation of the study procedure, the aims and objectives of the study, no force or cohesion was used. All the principles of ethics were applied.

3.9.2 Confidentiality of subject's Data

In collecting data, the laid down rules of confidentiality was applied. Only identification number and not names were used; participants were assured of the confidentiality of their data supplied by the researcher.

3.9.3 Beneficence

The study participants in the intervention arm gained more knowledge. Efforts will be made to delivered the same intervention to the study controls at the end of the study

3.9.4 Non-maleficence

The principle of non-maleficence was applied by ensuring that not more than minimal risk was applied in collecting data. Besides, the study does not involve any invasive procedures or collection of biological samples. Steps were taken to make the patient comfortable, the time for data collection was also minimised.

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3.9.5 Voluntariness

Study participants were not coerced into the study but were allowed to participate voluntarily and withdraw at any point in the course of the study without any adverse effects on them.

3.9.6 Justice

Efforts was made to ensure that all students were given equal opportunity to participate in the study and recruitment was equally distributed.

3.9.7 Conflict of interest

There was no conflict of interest.

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CHAPTER 4

Results

4.1 Sociodemographic characteristics of the respondents

The participants recruited for this study were ninety (45 in the intervention group and 45 in the control group). A total of 90 respondents successfully completed the questionnaires at baseline and post intervention. This gives a response rate of 100%.

The mean age of the respondents was 21.05 (SD ± 2.17) years with an age range of 18-24years, majority were males (84.4%) and over half (68.9%) were Christians. The sociodemographic characteristics of the study participants in the control group did not differ significantly from that of the intervention group in terms of age, gender and religion (see Table 4.1)

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Table 4.1: Socio-demographic characteristics of the respondents: Personal information.

Variables	Intervention group N=45 Frequency (%)	Control group N= 45 Frequency (%)	Total Frequency (%)	x^2 and p-value
Age (years)				
15-19	12 (26.7)	11 (14.4)	23 (25.6)	x^2=0.058
20- 24	33 (73.3)	34 (75.6)	67 (74.4)	p=0.809
Sex				
Male	36 (80.0)	40 (88.9)	76 (84.4)	x^2=1.353
Female	9 (20.0)	5 (11.1)	14 (15.6)	p<0.245
Religion				
Islam	13 (28.9)	15 (43.3)	28 (31.1)	x^2=0.207
Christianity	32 (71.1)	30 (66.7)	62 (68.9)	p=0.649
Influence of Religion on personal behaviour (Self-reported)				
Very much	41 (93.3)	43 (98.3)	84 (94.4)	x^2=1.886
Not much	4 (6.7)	2 (3.4)	6 (5.6)	p=0.390

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4.1.2 Family information on the respondents.

There was no statistical significant differences in the family information provided by the study participants in the control and intervention group in terms of family type, parent's marital status, influence of religion on family life and parent's level of education. However 62.2% of the respondents lived in monogamous family arrangements compared to 37.8% in polygamous settings (see Table 4.1.2).

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Table 4.1.2: Socio-demographic characteristics of the respondents: Family information

Variables	Intervention Group N=45 Frequency (%)	Control Group N= 45 Frequency (%)	Total N=90 Frequency (%)	x^2 value and p-value
Family type				
Monogamous	29 (64.4)	25(55.6)	56(62.2)	x^2=0.741
Polygamous	16(35.6)	20 (44.4)	39(37.8)	p=0.389
Marital Status of Parents				
Married	33 (73.3)	34(75.6)	64 (71.1)	x^2= 0.058
Others	12(26.7)	11(24.4)	23 (29.9)	p=0.809
Level of mother's education				
Less than secondary school	6 (6.7)	3 (6.7)	9(10.0)	x^2=1.529
Secondary School and above	32(71.1)	32(71.1)	64 (71.1)	p=0.465
I don't know	7 (15.6)	10(22.2)	17(18.8)	
Influence of religion on family life				
Very much	33(73.3)	38(84.4)	71(78.9)	x^2=2.638
Not much	12(26.7)	7(15.6)	19(21.1)	p=0.451

Others listed under marital status include –separated / divorced, father is dead, mother is dead and father and mother are dead

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4.1.3 School information of the respondents.

There was no statistical significant differences in the school information provided by the study participants in the control and intervention group (see Table 4.1.3).

Table 4.1.3: Socio-demographic characteristics of the respondents: School information N=90

Variables	Intervention N=45 Frequency (%)	Control N= 45 Frequency (%)	Total Frequency (%)	x^2 value and p-value
Do you like your school?				
Yes	42 (93.3)	44 (97.8)	86 (95.6)	x^2=1.047
No	3 (6.7)	1(2.2)	4 (4.4)	p=0.308
Do you do well academically?				
Yes	40 (88.9)	39 (86.7)	79(87.7)	x^2=0.104
No	5 (11.1)	6 (13.3)	11 (12.3)	p=0.748
Do you have any difficulties with your teachers				
Yes	8 (17.8)	7 (15.6)	15 (16.7)	x^2=0.080
No	37 (82.2)	38 (62.2)	75 (83.3)	p=0.500
Do you have a Guidance and Counsellor in your school?				
Yes	31 (68.9)	28 (62.2)	59 (65.6)	x^2=0.443
No	14 (31.1)	17 (37.8)	31 (34.4)	p=0.329

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4.1.4 Responses on exposure to mental health information.

Overall, there was a significant statistical difference between respondents in the intervention and control group in terms of exposure to mental health information. A higher proportion of the students in the control group (23.3%) affirmed family as a major source of their understanding for mental illness compared to the intervention group (10.0%) which was statistically significant (p=0.048). However, a sizeable percentage of the respondents in both groups affirmed television and home video (31.7%) as a major source of their understanding and knowledge of mental illness compared to school (27.5%) and other sources (See Table 4.1.4).

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Table 4.1.4: Responses on exposure to mental health information

Variables	Intervention Group N=45 Frequency (%)	Control Group N= 45 Frequency (%)	Total Frequency (%)	x^2 value and p-value
Source of information				
Family				
yes	4 (10.0)	11 (23.3)	15 (16.7)	x^2=3.920
no	41(90.0)	34(76.7)	75 (83.3)	p=0.048*
School				
yes	16 (33.3)	10 (21.7)	26 (27.5)	x^2=1.947
no	29 (66.7)	35 (78.3)	64 (72.5)	p=0.122
T.V and Home Video				
yes	16 (33.3)	13 (30.0)	29 (31.7)	x^2=0.458
No	29 (66.7)	32 (70.0)	61 (68.3)	p=0.479
Friends				
Yes	3 (5.0)	1 (1.7)	4 (3.3)	x^2=1.034
No	42 (95.0)	44(98.3)	86 (96.7)	p=0.695
Magazines and				
newspapers	3 (6.7)	0(6.7)	3 (6.7)	x^2=0.212
yes	42(93.3)	45 (93.3)	87 (93.3)	p=0.645
no				
Others	5 (11.7)	8(16.7)	13(14.2)	x^2=0.809
Yes	40 (88.3)	37 (83.3)	77 (85.8)	p=0.368
No				

Note- the significant value ($p<0.05$) is with asterisks

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4.2. Comparison of responses on knowledge of mental illness in Control and Intervention groups at baseline

Individual responses on the scales were also analysed for group differences. There was no statistically significant difference between both groups at baseline except that a higher proportion of the intervention group (51.1%) affirmed that bullying was a risk factor for suicide compared to the control group (14.5%) which was statistically significant ($p<0.001$) (see Table 4.2).

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Table 4.2: Responses on knowledge of mental illness in Control and Intervention groups at baseline

Items	Control group N =45		Intervention group N=45		x^2	p-value
	Agree	Disagree / Not sure	Agree	Disagree / Not sure		
	n(%)	n (%)	n (%)	n(%)		
1.Mental illnesses are caused by stress	11 (24.4)	34 (75.6)	15(33.3)	30 (66.7)	0.847	0.646
2. People can recover from mental illness	36 (80.0)	9 (20.0)	38 (88.9)	7 (11.2)	1.903	0.386
3. There is a stigma (shame) attached to people with mental health problems	25 (55.6)	20 (44.4)	29(64.4)	16 (35.6)	1.387	0.500
4.One in four people will develop mental illness over the course of a lifetime	14 (31.1)	31 (78.9)	11 (24.4)	34 (75.6)	2.411	0.300
5.Mental illnesses are caused by spiritual attack	14 (31.1)	31 (78.9)	22 (48.9)	23 (51.1)	3.155	0.206
6.Parents with mental illness always transmit it to their children	29 (64.4)	16 (35.6)	27 (60.0)	18 (40.0)	0.660	0.719
7.Mental illness cannot be treated	28 (62.2)	17 (37.8)	29 (64.4)	16 (35.6)	0.306	0.858
8.Depression is a type of mental illness	20 (44.4)	25 (55.6)	22 (48.9)	23(51.1)	1.180	0.914
9.People with Psychosis often see or hear what others cannot see or hear	22 (48.9)	23 (51.1)	22 (48.9)	23 (51.1)	0.890	0.641
10.Bullying is a risk factor for suicide	6 (14.5)	39 (85.5)	22 (48.9)	23 (51.1)	0.180	**0.001***
11.People who attempt suicide have often been depressed	25 (55.6)	20 (44.4)	23 (51.1)	22 (48.9)	31.277	0.914
12.People who experience trauma are likely to develop PTSD	23(51.1)	22 (48.9)	24 (55.6)	21 (44.4)	1.911	0.358
13.People with PTSD often suffer from flashback and nightmares	25 (55.6)	20 (44.4)	22 (48.9)	23 (51.1)	0.407	0.816
14.Gateway drugs include alcohol, marijuana and tobacco	23 (51.1)	22 (48.9)	34 (75.6)	11 (24.4)	6.005	0.050
15.Peer influence is a great factor in starting to use and abuse drug	32 (71.1)	12(28.9)	36 (80.0)	9 (20.0)	1.569	0.456

The significant value ($p<0.05$) is with asterisks

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4.2.1 Responses on attitude items in Control and Intervention groups at baseline

The responses of the students in the Intervention group differed significantly in only 1 out of the 8 items on the attitude scale. More (68.9%) respondents in the Intervention group wrongly agreed with the statement ‘People with depression always like to be alone, feel sad & wish to die’ compared to (62.2%) in the control group which was statistically significant (p=0.048) (See Table 4.2.1)

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Table 4.2.1: Responses on attitude items at baseline in both groups

Items	Intervention N=45 Agree n (%)	Intervention N=45 Disagree/ Not sure n (%)	Control N=45 Agree n (%)	Control N=45 Disagree/ Not sure n (%)	X²	P value
1.People with mental illness are always difficult to talk to	9(20.0)	36 (80.0)	35 (77.8)	10 (22.2)	5.270	0.768
2.People with mental illness are likely to become violent	37 (82.3)	8(17.7)	38 (84.4)	7 (15.6)	0.347	0.841
3.People with mental illness are weak and have only themselves to blame	12(35.6)	33(64.4)	16(35.6)	29 (64.4)	1.042	0.594
4.People with mental illness are always unpredictable	27 (60.0)	18(40.0)	31 (68.8)	14 (31.2)	0.935	0.627
5.People with depression always like to be alone, feel sad & wish to die	28 (62.2)	17(47.8)	33(73.3)	12 (26.7)	6.054	0.048*
6.Psychosis is a spiritual problem That cannot be treated in hospital	17 (47.8)	28 (62.2)	13(28.9)	32 (71.1)	0.843	0.656
7.People who joke about killing themselves do not always have a plan to do so	31 (68.8)	14 (31.2)	26(57.7)	19 (42.3)	3.303	0.192
8.People with PTSD do not need treatment because they outgrow it with time	12 (33.4)	33 (66.6)	19(42.3)	26 (57.7)	5.483	0.064

The significant value (p<0.05) is with asterisks

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4.2.2 Responses on social distance items at baseline in both groups

There was only one item with significant difference the participant's response to the items on the social distance scale which was statistically significant (p=0.026) [See Table 4.2.2].

Table 4.2.2: Responses on social distance items at baseline

Items	CONTROL N=45		INTERVENTION N=45		x^2	p- value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)		
1. Would you feel afraid to talk to someone with mental illness?	14 (31.1)	31 (68.9)	7 (25.6)	38 (84.4)	7.319	0.026*
2. Would you be upset to be in the same class with someone who had mental illness?	19 (46.7)	24 (53.3)	21(46.7)	24 (53.3)	1.66	0.920
3. Would you be able to be friends with someone who had mental illness?	28(62.2)	17 (47.8)	22 (48.9)	23 (51.1)	3.530	0.171
4. Would you be embarrassed if your friends knew that someone in your close family has mental illness?	21(46.7)	24(53.3)	21(46.7)	24 (53.3)	1.061	0.588

Note: the significant value p<0.05 is with asterisk

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4.2.3 Responses on General Help Seeking scale (GHSQ) items in both groups at baseline

At baseline, the study participant's response to the general help seeking scale differed significantly on 4 out of the 10 items (see Table below 4.2.3).

Table 4.2.3 Baseline responses on GHSQ in both group

Items	Control N=45		Intervention N=45		x^2	P- value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)		
1.Intimate partner	28(62.2)	17(37.8)	21(46.7)	24(53.3)	4.286	0.038*
2.Friend	29(64.6)	18(40.0)	15(35.4)	29(64.6)	3.600	0.058
3.Parents	25(55.6)	20(44.4)	22(49.3)	23(51.7)	0.009	0.764
4.Other relatives	25(62.2)	20(44.0)	22(49.3)	23(51.7)	0.048	0.826
5.Mentalhealth professional	27(60.0)	18(40.0)	27(60.0)	18(40.0)	3.685	0.055
6.phones/help lines	18(40.0)	27(60.0)	15(33.3)	30(66.7)	1.120	0.290
7.Doctor	26(57.8)	19(42.2)	25(55.6)	20(44.4)	0.720	0.396
8.religious minister	32(71.1)	13(28.9)	26(57.8)	19(42.2)	7.788	0.005*
9.Iwould not seek help	25(55.6)	20(44.4)	10(22.2)	35(77.8)	8.942	0.003*
10.I would seek help from Another source not listed	13(28.9)	32(71.1)	12(26.7)	33(73.3)	7.908	0.010*

Note: the significant value p<0.05 is with asterisk

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4.3 Comparison of the responses on the knowledge of mental illness between control and intervention group at immediate post -test

There was a statistical significant difference between the study participant's responses in 8 knowledge items at immediate-post-test

More students acknowledged that people can recover from a mental illness (86.7%) in the intervention group at immediate post intervention compared to the control group (64.4%) ($p = 0.008$). Equally, more students affirmed that gateway drugs include, marijuana, alcohol and tobacco at immediate-post intervention in the control group (87.2%) compared to the control group (60.0%) ($p < 0.039$). Similarly more students in the intervention (86.7%) group affirmed that depression is a type of mental illness compared to the controls (60.0%) ($p = 0.001$)

(See other items in Table 4.3)

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Table 4.3: Responses on knowledge of mental illness in Control and Intervention groups at immediate-post test

Items	Control group N =45		Intervention group N=45		x^2	P-value
	Agree	Disagree / Not sure	Agree	Disagree / Not sure		
	n (%)	n (%)	n (%)	n (%)		
1.Mental illnesses are caused by stress	20 (44.4)	25 (65.3)	35(73.7)	12 (26.3)	7.871	0.020*
2. People can recover from mental illness	29 (64.4)	16 (35.6)	39 (86.7)	6 (13.3)	9.756	0.008*
3. There is a stigma (shame) attached to people with mental health problems	28 (52.8)	17 (47.2)	25(55.6)	20 (44.4)	0.964	0.618
4.One in four people will develop mental illness over the course of a lifetime	13 (28.9)	32 (72.1)	24 (53.3)	21 (47.7)	5.557	0.062
5.Mental illnesses are caused by spiritual attack	20 (44.4)	25 (55.6)	16 (35.6)	29 (64.4)	0.915	0.633
6.Parents with mental illness always transmit it to their children	20 (44.4)	25 (55.6)	11 (24.4)	34 (75.6)	10.108	0.001*
7.Mental illness cannot be treated	18 (40.0)	27 (60.0)	33 (73.3)	12 (26.7)	1.008	0.315
8.Depression is a type of mental illness	27 (60.0)	18 (40.0)	39 (86.7)	6 (13.3)	9.293	0.010*
9.People with Psychosis often see or hear what others cannot see or hear	22 (48.9)	23 (51.1)	34 (75.6)	11 (24.4)	6.821	0.033*
10.Bullying is a risk factor for suicide	26 (57.8)	19 (42.2)	32 (71.1)	13 (28.9)	3.277	0.194
11.People who attempt suicide have often been depressed	27 (60.0)	18 (40)	39 (86.7)	6 (13.3)	9.239	0.010*
12.People who experience trauma are likely to develop PTSD	19(42.2)	26 (57.8)	35 (73.3)	12 (26.7)	9.641	0.008*
13.People with PTSD often suffer from flashback and nightmares	27 (60.0)	18 (40.0)	34 (75.6)	11 (24.4)	2.714	0.257
14.Gateway drugs include alcohol, marijuana and tobacco	27 (60.0)	18 (40.0)	37 (87.2)	8 (13.7)	6.469	0.039*
15.Peer influence is a great factor in starting to use and abuse drug	27 (60.0)	18(40.0)	33 (73.3)	12 (26.4)	3.616	0.164

Note- the significant value ($p<0.05$) is with asterisk

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4.3.1 Responses on attitude items at immediate-post intervention in both groups

The responses of the students in the Intervention group differed significantly in one out of the 8 items on the attitude scale. More (77.8%) respondents in the Intervention group disagreed correctly with the statement ‘People with post-traumatic stress disorder do not need treatments because they will outgrow it with time’ (p=0.003) compared to (60.0%) in the control group (see Table 4.3.1).

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Table 4.3.1: Responses on attitude items at immediate-post

Items	Intervention n=45		Control n=45		X^2	P value
	Agree n (%)	Disagree/ Not sure n (%)	Agree n (%)	Disagree/ Not sure n (%)		
1.People with mental illness are always difficult to talk to	32(71.1)	13 (28.9)	35 (77.8)	10 (22.2)	0.664	0.718
2.People with mental illness are likely to become violent	31 (68.9)	14(41.1)	35 (77.8)	10 (22.2)	1.242	0.537
3.People with mental illness are weak and have only them-selves to blame	16(35.6)	29(64.4)	24(53.5)	19 (46.5)	3.725	0.155
4.People with mental illness are always unpredictable	30 (66.7)	15(43.3)	29 (64.4)	16 (35.6)	1.617	0.446
5.People with depression always like to be alone, feel sad & wish to die	28 (62.2)	17(47.8)	31(68.9)	14 (41.1)	1.909	0.385
6.Psychosis is a spiritual problem That cannot be treated in hospital	18 (40.0)	27 (60.0)	16(35.6)	29 (64.4)	1.908	0.383
7.People who joke about killing Themselves do not always have a plan to do so	30 (52.2)	15 (43.3)	27(60.0)	18 (40.0)	0.687	0.709
8.People with PTSD do not need treatment because they outgrow it with time	18 (40.0)	27 (60.0)	10(22.2)	35 (77.8)	11.68 9	0.003*

Note: significant value $p<0.05$ is with asterisks

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4.3.2 Responses on social distance items at immediate-post

There was only one item with significant difference in the participant's response to the items on the social distance scale which was statistically significant (p=0.037) [see Table 4.3.2]

Table 4.3.2: Responses on social distance items at immediate-post

Items	CONTROL N=45		INTERVENTION N=45		x^2	p- value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)		
1. Would you feel afraid to talk to someone with mental illness?	21 (46.7)	24 (53.3)	23 (51.1)	22 (49.9)	0.356	0.837
2. Would you be upset to be in the same class with someone who had mental illness?	21 (46.7)	24 (53.3)	21(46.7)	24 (53.3)	2.087	0.352
3. Would you be able to be friends with someone who had mental illness?	26(67.8)	19 (42.2)	24 (53.3)	21 (46.7)	0.657	0.720
4. Would you be embarrassed if your friends knew that someone in your close family has mental illness?	25(65.6)	20(44.4)	20(44.4)	25 (65.6)	6.606	0.037*

Note: the significant value p<0.05 with asterisk

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4.3.3 Responses on General Help Seeking items at immediate post- test

At immediate post-test the study participants' response to the general help seeking scale significantly differed on 6 out of the 10 items in the intervention group compared to the control group (see Table below 4.3.3).

4.3.3: Responses on General Help Seeking items at immediate post- test

Items	Control N=45		Intervention N=45		x^2	P- value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)		
1.Intimate partner	21(46.7)	24(53.3)	36(80.0)	9(20.0)	6.667	0.010*
2.Friends	15(35.4)	29(64.6)	27(60.0)	18(40.0)	24.73	<0.001*
3.Parents	22(49.3)	23(51.7)	39(86.7)	6(13.3)	16.79	0.001*
4.Other relatives	22(49.3)	23(51.7)	28(62.2)	17(37.8)	2.217	0.316
5.Mentalhealth.professional	10(22.2)	35(77.8)	20(44.4)	25(55.6)	3.26	0.056
6.phones/help lines	15(33.3)	30(66.7)	27(60.0)	18(40.0)	6.429	0.011*
7.Doctor	25(55.6)	20(44.4)	39(86.7)	6(13.3)	7.465	0.006*
8.religious minister	26(57.8)	19(42.2)	38(84.4)	7(15.6)	1.746	0.186
9.I would not seek help	27(60.0)	18(40.0)	34(75.6)	11(24.4)	2.493	0.044*
10.I would seek help from Another source not listed	12(26.7)	33(73.3)	21(46.7)	24(53.3)	2.815	1.245

Note: significant p<0.05value Asterisked

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4.4 Comparison of the responses on knowledge of mental illness at baseline and immediate post intervention in the Intervention group alone

The study participant's responses differed significantly at immediate post intervention in the intervention group compared to baseline. More participants believed that one in four persons will develop mental illness at post intervention (53.3%) compared to baseline (24.4%) ($p=0.001$). Similarly more students affirmed that depression is a type of mental illness at immediate post intervention (86.7%) compared to baseline (48.8%) ($p<0.001$) [See other items in Table 4.4].

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Table 4.4: Responses on knowledge of mental illness at baseline and immediate post intervention in the Intervention group alone

Items	Baseline N =45		Immediate-post intervention N=45		P-value
	Agree n (%)	Disagree/ Not sure n (%)	Agree n (%)	Disagree/ Not sure n (%)	
1.Mental illnesses are caused by stress	15(33.3)	30 (66.7)	35(73.7)	12 (26.3)	<0.001*
2. People can recover from mental illness	38 (88.9)	7 (11.2)	39(86.7)	6 (13.3)	0.743
3. There is a stigma (shame) attached to people with mental health problems	29(64.4)	16 (35.6)	25(55.6)	20 (44.4)	0.384
4.One in four people will develop mental illness over the course of a lifetime	11 (24.4)	34 (75.6)	24 (53.3)	21 (47.7)	0.001*
5.Mental illnesses are caused by spiritual attack	22 (48.9)	23 (51.1)	16 (35.6)	29 (64.4)	0.022*
6.Parents with mental illness always transmit it to their children	27 (60.0)	18 (40.0)	11 (24.4)	34 (75.6)	<0.001*
7.Mental illness cannot be treated	29 (64.4)	16 (35.6)	33 (73.3)	12 (26.7)	0.498
8.Depression is a type of mental illness	22 (48.9)	23(51.1)	39 (86.7)	6 (13.3)	<0.001*
9.People with Psychosis often see or hear what others cannot see or hear	22 (48.9)	23 (51.1)	34 (75.6)	11 (24.4)	0.096
10.Bullying is a risk factor for suicide	22 (48.9)	23 (51.1)	32 (71.1)	13 (28.9)	0.173
11.People who attempt suicide have often been depressed	23 (51.1)	22 (48.9)	39 (86.7)	6 (13.3)	<0.001*
12.People who experience trauma are likely to develop PTSD	24 (55.6)	21 (44.4)	35 (73.3)	12 (26.7)	0.125
13.People with PTSD often suffer from flashback and nightmares	22 (48.9)	23 (51.1)	34 (75.6)	11 (24.4)	0.021*
14.Gateway drugs include alcohol, marijuan and tobacco	34 (75.6)	11 (24.4)	37 (87.2)	8 (13.7)	0.357
15.Peer influence is a great factor in starting to use and abuse drug	36 (80.0)	9 (20.0)	33 (73.3)	12 (26.4)	0.342

Note the significant p<0.05 value is with asterisks

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4.4.1: Responses on attitude items at baseline and at immediate post intervention in the intervention group alone

The study participant's responses differed significantly in only 1 item at immediate post intervention, in the intervention group compared to baseline. More participants rightly disagreed that 'people with mental illness are always difficult to talk to' at post intervention (77.8%) compared to baseline (22.2%) (p=0.039). [See other items in Table 4.4.1 below]

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Table 4.4.1: Responses on attitude items at baseline and immediate post intervention in the intervention group alone

Items	Baseline N=45		Immediate Post test N=45		p-value
	Agree n (%)	Disagree n (%)	Agree n (%)	Disagree n (%)	
1.People with mental illness are always difficult to talk to	35 (77.8)	10 (22.2)	10 (22.2)	35 (77.8)	0.039*
2.People with mental illness are likely to become violent	38 (84.4)	7 (16.3)	35 (77.8)	10 (22.2)	0.475
3.People with mental illness are weak and have only themselves to blame	25(55.6)	20 (44.4)	24(57.8)	19(42.2)	1.000
4.People with mental illness are always unpredictable	31 (64.4)	14 (35.6)	29 (64.4)	16 (35.6)	0.725
5.People with depression always like to be alone, feel sad & wish to die	33(68.9)	15 (41.1)	31(68.9)	14 (41.1)	0.810
6.Psychosis is a spiritual problem that cannot be treated in the hospital	13(28.9)	32 (71.1)	16(35.6)	29 (64.4)	0.201
7.People who joke about killing themselves do not always have a plan to do so	26(57.7)	19 (42.3)	27(60.0)	18 (40.0)	0.598
8.People with Post Traumatic Stress Disorder don't need treatment because they outgrow it with time	19(42.3)	26 (57.7)	10(22.2)	35 (77.8)	0.430

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4.4.2: Responses on social distance items at baseline and at immediate post intervention, in the intervention group alone

The study participant's responses did not differ significantly at immediate post intervention nor at baseline in any of the items on the social distance scale (see table 4.4.2

Table 4.4.2: Responses on social distance items at baseline and at immediate post intervention, in the intervention group alone

Items	Baseline N=45		Immediate post test N=45		p-value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	
1. Would you feel afraid to talk to someone with mental illness?	16(35.6)	29 (64.4)	23 (51.1)	22 (49.9)	0.514
2. Would you be upset to be in the same class with someone who had mental illness?	21(46.7)	24 (53.3)	21(46.7)	24 (53.3)	0.633
3. Would you be able to be friends with someone who had mental illness?	22(48.9)	23 (51.1)	24 (53.3)	21 (46.7)	0.743
4. Would you be embarrassed if your friends knew that someone in your close family has mental illness?	21(46.7)	24 (53.3)	20(43.7)	25 (65.6)	0.488

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4.4.3 Responses at baseline and immediate post- test on General Help Seeking Questionnaire (GHSQ) in the intervention group alone.

At immediate post-test the study participants response to the general help seeking scale improved significantly on 4 out of the 10 items in the intervention group compared to the control group (see Table below 4.4.3).

4.4.3 Responses at baseline and immediate post- test on GHSQ in the intervention group

Items	Baseline N=45		Immediate N=45		P-value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	
1.Intimate partner	21(46.7)	24(53.3)	36(80.0)	9 (20.0)	0.160
2.Friend	15(35.4)	29(64.6)	27(60.0)	18(40.0)	0.004*
3.Parents	22(49.3)	23(51.7)	39(86.7)	6 (13.3)	0.001*
4.Other relatives	22(49.3)	23(51.7)	28(62.2)	17(37.8)	0.051
5.Mentalhealth.professional	27(60.0)	18(40.0)	34(75.6)	11(24.4)	0.486
6.phones/help lines	15(33.3)	30(66.7)	27(60.0)	18(40.0)	0.033*
7.Doctor	25(55.6)	20(44.4)	39(86.7)	6 (13.3)	0.001*
8.religious minister	26(57.8)	19(42.2)	38(84.4)	7 (15.6)	1.000
9. would not seek help	10(22.2)	35(77.8)	20(44.4)	25(55.6)	0.261
10.I would seek help from Another source not listed	12(26.7)	33(73.3)	21(46.7)	24(53.3)	1.645

Note: significant value p<0.05 with asterisks

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4.5 Responses on knowledge of mental illness at baseline and immediate post-test in the control group alone.

There was a significant difference in the control group participant's responses at immediate post intervention in some of the knowledge items compared to baseline. More respondents stated that, 'mental illness cannot be treated at post intervention (62.2%) compared to baseline (40.0%) (p=0.001). Similarly, over half (57.8%) of the study participants affirmed that bullying is a risk factor for suicide (57.8%) at immediate post intervention compared to baseline (14.5%) (p=0.001) [See other items in Table 4.5]

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Table 4.5: Responses on knowledge of mental illness at baseline and immediate post-test in the control group

Items	Baseline N =45		Immediate post-test N=45		P-value
	Agree	Disagree / Not sure	Agree	Disagree / Not sure	
	n (%)	n (%)	n (%)	n (%)	
1.Mental illnesses are caused by stress	11 (24.4)	34 (75.6)	20 (44.4)	25 (65.3)	0.010*
2. People can recover from mental illness	36 (80.0)	9 (20.0)	29 (64.4)	16 (35.6)	0.029*
3. There is a stigma (shame) attached to people with mental health problems	25 (55.6)	20 (44.4)	28 (52.8)	17 (47.2)	0.246
4.One in four people will develop mental illness over the course of a lifetime	14 (31.1)	31 (78.9)	13 (28.9)	32 (72.1)	0.618
5.Mental illnesses are caused by spiritual attack	14 (31.1)	31 (78.9)	20 (44.4)	25 (55.6)	0.417
6.Parents with mental illness always transmit it to their children	29 (64.4)	16 (35.6)	20 (44.4)	25 (55.6)	0.185
7.Mental illness cannot be treated	28 (62.2)	17 (37.8)	18 (40.0)	27 (60.0)	0.001*
8.Depression is a type of mental illness	20 (44.4)	25 (55.6)	27 (60.0)	18 (40.0)	0.645
9.People with Psychosis often see or hear what others cannot see or hear	22 (48.9)	23 (51.1)	22 (48.9)	23 (51.1)	0.132
10.Bullying is a risk factor for suicide	6 (14.5)	39 (85.5)	26 (57.8)	19 (42.2)	<0.001*
11.People who attempt suicide have often been depressed	25 (55.6)	20 (44.4)	27 (60.0)	18 (40.0)	0.232
12.People who experience trauma are likely to develop PTSD	23(51.1)	22 (48.9)	19(42.2)	26 (57.8)	0.067
13.People with PTSD often suffer from flashback and nightmares	25 (55.6)	20 (44.4)	27 (60.0)	18 (40.0)	0.772
14.Gateway drugs include alcohol, marijuana and tobacco	23 (51.1)	22 (48.9)	27 (60.0)	18 (40.0)	0.323
15.Peer influence is a great factor in starting to use and abuse drug	32 (71.1)	12(28.9)	27 (60.0)	18(40.0)	0.032*

Note: significant value p<0.05 with asterisks

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4.5.1: Responses on attitude items at baseline and at immediate post intervention in control group alone

There was a significant difference in the study participant's responses on 2 of the attitude items. More respondents rightly disagreed with the statement that' people with mental illness are weak and have only themselves to blame.' at baseline (73.3%) compared to immediate post intervention (64.4%) (p=0.005) [See Table 4.5.1 below]

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Table 4.5.1: Responses on attitude items at baseline and at immediate post intervention in control group alone

Items	Baseline N=45		Immediate Post- test N=45		P -value
	Agree n (%)	Disagree n (%)	Agree n (%)	Disagree n (%)	
1.People with mental illness are always difficult to talk to	9(20.0)	36 (80.0)	32(71.1)	13 (28.9)	0.001*
2.People with mental illness are likely to become violent	37 (82.2)	8(17.8)	31 (68.9)	14(41.1)	0.165
3.People with mental illness are weak and have only themselves to blame	12(26.7)	33(73.3)	16(35.6)	29(64.4)	0.005*
4.People with mental illness are always unpredictable	27 (60.0)	18(40.0)	30 (66.7)	15(43.3)	0.264
5.People with depression always like to be alone, feel sad & wish to die	28 (62.2)	17(47.8)	28 (62.2)	17(47.8)	0.128
6.Psychosis is a spiritual problem that cannot be treated in the hospital	17 (47.8)	28 (62.2)	18 (40.0)	27 (60.0)	0.108
7.People who joke about killing them-selves do not always have a plan to do so	31 (68.9)	14 (41.1)	30 (66.6)	15 (33.4)	0.083
8.People with Post Traumatic Stress Disorder don't need treatment because hey outgrow it with time	12 (26.7)	33 (73.3)	18 (40.0)	27 (60.0)	0.129

Note: significant value p<0.05 with asterisks

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4.5.2: Responses on social distance items at baseline and immediate post intervention in the control group alone

There was no significant difference in the participant's response to the items on the social distance scale at both baseline and immediate post intervention (see table 4.5.2 below).

Table 4.5.2: Responses on social distance items at baseline and at post intervention in the control group

Items	Baseline N=45		Immediate Post-test N=45		p-value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	
1. Would you feel afraid to talk to someone with mental illness?	14 (31.1)	31 (68.9)	23 (51.1)	22 (49.9)	0.055
2. Would you be upset to be in the same class with someone who had mental illness?	19 (46.7)	24 (53.3)	21(46.7)	24 (53.3)	0.627
3. Would you be able to be friends with someone who had mental illness?	28(62.2)	17 (47.8)	24 (53.3)	21 (46.7)	0.617
4. Would you be embarrassed if your friends knew that someone in your close family has mental illness?	21(46.7)	24(53.3)	20(43.7)	25 (65.6)	1.000

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4.5.3 Responses at baseline and immediate post- test on General Help Seeking Questionnaire (GHSQ) in the control group.

There was no statistically significant difference in the study participant's response at both baseline and immediate post intervention to items on the general help seeking scale [see table 4.5.3 below]

Table 4.5.3 Responses at baseline and immediate post- test on GHSQ in the control group

N=45

Items	Baseline N=45		Immediate N=45		p-value
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	
1.Intimate partner	25(55.6)	20(44.4)	21(46.7)	24(53.3)	0.261
2.Friend	29(64.6)	18(40.0)	16(35.4)	29(64.6)	0.570
3.Parents	25(55.6)	20(44.4)	22(49.3)	23(51.7)	0.710
4.Other relatives	25(62.2)	20(44.0)	22(49.3)	23(51.7)	0.710
5.Mentalhealth.professional	27(60.0)	18(40.0)	27(60.0)	18(40.0)	1.000
6.phones/help lines	18(40.0)	27(60.0)	15(33.3)	30(66.7)	1.000
7.Doctor	26(57.8)	19(42.2)	25(55.6)	20(44.4)	0.420
8.religious minister	32(71.1)	13(28.9)	26(57.8)	19(42.2)	0.057
9.I would not seek help	25(55.6)	20(44.4)	10(22.2)	35(77.8)	0.070
10.I would seek help from Another source not listed	13(28.9)	32(71.1)	12(26.7)	33(73.3)	1.000

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4.6 Socio-demographic factors associated with baseline responses of all respondents.

The socio-demographic variables of respondents such as age, gender, family type, level and religion, associated with baseline responses of all respondents on the knowledge, attitude and social distance items are presented in Tables below

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4.6.1 Socio-demographic factors associated with baseline knowledge of all respondents

The mean knowledge score of all participants was 19.6 (SD - 4.1) with the minimum score being 8 while the maximum score was 29.

Out of the 90 respondents 17.8% scored above the average, 66.7%, had average knowledge scores while 15.6% had below average scores in knowledge of mental illness. There was no statistical significant difference in the responses of all the study participants on the knowledge items in terms of their age, gender, family type and religion. However, the respondents in Pre National diploma (Pre-ND) programmes had significantly better knowledge (75.0%) compared to those in pre degree (IJMB) (25.0%) (p=0.036) (See Table 4.6.1.).

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Table 4.6.1: Socio-demographic factors associated with baseline knowledge of all respondents N=90

Variable	Knowledge					
	Poor N=14	Fair N=60	Good N=16	Total N (%)	x^2	p-value
Age group (years)						
15-19	10 (11.1)	17 (28.3)	4 (17.4)	23(25.0)		
20-24	4 (8.9)	43 (71.7)	12 (17.9)	67(75.0)	1.181	0.554
Total	14(15.6)	60(71.7)	16(17.8)	90(100.0)		
Gender						
Male	13 (17.1)	51 (67.1)	12 (15.8)	76(84.4)		
Female	1 (7.1)	9 (64.3)	4 (28.6)	14(15.6)	1.855	0.396
Total	14 (15.6)	60(66.7)	16 (17.8)	90(100.0)		
Religion						
Christianity	8 (57.1)	42 (70.0)	12 (19.4)	62(68.8)		
Islam	6 (42.9)	18 (30.0)	4 (25.0)	28(31.1)	1.215	0.545
Total	14 (15.6)	60 (66.7)	16 (17.8)	90(100.0)		
Level						
IJMB	10(71.4)	31(51.7)	4(25.0)	45(50.0)		
PRE-ND	4(28.6)	29(48.3)	12(75.0)	45(50.0)	6.638	0.036*
Total	14(15.5)	60(66.7)	16(17.8)	90(100.0)		
Family type						
Monogamy	7(5.6)	32(59.3)	11(35.2)	56(62.2)		
polygamy	7(19.4)	28(52.8)	5(27.8)	34(37.8)	4.278	0.118
total	14(15.5)	60(66.7)	16(32.2)	90(100.0)		

The significant value ($p<0.05$) is asterisked

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4.6.2 Socio-demographic factors associated with baseline attitude of all respondents

The mean attitude score of all participants was 9.00 with a standard deviation of 2.6. With the minimum score being 9 and the maximum score was 16.

There were no significant associations between baseline attitude and participants sociodemographic factors. However, more males (70.0%) had positive attitudes towards persons with mental illness compared to females (30.0%) [See Table 4.6.2].

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Table 4.6.2: Socio-demographic factors associated with baseline attitude of all respondents
N=90

Variable	**Negative N= 17**	**Indifferent N=53**	**Positive N=20**	**Total n (%)**	**x^2**	**P-value**
Age						
15-19	5 (29.4)	14 (26.4)	4 (20.0)	23(25.0)	0.478	0.787
20-24	12(70.6)	39 (73.6)	16 (80.0)	67(75.0)		
Gender						
Male	15 (88.2)	47 (88.7)	14 (70.0)	76(84.4)	4.086	0.130
Female	2 (11.8)	6 (11.3)	6 (30.0)	14(15.6)		
Religion						
Christianity	13 (76.5)	35 (66.0)	14 (70.0)	62(68.8)	0.668	0.716
Islam	4(23.5)	18(34.0)	6(30.0)	28(31.1)		
Level						
IJMB	8(47.1)	26(49.1)	11(18.9)	45(50.0)	0.278	0.870
PRE-ND	9(52.9)	27(50.9)	9(8.3)	45(50.0)		
Family type						
Monogamy	12(17.9)	41((61.2)	14(20.9)	56(62.2)	0.577	0.749
Polygamy	5 (21.7)	12(52.2)	6(26.1)	25(37.8)		
Total	17(18.9)	53(58.9)	20(22.2)	90(100.0)		

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4.6.3 Socio-demographic factors associated with baseline social distance of all respondents.

The mean social distance score of all participants was 4.03 (SD=2.7) with the minimum score being 0 while the maximum score was 8.

The study participants regardless of their age, sex and religion did not differ significantly in their responses. Majority (80.0%) of the participants were in the indifferent range on the social distance score (See Table 4.6.3)

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Table 4.6.3: Socio-demographic factors associated with baseline social distance of all respondents N=90

Variable	Social Distance					
	Present N=10	Indifferent N=72	Absent N=8	Total n (%)	x^2	p-value
Age						
15-19	3 (30.0)	19(26.4)	1 (12.5)	23(25.0)		
20-24	7 (70.0)	53 (73.8)	7(87.5)	67(75.0)	0.847	0.655
Total	10 (11.1)	72 (80.0)	8 (8.9)	90(100.0)		
Gender						
Male	10 (100.0)	58 (80.6)	8(100.0)	76(84.4)		
Female	0(00)	14 (75.9)	0 (00)	14(15.6)	4.145	0.126
Total	10 (11.1)	72(80.0)	8(8.9)	90(100.0)		
Religion						
Christianity	7 (30.0)	52 (70.0)	3 (37.5)	62(68.8)		
Islam	3 (30)	20 (62.5)	5 (27.8)	28(31.1)	0.054	1.000
Total	10(11.1)	72(80.0)	8(8.9)	90(100.0)		
Family type						
Monogamy	9(13.4)	44(73.6)	3(13.0)	56(62.2)	1.898	0.387
Polygamy	1(2.6)	19(25.6)	5(29.2)	34(37.8)		
Total	10(11.1)	72(80.0)	8(8.9)	90(100.0)		

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4.6.4 Socio-demographic factors associated with baseline general help seeking behaviour of respondents

The mean general help seeking behaviour score of all participants was 10.77 (SD=3.9), with minimum score being 9 and the maximum score was 20.

The study participants regardless of age, sex and religion did not differ significantly in their responses. However majority of the participants were in the good range of help seeking behaviour for emotional problem (See Table 4.6.4).

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Table 4.6.4: Socio-demographic factors associated with baseline intended help seeking behaviour of all respondents.

N=90

Variable	**Help seeking behaviour**				
	Poor N=10	**Good N=80**	**Total n (%)**	**x^2**	**p-value**
Age					
15-19	2 (9.5)	21 (16.7)	23(25.0)		
20-25 and above	8 (21.6)	61 (88.3)	67(75.0)	0.070	0.748
Total	10(23.3)	80(88.2)	90(100.0)		
Gender					
Female	1 (12.0)	13(88.0)	14(15.0)		
Male	9 (25.6)	67 (85.6)	67(75.0)	0.360	0.549
Total	10(11.1)	80(88.2)	90(100.0)		
Religion					
Islam	3 (9.4)	25 (28.2)	28(31.1)		
Christianity	7(23.1)	55(71.9)	62(78.9)	0.582	0.792
Total	10(11.1)	80(88.2)	90(100.0)		
Family type					
Monogamy	8(23.1)	48(71.9)	56(62.2)	0.572	0.781
Polygamy	2(9.2)	32(28.2)	34(37.8)		
Total	10(11.1)	80(88.2)	90(100.0)		
Level					
IJMB	9(22.0.)	35(78.0)	45(50.0)		
PRE-ND	1(1.7)	55(98.3)	45(50.0)	0.592	0.761
Total	10(11.1)	80(88.2)	90(100.0)		

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4.7 comparison of Baseline and immediate post-test mean knowledge, attitude, social distance and help seeking scores of respondents in the intervention and control group

At baseline only the mean knowledge scores of the intervention group (20.5) (p=0.001) differed significantly from that of the control group (18.6) (p=0.034). However at post intervention, the mean knowledge score of respondents in the Intervention group at immediate-post-test was 22.3 and this value was significantly higher (p <0.001) than the mean knowledge score of respondents in the Control group (19.3). Likewise, the mean help seeking score of the respondents in the intervention group was significantly higher at immediate post – test (13.8) compared to the control group (8.2) (P =0.001) [see Table 4.7].

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Table 4.7: Comparison of the mean scores on knowledge, attitude, social distance and help seeking scores between the Control and the Intervention groups at baseline and immediate-post-test using independent sample t test

	N	Mean Scores	SD	T	95% Confidence Lower	Interval Upper	p-value
Knowledge scores							
Baseline							
Control	45	18.6	3.6	-2.1	-3.5	-0.3	**0.034***
Intervention	45	20.5	4.4				
Immediate post-test							
Control	45	19.3	3.9	-3.5	-4.6	-0.3	**0.001***
Intervention	45	22.3	4.1				
Attitude scores							
baseline							
Control	45	5.4	2.5	0.6	-0.7	1.4	0.617
Intervention	45	5.6	2.6				
Immediate post-test							
Control	45	5.3	3.1	0.9	-0.3	0.8	0.354
Intervention	45	5.6	2.8				
Social distance scores							
Baseline							
Control	45	3.9	2.2	-0.23	-1.0	0.8	0.772
Intervention	45	4.0	2.1				
Immediate post-test							
Control	45	4.1	2.7	0.46	-0.8	1.4	0.626
Intervention	45	3.9	2.7				
General help seeking Score							
Baseline							
Control	45	9.5	4.2	1.12	-9.9	3.5	0.265
Intervention	45	8.2	4.9				
Immediate post-test							
Control	45	8.2	6.4	-4.2	-8.2	-3.0	0.001*
Intervention	45	12.8	6.1				

N= number of respondents who had complete responses on all the items in each scale

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4.7.1 Comparison of the mean baseline and mean post –test scores on the outcome measures among the control and intervention group using paired t-test

Comparison of mean knowledge, attitude and social distance score within each group was done using paired t-test. There was no significant change in the mean scores of participants in the Control group on knowledge of mental illness, attitude, social distance and help seeking behaviour towards persons with mental illness at baseline and at immediate-post intervention.

However, the mean knowledge score of participants in the Intervention group at immediate-post intervention (22.3) was significantly higher than their mean knowledge score at baseline (20.5) which was statistically significant ($p<0.001$). Similarly the general help seeking behaviour score at immediate post- test (12.8) was significantly higher than at baseline (8.2) ($p<0.001$) However there was no increase recorded in the attitude score and social distance scores at immediate post intervention and at baseline (see Table 4.7.1).

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Table 4.7.1: Comparison of the mean scores in the control and intervention group at baseline and at immediate-post-test using paired t-test

	Control group N=45						**Intervention group N=45**					
	Mean score	**SD**	**Paired t**	**95% confidence**	**interval**	**P-value**	**Mean score**	**SD**	**Paired t**	**95% confidence interval**		**p-value**
				Lower	**Upper**					**Lower**	**upper**	
Knowledge												
Baseline	18.6	3.6	-1.2	-1.7	0.4	0.233	20.5	3.9	-3.5	-3.0	-1.3	0.001*
Immediate post test	19.3	3.9					22.3	4.1				
Attitude												
Baseline	5.4	2.5	-0.1	-1.0	0.8	0.853	3.4	2.8	-0.5	-1.6	0.9	0.514
Immediate post test	5.3	3.4					2.8	3.2				
Social distance	3.9	2.2	0.5	-0.5	0.9	0.609	5.3	2.7	0.4	-0.8	1.4	0.646
Baseline	4.0	2.7					5.6	2.7				
Immediate post test												
General help seeking												
Baseline	9.3	6.2	-1.8	-0.2	0.6	0.064	8.2	6.2	3.6	1.0	3.4	0.001*
Immediate post test	8.2	4.1					12.8	5.6				

N= number of respondents who had complete responses on all the items in each scale

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4.8 Analysis of Covariance (ANCOVA) for knowledge of mental health and help seeking behaviour for emotional problems contained in table 4.8 and table 4.8.1

Post intervention knowledge of mental health score.

Analysis of co-variance (ANCOVA) was performed on two of the outcome variables to determine the effect of the intervention at improving mental health knowledge and help seeking behaviour for emotional problems. The pre - intervention scores were entered as covariates and controlled for. The post - intervention scores were used as dependent variables while the fixed factor was the group.

The training programme showed a statistically significant intervention effect on mental health knowledge (p=0.001) and explained 23% variation in the post intervention mental health knowledge score with a medium (Cohens d=0.75) effect size (See result below).

Table 4.8.: Test of between subject effects on mental health knowledge

Source	df	f	P	Partial eta squared
Corrected model	2	24.15	.000	.35
Intercept	1	34.90	.000	.28
Baseline	1	31.60	.000	.26
Intervention group	1	13.19	.001	.23
Total	90			
Total corrected	89			

Significant at p<0.05

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4.8.1 ANCOVA post intervention score on the general help-seeking behaviour for emotional problem

The training programme showed a statistically significant intervention effect on help seeking behaviour ($p<0.001$) and explained 43% variance in the post intervention help seeking behaviour score with a medium effect size (Cohens d =0.77) See result below

Table 4.8.1:Test of between subjects effects on help seeking behaviour scale

Source	df	f	P	Partial eta squared
Corrected model	2	42.28	.000	.49
Intercept	1	2.112	.150	.02
Baseline	1	55.18	.000	.38
Intervention group	1	66.82	.000	.43
Total	90			
Total corrected	89			

Significant at $p<0.05$

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4.8.2: Determination of the intervention effect size

The effect size was determined using the calculation Cohen's d = $(M_i - M_c)/SD_{ic}$

Where M_i is the mean post-test score of the intervention group,

M_c is the post - test mean score of the control group,

SD_{ic} is the pooled standard deviations of both groups.

Table 4.8.2:Intervention effect size

Post intervention Outcome variables	**Mean difference in scores**	**SD**	**pooled SD**	**MI-MC**	**Cohen's d**
Change in mean knowledge Scores					
Control	19.3	3.9	4	3	0.75
Intervention group	22.3	4.1			
Change in mean General help Seeking score					
Control	9.5	6.2	5.9	5.6	0.77
Intervention group	12.8	5.6			

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4.9 Students' evaluation of the effectiveness of the training programme

The effectiveness and relevance of the mental health-training programme was evaluated by Students in the Intervention group alone. More of the study participants (48.9%) noted that they had learnt most about mental health from the lecture sessions, followed by group discussion (28.9%), video (13.3%) and the least from the questions and answer (2.2%). More of the study participants (53.3%) stated that they enjoyed the lecture section the most, followed by the video section (20.0%).

4.9.1 Socio-demographic variables associated with participants' response on the evaluation of the training programme

Comparison between the ages and gender of participants and their responses on what aspect of the programme they enjoyed and learnt from the most did not differ significantly. More males (77.8%), and older participants aged 20 -24years (66.0%) enjoyed and learnt most from the lecture, group discussion. Compared to females (22.1%) and the younger participants (44.0%). Equally, a higher percentage (97.8%) of the study participants agreed that the programme was useful to them as college students.

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4.9.2 Qualitative Analysis of the Intervention Programme

4.9.2.1 What did you like about the information you received?

Majority of the study participants (93.3%) stated that the programme was very enlightening and interesting (See Table 4.9.2.1), they also liked the group discussion and video presentation. They stated that, they have been educated about mental illness, its treatment, prevention and their views about mental illness had changed. Besides they also stated that they can now take better care of their mental health and seek help when emotionally down.

Table 4.9.2.1: What did you like about the information you received?

N=45

Theme	n	%
Increased awareness about mental illness and recognition of someone with mental illness		
"It makes you know more about mental illness"	29	64.4
"To know the symptoms and identify a person with mental illness"	8	17.8
"It enlightened me more about mental illness		
"It makes me to know that people with mental illness can be treated"	8	17.8
Increased help seeking behaviour		
"It makes me to speak out and seek help for mental illness"	40	88.8
"It makes me to know that I should talk to my friends about my problem"	5	11.2
Structure/presentation/ content of the lecture		
"The lecture was very interesting"	31	64.7
"I liked the video"	4	9.0
"I liked the description of mental illness"	3	7.3
"I loved the group discussions"	7	19.0

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4.9.3. What did you not like about the information you received?

Majority of the study participants (96.6%) noted that they liked everything about the information they received. However (4.5%) of the participants stated that the programme was time consuming and they did not like the case vignette on suicide (See table 4.9.3)

Table 4.9.3: What did you not like about the information you received?
N=45

Theme	n	%
Lecture methods		
"The lecture was time consuming"	2	4.5
Negative emotional reactions		
"When I was taught about suicide and self-harm, I was scared"	2	4.5
Symptoms of / behaviour towards persons with mental illness		
"I did not like the symptoms of depression" "	2	4.5
"What I did not like is about the person that committed suicide"	2	4.5

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Chapter five

Discussions, conclusions and recommendations

5. 1 Discussion

This study evaluated the effectiveness of a mental health training programme among young people in Kogi State Polytechnic. Specifically it aimed to assess knowledge, attitude, and social distance towards persons with mental illness as well as help seeking behaviour of young people for emotional problem at pre and post intervention and to compare with a control group.

5.1.1 Socio-Demographic Characteristics of the Study Participants

Global studies of knowledge, attitude and social distance towards persons with mental illness have included students from college and university institutions (Adewuya and Makanjuola, 2005, Rickwood et al., 2005, William et al 2006, Youssef et al., 2012,). In this present study, the mean age of the respondents was 21.05 (SD ± 2.17) years with an age range of 18-24years. Study Participants were young Kogi State Polytechnic students. These studies report different mean ages of study participants based on the different research methodologies used. In a study carried out by Adewuya and Makanjuola, 2005 in South West Nigeria, amongst undergraduate students to determine attitude and social distance toward people with mental illness, the mean age of the study participants was 27.07years (SD ± 7.17). While Rickwood et al., 2005 reported 14 – 25 years as the age range among young people in South Wales, while studying young peoples' help seeking behaviour for emotional problem. In this present study males constitute over three quarter in both groups. This is in keeping with other studies from this region (Adewuya and Makanjuola, 2005, Oduguwa et al., 2014) which found over half of the study participants to be males. The higher preponderance of males recorded in this study may be attributed to the fact that more males attend school in northern Nigeria compared to the females (UNICEF Nigeria, 2012). However, well over half of the study participants were Christians.

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This may be due to the fact that, it is not only Kogi state indigenes that are admitted for study in the college. Christians from neighbouring states such as Benue and Ondo are also admitted and this may have contributed to the high Christian population. Well over half of the study participants live in monogamous family arrangements. This may be linked to the high percentage of the respondents practicing Christianity as a religion.

In both groups, well over a third of the respondent's parent's level of education was secondary school and above. This corresponds to other studies from this region (Bella-Awusah et al., 2014, Oduguwa et al., 2014). Furthermore, people whose children go to the university are likely to have higher levels of education themselves. Hence the great number of respondents affirming this level of parental education.

5.1.2 Socio-demographic characteristics associated with baseline knowledge, attitudes social distance towards people with mental illness and help seeking behaviour in both study groups

At baseline, the current study found that, less than a third of all the study participants irrespective of age, gender, religion and family type had 'above average' score in their knowledge of mental illness. This finding is consistent with other studies on mental health knowledge. Globally studies report poor knowledge of mental illness among young persons (Pinfold et al., 2003, Henderson and Thornicroft et al., 2009, Dogra et al., 2011). In Africa, a systematic empirical study of knowledge and attitude of mental illness among University undergraduates in Cameroon, suggests gaps in students' knowledge of mental illness with particular reference to the causation of specific disorders (Nguedo, 2015).

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Similarly more males (28.6%) had ‘above average’ score in their knowledge of mental illness compared to the females (15.8%). However, the association between gender and knowledge was not statistically significant. While students aged 20 years and above had above average knowledge scores compared to those aged 19 years and below (16.4%).This result is in keeping with the findings of a study which looked at similar issues among secondary school adolescents (Oduguwa et al., 2014). This study showed that, the older adolescents had better knowledge of mental illness compared to the younger adolescents. This may be linked to greater maturity and understanding by older adolescents.

At baseline, the current study identified a significantly higher proportion of males indicating positive attitudes towards persons with mental illness while majority of the females fell in the indifferent category in their attitude towards persons with mental illness. The reason for this is not quite clear but a similar study with school adolescents found that females were less assertive in answering questions and more willing to accept their uncertainty compared to males (Dogra et al., 2011).

However, at baseline more females and the older adolescents aged 20 years and above sought help for emotional problems compared to males. This is consistent with other studies which reported increased help seeking behaviour with increased age and females being more likely to seek help for emotional problem compared to their male counterparts. This may be ascribed to better mental health knowledge by older adolescents and gender role socialization of females (Gumundottir, 2002, Ortega and Alegaria, 2002, Gulliver et al., 2010). Females are socialised to accept help more, compared to their male counterparts.

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In terms of the respondent's source of mental health knowledge, both groups affirmed television and home video as a major source of their understanding and knowledge of mental health. This is similar to a recent study carried out by Oduguwa et al., 2014 which also found that television and home video was a major source of the study participant's source of mental health knowledge. This may be linked to increased ownership of television, extensive viewer time by young people and depiction of mental illness as a major theme, hence the reason for it being the major source of mental health knowledge in this study (Atilola and Olayiwola, 2012).

5.1.3 Effects of the mental health training programme

The findings of this present study indicates that the intervention was effective at producing change in young people's mental health knowledge. The control group had lower mean scores in knowledge of mental illness compared to the intervention group.

At post intervention, the study participants differed significantly in eight (8) knowledge items compared to one (1) at baseline. This is in keeping with findings from other studies around the globe which reported significant increase in mental health knowledge at post intervention in study participants (Youssef et al., 2012, William et al., 2006, Bella et al., 2012, Papish et al., 2013, Youssef et al., 2012, Oduguwa et al.,2014). Additionally, the intervention produced a moderate effect on knowledge of mental illness (Cohens d = 0.75)

At baseline and post intervention both groups did not differ significantly in any of the attitude items. In a study of Nigerian school children, the children displayed stigma towards mental illness (Bella et al., 2012) The displayed negative attitude was ascribed to a lack of Knowledge

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regarding mental health problems (Gureje et al.,2005., Dogra et al., 2011, Bella-Awusah et al., 2014). Negative attitudes may have been fuelled by the media depictions of mental illness, which was the most common source of mental health knowledge by the study participants. (Atilola and Olayiwola, 2012). Moreover, attitudes are formed early in life and becomes worse as people age and have been described as difficult to change with training alone (Alexander and link 2007, Corrigan et al., 2001).

At baseline and post intervention, the participants in the current study indicated a desire for social distance from people with mental illness which was similar to findings from other studies around the globe (Pinfold et al., 2003, Gureje et al., 2005, Adewuya and Makanjuola, 2005, 2005, Dogra et al., 2011, Corrigan et al, 2012). Irrespective of people's age, they have often expressed a desire to be socially distant from persons with mental illness. Correspondingly social distance gap increases with the level of intimacy required for such a relationship (Weiss et al., 1994). The more intimate the relationship the less willing is an individuals to interact with someone with a mental illness (Adewuya and Makanjuola, 2005).

At baseline, the groups differed significantly on 4 items of the General Help Seeking scale however, at post intervention 6 out of the help seeking scale items became significantly different between the two groups. A study by Gulliver et al., (2010), reports that young people feel reluctant to seek help despite the high prevalence of mental illness in their age group. Stigma was identified as the foremost reason for refusal to seek help and the use of informal sources of care (WHO, 2005). At post intervention, respondents were more willing to seek help from intimate partner (73.3%), parents (88.9%), doctor (82.2%) and phone help lines (60.0%) compared to baseline where they were more willing to seek help from intimate partners

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(46.7%), religious leaders (52.8%) and from no one (55.6%). This finding is similar to other studies from around the globe that looked at help seeking behaviour for emotional problems (Rickwood et al., 2005, Wang et al., 2007, Wilson et al., 2007, Gulliver et al., 2010). Young people have been reported to prefer to seek help from someone whom they are familiar with and have confidence and trust in such as their family, friends, family doctors and the internet due their desire for confidentiality. Young people also prefer to seek help from informal before turning to formal sources of help (Boldero and Fallon, 1995). Additionally, the intervention produced a moderate effect on help seeking behaviour for emotional problem (Cohens d= 0.77)

The outcome of this study re-affirms that short training sessions are not only feasible and practicable but are also effective at producing changes in knowledge of mental illness among college students. However, they are less effective at changing negative attitudes towards affected persons. Unlike the Oduguwa et al., (2014) study, this study recorded significant positive changes only in participants' knowledge of mental illness and help seeking behaviour but none in attitude and social distance towards persons with mental illness. This might be that Oduguwa study population were younger [mean age 14.9 (±1.2) years] and may be more open to change (Oduguwa et al., 2014). Furthermore attitudes are formed early in life and becomes worse as people age (Alexander and Link, 2003, Wahl et al., 2014). Studies from around the globe that recorded changes in attitude and social distance used a longer period of training sessions with study participants (Corrigan et al., 2012, Oduguwa et al., 2014, Gulati et al., 2014). Equally, such studies utilized a face to face contact method in their training programmes such that their participants had the opportunity to meet and interact with persons who were living or had recovered from a mental illness (Watson et al., 2004, Corrigan et al.,2012,). The current study only used video as a form of contact but this however did not produce any significant change in the study participants attitude and social distance towards mental illness.

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5.1.4 Students Evaluation of the Mental Health Training Programme

The mental health training programme in this study utilized a variety of teaching methods such as didactic lecture sessions, group discussion, short video show, question and answer and drama. Majority of the participants (53.3%) enjoyed and learned most from the lecture aspect of the training, followed by Video (20.0%), only 13.3% had enjoyed group discussion more than other aspects of the trainings. This may be because the participants come from a formal school setting where lecturing is the main teaching method used for learning and receiving instructions. The question and answer aspect was considered the weakest training mode for learning about mental illness. It may be that participants did not feel knowledgeable enough, or are yet to familiarise with each other (all new students just resuming for pre - degree programmes). It could likely be that they are uncomfortable in the question and answer sessions or lack motivation.

A few participants mentioned that they did not like the case vignette on depression and suicide. It created fear in them, it might be that they had experienced or witnessed such scenarios in real life.

5.2 Conclusion

The findings of the study show that college students have some degree of mental health knowledge obtained majorly from television and home videos. Like the general public, they have negative attitudes and high social distance. They are more likely to seek help from informal sources. A short intense multiple method, mental health training programmes appears effective at improving mental health knowledge and help seeking behaviours of young people for emotional problems but not attitudes and social distance .

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The strengths of this study is that, it is among one of the few studies from the northern part of the country. Similarly, the use of multiple methods of learning including lecture, group discussion, Video, drama and the use of questions and answers to boost mental health knowledge, and improve on help seeking behaviour of the study participants.

Limitations

The 3rd week planned post intervention outcome assessment could not be administered. Similarly, the duration of the programme was short. Besides, the groups were predominantly male so these views may not generalise across gender. Another reason for the lack of change in social distance and attitude score of the participants may be due to the fact that the video of famous people with mental illness was western (the video contains only images of people from outside the country).

5.3 Recommendations

Based on the findings of this study, the following recommendations are suggested:

1. There is a need for mental health training at all levels. Based on the fact that attitude are formed early in life, this training should start as early as primary school and could be part of a school mental health programme.

2. There is also a need for mental health professionals to partner with the movie industry to produce films that are educative and project mental illness in a better light. This may go a long way at improving attitudes and social distance against people with mental health problems

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References

Abasiubong, F., Atting, I., Bassey, E. & Ekott, J. 2008. A comparative study of use of psychoactive substances amongst secondary school students in two local Government Areas of Akwa Ibom State, Nigeria. *Nigerian journal of clinical practice,* 11**,** 45-52.

Abdulmalik, J., Omigbodun, O., Beida, O. & Adedokun, B. 2009. Psychoactive substance use among children in informal religious schools (Almajiris) in northern Nigeria. *Mental Health, Religion and Culture,* 12**,** 527-542.

Adewuya, A. O. & Makanjuola, R. O. 2005. Social distance towards people with mental illness amongst Nigerian university students. *Social psychiatry and psychiatric epidemiology,* 40**,** 865-868.

Adewuya, A. O. & Ologun, Y. A. 2006. Factors associated with depressive symptoms in Nigerian adolescents. *Journal of adolescent health,* 39**,** 105-110.

Alexander, L. & Link, B. 2003. The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health,* 12**,** 271-289.

Allen, R. & Nairn, R. G. 1997. Media depictions of mental illness: an analysis of the use of dangerousness. *Australian and New Zealand Journal of Psychiatry,* 31**,** 375-381.

Amuyunzu-Nyamongo, M. The social and cultural aspects of mental health in African societies.

Aniebue, P. & Onyema, G. 2008. Prevalence of depressive symptoms among Nigerian medical undergraduates. *Tropical doctor,* 38**,** 157-158.

Atilola, O. 2015. Mental health service utilization in sub-Saharan Africa: is public mental health literacy the problem? Setting the perspectives right. *Global health promotion***,** 1757975914567179.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Atilola, O. & Olayiwola, F. 2012. The Nigerian home video boom: Should Nigerian psychiatrists be worried? Lessons from content review and views of community dwellers. *International Journal of Social Psychiatry,* 58**,** 470-476.

Austin, L. S. & Husted, K. 2014. Cost-effectiveness of television, radio, and print media programs for public mental health education. *Psychiatric Services*.

Babatimehin, O., Ayanlade, A., Babatimehin, M. & Yusuf, J. O. 2011. Geo-Political Patterns of Health Care Facilities in Kogi State, Nigeria. *Open Geography Journal,* 4**,** 141-147.

Battaglia, J., Coverdale, J. H. & Bushong, C. P. 1990. Evaluation of a Mental Illness Awareness Week Program. *Am J Psychiatry,* 147**,** 324-329.

Belfer, M. L. 2008. Child and adolescent mental disorders: the magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry,* 49**,** 226-236.

Belfer, M. L. & Nurcombe, B. 2007. The epidemiology and burden of child and adolescent mental disorder. *The Mental Health of Children and Adolescents: An Area of Global Neglet. West Sussex: John Wiley & Sons Ltd***,** 27-42.

Bella, T., Omigbodun, O., Dogra, N. & Adeniyi, Y. 2012. Perceptions of mental illness among Nigerian adolescents: an exploratory analysis. *International Journal of Culture and Mental Health,* 5**,** 127-136.

Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A. & Kaufman, J. 1996. Childhood And Adolescent depression: a review of the past 10 years. Part II. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35**,** 1575-1583.

Blow, F. C., Oslin, D. W. & Barry, K. L. 2002. Misuse and abuse of alcohol, illicit drugs, and psychoactive medication among older people. *Generations,* 26**,** 50.

Boldero, J. & Fallon, B. 1995. Adolescent help-seeking: What do they get help for and from whom? *Journal of Adolescence,* 18**,** 193-209.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Bovier, P. A., Chamot, E. & Perneger, T. V. 2004. Perceived stress, internal resources, and social support as determinants of mental health among young adults. *Quality of Life Research,* 13**,** 161-170.

Boydell, K. M., Pong, R., Volpe, T., Tilleczek, K., Wilson, E. & Lemieux, S. 2006. Family perspectives on pathways to mental health care for children and youth in rural communities. *The Journal of Rural Health,* 22**,** 182-188.

Busari, A. O. 2014. Assessing Prevalence Of Trauma And The Risk Of Post-Traumatic Stress Disorder Among Youths Within The School Community. *African Journal For The Psychological Studies Of Social Issues,* 17**,** 42-54.

Callanan, V. J. & Davis, M. S. 2012. Gender Differences In Suicide Methods. *Social Psychiatry And psychiatric epidemiology,* 47**,** 857-869.

Cerel, J., Jordan, J. R. & Duberstein, P. R. 2008. The Impact Of Suicide On The Family. *Crisis,* 29**,** 38-44.

Chisholm, D., Sanderson, K., Ayuso-Mateos, J. L. & Saxena, S. 2004. Reducing The Global burden of depression. *The British Journal of Psychiatry,* 184**,** 393-403.

Clark, D. B. & Kirisci, L. 1996. Posttraumatic stress disorder, depression, alcohol use disorders and quality of life in adolescents. *Anxiety,* 2**,** 226-233.

Clark, D. B., Smith, M. G., Neighbors, B. D., Skerlec, L. M. & Randall, J. 1994. Anxiety disorders in adolescence: Characteristics, prevalence, and comorbidities. *Clinical Psychology Review,* 14**,** 113-137.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M. & Goldstein, H. 2001. Three strategies for changing attributions about severe mental illness. *Schizophrenia bulletin,* 27**,** 187.

Corrigan, P. W. & Watson, A. C. 2002. Understanding the impact of stigma on people with mental illness. *World Psychiatry,* 1**,** 16.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Cortina, M. A., Sodha, A., Fazel, M. & Ramchandani, P. G. 2012. Prevalence of child mental health problems in sub-Saharan Africa: a systematic review. *Archives of pediatrics & adolescent medicine,* 166**,** 276-281.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I. & Rowlands, O. J. 2000. Stigmatisation Of people with mental illnesses. *The British Journal of Psychiatry,* 177**,** 4-7.

Cuffe, S. P., Addy, C. L., Garrison, C. Z., Waller, J. L., Jackson, K. L., Mckeown, R. E. & Chilappagari, S. 1998. Prevalence of PTSD in a community sample of older adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry,* 37**,** 147-154.

Degenhardt, L., Chiu, W.-T., Sampson, N., Kessler, R. C., Anthony, J. C., Angermeyer, M., Bruffaerts, R., De Girolamo, G., Gureje, O. & Huang, Y. 2008. Toward a global view of alcohol, tobacco, cannabis, and cocaine use: findings from the WHO World Mental Health Surveys. *PLoS Med,* 5**,** e141.

Dogra, N., Omigbodun, O., Adedokun, T., Bella, T., Ronzoni, P. & Adesokan, A. 2011. Nigerian secondary school children's knowledge of and attitudes to mental health and illness. *Clinical child psychology and psychiatry***,** 1359104511410804.

Eagly, A. H. & Chaiken, S. 2007. The advantages of an inclusive definition of attitude. *Social Cognition,* 25**,** 582-602.

Etten, M. L. V., Neumark, Y. D. & Anthony, J. C. 1999. Male-female differences in the earliest stages of drug involvement. *Addiction,* 94**,** 1413-1419.

Gonzalez, J. M., Alegria, M. & Prihoda, T. J. 2005. How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology,* 33**,** 611.

Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A. & Zeber, J. E. 2011. How the relationship of attitudes toward mental health treatment and service use differs by age,

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

gender, ethnicity/race and education. *Social psychiatry and psychiatric epidemiology,* 46**,** 45-57.

Greenberg, P. E., Kessler, R. C., Birnbaum, H. G., Leong, S. A., Lowe, S. W., Berglund, P. A. & Corey-Lisle, P. K. 2003. The economic burden of depression in the United States: how did it change between 1990 and 2000? *Journal of clinical psychiatry,* 64**,** 1465-1475.

Gudmundsdottir, D. 2002. A study of adolescents' attitudes towards mental health: the Icelandic Mental Health Promotion Project. *Journal of mental health promotion,* 1**,** 32-35.

Gulliver, A., Griffiths, K. M. & Christensen, H. 2010. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry,* 10**,** 113.

Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O. & Kola, L. 2005. Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry,* 186**,** 436-441.

Gureje, O., Olley, B. O., Olusola, E.-O. & Kola, L. 2006. Do beliefs about causation influence attitudes to mental illness? *World Psychiatry,* 5**,** 104.

Gureje, O., Olowosegun, O., Adebayo, K. & Stein, D. J. 2010. The prevalence and profile of non-affective psychosis in the Nigerian Survey of Mental Health and Wellbeing. *World Psychiatry,* 9**,** 50-55.

Harwood, R. 2006. Teeth and their Use—Enforcement Action by the Three Equality Commissions. *London: Public Interest Research Unit*.

Henderson, C. & Thornicroft, G. 2009. Stigma and discrimination in mental illness: Time to Change. *The Lancet,* 373**,** 1928-1930.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Javidi, H. & Yadollahie, M. 2011. Post-traumatic stress disorder. *The international journal of occupational and environmental medicine,* 3.

Kandel, D. B., Yamaguchi, K. & Chen, K. 1992. Stages of progression in drug involvement from adolescence to adulthood: further evidence for the gateway theory. *Journal of studies on alcohol,* 53**,** 447-457.

Kelly, C. M., Jorm, A. F. & Wright, A. 2007. Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Med J Aust,* 187**,** S26-30.

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S. & Ustun, T. B. 2007a. Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry,* 20**,** 359.

Kessler, R. C., Angermeyer, M., Anthony, J. C., De Graaf, R., Demyttenaere, K., Gasquet, I., De Girolamo, G., Gluzman, S., Gureje, O. & Haro, J. M. 2007b. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry,* 6**,** 168.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L. A., Srinath, S., Ulkuer, N. & Rahman, A. 2011. Child and adolescent mental health worldwide: evidence for action. *The Lancet,* 378**,** 1515-1525.

Kleintjes, S., Flisher, A., Fick, M., Railoun, A., Lund, C., Molteno, C. & Robertson, B. 2006. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa: original article. *South African Psychiatry Review,* 9**,** 157-160.

Li, J., Li, J., Huang, Y. & Thornicroft, G. 2014. Mental health training program for community mental health staff in Guangzhou, China: effects on knowledge of mental illness and stigma. *International journal of mental health systems,* 8**,** 49.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Lindsey, C. R. & Kalafat, J. 1998. Adolescents' views of preferred helper characteristics and barriers to seeking help from school-based adults. *Journal of Educational and Psychological Consultation,* 9**,** 171-193.

Link, B. G. & Phelan, J. C. 2001. Conceptualizing Stigma. *Annual review Of Sociology***,** 363-385.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S. & Phelan, J. C. 2014. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric services*.

Makanjuola, A. B., Daramola, T. O. & Obembe, A. O. 2007. Psychoactive substance use among medical students in a Nigerian university. *World Psychiatry,* 6**,** 112.

Michaud, C. M., Murray, C. J. & Bloom, B. R. 2001. Burden of disease—implications for future research. *Jama,* 285**,** 535-539.

Mojtabai, R., Olfson, M. & Mechanic, D. 2002. Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry,* 59**,** 77-84.

Moses, T. 2010. Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social science & medicine,* 70**,** 985-993.

Mynors-Wallis, L., Gath, D., Lloyd-Thomas, A. & Tomlinson, D. 1995. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *Bmj,* 310**,** 441-445.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E. & Prinstein, M. J. 2006. Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry research,* 144**,** 65-72.

Omigbodun, O. & Babalola, O. 2004. Psychosocial dynamics of psychoactive substance misuse among Nigerian adolescents.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Omigbodun, O. O. 2004. Psychosocial issues in a child and adolescent psychiatric clinic population in Nigeria. *Social Psychiatry and Psychiatric Epidemiology,* 39**,** 667-672.

Opler, M., Sodhi, D., Zaveri, D. & Madhusoodanan, S. 2010. Primary psychiatric prevention in children and adolescents. *Annals of Clinical Psychiatry,* 22**,** 220-234.

Oshodi, O., Aina, O. & Onajole, A. 2010. Substance use among secondary school students in an urban setting in Nigeria: prevalence and associated factors. *African journal of psychiatry,* 13.

Östman, M., Wallsten, T. & Kjellin, L. 2005. Family burden and relatives' participation in psychiatric care: are the patient's diagnosis and the relation to the patient of importance? *International Journal of Social Psychiatry,* 51**,** 291-301.

Papish, A., Kassam, A., Modgill, G., Vaz, G., Zanussi, L. & Patten, S. 2013. Reducing the stigma of mental illness in undergraduate medical education: a randomized controlled trial. *BMC medical education,* 13**,** 141.

Patel, V., Flisher, A. J., Hetrick, S. & Mcgorry, P. 2007. Mental health of young people: a global public-health challenge. *The Lancet,* 369**,** 1302-1313.

Perkonigg, A., Kessler, R. C., Storz, S. & Wittchen, H. U. 2000. Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. *Acta psychiatrica scandinavica,* 101**,** 46-59.

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P. & Graham, T. 2003. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *The British Journal of Psychiatry,* 182**,** 342-346.

Pinto-Foltz, M. D. & Logsdon, M. C. 2009. Reducing stigma related to mental disorders: initiatives, interventions, and recommendations for nursing. *Archives of psychiatric nursing,* 23**,** 32-40.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Pinto-Foltz, M. D., Logsdon, M. C. & Myers, J. A. 2011. Feasibility, acceptability, and initial efficacy of a knowledge-contact program to reduce mental illness stigma and improve mental health literacy in adolescents. *Social science & medicine,* 72.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R. & Rahman, A. 2007. No health without mental health. *The lancet,* 370**,** 859-877.

Rae-Grant, N., Thomas, B. H., Offord, D. R. & Boyle, M. H. 1989. Risk, protective factors, and the prevalence of behavioral and emotional disorders in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry,* 28**,** 262-268.

Rahman, A., Mubbashar, M., Gater, R. & Goldberg, D. 1998. Randomised trial of impact of school mental-health programme in rural Rawalpindi, Pakistan. *The Lancet,* 352**,** 1022-1025.

Reid, G. J., Cunningham, C. E., Tobon, J. I., Evans, B., Stewart, M., Brown, J. B., Lent, B., Neufeld, R. W., Vingilis, E. R. & Zaric, G. S. 2011. Help-seeking for children with mental health problems: Parents' efforts and experiences. *Administration and Policy in Mental Health and Mental Health Services Research,* 38**,** 384-397.

Rickwood, D., Deane, F. P., Wilson, C. J. & Ciarrochi, J. 2005. Young people's help-seeking for mental health problems. *Advances in Mental Health,* 4**,** 218-251.

Sadock, V. & Sadock, B. 2007. Synopsis of psychiatry. 10th. USA: Lippincott Williams &Wilkins.

Schrijvers, D. L., Bollen, J. & Sabbe, B. G. 2012. The gender paradox in suicidal behavior and its impact on the suicidal process. *Journal of affective disorders,* 138**,** 19-26.

Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B. & Stein, D. 2004. Trauma exposure and post-traumatic stress symptoms in urban African schools Survey in CapeTown and Nairobi. *The British Journal of Psychiatry,* 184**,** 169-175.

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Silverman, M. M. 2006. The language of suicidology. *Suicide and Life-Threatening Behavior,* 36**,** 519-532.

Simon, G. E. 2003. Social and economic burden of mood disorders. *Biological psychiatry,* 54**,** 208-215.

Starling, J. & Feijo, I. 2012. Schizophrenia And Other Psychotic Disorders Of Early Onset. *IACAPAP Textbook of Child and Adolescent Mental Health*.

Stuart, H. 2006a. Media portrayal of mental illness and its treatments. *CNS drugs,* 20**,** 99-106.

Stuart, H. 2006b. Reaching out to high school youth: the effectiveness of a video-based antistigma program. *Canadian Journal of Psychiatry,* 51**,** 647.

Thornicroft, G., Rose, D., Kassam, A. & Sartorius, N. 2007. Stigma: ignorance, prejudice or discrimination? *The British Journal of Psychiatry,* 190**,** 192-193.

Tunde-Ayinmode, M., Adegunloye, O., Ayinmode, B. & Abiodun, O. 2012. Psychiatric disorders in children attending a Nigerian primary care unit: functional impairment and risk factors. *Child and adolescent psychiatry and mental health,* 6**,** 1-8.

UNICEF 2011. *The State of the World's Children 2011-Executive Summary: Adolescence an Age of Opportunity,* Unicef.

Van Etten, M. L. & Anthony, J. C. 1999. Comparative epidemiology of initial drug opportunities and transitions to first use: marijuana, cocaine, hallucinogens and heroin. *Drug and Alcohol Dependence,* 54**,** 117-125.

Volkow, N. & Li, T.-K. 2005. The neuroscience of addiction. *Nature neuroscience,* 8**,** 1429-1430.

Wahl, O. 2003. Depictions of mental illnesses in children's media. *Journal of Mental Health,* 12**,** 249-258.

Wahl, O., Susin, J., Lax, A., Kaplan, L. & Zatina, D. 2014. Knowledge and attitudes about mental illness: A survey of middle school students. *Psychiatric Services*.

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AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Wakefield, M. A., Loken, B. & Hornik, R. C. 2010. Use of mass media campaigns to change health behaviour. *The Lancet,* 376**,** 1261-1271.

Wang, P. S., Angermeyer, M., Borges, G., Bruffaerts, R., Chiu, W. T., De Girolamo, G., Fayyad, J., Gureje, O., Haro, J. M. & Huang, Y. 2007. Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry,* 6**,** 177.

Watson, A. C., Otey, E., Westbrook, A. L., Gardner, A. L., Lamb, T. A., Corrigan, P. W. & Fenton, W. S. 2004. Changing middle schoolers' attitudes about mental illness through education. *Schizophrenia Bulletin,* 30**,** 563-572.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., Charlson, F. J., Norman, R. E., Flaxman, A. D. & Johns, N. 2013. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet,* 382**,** 1575-1586.

Wilkinson, R. G. & Marmot, M. G. 2003. *Social determinants of health: the solid facts*, World Health Organization.

Wille, D.-P. N., Bettge, S., Ravens-Sieberer, U. & Group, B. S. 2008. Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *European child & adolescent psychiatry,* 17**,** 133-147.

Williamson, T. 2002. *Knowledge and its Limits*, Oxford University Press.

Youssef, F. F., Bachew, R., Bodie, D., Leach, R., Morris, K. & Sherma, G. 2012. Knowledge and attitudes towards mental illness among college students: Insights into the wider English-speaking Caribbean population. *International Journal of Social Psychiatry***,** 0020764012461236.

WHO mental disorder fact sheet, 2016

WHO (2008), Scaling up Care for Mental Neurological and Substance use Disorder

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APPENDIX 1

SCHOOL HEALTH QUESTIONNAIRE (ENGLISH VERSION)

Serial Number: __ __/ __ _/____

Today's Date: __ __/__ __/__ __

Please write the answers to the questions or draw a circle where it applies to you. This is not an examination it is only to find out about you and your health.

SECTION I

Personal Information

1. Name of School:

2. Level:

3. Where do you live? (Address of Present Abode):

4. What is your date of birth? Date of Birth: _____ ______ ________

Day Month Year

5. How old are you? ____

6. Are you a boy or a girl? (a) Boy (b) girl

7. Do you practise any religion? No Yes

8. Please write down the exact place you attend for worship

____

(a) Islam (b) Orthodox Christian (c) Pentecostal Christian (d) Traditional religion (e) Other

9. How much does the teaching of your religion guide your behaviour?

(a) Very much (b) much (c) Just a little (d) Not at all

10. How much does the teaching of your religion guide your family life?

(a) Very much (b) much (c) Just a little (d) Not at all

Family Information

11. Family Type:

(a) Monogamous (b) Polygamous

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12. Number of Mother's Children:

13. Number of Father's Children:

14. What is your position among your father's children?

15. What is your position among your mother's children?

16. Marital Status of Parents:

(a) Married (b) Separated/Divorced (c) Father is dead (d) Mother is dead (e) Mother & Father are dead

17. How many husbands has your mother had?

18. Who do you live with presently?

(a) Parents (b) Mother (c) Father (d) Grandparents (e) Grandmother

(F) Grandfather (g) other [please specify] __________________

19. Who brought you up from your childhood?

(a) Parents (b) Mother (c) Father (d) Grandparents (e) Grandmother

(f) Grandfather (g) other [please specify] __________________

20. How many different people have you left your parents to live with from your childhood? ____

21. If more than one person, list the people, time spent and whether experience was good or bad?

Person lived with	from which age to which age	Experience (good or bad)
_______________	___________	_____________
_______________	___________	_____________
_______________	___________	______________

22. Do you do any kind of work to earn money before or after school? Yes No

23. If yes, please describe what you do ____

24. Level of Father's Education

(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School

(e) Post-Secondary (Non-University) (f) University Degree and above (g) I do not know

25. Occupation of Father: [Write the exact occupation] _______________________/ I do not know

26. Level of Mother's Education

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(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School

Post-Secondary (Non-University) (f) University Degree and above (e) I do not know

27. Occupation of Mother: [Write in the exact occupation] ____________________/ I do not know

28. Do you like your family? Yes No

29a. If Yes, Why? ____

29b. If No, Why? ____

School-Related Questions

30. Do you like your school? Yes/ No

31. How many children are there in your class? __

32. Do you do well academically? Yes No

33a. If Yes, explain____

33b. If No, explain____

34. Are you having difficulties with your lecturers? Yes No

35. If yes, what sort of difficulties? ____

36. Do you have guidance counsellors in your school? Yes No

37. Have you ever gone to see them? Yes No

38. If yes, what did you go to see them for? ____

39. If you have a problem at school would you go to the guidance counsellor for help? Yes No

40a. If yes, why would you go?

40b. if no, why not?

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APPENDIX II

KNOWLEDGE, ATTITUDE AND SOCIAL DISTANCE QUESTIONNAIRE

Student ID: **Class ID:** **School ID:**

Questionnaire---2

People have different experiences and feelings about those who have experienced mental illness. The following questions ask you to describe some of your views.

1. **What sorts of words or phrases might you use to describe someone who experiences mental illness?**

____

____

____

____

2. **The following statements are commonly held beliefs about mental illness. Can you tell us whether *you* personally agree or disagree with each statement?**

	Agree	**Disagree**	**Not Sure**
People with mental illness are always difficult to talk to	☐	☐	☐
People with mental illness are likely to become violent	☐	☐	☐
Mental illnesses are caused by stress	☐	☐	☐
People can recover from mental illness	☐	☐	☐
People with mental illness are weak and have only themselves to blame	☐	☐	☐
People with mental illness are always unpredictable	☐	☐	☐
There is a stigma (shame) attached to people with mental health Problems	☐	☐	☐
One in four people will develop mental illness over the course of a Life time	☐	☐	☐

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Mental illnesses are caused by spiritual attack.

Parents with mental illness always transmit it to their children.

Mental illness cannot be treated

Depression is a type of mental illness

People with depression always like to be alone, feel sad & wish to die

People with Psychosis often see or hear what others cannot see or hear

Psychosis is a spiritual problem that cannot be treated in the hospital

Bullying is a risk factor for suicide

People who attempt suicide have often been depressed

People who joke about killing themselves do not always have a plan to do so

People who experience trauma are likely to develop Post Traumatic Stress Disorder

People with Post Traumatic Stress Disorder do not need treatment because they outgrow it with time

People with Post Traumatic Stress Disorder often suffer from flashback and nightmares

Gateway drugs include alcohol, marijuana and tobacco

Peer influence is a great factor in starting to use and abuse drugs

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People react to those who have mental illness in different ways

(Please tick only one box for each statement)

3. Would you feel afraid to talk to someone with mental illness?

Definitely ☐ *Probably* ☐ *probably not* ☐ *definitely not* ☐ *don't know* ☐

4. Would you be upset or disturbed to be in the same class with someone who had Mental illness?

Definitely ☐ *Probably* ☐ *probably not* ☐ *definitely not* ☐ *don't know* ☐

5. Would you be able to be friends with someone who had mental illness?

Definitely ☐ *Probably* ☐ *Probably not* ☐ *Definitely not* ☐ *Don't know* ☐

6. Would you be embarrassed if your friends knew that someone in your close family had mental illness?

Definitely ☐ *Probably* ☐ *Probably not* ☐ *Definitely not* ☐ *Don't know* ☐

9. **Where have you obtained *most* of your understanding and knowledge of mental health problems from?**

☐ Family
☐ School *Ile*
☐ T.V and Home videos
☐ Friends
☐ Magazines and newspapers
☐ Others (please describe)

____

Thank you for completing this survey

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APPENDIX III

General Help Seeking Questionnaire for emotional problems

Serial no: ____/ ____ /____

Date: ____/_____/_____

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem.

Please circle the number that shows **how likely it is** that you would seek help from each of these people for a personal or emotional problem, in the **next 4 weeks?**

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)_________________________________	1	2	3	4	5	6	7

Thank you for completing this survey.

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APPENDIX IV

Student Evaluation form

Mental Health Training Programme

Student ID: **Class:** **campus ID:**

Dear Student,

I would be very grateful if you would provide feedback on the training programme. Your feedback would be helpful towards improving on this.

Please circle the answer that applies to you and write out the other responses.

Thank you very much.

1. What aspect of the training programme did you enjoy the most?
   a. Lecture b. Question & Answer c. Group discussion d. Drama
   b. e .Other Aspect, please specify_______________________________________

2. From which part of the training did you learn about mental health the most?
   a. Lecture b. Question & Answer c. Group discussion d. Drama
   e .Video show. F. Other Aspect, please specify_______________________________________

3. What did you like about the information you received? ____

4. What did you not like about the information you received? ____

5. Do you think this programme is useful for you as school children?
   a. Yes b. No c. Don't know

If yes, why is it useful? ____

If no, why is it not useful? ____

6. Has this programme been of benefit to you?
   a. Yes b. No c. Don't know

If yes, how was it of benefit? ____

If no, why is it not of benefit? ____

7. Has this programme been of benefit to your school?
   a. Yes b. No c. Don't know

If yes, how is it of benefit ____

If no, why is it not of benefit? ____

8. Has this programme been of benefit to your family?
   a. Yes b. No c. Don't know

If yes, how is it of benefit ____

If no, why is it not of benefit? ____

9. Has this programme been of benefit to your community?
   a. Yes b. No c. Don't know

If yes, how is it of benefit ____

If no, why is it not of benefit? ____

Thank you for you for your feedback.

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APPENDIX V

Mental health training materials

MENTAL HEALTH TRAINING MATERIALS FOR STUDENTS IN KOGI STATE POLYTECHNIC LOKOJA

Training needs assessment

Studies carried out among young people in Nigeria, although few, have revealed that, like the Nigerian adult population and their young Western counterparts, Nigerian adolescents show stigmatizing attitude towards mental illness (Dogra *et al*, 2011). This attitude is often rooted in poor knowledge of mental illness (Dogra *et al*, 2011).

Studies reveal that through interventions stigmatising attitudes can be changed (Rahman *et al*, 1998, Bella *et al*., 2011). An intervention study carried out among secondary school adolescents in rural and urban areas in southern Nigeria, using a 3hour educational strategy improved knowledge of mental illness but did not improve attitude and social distance. A more recent study carried out among adolescent secondary school students in south west Nigeria (Oduguwa 2015) added the use of drama to a purely educational method and recorded improvements in knowledge of mental illness and attitude but not in social distance These changes were sustained over 6 months. These studies suggests that to obtain a better result for a future research, then the use of contact with persons who have recovered from a mental illness should be added to an intervention of a longer duration that addresses local beliefs about mental illness.

This current study is a replication of the Oduguwa study but, among college (polytechnic) students. The study will carry out an intervention of a duration of 5hours over 3 consecutive days. This study will employ drama, video show, case vignettes, group discussion and lecture.

Depression, anxiety and substance abuse have been reported as the most common mental illness in a community survey carried out in Nigeria among adult population from 2001 to 2003 (Gureje *et al*., 2006), and psychosis is regarded as the most stigmatised. Also, in a Nigerian study conducted among adolescents, 20% of the participants reported having suicidal ideation and 12% had attempted suicide in the past 1 year (Omigbodun *et al*., 2008). Thus, the present study will focus on these 5 types of mental illness: Psychosis, Depression, Anxiety (PTSD), Substance abuse and Suicide &self-harm.

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TRAINING COURSES

The training will consist of 3 sessions:

Session 1 awareness about mental health and mental illness

Session 2 address myths surrounding mental illness and video show

Session 3 recap of sessions 1, 2, and drama

Each session will last for about 1hour 30minutes each and will be carried out over 3 consecutive days

TARGET GROUP FOR TRAINING

The target group for the study will be Kogi State Polytechnic Students in Pre- ND and Pre-Degree. Participants are not expected to have undergone any previous training on mental health and mental illness.

SHORT TASK DESCRIPTION

Job description

Study participants will be better aware about mental health and illness, and will be able to relate well with persons with mental illness

Expected learning outcomes

Knowledge

- At the end of the training, study participants will be able to
- Describe and differentiate between mental illness and mental health
- State how common mental illness is
- List the possible causes of mental illness
- Identify 5 types of mental illness
- State the myths about mental illness and the facts that tackle such myths

Attitude

At the end of the training, study participants will be able to

- Demonstrate non-judgmental behaviour towards persons with mental illness
- Demonstrate sensitivity and empathy to persons with mental illness

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Skills

- Identify persons with mental illness and give advice on referral

TYPE OF TRAINING

Short training sessions spread over 3 days

TRAINER

Researcher

CURRICULUM DEVELOPMENT

Course Aim

To provide study participants with factual information and increase their awareness about mental health and mental illness, and to reduce negative attitude and stigmatising behaviour towards persons with mental illness

Venue

School halls or large classrooms as provided by each school

No of participants

A total of 90; 45 each per campus

Teaching methods

Task

• Knowledge	Lecture, group discussion, hand-outs
• Attitude	Discussion and demonstration
• Skills	Lectures and discussions

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CASE VIGNETTES -TYPES OF MENTAL ILLNESS

1

Ojonimi is a 13-year-old girl. She was brought to the clinic by her aunty (father's sister). Both Ojonimi and her aunt were spoken to separately.

Her aunt said that over the last few months she noticed that Ojonimi had been very unhappy. She complained of aches and pains very often and had missed school several times because of this. She has had to repeat a class. Ojonimi said she was unhappy. She also felt very angry with herself and everyone around. She found it difficult to follow the lessons at school. She was awake a lot at night and no longer enjoyed her food. She had thoughts of killing herself and also dreamt she was killed. Ojonimi is the 3rd of 4 children. Her father is a car electrician and her mother sells goats. Some years ago, Ojonimi's mother had had similar experience as Ojonimi is having now and had almost killed herself.

Ojonimi was sent by her parents a year ago to live with her aunty to help look after her aunt's new baby. Her other brothers and sisters live with their parents. Ojonimi said she was very unhappy living with her aunty and wanted to return to her parents, but she was too frightened to mention this to her aunty.

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2

Ona is a 13-year old male student in JSS 3. He attends a boarding school. One day, during one of the holidays at home, he was rushed to the hospital in an unconscious state after being found

hanging in an uncompleted building close to his parents' house. On examination, Ona's right arm had lots of scars. When Ona was questioned, he said that the scars were inflicted on his arm by himself. He said that he feels miserable and unloved most of the time. He also said that his parents do not visit him regularly in school and they come late to pick him from school for holidays. Furthermore, he mentioned that his seniors in school usually punish him and give him work to do till late at night, yet he has to wake up very early in the morning for jogging. The seniors also collect all his provisions and he is often starved. He often felt weak and did not feel like playing with his friends so he became lonely and was always by himself. Many times, he would cry to bed feeling miserable. His academic performance began to drop too.

His parents thought that his bad performance was because he was playful and always scolded him whenever he came home.

3

Faseyi is an 18-year old boy. He is a truck driver. He was expelled from school in Senior Secondary School 2 (SS2) because of poor academic performance and truancy. Faseyi had his first taste of alcohol at age of 12 when his grandfather gave him and other children palm-wine. They loved the taste and 'calming effect' of the palm-wine. From them on, he would go alone

to steal palm-wine from gourds and also began to buy palm-wine regularly. He was told by older men in the neighbourhood that palm-wine was good for preventing fever. At age of 16, Faseyi began to smoke cigarette in order to impress his peers.He would use his pocket money or steal from his parents to buy cigarettes. After smoking cigarettes for a year, he was advised to start smoking cannabis by an older friend because cannabis aided academic performance. He felt increased strength, appetite & libido after smoking cannabis. Since then, he has experienced increased desire for cannabis and has smoked 3 wraps of cannabis every day for 3years.

Faseyi's father has 6 wives. His relationship with his parents is not cordial so he lives alone in a face to face rented house.

4

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Lape and Junior were very good friends. They were both 11 years old and in J.S.S 2. Lape and Junior live in the same neighbourhood. They walk to and back from school together. Over the past few months, their neighbourhood has been attacked by gunmen who often used explosives on residential areas. One midnight, Lape heard a loud blast from his room that shook his bed. Afraid he ran to his parents' room and was soothed back to bed.

In the morning, Lape learnt that the blast he heard was as a result of the explosives that gunmen had used on some houses in his neighbourhood. He also learnt that Junior and his family were burnt to ashes. Lape wept and refused to go to school for a long time. He is easily startled and has been having difficulty staying asleep because he often has this nightmare that his neighbourhood was bombed and burnt to ashes. Sometimes, while in the company of others, he stands numb, looks frightened and is unable to move for a few minutes.

5

Moji is a 17 year old S.S. 1 student who lives with her parents. Moji has some difficulty with her academics and has had to repeat J.S.3. Moji's mother noticed some changes in she behavior when she came back from a trip she had recently embarked on. Moji became more outspoken than she used to be. Sometimes, she would say things that nobody understands.

One day, Moji became very aggressive. She said she could hear and see people that other people could not hear and see. She said she could hear these people planning to kill her by taking her away from home and sucking her blood. Because of this, she moved frantically through the house closing every door and window. At another time, she said that the people wanted to make her deaf and dumb and so she became very scared.

Since 3 days ago, Moji has refused to leave the house. She would not eat or talk to anybody and would not take her bath or change her clothes, like she normally used to.

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6

Mr. Kiitan comes home from work at about 6pm every day. He leaves home almost an hour later once it is dark because of poor power supply and goes to a nearby local parlour. 3 years ago when he started visiting the beer parlour, he would only drink one bottle. Now, he drinks 3 bottles each night. He returns home at 10pm each night and goes straight to bed

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CASE VIGNETTES-MYTHS AND BELIEFS ABOUT MENTAL ILLNESS (1)

Hi

My name is Bifolu Kukoyi. I just resumed back to school after a 2-month compulsory break. The last few weeks that led to my absence from school had been characterized by unusual behaviour. My parents told me that on two different occasions while my teachers were in class, I had laughed out loudly for no reason and was sent out of the class. On another day, during a lecture free period, I suddenly got up from my seat and ran out of the class claiming that some people were running after me with cutlass. My parents were called to pick me up. They took me to a traditional healer's house where we were told that my paternal grandmother in the village was responsible for my behaviour. I wanted to tell the herbalist that he was lying because my grandmother was a very kind woman and would not hurt a flea but no one listened to me. I spent 2 weeks in the herbalist's place. I was chained and given some concoctions to drink every day. My condition however worsened and my parents took me away from there. A neighbour advised them to take me to a spiritualist. There, I was placed on dry fast and flogged every evening so as to chase away the evil spirit in me but my condition did not improve. I passed out for several days after an evening's beating. I sincerely hoped that I should not return. I became so lean and could barely stand.

One day, one of my Aunties who worked in a mental health clinic heard about my condition. She encouraged my parents to bring me to their hospital and assured them that I would get appropriate treatment but my parents were reluctant. People had told them that my condition was not a "white man's" condition and cannot be treated in a hospital. Some had even told them that my kind of had no cure. After much persuasion from my Aunty, my parents decided to give it a try. They took me to the hospital. We were attended to by a doctor who asked us many question. At the end, I was diagnosed with Psychosis and I was admitted immediately and given some medications to treat the illness. I began to get better. I became stable and was discharged 4 weeks later.

I returned to school but I had missed 2 and half months. My teachers tried to rush me because examination was in 3 weeks' time. They meant to help me but I was having a hard time coping because I was overwhelmed. Worse still, none of my classmates wanted anything to do with me. They avoided me like I was a plague. They called me bad names and teased me sore. During break, other students would take another path when they see me coming. Some would stand in group and gossip about me.

I have lost my voice trying to tell them that I am normal and that I deserve to be treated like other children but no one listens. Can anyone please help me?

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2

Hi

My name is Tola Alade. I am 18 years old and an undergraduate at the University of Lagos. I don't mean to blow my trumpet but I know that I am very brilliant. However, about 3 years ago, when I was in SS 2, I began to do badly in my school work and I hated school. I could not concentrate in class and I was often weepy. I talked to no one, even my very close friends. I was unhappy all the time, constantly felt weak and wished to die. This went on for several weeks and my teachers became worried because my grades dropped very low. I was asked to withdraw from school until I become well.

At home, I would lock myself up and refuse to see anyone. I ate little food and usually stayed awake most nights crying. My parents had initially thought that I was just being lazy and trying to play smart. One Saturday morning, I did not join the family at devotion. My mother stumped angrily into the room, yanked the cover clothe from my body and was about to spank me when she noticed that I was crying again. I told her that I felt very weak and cannot move my body. My mother was scared and I was rushed to the hospital. After several medical tests, the Doctors said they found nothing wrong with my body system but they referred me to the Psychiatry clinic.

The Psychiatrist asked me and my parents lots of questions about my illness. My parents mentioned that I had lost my cousin about 3 weeks before the illness started and I also confessed that some SS 3 boys in my school had been threatening to beat me up if I refuse go out with them. After listening to us, he explained that I was depressed. He said that I would not need any medication but he would engage me in a form of psychotherapy. This meant that he would see me over a period of time. During these meetings, he spoke with me about how my thoughts, feelings and actions interact and taught my techniques to combat negative thoughts so she could feel better and act right. He also spoke with the principal of my school about the boys who were threatening me and they were dealt with. Soon I began to feel well.

When I returned back to school, my teachers were very kind to my. Some of my classmates however used to tease me and call me 'cry cry baby'. I was given more time to turn in my assignment and my parents got me lesson teachers so that I could catch up with my academic work. With time, I began to top my class again. I made up my mind to be a Doctor and I was made the Health Prefect in SS3. I made my senior WAEC in one sitting and that same year, I gained admission into the University of Lagos to study Medicine.

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APPENDIX VI

Training schedule

Day 1

Pre-test: This will last for about 45 minutes

Introduction

A brief introduction about the training programme will be delivered.

Didactic lecture

A period of about 10 minutes will be used to elicit the participants' knowledge and attitude about mental health and mental illness. Lecture about mental health and illness will be delivered using power point, marker board or blackboard. The definition of mental health and mental illness, prevalence of mental illness, types of mental illness and factors that could predispose an individual to mental illness will be covered

The participants will be required to read through the first case vignette, highlight the distressing behaviour and/or negative emotions in the vignette. The facilitator will explain symptoms highlighted in the case, mention the name of the mental illness, its prevalence and other symptoms.

Group discussion

Participants will be divided into 9-10 groups of 8-10. Each group will chose a group leader to coordinate the group. The groups will be assigned a case vignette each and will be required to highlight the distressing behaviour and/or negative emotions in the vignette, as well as the predisposing factors for a period of about 10 minutes at the end of which the group leader or a group representative will explain the points that the group are able to come up with. Other group members will also make contributions and agree or disagree with the points made. Finally, the researcher will commend the effort of the group, make corrections where necessary and provide factual information about the mental illness in the vignette.

Questions and answers

The facilitator will give room for participants to ask questions

The day will close with a brief recap of the day's lessons.

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Day 2

Introduction

A brief recap of the previous day's lesson.

Didactic lecture and video show

Participants will be asked to state common myths and beliefs about mental illness that they know. The researcher will counter the elicited beliefs about mental illness with factual information about mental illness and play the video at the end of the discussion.

Group discussion

The participants will return to their groups, read and discuss the second set of case vignettes that highlights myths associated with mental illness, appropriate places to seek for mental health care and appropriate behaviour towards persons with mental illness.

Questions and answers

The facilitator will give room for participants to ask questions and also asked them questions based on the topics that had been considered.

The day will end with a brief recap of the day's lessons.

Day 3

Introduction

This will include a recap of all the lessons that had been taught. Participants will be allowed to ask questions some of which their fellow participants will able to answer correctly while the researcher will provide or correct wrong impressions about the lessons taught.

Drama

Voluntary participants will be selected to act a drama drawn from one of the case vignettes examined. At the end of the drama, major themes which the drama portrayed will be discussed.

Immediate-post-test

Participants will complete the KASD scale again. This is expected to last for about 10-15 minutes.

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APPENDIX VII

Letter conveying ethical approval and school permission to conduct research in Kogi State Polytechnic, from the Federal Medical Centre Ethical Committee and the Registrar, Kogi State Polytechnic, Lokoja.

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FEDERAL MEDICAL CENTRE LOKOJA
ETHICAL COMMITTEE

FMCL|MED|115|Vol.II|212

Date: 3 April 2016

EFFECT OF A MENTAL HEALTH TRAINING PROGRAM ON MENTAL HEALTH KNOWLEDGE, ATTITUDE AND HELP SEEKING BEHAVIOUR OF YOUNG PEOPLE IN KOGI STATE POLYTECHNIC

Name of Applicant/ Principal Investigator: **Mrs. Lydia Audu Ibrahim**
Address of Applicant: The Centre for Child & Adolescent Mental Health, University of Ibadan
Date of receipt of application: 22/02/2016
Type of Review: Full Committee Review
Date of full Committee Decision on the Research: 18/04/2016
Date of full Committee Approval: 18/04/2016

Notice of Full Committee Approval

I am pleased to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been reviewed by the FMCL Ethical Review Committee (ERC) and given full Committee approval.

This approval dates from *03/05/2016* to 03/04/2017, Your work will be monitored by Dr. Egbeola A. A. C. (FMCPsych) to ensure compliance with the approved protocol. If there is delay in starting the research, please inform the ERC so that the dates of the approval can be adjusted accordingly.
Note that no participant accrual or activity related to this research may be conducted outside these dates.

The FMCL Ethical Research Committee (ERC) requires you to comply with all the institutional guidelines & regulations and ensure that all adverse events are reported promptly to the ERC No changes are allowed in the research without prior approval by the ERC. Please note that the ERC reserves the right to conduct monitoring/oversight visit to your research site without prior notification.

Thank You.

Dr. Osawe Osayande Osa (MBBS, FMCOph)
Chairman, FMCL Ethical Research Committee (ERC)

Chairperson
DR. OSAYANDE OSAWE OSA
MB,BS, Fmcophth

Secretary
ABDULLAHI ABDULRAHAMA
BA hons

Financial Officer
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KOGI STATE POLYTECHNIC, LOKOJA

P.M.B. 1101 LOKOJA KOGI STATE, NIGERIA

OFFICE OF THE REGISTRAR

RECTOR
Isa Mohammed (MNIM)
B. A; MPA; M.Sc.

REGISTRAR
Alh. U. O. Saliu (MNIM)
B.Ed, M.Ed.

email:registra@kogistatepoly.edu.ng

Date 5th May, 2016

KGSP/REG/SP/448/176

Mrs. Lydia Ibrahim
Medical Centre
Kogi State Polytechnic
Lokoja

RE: APPLICATION TO CARRY OUT A MENTAL HEALTH TRAINING PROGRAMME FOR STUDENTS IN THE POLYTECHNIC

Kindly refer to your letter dated 18th February, 2016 on the above subject matter.

I am directed to convey management approval for you to carry out a Mental Health Training programme for students in the Polytechnic.

Please note that the population sample is the Pre-ND students.

I wish you success in your programme.

Thank you.

Okpe Elizabeth
For: Ag. Registrar

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Informed Consent form

The effect of a mental health training programme on the mental health knowledge, attitudes and intended help-seeking behaviour of young people

Date: 4th April, 2016.

Good day and thank you for your time

My name is Lydia Audu Ibrahim of the department of Child and Adolescent Mental Health, University College Hospital, Ibadan. I am carrying out a study in partial fulfilment of the Master of Science Degree in Child and Adolescent Mental Health.

The overall aim of this study is to evaluate the effect of mental health training programme on the mental health knowledge, attitudes and intended help-seeking behaviour of young people in Kogi State Polytechnic.

In the course of this study, you will be asked some questions concerning your personal information and views about mental illness and persons with mental illness. In total we anticipate to interview 90 young people in Kogi State polytechnic.

Your participation in this research will not cost you anything. You are expected to remain in this research for a period 3 weeks. Each session or contact will last for 45 minutes. All information collected in this study will be coded and no names will be recorded. The codes cannot be linked to you in anyway, neither will your name or identifier be used for publication or reports from this study.

Your participation in this research is entirely voluntary. If you choose not to participate, it will not have any adverse effects on you. You are also free to withdraw from the study at any point in time you wish to do so.

Your honest answers to this questions will help our understanding of young people's knowledge, attitudes and intended help-seeking behaviour towards mental illness and help us to develop appropriate interventions to correct negative attitudes. We will greatly appreciate your response and participation in this study.

Consent: now that the study is fully explained to me and I understand the content of the study process, I am willing to participate in this study.

Signature_____________________________ **Date** ______________________________

Name ____

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