DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

BY

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DECLARATION

I hereby declare that this research was conducted by me, and that this work has not been presented to any other body for examination purpose.

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CERTIFICATION

We hereby certify that this proposal was written by Dr Rabi Ilemona Ekore, and has been reviewed and approved by us.

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DEDICATION

To all the children and adolescents

Who for reasons not meaningful to them

And who for no fault of theirs

Find themselves in especially difficult circumstances.

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LIST OF ACRONYMS

AIHW: Australian Institute for Health and Welfare

CBT: Cognitive Behaviour Therapy

CGPA: Cumulative Grade Point Average

DALY: Disability Adjusted Life Years

EPQ: Eysenck Personality Questionnaire

FGD: Focus Group Discussion

FGP: Focus Group Participants

GBD: Global Burden of Diseases

HIV: Human Immunodeficiency Virus

IMI: Individual Motivational Interviewing

mhGap: Mental Health Gap Action Programme

MIS: Management Information Systems.

PMI: Peer-Enhanced Motivational Interviewing

SBI: Screening and Brief Interventions.

SPSS: Statistical Package for the Social Sciences

UCH: University College Hospital

UHS: University Health Service

UNAIDS: Joint United Nations Programme on HIV/AIDS

WAYI: West African Youth Initiative

WHO: World Health Organisation

ABSTRACT

Background: There is a significant burden of mental health disorders among college/university students, many of which are untreated. The treatment gap, with respect to the management of mental health problems in students remains a pervasive and on-going problem in the delivery of mental health care. This is largely a direct result of an acute shortage of mental health professionals. Available evidence shows that the most effective set of people to provide alternatives of such services to students are their fellow students or peers, referred to as peer counsellors. This study was aimed at developing and providing peer counselling services for students of the University of Ibadan.

Methodology: Twenty prospective volunteer mental health peer counsellors were recruited through poster advertisements, had personality tests using the modified Eysenck Personality Inventory (EPI) which assessed for extraversion (sociability) and neuroticism (emotionality), focus group discussions, and pre-intervention assessments. They subsequently had a two-day training on the identification of common mental health issues, peer counselling and communication skills, followed by a post-intervention assessment. The trained peer counsellors then commenced peer counselling activities. The focus group discussion recording was transcribed and analysed by themes; the quantitative data was analysed using descriptive statistics such as means, percentages, proportions and range. Chi-square and student t-tests were used to compare proportions and means respectively at 5% level of significance.

Results: A total of twenty (20) participants took part in the study. The mean age of the volunteer peer counsellors was 20.2 (±2.6) years. There were 9 (45.0%) male and 11 (55.0%) female volunteers. The mean extraversion score was 9.9 (±3.1) and the mean neuroticism score was 9.6 (±4.2). The scores from both domains were used to categorize the prospective peer counsellors into the four temperaments, and thirteen (65.0%) of the volunteers were found to possess phlegmatic temperaments, 4 (20.0%) had sanguine, 2 (10.0%) had melancholic while 1 (5.0%) had choleric temperaments. The focus group revealed some terms which students use to refer to mental illness, were able to identify some symptoms of mental illness, and described some

perceived roles of family, peers and friends in the cause and treatment of mental illness. They also mentioned the ability to identify symptoms of particular illnesses, how to assess and handle some cases, approach persons with mental illness, listening and understanding skills, be patient and focused as training needs. The mean pretest score was 24.0 (±2.3) while the mean posttest score was 27.5 (±1.2). Paired t-test analysis of the pre and post-intervention scores showed a significant improvement in knowledge generally ($p<0.05$). In addition, there was a significant change in knowledge in both the male and female participants ($p = 0.004$ and $p = 0.00$ respectively), in only the 16-20 year old group of participants ($p = 0.00$), and in participants according to level of study ($p = 0.02$, $p= 0.01$and $p=0.04$ for 200, 300 and 400 level respectively). Some of the trained mental health peer counsellors have been involved more in raising awareness about mental illness by means of information and educational stickers. Three clients have been attended to and one client has been referred to the clinic.

Conclusion: The mental health peer counselling training programme is effective in increasing the knowledge base of volunteer mental health peer counsellors.

Key Words: Peer Counselling; Mental Health; University Students; Volunteer

CHAPTER ONE

INTRODUCTION

1.1 Background

The global disease burden report of the World Health Organization (WHO) attributes about 14% of global burden of diseases to neuropsychiatric conditions (WHO, 2008). The WHO also declared mental health disorders as one of the leading causes of disability in persons aged 15 – 44 years (WHO, 2008). Similarly, recent findings from world-wide community surveys indicate that about one-quarter of youths experienced a mental health disorder during the past year, and one-third of youths experience mental health difficulties during their lifetime (Merikangas et al, 2010; Dadwani and Tintu, 2014).

In line with a huge burden of mental health disorders among young people, there is a corresponding significant burden of mental health disorders among college/university students, many of whom remain untreated (Hunt and Eisenberg, 2010).In the same study which was a survey of data from random samples in 26 colleges and universities in the United States of America in 2007 and 2009,Hunt and Eisenberg (2010) found that 17% of the students were diagnosed for depression and 10% for anxiety disorder. According to Merikangas et al (2010), a wide spectrum of mental health disorders is prevalent among college students, the most common being anxiety, behavioural, mood and substance abuse disorders; and according to the authors, less than half of those found to be affected by mental illness are opportune to receive treatment from mental health specialists. The WHO recognizes the fact that the treatment gap (the number of people with an illness, disease or a disorder who need treatment but do not get it) for mental disorders is large all over the world, and that between 76% and 85% of people with severe

mental disorders in low and middle-income countries receive no treatment for their mental health conditions, and that the corresponding figures for high income countries, although lower than in low and middle-income countries(between 35% and 50%), are also high (WHO, 2013).

The treatment gap identified in the cited studies above is a pervasive and on-going problem in the delivery of appropriate mental health care, and it is deemed to be a direct result of an acute shortage of mental health professionals, especially in low- and middle-income countries (WHO mhGAP, 2008; Bruckner et al, 2011). It is in realization of this problem that the WHO developed the mental health Gap Action Plan (mhGAP), a programme aimed at scaling up services for mental, neurological and substance misuse disorders with particular attention to low- and middle-income countries where there is more acute shortage of mental health professionals with its attendant acute shortage of mental health service (WHO mhGAP, 2008). The idea of mhGAP is that with proper care, psychological assistance and medication, a lot of people can be treated by health care professionals for common neuro-psychiatric problems and subsequently learn to live normal and productive lives. The mhGAP is also aimed at reducing the treatment gap for mental illnesses by training non-mental health specialists such as general physicians, nurses, pharmacists, social workers, and others to provide psychosocial care for those with mental health or psychological issues (mhGAP, 2008).

The essence of the mhGAP can also be employed to reduce treatment gap among college students by training students to provide non-specialist or paraprofessional mental health care for them. From available evidence, the most effective set of people to provide such services are their fellow students or peers, who after appropriate training are referred to as peer counsellors.

Peer counselling refers to “a variety of interpersonal helping behaviours assumed by non-professionals who undertake a helping role with others with whom they share related values,

experiences, lifestyle, and approximately the same age" (Nelson-Jones, 2005). Nelson-Jones further states that the process of peer counselling help individuals to use existing resources to cope with life better (Nelson-Jones, 2005). As mentioned earlier, available evidence has shown that peer counselling is a more effective way of addressing behavioural issues in young people as they have been observed to first turn to one another for help in times of need or crisis (Pritchard et al, 2007). A peer health coaching programme for patients of 6 public health clinics at the San Francisco Bay Area in the United States of America, for instance, resulted in significant improvement of diabetes control in a group of low-income primary care patients (Thorne et al, 2013). Similar programmes have been used to effectively provide psychosocial intervention in cancer patients/survivors (Alicock M et al, 2014), and HIV/AIDS patients (Ti L et al 2013). Peer education programmes have also been successfully used in HIV prevention in Nigeria (Ajuwon et al, 2008; Akanle, 2010; Onyegegbu and Nwagbo, 2009).

In college/university campuses in most developed countries, peer counsellors manage students with mental health or behavioural issues and evidence of their effectiveness abound as there are intervention programmes for a variety of problems ranging from anxiety disorders to substance abuse or misuse, and suicide-related issues (O'Leary T et al, 2007; Harvard UHS; Mastroleo et al, 2008). In Nigeria, the University of Ibadan has a funded peer education programme for the prevention of HIV/AIDS among students for which a training manual was developed (Shokunbi and Ajuwon, 2008).

1.2 STATEMENT OF THE PROBLEM

There is a huge burden of mental health problems worldwide, including Nigeria. Over an 18-month period (March 2013 – September 2014), 116 (38.8%) of the 299 patients seen at the

weekly mental health clinic of Jaja Clinic, University of Ibadan, were students. Cases seen include mood disorders like anxiety, depression and bipolar affective disorder, substance misuse, suicidal thoughts, schizophrenia/psychosis, epilepsy and somatization disorder (unpublished data from the medical records, Jaja Clinic, 2013-2014).

Despite the evidence that peer education is effective in preventing HIV/AIDS (Ajuwon et al, 2008; Akanle, 2010; Onyegegbu and Nwagbo, 2009), in alleviating psychosocial problems in cancer survivors (Alicock M et al, 2014), and in improving treatment adherence in people living with HIV/AIDS and other chronic physical illnesses, this strategy has not been applied to mental health problems among university students This study is designed to address this treatment gap.

1.3 JUSTIFICATION

Research consistently reports that distressed college students first turn to their friends for help as they are considered to be more trustworthy than others such as their parents, teachers or other adults. Evidence also supports the effectiveness of non-pharmacological therapy like psycho-education and cognitive behavioural therapy (CBT), and the effectiveness and safety of peer- based counselling in managing many of the mental health or psychological issues (WHO mhGAP, 2008; Mastroleo et al, 2008, O'Leary et al, 2007). There is also a dearth of mental health professionals. Hence, the need to train peer counsellors, and promote their involvement in managing college/university students with mental health or psychological issues.

The study participants stand to acquire skills that will help them identify and refer students with mental health issues and meet the psycho-social needs of some of them, helping to reduce the treatment gap that is posing a very big problem in the provision of mental health care.

These skills may also be beneficial to the participants personally, as the training imparts on them a sense of duty and responsibility, and will help to develop their communication and leadership skills.

This study will also provide data that will serve as evidence to support the effectiveness of training peer counsellors, and the effectiveness of peer counselling training programmes. With a reasonable number of trained peer counsellors, there would be a reduction of the existing treatment gap and a corresponding reduction in the prevalence of mental health issues in people in the society.

1.4 OBJECTIVES OF THE STUDY

1.4.1 Aim:

To develop and provide mental health peer counselling services for undergraduate students of the University of Ibadan.

1.4.2 Specific Objectives:

1. To assess the pre-intervention knowledge of mental health issues among volunteer prospective peer counsellors.
2. To increase peer counsellors' knowledge of symptoms and signs of common mental health-related problems and counselling methods.
3. To imbue in peer counsellors a positive attitude towards helping students in need.
4. To improve the ability of the peer counsellors to provide counselling and psychosocial support for undergraduate students with mental health issues in the University of Ibadan.

5. To assess the post-training activities of the trainees.

1.5 Primary Outcome Measures

1. Knowledge and improved attitude towards common mental health issues among students of the University of Ibadan.
2. Skills to identify common mental health issues, and either referring them to the designated mental health professionals or providing psychosocial support for them.
3. Number of students reached with peer counselling interventions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Burden of Global Mental Health Problem

Burden of disease generally refers to a measure used to assess and compare the impact of diseases and injuries on the general population by quantifying health loss due to disease and injury that remains after treatment and rehabilitation (AIHW, 2013). One factor used to measure burden of disease is the disability-adjusted-life-years (DALY), which is a combination of the number of years of life lost due to premature mortality and the number of years of life lost due to time lived in states of less than full health.

At its 65th World Health Assembly in 2012, the World Health Organization expressed concern about the fact that "millions of people worldwide are affected by mental disorders, and that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and also that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders accounted for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively"(WHO, 2013). As seen in the preceding information, the WHO Global Burden of Diseases Report adopted the DALY in measuring burden of diseases (WHO,

2009), and the same report put the DALY due to mental, neurological and substance abuse disorders at 14% (Bruckner et al, 2011).

The burden of mental health diseases affects not only the individual suffering from the illness, but also the entire members of the individual's family and the entire members of the community in which the individual with mental health issues lives. The individual suffers not only from the biological effects of the illness and medication but also psychosocial and economic effects. Academic activities and achievements are usually hindered, and oftentimes such individuals are unable to lead optimal professional/work lives. The families of the person with mental health issues also suffer economic difficulties oftentimes emanating from recurrent health care expenditures (including cost of logistics and treatment), lost income, emotional reaction to the mental illness of their loved ones, the stress of coping with the disturbed behaviour of the person with mental health issues, recurrent disruption of household routine and restriction of social activities (WHO 1997).

2.2 Burden of Mental Health Problem among College Students

As earlier mentioned, the global disease burden report of the WHO attributes about 14% of global disease burden to neuropsychiatric conditions (WHO, 2009). In addition, the WHO also declared mental health disorders as one of the leading causes of disability in persons aged 15 – 44 years (WHO, 2009), just like recent findings from world-wide community surveys in the USA and India that revealed that about one-quarter of youths experienced a mental health disorder during the past year, and one-third experience the same during their lifetime (Merikangas et al, 2010; Dadwani, 2014). Another study by Blanco et al (2008) revealed that almost half of college-age individuals had a psychiatric disorder in the past year. The same study concluded that

psychiatric disorders, particularly alcohol use disorders, are common in the college-age population. This corroborates the findings by Hunt (2010) and Merikangas et al (2010) as mentioned earlier.

Available evidence suggests that there is a wide spectrum of mental health problems seen among college/university students world-wide, and these mental health problems vary in their levels or degrees of severity. Again, apart from the mental problems with biological predisposition and precipitation the range of mental health problems seen among college/university students who are predominantly teenagers/adolescents are as diverse as their individual world-views, environments and experiences. Blanco et al (2008) found that the most prevalent disorders in the college students were alcohol use disorders (20.37%), followed by personality disorders (17.68%)) while in the non-college students, personality disorders were most prevalent (21.55%) followed by nicotine dependence (20.66%).Merikangas et al (2010) in a study on lifetime prevalence of mental health disorders among adolescents in the United States of America, found that anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%). However, another study among university students in India found a prevalence rate of 79.2% for depression, with 26.6% having mild depression and 41.2% having moderate depression (Naushad et al, 2014). This is an exceptionally high prevalence rate and the authors would hopefully seek for an explanation for this in a subsequent study.

A study was conducted by Omigbodun et al (2006) to identify stressors and psychological morbidities among students of medicine and other allied health professions in Nigeria and stressors identified by the medical and dental students include frequent industrial strikes (by lecturers and health care workers), overcrowding, excessive school work and lack of holiday

while those identified by students of nursing and other allied health professions include noisy environment, security and transportation. Generally, identified stressors associated with psychological distress in the students include excessive school work, congested classrooms, industrial actions (strikes) by faculty, lack of laboratory equipment, family problems, insecurity (lack of security), financial and health problems. The study concluded that while stressors outside the reach of the school authorities are difficult to control, academic support including providing a conducive learning environment, advice on means for sustenance, and added support during periods of transition are key areas for psycho-social interventions (Omogbodun et al, 2006).

Another study by Bella and Omigbodun on social phobia in Nigerian University students revealed a life-time and 12-month prevalence of 9.4% and 8.5% respectively. The study also revealed that lifetime depression, psychological distress and perceived poor overall health were also observed to remain strongly and independently associated with social phobia (Bella and Omigbodun, 2009).

An emerging area of potential psychological or mental health concern for college/university students in Nigeria is that of sexuality, and with the world now very much a global village, significant attention should be given to the subject. A recent study by Gesinde *et al* (2013) on the status as well as gender differences in 12 aspects of psychosexual life-style of university students in Southwest, Nigeria revealed that the participants reported higher mean scores for psychosexual constructs of sexual esteem, satisfaction, internal control, consciousness, assertiveness, external control, and motivation respectively, and lower mean scores for sexual depression, monitoring, preoccupation, anxiety, and fear of sex in that order. In addition, there were no significant gender-based differences on sexual esteem and depression of the participants. The study concluded with a recommendation among others that counsellors should broaden

sexual recovery psychotherapeutic intervention programmes that will further enhance self-report on university students' psychosexual lifestyles.

Attempted/completed suicide is also quite a significant mental health issue among college/university students. So is the problem of rape, and other forms highly traumatic events. These, however, require advanced forms of psychotherapy by trained professionals/specialists and would not form part of the training content of this project.

2.3 Definition of Peer Counselling

Counselling refers to the process of dialogue between a person and a care provider aimed at enabling the person cope with an on-going problem and make informed personal decisions related to the problem at hand. There are basically two types of counselling, namely directive and non-directive counselling. In the case of the former, the procedure is led by the counsellor while in the case of the latter the counsellor allows the individual being counselled to express the problems at hand and resolve difficulties with a minimal direction by the counsellor. Both types of counselling have different techniques which are employed as the situation demands. Counselling is also done in stages. There are basically four stages (Stage I – Stage IV) in the counselling process and these include Listening and Exploration, Understanding, Problem-Solving and Termination in that order. (Jegede, 2008).

Peer counselling, as earlier mentioned, is described by Nelson-Jones as "a variety of inter-personal helping behaviours assumed by non-professionals (like students, community members, church members, or members of a social group) who undertake a helping role with others with whom they share related values, experiences, lifestyle, and approximately the same age" (Nelson-Jones R, 2005).The British Association of Counselling defines counselling as "the

skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources" (Clarkson, 1998). It goes further to describe the counsellor's role as having to facilitate the client's work in ways that respect the client's values, personal resources and capacity for self-determination. The client's values may have very strong cultural and religious influences and these must be taken into consideration and respected by the peer counsellor at all times.

Odirile (2012) describes peer counseling as a helping process that involves two people or a group of people who have a number of things in common. He further explains that it is a way of relating, responding and helping aimed at exploring the feelings, thoughts, issues and concerns of the individual in need, with the hope of reaching a clear understanding in order to enable such individual make informed decisions. This is similar to the description of peer counselling by Jegede (2008), as a process that is carried out as a one-to-one interaction, followed by group interaction. Jegede further states that during this process, experiential information is shared among the peer group to modify knowledge, attitude and beliefs to bring about change at the individual level (Jegede, 2008).

The key element, according to Nelson-Jones, in counselling is reflective listening on the part of the peer counsellor. This is meant to encourage the students/persons in need to think about and try to resolve their own difficulties or problems through strategies invented or reasoned out by them (Nelson-Jones R, 2005). Coulshed and Orme (2006) assert that the peer counsellor is generally required to listen, observe and respond appropriately to the person in need. Of great importance also is the possession of communication skills such as attending, specifying, confronting, questioning, reflecting feelings and content, personalizing, problem-solving and action planning. The College/University peer counsellor meets with fellow students

in need of attention individually, and is meant to listen to their complaints, advise and refer them to professional service providers, or provide general psychosocial support to them.

To effectively listen and respond appropriately, Couldshed and Orme (2006) suggest that (peer) counsellors must own seven qualities namely empathy, respect, concreteness, self-knowledge and self-acceptance, genuineness, congruence, and immediacy. According to Ajuwon (2008), peer education is based on the principle that a member of the group is in the best position to educate and influence the behaviours of his or her colleagues. That is, young people have been noted to have or exert powerful influences over one another, whether positively or negatively. This factor can be successfully channeled into educating and helping themselves positively, especially with regards to providing psychosocial support to those in need.

2.4 Counselling Needs of College/University Students

There is no doubt that the peer counselling needs of individuals vary greatly, depending on the nature of the problems they are experiencing and depending on their environment. This is even more so among college/university students, especially those in their early years as majority of them are still adolescents/teenagers, and are experiencing the storms of transition between childhood and adulthood. The various studies mentioned in this section attest to that fact. For instance, a comprehensive community based study done in Iran to assess the educational needs of youth peer educators revealed that majority of participants emphasized on the importance of mental health, life skills, AIDS prevention, contraception methods, and healthy nutrition as the main training topics(Djalalinia et al, 2013).In another survey of about four hundred undergraduate students of the Ankara University, Turkey, Atik and Yalcin (2010) revealed that students desired greater counselling needs in academic, relational, emotional and career issues.

In a similar vein, a study done to assess the counselling needs of university students in Kenya revealed that career/educational needs, life skills needs and personal needs are major needs among university students, with personal needs having the highest score. The authors suggest that the findings of this study may be a pointer for those concerned that students' needs are ever changing and thus a continuous needs assessment is essential in order to offer guidance and counselling services that are congruent to the needs of the student in the Kenyan universities (Karimi et al, 2014).

In Nigeria, a study by Omigbodun et al (2004) that assessed the stressors and counselling needs of undergraduate nursing students in Ibadan revealed that common stressors included excessive schoolwork, financial problems, inadequate recreational facilities, and overcrowded accommodations. Findings from the same study revealed an association between reporting inconsiderate, insensitive lecturers as stressors and evidence of psychological distress. Many of the students (60%) felt counselling would help them, and most of them desired counselling for academics, finances, and relationships. Similarly, Aluede et al (2006) in a study of the academic, career and personal needs of students in another Nigerian university found that irrespective of students' residential status, gender, age and relationship status, the students indicated time-management as the most pressing counselling need. This was followed by drug concerns, family problems, career needs, relationship problems, finance, sexual harassment, academic ability, personality types, anxiety/depression, differential treatment and self-evaluation.

There is obviously no doubt that the peer counselling needs of college/university students would be as diverse as their individual world-views, environments and experiences. However, some of the needs are more common than others and detailed attention should be paid to the more common or trending peer counselling needs while developing and providing peer

counselling services in colleges/universities. This would ensure better efficiency of the peer counselling services provided for the students, thus improving their overall well-being and their academic performances.

2.5 Availability and Accessibility of College/University Mental Health Services Worldwide.

Most colleges and universities in the developed countries have peer counselling or peer mentoring services for their students, especially the freshmen. The peer counsellors/mentors are usually trained second year students and they are available to guide the freshmen through an array of potentially stressful academic and social activities in school. Colleges and universities like Harvard University, Yale University, Trinity College Dublin (Kracen, 2003) and many others have well-established peer counselling programmes. Despite the availability of peer counselling services in the United States of America, research has shown however that the international college students are often reluctant to utilize them. This has been adduced to several reasons such as culture shock, communication problems and even less availability of mental health services in their home country, and that they did not believe counselling would be helpful to them (Tilliman, 2007).

In her M.Sc. thesis, Weckwerth (2010) conducted a study aimed at understanding the needs of students with mental health issues at the Wilfrid Laurier University, Canada. Her findings amongst others include the fact that students with mental health issues need specialized supports, like peer support groups, apart from the counselling services they were already getting. However, according to Kitzrow (2003), students themselves often are not aware of the available mental health resources on campus or may be reluctant to use them. She recommends an ongoing

education, outreach, and advertising campaign to inform them about mental health issues and encourage them to use the services available to them.

In Nigeria, there is dearth of data or information on functional institutional mental health services, including peer counselling services, specifically for college/university students. They are either unavailable, or available and functional but never analysed and subsequently disseminated information about their services. It is pertinent to note here that the University of Ibadan has a campus-based mental health clinic within the University Health Service (Jaja Clinic), being run currently by visiting psychiatrists from the University College Hospital (UCH)/College of Medicine, University of Ibadan. The Clinic is runs once in a week and services are majorly medical, but this may be due to time constraint and a very low doctor-patient ratio. The author is, however, not aware of any published information emanating from this mental health clinic.

Meanwhile, even if mental health services are available, they may not be accessible to the end-users or the end-users may decide not to utilize the services being offered for one reason or another. Ojedokun (2011) in a study of the psychological predictors of attitude towards seeking professional psychological help among Nigerian university students found significant independent and joint influence of health locus of control, mindfulness, openness to experience, personal growth initiative, and sense of coherence on attitude towards seeking professional psychological help. Findings from his study suggest that mental health professionals and psychological well-being experts might improve students' engagement in psychological counselling through changing their attitudes toward seeking professional help, by modifying their unfulfilled psychological, emotional, and social needs. In other words, paying attention to the unfulfilled psychological, emotional and social needs of students even when they apparently

present only with physical illnesses, can help change their attitudes towards seeking professional help.

2.6 Effectiveness of Peer-Based Counselling Services for HIV/AIDS Prevention and Reproductive Health

Most available evidence support the effectiveness of peer education programmes as means of increasing knowledge and modifying behaviour and attitude, especially towards HIV prevention. A quasi-experimental study was conducted by Ajuwon and Brieger in 2007 to compare the relative efficacy of teacher instructions alone, peer education alone, and a combination of these two on reproductive health knowledge, attitude, perceived self-efficacy and sexual practices among secondary schools students in the Ibarapa district of Southwestern Nigeria. Three groups received intervention while a control group received no intervention. By follow-up survey after one academic session, all three intervention schools showed significant knowledge gains, while the control school students' mean score increased slightly. Increase in knowledge was greatest among the group that received a combination of teacher instructions and peer education, followed by the group that received peer education alone, then those that received teacher instructions alone. The least increase in knowledge was seen in the control group (Ajuwon & Brieger, 2007). In another study to assess whether peer education is an effective method of HIV/AIDS awareness among adolescents, the authors were able to demonstrate increased knowledge and decreased misconception and sexual risk behaviour in adolescents receiving peer education, compared to those not receiving peer education (van der Maas and Otte, 2009).

The West African Youth Initiative (WAYI), an adolescent reproductive health peer education implementation and evaluation programme demonstrated significant differences over time and between the intervention and control groups concerning reproductive health knowledge, use of contraceptives, willingness to buy contraceptives, and self-efficacy in contraceptive use. The project findings were suggested as evidence that peer education is most effective at improving knowledge and promoting attitudinal and behavioural change among young people in school settings (Brieger et al, 2001). In a similar vein, a meta-analysis of peer education programmes for HIV prevention in developing countries demonstrated a significant association of the programmes with increased HIV knowledge among others. There was, however, a non-significant effect on sexually transmitted infections and the conclusion of the meta-analysis was a suggestion that peer education programmes in developing countries are moderately effective at improving behavioural outcomes but did not demonstrate any impact on biological outcomes (Medley et al, 2009).

2.7 Benefits of Peer-Based Mental Health Counselling Services in Colleges and Universities

Evidence abounds in support of the benefits of mental health peer counselling services in their various modalities. That is, the various mean of delivering mental health peer counselling services have been proven to be effective. This may likely to be connected to a finding from a needs assessment with peer education managers involved in the International Consultation on Peer Education and HIV/AIDS in Kingston, Jamaica, organised by the Joint United Nations Programme on HIV/AIDS (UNAIDS), in which the respondents defended their choice of peer

education as an effective means of reducing HIV/AIDS by asserting that "peer education is based on a behavioural theory that is premised on the idea that people make behavioural changes because of the subjective judgment of close and trusted peers who have adopted changes and who act as persuasive role model, and not because of scientific evidence" (UNAIDS, 1999).

Instances of the effectiveness of peer-based mental health counselling include a telephone-based peer support programme for supporting people with depression was associated with increased healthcare satisfaction and modest improvement in depressive symptoms, daily functioning, quality of life, and overall psychological health (Travis et al, 2010). Similarly, a pilot study was done to evaluate the effectiveness of incorporating a peer in a brief motivational intervention on reductions in alcohol use in students mandated to receive treatment after violating campus alcohol policy. At 1-month follow-up, the within-group reductions in alcohol use was 3 times larger on average for the peer-enhanced motivational intervention (PMI) group than for the individual motivational intervention (IMI) group. The authors conclude that there is an indication of promise by including peers in brief motivational intervention for mandated students (O'Leary T, 2007).A similar study done in South Africa to assess the effectiveness of Screening and Brief Interventions (SBI) for alcohol problems among university students showed significantly positive results (Pengpid et al, 2013).Similarly in Canada, a peer counselling model developed for use in secondary schools demonstrated that the peer counselling program had been effective in meeting some of the needs of students in tutoring help and in interpersonal relationship(McIntyre et al, 1982).

In this era of high internet connectivity and usage, it would be interesting to discover the role the internet in general, and the social media in particular, would play in the course of

providing or delivering mental health services by the peer counsellors. This, hopefully would be revealed from the focus group discussions, and through the evaluation of the services provided by the mental health peer counsellors.

From the preceding discussion, it is obvious that (college) peer mental health services have proven to be beneficial to the institution, the peer counsellor and the student in need. Students in need are assisted with various psychological services. The peer counsellors get opportunities to develop skills, adopt responsibility, meet new people and contribute to the welfare of the university community (Odirile, 2012).The university gets to offer cost-effective support options to students to complement available professional services. However, as laudable as the concept of peer counselling services may seem, it is very important to note that peer counselling services are meant to complement professional counselling services, rather than seek to replace same.

CHAPTER THREE

METHODOLOGY

3.1 Study Setting

The study took place in the University of Ibadan. Located in Ibadan, South-West Nigeria, the University of Ibadan is Nigeria's premiere university and boasts of a wide array of courses and a culturally diverse population of staff and students. There are a total of thirteen thousand and forty-four (13,044) undergraduate students in fifteen faculties, namely Arts, Education, Science, the Social Sciences, Technology, Public Health, Agriculture, Wild Life and Fisheries, Pharmacy, Veterinary Medicine, Basic Sciences, Clinical Sciences, Law, and Dentistry. There are a total of nine undergraduate halls of residence, namely Queen Elizabeth, Queen Idia, Sultan Bello, Tedder, Mellanby, Kuti, Independence, Nnamdi Azikiwe, Obafemi Awolowo and Alexander Brown Halls. The Alexander Brown Hall is the hall of residence for medical students in their clinical years and is located within the premises of the University College Hospital (UCH) and so was excluded from this study, as supervision of the peer counsellors residing there would have been cumbersome. Queen Elizabeth and Queen Idia Halls are female halls of residence, Obafemi Awolowo Hall is a mixed Hall while the rest are male halls of residence. In

addition to undergraduate students, the clinic also caters for thirteen thousand, five hundred and sixty-six post-graduate students, one thousand five hundred and forty-eight teaching staff and four thousand five hundred and twenty-eight non-teaching staff.

Located within the university campus, the University Health Service, University of Ibadan, is made up of Jaja Clinic and the Environmental Health Unit. Jaja Clinic is a comprehensive health centre which runs an Out-patient, Immunization, Family Planning, Mental Health, Chest (Asthma), Hypertension, Diabetes, Gynaecology, Optometry and Physiotherapy clinics. It also runs a 20-bed sick bay for short stay admissions. The clientele ranges from all registered students of the university to members of staff and their dependants, subscribers of the National Health Insurance Scheme who chose Jaja Clinic as their primary care provider (including civil servants from other ministries, departments and agencies), and emergency cases brought from the surrounding environs who are neither staff nor students.

The clinic staff consists of twenty-two medical doctors, about thirty nurses, and pharmacists, laboratory scientists and technologists, optometrists, physiotherapists, environmental health officers, medical social workers, medical records officers, porters, health assistants, and a host of administrative officers and information technology officers.

3.2 Study Design

The study was an intervention study.

3.3 Study Population

Volunteer undergraduate students of the University of Ibadan, who met the inclusion criteria. Being a pilot study, training of peer counsellors and subsequent peer counselling activities were to commence for undergraduate students since they are younger and less mature and may have less effective coping skills for psychosocial problems, compared to the post-graduate students.

3.3.1 Inclusion Criteria

- Second, third and final-year undergraduate students. First year students were not included in the study because they are new in the institution and are still trying to adjust to academic, social and other activities.
- CGPA of 3.0 and above. This is to ensure that the prospective counsellors are coping fairly well academically, and may be able to shoulder additional responsibilities while maintaining acceptable academic performances. The prospective peer counsellors were required to present print-outs of their academic transcripts from the previous academic session.
- Written Informed consent: This was obtained after the essence of the study was explained to the volunteers (see Appendix VIII).
- Emotional Stability: The student must be emotionally stable. This was determined personality test.

3.3.2 Exclusion Criteria

- Unwillingness to give consent.
- First year students.
- Emotional Instability (Highly neurotic).

3.4 Sample Size Estimation

This was calculated based on a formula comparing proportion between two groups. From an estimate of pretest knowledge (of HIV Prevention) of 30.8% and post-test knowledge of 70.9% observed in a study among primary health care workers in Oyo State by Ajuwon et al (2008) the estimated sample size (n) is (as used by Akinyemi J in an unpublished Basic Statistics lecture notes):

$$n = K \{P_1 (100-P_1) + P_2 (100 - P_2)\}/ (P_1- P_2)^2$$

where:

n = estimated sample size

K (constant factor of one-sided test when power of test is 90%,

and 5% level of significance) = 8.6

P1 (value of pretest knowledge) = 30.8%

P2 (value of post-test knowledge) = 70.9%

Therefore,

$$n = 8.6\{30.8(100 – 30.8) + 70.9(100 – 70.9)\}/(30.8 – 70.9)^2$$

$$n = 8.6\{30.6(69.2) + 70.9 (29.1)\}/(-40.1)^2$$

n = 8.6(2131.36 + 2063.19)/1608.01

n = 8.6(4194.55)/1608.01

n = 36073.13/1608.01

n = 22.43

Therefore, the estimated sample size for the study was 22 participants in the trainee group.

If an attrition rate of 10% is expected, then the number of participants to be recruited for the study would be:

n = (100 x 22)/(100-10)

n = 2200/90

n = 24.4

n ~ 24

Therefore, at least 24prospective trainees (study participants) were recruited for the study in order to make up for possible attrition. This was because there was likelihood of some prospective peer counsellors discontinuing from the programme after being recruited or trained.

3.5 Sampling Method

Prospective volunteer mental health peer counsellors were recruited from the halls of residence. Notices of recruitment in the form of posters (see Appendix XVII) were placed on notice boards in all undergraduate halls of residence except in Alexander Brown Hall. The poster

solicited volunteers and had the telephone number and email address of a contact person (the researcher). Interested prospective volunteer peer counsellors then contacted the researcher through a supplied phone number or email address to indicate their interest in the programme.

Personality Test

Interested participants were invited for personality tests to ensure they possess desirable personality traits. This was to ensure that they were emotionally stable and could relate well with their peers. The Eysenck Personality Inventory (EPI) was used to assess personality (temperament) type, and it was used to specifically assess levels of extraversion and neuroticism. The extraversion and neuroticism scores were then used to classify the participants into one of four basic temperaments (see Eysenck Personality Inventory as explained in Data Collection Instruments).

Focus Group Discussion (FGD)

There was a pre-intervention assessment of the knowledge of the participants, using the modified mhGAP Knowledge Questionnaire (see Appendix XI), before the Focus Group Discussion (FGD). The recruited volunteers from all the halls of residence subsequently took part in the focus group discussions at Jaja Clinic, University of Ibadan. There were a total of three sessions of FGD, one session with female volunteers (seven participants) and two sessions for male volunteers (five participants per group). There was need for segregation of the volunteers on gender basis because their peer counselling activities would be hall (of residence)-based, and there was a need to reduce the level of inhibition, and forestall undue emotional

attachments that may arise if peer counsellors had to attend to clients of the opposite sex. The FGD sessions were held on March 30th and 31st, 2015. There were two sessions on March 30th and one session on March 31st.

Each session commenced with introduction of the researcher and all the Focus group Participants (FGPs). Using the FGD guide (see Appendix XII), the discussions commenced with all the FGPs participating actively. All discussions were moderated by the researcher, recorded with two digital voice recorders by two research assistants, and notes were taken by the researcher.

Peer Counselling Training Programme

The volunteer peer counsellors then had a training programme which took place over two days (8th and 9th of April, 2015). The training modules were prepared based on the training needs assessment at the FGD. The participants were trained on a total of eleven modules (see Appendix XVIII). This was followed by a post-intervention assessment of the knowledge of the study participants using the modified mhGAP Knowledge Questionnaire. Figure 1 is a flowchart depicting the research methodology.

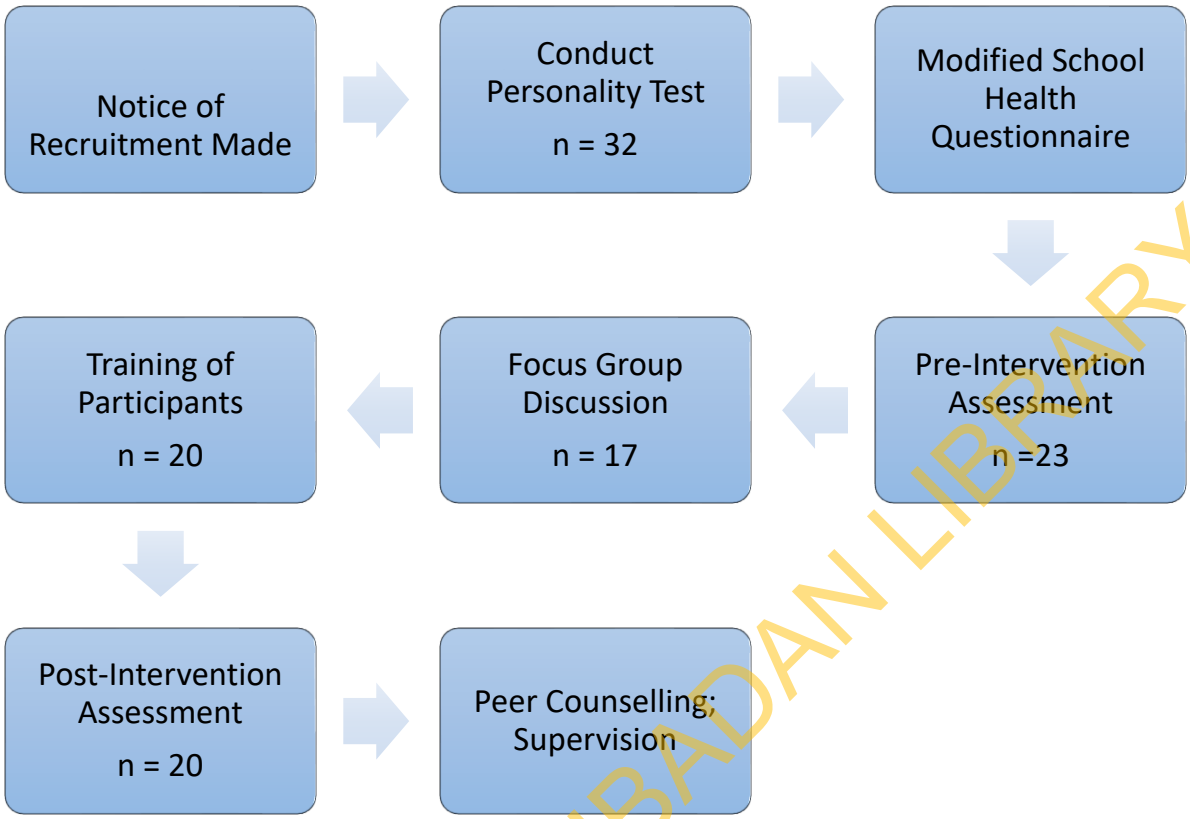


Figure 1: Flow Chart of Research Methodology

3.6. Duration of the Study

The entire study took place over a three-month period. The timeline for the study is as outlined in Appendix VII.

3.7 Data Collection Instruments

Four (4) instruments were used to collect data, and they included:

1. The Eysenck Personality Inventory (EPI); (see Appendix IX): The EPI is a brief questionnaire used to measure personality traits. It is a self-rating instrument that assesses neuroticism (emotional stability) and extraversion (sociability). Each dimension is measured by 24 questions, and an additional nine (9) questions for a Lie Scale which assesses for high desirability response. A high scorer on the neuroticism dimension is an anxious, worrying, moody and subsequently disturbed individual, while the low scorer on the neuroticism dimension is an emotionally stable individual that is usually calm, even-tempered, controlled and unworried. A high scorer on the extroversion dimension is considered an extrovert and is sociable, craves excitement, has many friends, needs to have people to talk to, is impulsive among others. A low scorer on the extraversion dimension is considered an introvert and is typically quiet, introspective, reserved and distant among others (Oladimeji, 2002). The results or scores from the two dimensions (neuroticism and extraversion) can be combined to determine an individual's temperament. The four basic temperaments include sanguine, phlegmatic, melancholic and choleric temperaments (Tans4mind, 2015).

2. Modified Socio-demographic (School Health) Questionnaire (see Appendix X): The socio-demographic questionnaire consisted of questions related to socio-demographic characteristics adapted from a questionnaire used in a previous study on adolescents in rural and urban Ibadan (Omigbodun et al, 2008). This was modified by the researcher of the current study and used to collect the socio-demographic data of all the study participants.

3. The Modified WHO mhGap Knowledge Questionnaire [(see Appendix XI). The WHO mhGAP Knowledge Questionnaire was modified by the researcher to suit the current study (WHO mhGAP, 2008)).

4. Focus Group Discussion Guide: This consists of a set of questions developed by the researcher to assess the opinions, experiences and training needs of prospective volunteer peer counselors (see Appendix XII).

Records of Activities of Peer Counsellors were obtained from:

i) Client attendance record (see Appendix XIII).

ii) Peer Counselling Activity Log Book (see Appendix XIV).

3.8. Procedure for Data Collection

The instruments of data collection were first pretested with some undergraduate students of the University of Ibadan who had not previously volunteered for the programme. This entire study was done in three parts consisting of a knowledge pretest and training needs assessment (through focus group discussions), training of prospective peer counsellors and post-test, then commencement of peer counselling services and supervision of the peer counsellors. Data was collected each time any of these activities took place.

Part I: Knowledge Pre-test/Training Needs Assessment

A knowledge pretest assessment was conducted to assess the baseline knowledge of the study participants. The mhGAP pretest questionnaire was modified by the researcher and used

for this purpose (see Appendix XI). Focus Group Discussions was conducted to determine the training needs of the volunteers. This assessed their level of knowledge and their attitudes towards mental illness, their personal experiences of mental illness (for example having a family member or friend who is living with a mental illness), what mental health services they want provided for the students of the university, and what specific mental health issues they wanted to be trained on. Three focus group discussions were conducted, each consisting of about 5 – 7participants. There was one FGD session for participants from the two female halls of residence, and two sessions for the study participants from the male halls of residence (see Table 1).

Table 1: Focus Group Discussion Schedule

FGD GROUP	Number of FGD	Number of Participants Per Session
Male	2	5
Female	1	7
Total	3	17

Each of the FGD session was held at the seminar room of the Maternity Building, Jaja Clinic, University of Ibadan, and was conducted by the researcher. Each session lasted for 45 minutes to one hour. The discussions were recorded using multiple battery-operated voice recorders. Voice recordings were subsequently transcribed, then analysed.

Part II: Training of Prospective Peer Counsellors

The training of prospective mental health peer counsellors took place over two (2) days. Training was aimed at increasing the ability of the peer counsellors to identify and refer commonly encountered mental health problems, and provide counselling and psychosocial support to the students in need. Findings from the Focus Group Discussion were used to design the contents for the training programme.

The focus of the training was on the identification and referral of students having mental health problems, and provision of counselling and psychosocial support. The facilitators for the training included the researcher and three other invited resource persons (including a psychologist, a physician and a nurse). The training lasted for about three hours each day, and the didactic and role play methods were employed. The Modules covered on the first day of the training included Introduction to Mental Health, Depression, Epilepsy, Psychosis, Bipolar Disorder and Stress. On the second day, they were taken on Alcohol and Drug Use Disorders, General Principles of Care, Communication Skills, Behavioural Emergencies and Peer Counselling. There was also role play on Epilepsy on the first day and a practical session on awareness creation during which short-message stickers were designed, on the second day of the training. Some modules included discussions on relaxation techniques and the participants were taught techniques like breathing exercises, progressive muscle relaxation and positive imagery.

The mhGAP training manual (or intervention guide) was developed by the WHO to increase the capacity of non-specialists or primary health care providers in the delivery of an integrated package of mental health care, by means of protocols developed for clinical decision making. Specific modules contained in the mhGAP training manual include those on General

Principles of Care, Depression, Psychosis, Epilepsy/Seizures, Developmental Disorders, Behavioural Disorders, Dementia, Alcohol Use Disorders, Drug Use Disorders, Self-harm/Suicide, Other Significant Emotional or Medically Unexplained Complaints, and Conditions Specifically Related to Stress.

After the training on identification of specific mental health issues, the peer counselling trainees were then taught how to record and keep logs of the peer counselling activities they conduct(record keeping). Finally, there was a discussion on the roles and responsibilities of the volunteer peer counsellors. The trained mental health peer counsellors were made to realize the need to be committed to the programme and always remember that the training is not for personal benefit, but for the benefit of others in need. A knowledge post-intervention test was conducted immediately after the training to assess the effectiveness of the training.

Part III: Commencement of Peer Counselling Services

- **Commencement of peer counselling services**: Post-training, peer counselling services commenced in the halls of residence. Trained peer counsellors kept logs of services rendered, using the Management Information System (MIS) forms. Standard recording forms that were adapted from a format used in a previous HIV peer counselling training programme done in the University of Ibadan to train peer educators to conduct peer-led education activities aimed at HIV/AIDS prevention (see Appendix XV and Appendix XVI), were given to the trainees, who used these to record every peer counselling activity.

- **Supervision of Peer Counsellors**: This was done over a three-week period through mobile phone communication and one meeting with the trained mental health peer counsellors on Tuesday 28th of April, 2015 at Jaja Clinic, University of Ibadan. The meeting gave the mental health peer counsellors opportunities to identify problems they have observed with counselling sessions, and the peer counsellors provided motivation for one another. In addition, the meeting provided an opportunity to update the knowledge of the trained mental health peer counsellors by supplying them with additional information. The filled record sheets where they recorded counselling activities were collected from them, and they were motivated with incentives as appropriate (some phone air time).

3.9 Data Management and Analysis

The recordings of the FGD were transcribed and statements (responses) from the Focus Group Discussion were coded to determine emergent themes. Recurrent themes were then identified, and analysis of the themes was done. This guided the development of the content for the peer counselling training programme.

The quantitative data obtained from the study was analysed using the 21st version of the Statistical Package for the Social Sciences (SPSS 21) software. Frequency distribution of socio-demographic data of the participants (from the modified school health questionnaire) was done. The results of the knowledge pre-test and post-test were compared using the paired t-test

analysis. The pre and post intervention knowledge of the participants were also compared with the demographic characteristics of the participants using a paired t-test analysis.

Descriptive analysis to obtain the frequency distribution of records that were kept by the trained peer counsellors, including client attendance record (see Appendix XIII) and peer counselling activity log (see Appendix XIV) was done. The client attendance record contained information about the peer counsellor's identity, sex, date of consultation, client identity, hall of residence, department/level, email address, phone number and subject/nature of counselling. The peer counselling activity log book included information about the client's identity, sex, age, hall of residence, department, peer counsellor identity, presenting complaints, intervention or referral (and reason for referral).

3.10. Ethical Considerations

Ethical approval was obtained from the Ethical Review Committee of the Oyo State Ministry of Health (see Appendix IV). Permission was also obtained from the Student Affairs Division of University of Ibadan (see Appendix VI). Individual informed consent was obtained from the prospective participants of the study (see Appendix VIII), with the following clarification:

1. CONFIDENTIALITY OF DATA: The prospective participants who are volunteers were identified by a triple digit serial number. Personality, knowledge pre- and post-tests were administered to the study participants and results of these were kept safely and securely by the researcher. In addition, the study participants were taught the rudiments of

confidentiality and they were encouraged to strictly observe same for all counselling and record keeping activities. All data collected were used for research purpose only.

2. BENEFITS TO THE PARTICIPANTS: The main aim of the study is to train undergraduate university students, at no cost, to provide mental health peer counselling services to their fellow students in need. The study participants stand to acquire skills that will help them identify and refer students with mental health issues, and meet the psychological needs of some of them. These skills may also be beneficial to the participants personally, and the training imparts on them a sense of duty and responsibility. The training will also develop their communication and leadership skills.

3. NON-MALEFICENCE TO PARTICIPANTS: The training did not expose the participants to any physical harm. There may have been a bit of emotional disturbance before the training, particularly during the focus group discussion when questions about personal experiences with mental illness (self, family and friends) were asked, although they were not obliged to reveal personal information. However, it was believed that post-training, a better understanding of the various forms of mental illness will resolve any lingering emotional distress.

4. RIGHT TO DECLINE/WITHDRAW FROM THE STUDY: The participants were informed that they individually had a right not to consent to take part in the study, or to withdraw at any point in time without being victimized subsequently. The researcher was responsible for all costs that were incurred in the course of the research work, while the participants were duly compensated with some incentives (phone airtime).

CHAPTER FOUR

RESULTS

QUALITATIVE DATA

4.1 Focus Group Discussion Findings

A total of seventeen volunteers participated in the FGDs. There were three separate groups, one for participants from the female halls of residence, and two for participants from the male halls of residence. Each FGD lasted between45 minutes and one hour. Ten (58.8%) of the participants were male, while seven (41.2%) were female.

4.1.1 Findings

Knowledge of Mental Illness

Mental illness was described by the focus group participants with terms like "mentally incomplete", "disturbed", "a deviation from oneself", "emotionally down", "constantly depressed", "psychologically unfit/unbalanced", "battling with things within oneself", "a deficiency in the mind", "any illness that causes deviations from normal", "abnormal behaviours", "derailing of the mind from reality", "not being in the right state of mind", "malfunctioning of one's brain". This is supported by a quote from a male FGP thus:

"I think it is all about disorderliness of the brain; and most times, while people see something as red, you may see it as white (not literally)".

One of the male FGPs said *"Mental illness is the malfunctioning of one's brain as a result of the absence of the person's defense mechanism; without the functional defense mechanism, there will definitely be mental illness".*

The participants identified specific mental illnesses to include depression, hallucination, poor eating habits, schizophrenia, fatigue, stress, insomnia, drug addiction, unnecessary anger, transfer of aggression, bipolar disorder, multiple personality disorder, psychosis, and ADHD.

Common Names/Terms Used to Describe Mental Illness on Campus

The FGPs volunteered a total of 20 names/terms that are used to refer to or describe mental illness or people experiencing mental health problems. Table 2 below is a list of the names/terms.

TABLE 2: Common Names/Terms Used to Describe Mental Illness on Campus

S/NO	NAME/TERM	TRANSLATION OF THE LOCAL TERMS
1	"wéré!"	Mad person
2	"scoin-scoin"	Mentally deranged
3	"Aro"	Location of one of the Federal Neuropsychiatric Hospitals in Nigeria (Aro, Abeokuta, Ogun State)
4	Imbalance	
5	Breakdown	
6	"kolo"	Mentally deranged
7	"nkan ti tasi l'opolo"	Something has splashed onto his/her brain.
8	Mood switch	
9	Issues	
10	Brain touch	
11	Psycho	
12	Madness	
13	'West G"	West West Ground (One of the Psychiatric Wards at the University College Hospital, Ibadan, Oyo State)
14	"inwin"	Insanity
15	"eleyi s'inwii"	This person is insane
16	"Alasé	Out of context
17	"iwé!"	Book!
18	Prof	Professor
19	Unbalanced	
20	Yaba Left	Location (bus-stop) of a Federal Neuropsychiatric Hospital in Nigeria (Yaba, Lagos State)

Participants Perceived Causes of Mental Illness

The family (background/pressure), peer pressure and stress were the commonest themes that emerged from the FGPs as causes of mental illness. Others include inferiority complex or low self-esteem, relationship problems (break-ups), anxiety, genetic causes (heredity), culture clashes, women, substance abuse and loneliness. Experiences which one cannot handle, like with lecturers or academic work was also mentioned as a possible cause of mental illness among students. For instance, a male Focus Group Participant reported the cause of mental illness as follows:

"I think the first cause is the family background. The family background goes a long way in influencing the development of a mental illness and it reaches to one's finances which, when unstable, may lead to depression. They are all interwoven - one thing leads to another; it's like a chain of reactions".

Another male FGP identified *"A separated home, for example".*

"If the person is from a good and stable family, but in school he attaches himself to bad friends, the desire to associate with them may overcome his desire to do good; and this may lead to negative activities which could cause harm to the individual as well as his family, and consequently lead to a mental illness."

Knowledge of Signs and Symptoms of Mental Illness

The participants described various indicators of mental illness in those affected. Such indicators include abnormal behavior, abnormal appearance, abnormal speech, wrong reactions to situations, poor sleep, being unusually quiet, sudden withdrawal by someone who used to be

very vibrant, deteriorating academic performance, abnormal weight gain, getting afraid easily, avoiding of social interactions, moodiness, distorted/faulty thinking, and faulty perception. According to one of the male FGPs,

"Normally, males wear trousers; but if a male should go on to put on a skirt, then something is wrong somewhere. Thus, even from appearance, we can detect errors in individuals. Also, the composure – the way one talks and looks, could help indicate that one is mentally disturbed."

One of the female participants felt being quiet does not necessarily connote mental illness, as outlined below:

"Most times, it might not really be identified from being quiet because a number of people are naturally quiet. They just like being quiet. I think it could be from the way the person talks; when you ask the person a question, the reply received may indicate that something is not right with the person. They may also use drugs excessively and they may regularly feel 'sick'. In class, they may also have difficulty interacting with their lecturers."

A female participant said: *"Discussions with the person don't feel like discussions; the person is just uninterested."*

One of the male participants also said: *"Also a situation whereby a person talks unnecessarily and pointlessly, and has difficulty in moving on from one topic of discussion to another (persistently maintaining a topic of discussion for no reason whatsoever) would indicate a mental illness in the person."*

Resources Available in University of Ibadan for Prevention and Management of Mental Illness

Surprisingly, a sizeable number of the FGPs were not aware of any of the resources available on campus to treat students with mental health issues. However, Jaja Clinic, the Youth Friendly Centre, and the Students Help Centre (Faculty of The Social Sciences) were mentioned by some of the FGPs. In addition, some departments are said to have guidance counsellors (although they are of the opinion that students hardly go there). The Gender Mainstreaming Group was also mentioned, which the male FGPs felt is a feminist resource that is focused only on empowering females. The FGPs feel publicity about these available resources is very poor.

All the FGPs felt that students experiencing mental health challenges are not being adequately cared for, especially since the conditions of many of them "escalate" during exams.

Academic Functioning of Students with Mental Illness

All The FGPs are of the opinion that people having mental health issues should be allowed to attend school. Reasons given include the opinion that they are normal people with problems, it is their constitutional rights, and that their performances can improve with treatment. They also opined that this depended on the severity of the illness. Further discussions resulted in diverse opinions such as:

"Yes, they should be in school because I believe that with proper treatment, they can do well in school. Some of these students can actually function in key roles if they are tailored rightly."

"We are the same and so we ought to have equal opportunities; they just need to know their limits."

"People with mental illnesses are actually normal people with problems, so it's just about facing problems and most times, the key to facing problems is to interact with people."

"Yes, they should be in school, but provisions should be made to cater for their mental illness."

"It depends on the mental illness and the severity of the illness on the individual. I think some people develop mental illnesses in school, resulting from various challenges associated with schooling. However, if they can cope with schooling while handling the mental illness, then they should be in school. In my opinion, it is important that they get help in school before going to face the rest of the world."

*"Constitutionally, they are to be allowed because it is their right – they have rights to education, and if at all they are violent or destructive, then it is the duty of the management to invite or to collaborate with medical experts or social workers to be in guide of such a person. This is because if such a person can really be rehabilitated, he can be a better person to the society and perhaps even be worthy of emulation to others. The reason I say they should be allowed is resulting from my little experience with a mentally ill individual; this young man, with the aid of little things from the church and friends, represented and won a prize for the University of Ibadan. So if such a person is deprived of education, he becomes a nuisance to the society rather than a hero in the society (*response from a male participant)*."*

Knowledge of Effect of Mental Illness on an Individual

Common identified themes here include daily functioning, thought patterns, academics, concentration, relationships, social life, religiously, self-esteem. According to some FGPs, "it affects the individual in all ramifications of life".

Perceived Ways of Assisting Persons Experiencing Mental Health Issues to Cope Better in School

The FGPs suggested that the provision of proper and adequate treatment facilities (including counsellors at faculties/departments, mental institutions), social support (from family/friends/peers), empathy, sensitization programmes (including awareness campaigns and orientation for fresh students). They also suggested prompt identification, treatment and regular (daily) monitoring of such individuals.

"There should be awareness campaigns as with HIV/AIDS. Some people think it's just part of them like 'Maybe I just have random sudden outbursts of anger', but they are unaware of their condition; if they are made aware of their condition, then they could seek aid. They should also inform friends and family so that these friends and family can relate better with them."

Knowledge of and Personal Experience with Persons Suffering from Mental Health Issues

Almost all the FGPs know, or have ever had personal encounters with persons suffering from a mental illness, and majority of them described their experience as scary. One FGP found it amusing at first, but became scared when the person got worse. Another FGP described it as:

"It was scary - someone you know transforming into someone you don't know."

Another response indicated the need to communicate with individuals suffering from mental health issues.

"I've had experiences with mentally ill people, and I try to reach out with words. 'Impression without expression leads to depression' - a lot of people don't want to talk sometimes, but it helps to just let it out."

Perceived Roles of Family/Peers/Friends in the Development of Mental Illness

The FGPs stressed that the family plays a significant role in the development of mental illness, by being over demanding, mounting excessive pressure, being intolerant, being unsupportive, and being physically and verbally abusive. Lack of care and rejection of a person by the family were also mentioned.

Friends/peers are said to contribute to the development of mental illness by bullying, mounting pressures, telling expensive jokes at the expense of the person, disappointments and relationship problems.

Perceived Roles of Family/Peer/Friends in the Treatment of Mental Illness

The FGPs were of the opinion that the role the family/ friends/peers play can have a significant impact on the treatment of an individual suffering from mental illness. Some of the roles mentioned include providing care and affection especially during rehabilitation, being understanding, accepting the person, and providing support and guidance. Love and friendship are said to be key factors in caring for the person suffering from mental illness. Giving persons with mental illness their due respect, encouraging them, playing with such persons, being good listeners to them, and not judging them too quickly were also suggested as ways of helping them. According to one of the FGPs,

"Friends are key because the mentally ill don't often take themselves to the help facilities, but it's their friends especially that help them."

Another FGP had this to say:

"Friends and family have a big role to play. In the story of Ben Carson (a renown paediatric neurosurgeon), we can see the role his mother played in guiding Ben Carson, even when he was facing difficulties."

Willingness to be a Helper/Friend to a Person Experiencing Mental Health Issues

All the FGPs indicated that they would definitely like to be friends/helpers of persons experiencing any form of mental health issues.

Perceived Training Needs of Prospective Volunteer Peer Counsellors

The ability to identify symptoms of particular illnesses, how to assess and how to handle some cases, how to approach persons with mental illness, listening and understanding skills, how to be patient and focused were mentioned. The FGPs feel they will also need to learn to be sensitive, empathic and trustworthy, and learn about the various temperaments. The need to be prayerful, diplomatic and trustworthy were also mentioned.

"Patience with them, understanding what they are going through (if I don't understand what the person is going through, I doubt I'd be able to show empathy or relate with the person), tolerance with them, and also to be able to make myself available whenever they need my help."

"It's also important to be very diplomatic in replying to situations/questions because people with mental illnesses have 'walls' which they don't easily let people climb; so to get to understand them well, one has to be diplomatic."

QUANTITATIVE DATA

4.2 Socio-Demographic Characteristics of the Trained Peer Counsellors

A total of 20 student volunteers underwent training as mental health peer counsellors (twelve of the volunteers either did not present at all for the training or did not complete the training). The mean age of the volunteer peer counsellors was 20.2 (±2.6) years. Sixteen (80.0%) of the volunteers were between 16 and 20 years of age, 3 (15.0%) were between 21 and 25 years while 1 (5.0%) was between 26 and 30 years of age. There were 9 (45.0%) male and 11 (55.0%) female volunteers. Nineteen (95.0%) of them were Christians while only 1 (5.0%) was Muslim. Sixteen (80.0%) were Yoruba by tribe, 3 (15.0%) were Igbo while 1 (5.0%) was efik/Ibibio.

A total of 18 (90.0%) of the volunteers were from monogamous homes, while 2(15.0%) were from polygamous homes. The parents of 16 (80.0%) of them were still married, 2 (10.0%) of them had lost their fathers, and those of 1 (5.0%) of them were divorced.

Four (20.0%) of the volunteers were of the Obafemi Awolowo Hall, 4 (20.0%) were of the Queen Idia Hall, 3 (15.0%) were of Queen Elizabeth II Hall, 3 (15.0%) were of Tedder Hall, 2 (10.0%) each were from Independence and Kuti Hall, while 1 (5.0%) each were from Nnamdi Azikiwe and Sultan Bello Hall.

All the twenty (100%) volunteers affirmed that they liked the University of Ibadan, being their current university. Sixteen (80%) of them felt they were doing well academically, while 3(15%) felt otherwise. About 5 (25%) of them felt they were having difficulties with their lecturers.

A total of 17 (85%) of the volunteers agreed that there are guidance counsellors in the university, however, only 7 (35%) of the volunteers have ever gone to see the guidance

counsellors. Meanwhile, 14 (70%) of them said they would go and see the university counsellor(s) if they had a problem. Table 3 below is a depiction of the socio-demographic characteristics of the volunteer peer counsellors.

TABLE 3: Socio-demographic Characteristics of the Volunteer Peer Counsellors (N = 20)

ITEM		n	%
Age (in years) **Mean age = 20.2 years** **S.D. = 2.6 years**	16 – 20	16	80
	21 – 25	3	15
	26 – 30	1	5
Sex	Female	11	55
	Male	9	45
Religion	Christian	19	95
	Muslim	1	5
Ethnic Group	Yoruba	16	80
	Igbo	3	15
	Efik/Ibibio	1	5
Faculty	The Social Sciences	6	30
	Science	4	20
	Education	3	15
	Law	2	10
	Arts	2	10
	Technology	1	5
	Pharmacy	1	5
	Public Health	1	5
Level	200	4	20
	300	9	45
	400	7	35
Hall	Queen Idia	4	20
	Obafemi Awolowo	4	20
	Queen Elizabeth II	3	15
	Tedder	3	15
	Independence	2	10
	Kuti	2	10
	Nnamdi Azikiwe	1	5
	Sultan Bello	1	5

4.3 PERSONALITY TRAIT (EPI)

A total of thirty-two volunteers took the EPI test (including the FGD participants). However, only twenty volunteers completed the training, hence, the EPQ result of the 20 trained peer counsellors was reported.

The EPI assessed for extraversion and neuroticism. The mean extraversion score was 9.9 (±3.1), the mean neuroticism score was 9.6 (±4.2). The scores from both domains were used to categorize the prospective peer counsellors into the four temperaments namely sanguine, phlegmatic, melancholy and choleric. Thirteen (65.0%) of the volunteers were found to possess phlegmatic temperaments, 4 (20.0%) had sanguine, 2 (10.0%) had melancholy while 1 (5.0%) had choleric temperaments (see Appendix XXIII). Figure 2 below is a bar chart depicting the temperaments of the volunteer peer counsellors.

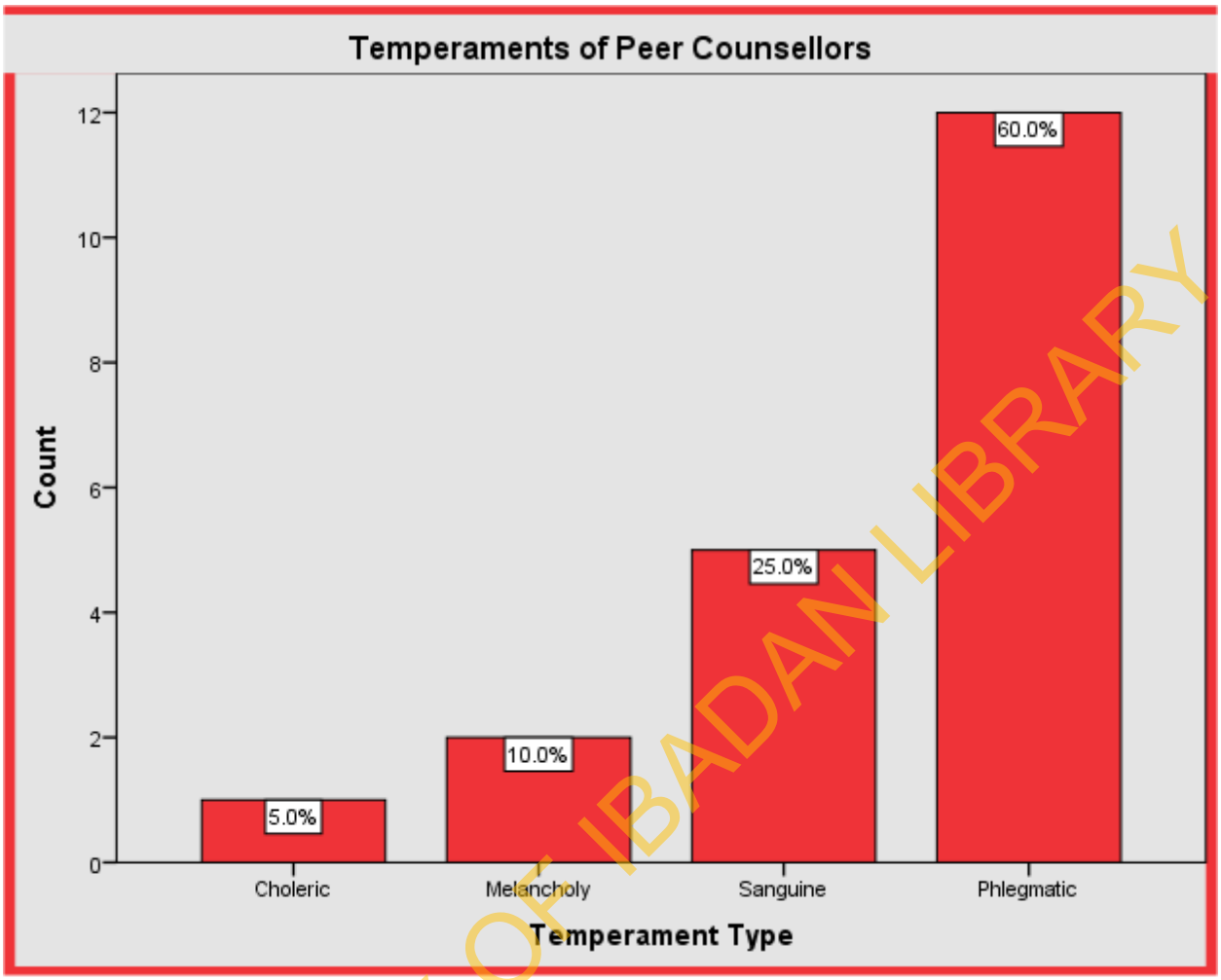


Figure 2: Temperaments Types of the Volunteer Peer Counsellors

Table 4 is a representation of the demographic distribution of the participants across the four temperaments. About 25.0% and 35.0% of the male and female participants respectively had predominantly phlegmatic temperaments, while 15.0% and 10.0 of the male and female participants respectively had predominantly sanguine temperaments. Fifty percent of the 16-20 years old participants had phlegmatic temperaments while 15.0% of them had sanguine temperaments. Among the 20-25 year old participants, 10.0% had phlegmatic temperaments

while 5.0% had sanguine temperaments. Based on level of study, 25.0% of the participant in 300 level had melancholy, 25.0% had phlegmatic and 10.0% had sanguine temperaments.

Table 4: Demographic Distribution of the Temperaments of the Participants (N = 20)

Demographic Factor		Type of Temperament				
		Sanguine n (%)	Phlegmatic n (%)	Melancholy n (%)	Choleric n (%)	Total
Sex	Male	3 (15)	5 (25)	1 (5)	0 (0)	9 (45)
	Female	2 (10)	7 (35)	1 (5)	1 (5)	11 (55)
Age (years)	16-20	3 (15)	10 (50)	2 (10)	1 (5)	16 (80)
	21-25	1 (5)	2 (10)	0 (0)	0 (0)	3 (15)
	26-30	1 (5)	0 (0)	0 (0)	0 (0)	1 (5)
Level of study	200	0 (0)	3 (15)	0 (0)	1 (5)	4 (20)
	300	2 (10)	5 (25)	5 (25)	0 (0)	12 (60)
	400	3 (15)	4 (20)	0 (0)	0 (0)	7 (35)
Faculty Group	Education/Arts	2 (10)	2 (10)	0 (0)	1 (5)	5 (25)
	Soc Science/Law	2 (10)	6 (30)	0 (0)	0 (0)	8 (40)
	Science/Technology	1 (5)	3 (15)	1 (5)	0 (0)	5 (25)
	Public Health/Pharmacy	0 (0)	1 (5)	1 (5)	0 (0)	2 (10)

4.4 PRE-TEST AND POST-TEST SCORES

A total of 20 volunteers completed knowledge pretest, training programme and the knowledge posttest. The mean knowledge pretest score was 24.0 (±2.3) while the mean knowledge posttest score was 27.5 (±1.2). Out of a total of 30 points, the minimum pretest score was 18, while the maximum pretest score was 28 points. The minimum post-test score was 26 points and the maximum post-test was 30 points (see Figure 3 below).

Figure 3: Bar Chart Depicting the Mean Knowledge Pretest and Posttest Scores of the Volunteers

4.4.1 Analysis of Knowledge Pretest and Post-test Scores

A paired t-test analysis of the pretest and posttest scores revealed a mean difference of 3.5 with a 95% confidence interval of 2.3 to 4.6. The test statistic twas6.4 with a degree of freedom (df) of 19 and a p-value of 0.00 (see Table 5).

Table 5: Result of the Paired T-test Analysis of the Knowledge Pretest and Posttest

Paired Differences					t	df	p-value
Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
			Lower	Upper			
-3.45000	2.42	.54035	-4.58096	-2.31904	-6.4	19	.00

4.4.2 Demographic Characteristics of the Respondents and Outcome of Training

Table 6 below represents the outcome of training on the knowledge of the participants based on their demographic characteristics. There was a significant change in knowledge in both the male and female participants (p = 0.004 and p =0.001 respectively), in only the 16-20 year old group of participants (p = 0.00), and in participants according to level of study (p = 0.02, p= 0.01andp=0.04 for 200, 300 and 400 level respectively). Likewise, there was significant change in the knowledge of the participants based on their faculties.

Table 6: Demographic Characteristics and Outcome of Training (N = 20)

		Pre-test		Post-test		t-test
		n	$\bar{x}$ (±s.d)	n	$\bar{x}$ (±s.d)	
Sex	Male	9	24.7 (2.3)	9	27.6 (1.5)	t= 4.0;df = 8; p=0.004
	Female	11	23.5 (2.3)	11	27.4 (0.9)	t = 4.9; df = 10; p = 0.001
Age (in years)	16-20	16	23.5 (2.6)	16	27.3 (1.1)	t = 6.5; df = 15; p = 0.000
	21-25	3	26.0 (2.0)	3	27.3 (0.6)	t = 0.91; df = 2; p=0.46
	26-30	1		1		
Levels	200	4	23.8 (1.0)	4	27.0(0.8)	t= 4.3; df= 3;p= 0.02
	300	9	23.5 (2.3)	9	27.4 (0.9)	t = 4.9; df = 8; p = 0.01
	400	7	25.0 (2.1)	7	27.4 (1.3)	t = 3.0; df = 6; p = 0.04
Faculty	Education/Arts	5	24.0 (2.0)	5	27.2 (1.3)	t = 3.3; df = 4; p = 0.03
	Social Science/Law	8	25.3 (1.8)	8	27.9 (1.4)	t = 3.6; df= 7; p= 0.009
	Science and Technology	5	22.8 (1.3)	5	27.0 (1.0)	t= 8.6; df= 4; p=0.001
	Public Health/Pharmacy	2	22.0 (5.7)	2	27.5(0.7)	t = 1.22; df= 1; p = 0.44

4.4.3 Personality Type and Outcome of Training

A paired t-test analysis was done to determine the outcome of training among the different types of temperaments revealed significant changes in the post-test knowledge in all groups except for the choleric temperament group which was not analysed on account of an insufficient sample size. There was statistically significant change in knowledge among those with sanguine (p = 0.04), phlegmatic (p = 001) and those with melancholy temperaments (p = 0.04), as shown in Table 7 below.

Table 7: Personality Type and Outcome of Training

Temperament Type	Pre-test		Post-test		t-test
	N	$\bar{x}$ (±s.d)	N	$\bar{x}$ (±s.d)	
Sanguine	5	24.2 (2.6)	5	27.6 (1.8)	t = 2.9; df = 4; p = 0.04
Phlegmatic	12	24.1(2.4)	12	27.5(1.1)	t = 4.7; df = 11; p = 0.01
Melancholy	2	23.5 (3.5)	2	27.0 (0.0)	t = 1.4; df = 1; p= 0.04
Choleric	1		1		Not applicable

4.4.4 Cumulative Grade point Average (CGPA) and Knowledge Pretest and Post-test

The mean CGPA was 4.2 (±1.1). A Pearson correlation analysis was done to determine the extent of linear relationship between the CGPA and the knowledge pretest and post-test score. Analysis revealed a correlation coefficient of r = 0.24, p> 0.05 for pretest, and a correlation coefficient of r =0.26, p> 0.05 for the knowledge post-test. This implies that there is a positive but weak relationship between the participants' CGPA and their pre and post intervention knowledge. The relationship was, however, not significant (See Table 8 below).

Table 8: CGPA and Pre and Post Intervention Knowledge.

	Mean CGPA	**r**	**p-value**
Pretest	4.2 (±1.1)	0.24	0.32
Post-test	4.2 (±1.1)	0.26	0.28

4.5 Post-Training

4.5.1 Peer Counselling Activities

Thus far post-training, the trained mental health peer counsellors have only been able to engage more in raising awareness about mental illness by means of information and educational stickers designed during the training programme. Only three of them had attended to clients, and only two clients had been referred to the clinic so far (see Table 9 below).

Table 9: Data from MIS Forms

Number of clients seen = 2

S/No	Nature of problem	Action of Peer Counsellors
1.	1. Relationship problems. 2. Abnormal thought and speech	• Psycho-education • Referral
2	1. Academic problem	• Psycho-education • Behavioural modification

4.5.2 Supervision of Peer Counsellors

A meeting was scheduled with the trained peer counsellors three weeks post-training. The meeting held at 2pm on Tuesday, the 28th of April, 2008 at Jaja Clinic, University of Ibadan. Only three of the trained peer counsellors were in attendance while one sent her apologies for not

being able to attend. The activity log sheets were submitted by those who had attended to some clients.

The peer counsellors present were each notified of their temperament based on the analysis of the EPQ they each completed. They were also each presented with a copy of the strengths and weaknesses of each temperament. There was a lengthy discussion about the temperaments as each of them sought to know the implication of their temperaments on relating with clients. Finally, a record of the number of mental health peer counsellors who attended the supervisory meeting was kept. They were encouraged to contact the supervising mental health specialists so as to seek assistance whenever necessary.

4.6 Limitations of the Study

Despite the conclusions drawn, there were limitations in the study. For instance, there was no initial community (campus)-wide survey to determine their mental health issues and treatment needs. Another major limitation of the study concerns the relatively unpredictable nature of the annual academic calendar of the university which caused a lot of delay in the commencement of activities for the training programme. The unstable and threatening political atmosphere at the commencement of the new academic session also affected the programme. Some volunteers were not allowed to return to school by their parents, until after the presidential and gubernatorial elections in March/April, 2015.

The highly variable nature of the academic time-table of the volunteers was also an issue. The training programme, on each of the two days had to commence at 2pm with the hope that most of the volunteers would have had all or most of their lectures for the day. That left us with

short training periods each day (3 hours) as there was need to prevent fatigue in the participants. The duration for follow-up and assessment of the activities of the peer counsellors had to be shortened due to the delayed resumption of students, vis-à-vis the time-frame for the study. Nevertheless, the outcome of the study provides greater insight to the understanding of the training needs that will enable the participants to be effective as peer counsellors. Finally, the study has provided the framework to promote mental health advocacy, especially among adolescents and young adults.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Socio-Demographic Characteristics of Study Participants

The study participants were mainly adolescents/young adults, with ages ranging from 16 to 29 years. This age range is quite ideal as it is representative of the various undergraduate age groups. There were more female than male volunteers, more Christians than Muslims and most of the volunteers were of the Yoruba ethnic group.

All the undergraduate halls of residence except Mellamby Hall, were represented with Obafemi Awolowo and Queen Elizabeth II Hall having the highest number of representatives. There was a volunteer from Mellamby hall but he did not turn up at all for any part of the study.

The volunteers came from the various academic faculties in the university, with the Faculty of The Social Sciences having the most number of representatives, followed by the Faculty of Science. Meanwhile, the Faculties of Pharmacy, Technology and Public Health had the least number of representatives. There were no representatives from the Faculties of Basic Medical Sciences, Agriculture and Wild Life/Forest Resources Management.

5.2 Focus Group Discussion

5.2.1 Knowledge about Mental Illness

Responses elicited from the FGPs revealed a diverse array of concepts of mental illness. The participants believed mental illness to include problems like deviation from oneself, being

disturbed, being emotionally down, being psychologically unfit or imbalanced, battling with things within oneself, not being in the right state of mind, malfunctioning of the brain, and a host of others. This revealed that the FGPs generally had some idea of what mental illness is about, albeit somewhat vague and stigmatizing.

The FGPs also correctly mentioned some common mental health disorders such as schizophrenia, depression, psychosis, ADHD, bipolar disorder, drug addiction, anger (management) issues and a host of others. These identified disorders were however, mentioned mostly by FGPs who were students of the Department of Psychology who may have had formal lectures on mental health disorders.

5.2.2. Common Names/Terms Used to Describe Mental Illness on Campus

"Wéré!", "scoin-scoin", "Aro", "imbalance", "breakdown", "kolo", "nkan ti tasi l'opolo", "mood switch", "issues", "brain touch", "psycho", "madness", "Prof", "iwé!", "Alase", "eleyi s'inwii", "inwin" "West West G" (West West Ground), "Yaba Left" and "unbalanced" were names/terms used to describe those with mental health issues on campus. These terms are obviously derogatory and stigmatizing and may themselves have negative impact on the mental health of the affected person. Apart from the local names, most of the names given by the participants are quite similar to those mentioned by the participants in a study that took place in England, to explore the role of stigma in relation to treatment avoidance (Rose et al, 2007). This revelation highlights the fact that stigmatization is still a problem in mental health care across cultures.

Stigmatization not only lowers the self-esteem of those affected, it may lead to mood disorder and poor treatment adherence (pharmacological or non-pharmacological). Hence, the

trained peer counsellors would have to make extra efforts (such as increasing activities aimed at raising awareness of the problem of stigmatization) to address this issue so that individuals experiencing mental health issues would feel free to seek their services.

5.2.3 Participants Perceived Causes of Mental Illness

The FGPs mentioned family problems, peer pressure and stress as common causes of mental health issues among students. They also mentioned issues like inferiority complex, low self-esteem, relationship problems, anxiety, genetic inheritance, culture clash, women, substance abuse, loneliness, and problems with academics (including problems with lecturers or poor academic performance) as causes of mental health issues.

These factors mentioned above are established causes of mental health problems. For example, family structure and functioning has been found to profoundly affect the psychological well-being of individuals. A previous study reported by Huygens (1982) identified psychological and social characteristics of parents as strongly correlated with the frequency of illness in their children. This is in line with the perceived causes of mental health problems as reported by the FGP in the present study. Therefore, genetic transmission is one of the established means of acquiring mental health issues.

Apart from the genetic factors, FGP also mentioned that substance abuse, inferiority complex, low self-esteem and poor academic performance (intellectual problems) are established psychological causes of mental health problems as they eventually almost always lead to mood disorders if not detected and managed early. Social problems such as relationship problems, culture clash, and loneliness do eventually result in mental health problems especially if the affected individuals possess poor coping skills or mechanisms. These findings are also similar to

those reported by Omigbodun et al (2004) that assessed the stressors and counselling needs of undergraduate nursing students in Ibadan. The same study revealed that common stressors included excessive schoolwork, financial problems, inadequate recreational facilities, and overcrowded accommodations, and a revelation of an association between reporting inconsiderate, insensitive lecturers as stressors and evidence of psychological distress. The findings also corroborate a previous study by Aluede et al (2006) in a Nigerian University, which showed that irrespective of students' residential status, gender, age and relationship status, the students indicated drug concerns, family problems, career needs, relationship problems, finance, sexual harassment, academic ability, personality types, anxiety/depression, differential treatment and self-evaluation.

It is important to note that none of the FGPs mentioned spiritual factors contrary to the widely held cultural belief as a cause of mental health issues. The position is salient due to the strong belief in spiritual causes of mental health challenges in this part of the world, such that there is greater tendency to first seek for a solution in spiritual houses or homes before visiting the hospital or formal health setting.

5.2.4 Knowledge of Signs and Symptoms of Mental Illness

Responses from the FGPs revealed an impressive level of awareness of the tell-tale signs of mental illness in an individual. Some of these included abnormal behavior, abnormal appearance, abnormal speech, wrong reactions to situations, poor sleep, being unusually quiet, sudden withdrawal by someone who used to be very vibrant, deteriorating academic performance, among others. This is an indication that the trained mental health peer counsellors would have little or no difficulty identifying individuals experiencing mental health problems,

especially those exhibiting externalizing symptoms or behaviours. On the long run, this would enhance their peer counselling activities.

5.2.5 Resources Available in University of Ibadan for Prevention and Management of Mental Illness

Most of the FGPs were not aware of the resources available for the management of persons with mental health issues on campus. Surprisingly, they were also not aware that a mental health unit is fully functional at the University health Service (Jaja Clinic). However, Jaja Clinic, the Youth Friendly Centre, and the Students Help Centre (Faculty of The Social Sciences) were mentioned by some of the FGPs. Some departments are said to have guidance counsellors (although they are of the opinion that students hardly go there). The Gender Mainstreaming Group was also mentioned, which the male FGPs felt is a feminist resource that is focused only on empowering females. This trend is quite worrisome as the university usually organizes orientation programmes for newly admitted students and information about health care services is often provided during this period. In addition, if students are not aware of the existence of such services or centres then they would definitely not know to seek professional help if and when needed. Hence, they may suffer unduly, enduring mental health problems while struggling with their academic activities. This in turn may adversely affect their academic performance, and poor academic performance may in turn aggravate the mental health problem, setting off a vicious cycle.

These findings are supported by those of Kitzrow (2003) in a review of the mental health needs of college students in the United States of America. It revealed that students themselves

are often not aware of the available mental health resources on campus or may be reluctant to use them.

However, it was found that the FGPs feel publicity about these available resources is very poor. This opinion is corroborated by the large number of FGPs who were not aware of the existence of facilities or resources available on campus to manage students with mental health issues. Kitzrow (2003) recommends an ongoing education, outreach, and advertising campaign to inform students about mental health issues and encourage them to use the services available to them. Therefore, in the present study, the trained mental health peer counsellors are expected to engage in activities to create awareness of availability of the various mental health care services available on campus.

The volunteers reported that students suffering from mental health issues are not adequately cared for by the university. According to them, the rate at which students with mental illness break down or relapse during end-of-semester examinations confirm the assertion. The increased rate of relapse of persons experiencing mental health problems may actually be a reflection of the fact that such persons are exposed to greater stress levels during examinations or possess less than optimum coping skills to function effectively when faced with challenges, including increased academic demands as seen during examination period.

5.2.6 Academic Functioning of Students with Mental Health Issues

Participants strongly opined that persons experiencing mental health issues should be allowed to be in school as it is their constitutional right. Excluding them from school would not only be stigmatizing but also deny the victim an opportunity for personal development and

subsequent adaptive functioning in life. They reported that mental health issues can affect all aspects of an individual's life, that is, biologically, socially, psychologically and financially.

The FGPs suggested ways of assisting persons with mental health issues to cope better in school. Suggestions include the provision of proper and adequate treatment facilities (including counsellors at faculties/departments, mental institutions), social support (from family/friends/peers), empathy, and sensitization programmes (including awareness campaigns and orientation for fresh students). They also suggested prompt identification, treatment and regular (daily) monitoring of such individuals. Their suggestions can be summarized as the provision of bio-psycho-social care for individuals experiencing mental health problems. It will ensure optimal recovery such that academic functioning among others will be at its best. These suggestions are similar to those made by the respondents in the study by Omigbodun et al (2006) on the stressors and psychological symptoms in medical students and students of allied health professions in Nigeria.

5.2.7 Perceived Roles of Family/Friends/Peers in the Cause and Treatment of Mental Illness

The FGPs strongly felt that the family, friends and peers played major roles both in the cause and treatment of mental health issues. They identified the family as playing a significant role in the development of mental illness by being over demanding, mounting excessive pressure, intolerant, unsupportive, lack of care and rejection of a person, and being physically and verbally abusive. Friends/peers were said to contribute to the development of mental illness through acts like bullying, mounting pressures, telling expensive jokes at the expense of the person, disappointments and relationship problems. As mentioned earlier, the structure and function of

the family plays a role in the psychosocial predisposition of an individual to mental illness. The same goes for peers and friends, whose influence on an individual can sometimes even be greater than that of the family.

Some of the roles of family, friends and peers in the treatment of persons with mental illness include providing care and affection especially during rehabilitation, showing understanding, accepting the person, and providing support and guidance. Love and friendship are said to be key factors in caring for the person experiencing mental health issues. Giving persons with mental illness their due respect, encouraging them, playing with such persons, being good listeners to them, and not judging them too quickly were also suggested as ways of helping them. It is a known fact that the family, friends and peers can wield strong psychosocial influences in the perpetuation or mitigation of symptoms of mental illness. Hence, their roles in the causation of mental illness in an individual should always be explored so that these would be factored into measures to provide solutions for the individual experiencing the problem.

5.2.8 Peer Counselling Training Needs

The areas of need for their training, as indicated by them, included the ability to identify symptoms of particular illnesses, how to assess and how to handle some cases, how to approach persons with mental illness, listening and understanding skills, how to be patient and focused were mentioned. The training needs indicated by the volunteer mental health peer counsellors reflect the fact that they seem to have a reasonably good level of awareness of mental health issues are aware of what knowledge or skill they would need to render help to people with mental health problems. This is similar to the findings of Djalaninia et al (2013) whose research into the needs of youth peer educators in Iran revealed that majority of participants emphasized

on the importance of mental health and life skills as the main training topics, among others (Djalalinia et al, 2013). The FGPs felt they will also need to learn to be sensitive, empathic and trustworthy, and learn about the various temperaments. The need to be prayerful, diplomatic and trustworthy were mentioned as well. This is an indication that the volunteer mental health peer counsellors are aware of the fact that they would need to possess certain qualities to enable them function effectively as mental health peer counsellors. They also recognize the role of spirituality in the causation and treatment of mental health problems.

5.3 Personality Profiles/Temperaments of the Respondents

Based on the results of the EPI test taken by the study participants, they were classified into one of the four basic temperaments of sanguine, phlegmatic, choleric and melancholy. This classification represents their predominant temperament. However, an individual can possess a combination of two or more temperaments. Analysis of the EPI revealed that majority of the volunteer peer counsellors had phlegmatic temperaments, followed by those with sanguine temperaments.

Phlegmatic or stable introverts possess qualities like being even-tempered, reliable, controlled, peaceful, thoughtful, careful and passive. The sanguines are also known as stable extroverts and possess qualities like talkative, outgoing, responsive, easy-going, leadership and carefree. Cholerics or unstable extroverts possess qualities like touch, restless, excitable, changeable, impulsive and irresponsible. Melancholy or unstable introverts possess qualities like being quiet, reserved, pessimistic, sober, rigid, anxious and moody (Trans4mind, 2015).

According to Colburn et al (2012) in a study on the influence of personality differences on the quality of supervision relationships, personality variables are pivotal to successful

therapeutic relationships and outcomes. The emotional stability observed in majority of the volunteer peer counsellors is desirable as it is an indication of emotional control and experience negative affect only under extreme pressure or major stress.

Armed with an awareness of their individual temperaments, the volunteer mental health peer counsellors are in better positions to relate well with their clients by focusing and building on their individual strengths, and ensuring their weaknesses do not hinder the peer counselling activities. Appendix XXII is a list of the characteristics of the four basic temperaments depicting the strengths and weaknesses of each temperament (LaHaye T, 1984).

5.4 Effectiveness of the Intervention Programme (Training of Volunteer Peer Counsellors)

The paired t-test analysis of the knowledge pretest and post-test scores revealed that the change in knowledge post training was significantly different from the pre-training knowledge of the volunteer mental health peer counsellors. The efficacy of the training of volunteer peer counsellors was reflected in significant change in the level of knowledge of the study participants as indicated by the pretest and post test scores. The significant improvement on the participants' knowledge is an indication of the effectiveness of the peer counselling training programme that involved students of the University of Ibadan. The efficacy of the intervention corroborates previous studies that reported the effectiveness of peer counselling training programmes for reproductive health issues (Brieger et al, 2001; Ajuwon & Brieger, 2007) and HIV/AIDS (van der Maas and Otte, 2009; Medley et al, 2009).

It has been mentioned in earlier discussions that there exist a significant burden of mental health problems in college/university students. The effectiveness of peer-based programmes in managing the various forms of mental health or psycho-social problems is no longer in doubt. This is a direct reflection of the effectiveness of various training programmes for peer support providers. The findings from this study supports available evidence that knowledge and skill-based training programmes are almost always effective in significantly increasing the knowledge and skills of the trainees.

5.5 CGPA and Pre and Post-Intervention Knowledge

Statistical analysis revealed a positive but weak and insignificant relationship between the reported CGPA and the participants' pre and post intervention knowledge. This means that the CGPA may not necessarily be a good inclusion or exclusion criterion. Rather, students who are peer counsellors, just like their clients, may benefit from skills acquired during peer counsellors' training like time management, study skills and behavioural modification that will help to improve their CGPA (Odirile, 2012). In other words, prospective mental health peer counsellors with low CGPA (that is those struggling with their academic work) may actually benefit from the training programme by adapting skills learnt during the training to improve their academic performance.

5.6 Supervision of Post-Training Activities of the Peer Counsellors

For the present study, there was very limited time to allow for the peer counsellors to carry out some of the activities they were trained for. Those in attendance said they were still having logistic challenges. Most of them were yet to be given accommodation as at the day of

the meeting. And a good number of them were also attending lectures as at the time of the meeting.

The trained peer counsellors in attendance, however, gave reports of their activities thus far. The peer counsellors had been engaged in educating friends about basic mental health issues. They had also placed stickers on notice boards in their halls of residence and planned to place the door stickers on their doors once they move into their rooms. Two of them discussed the cases they saw, and they were advised on the next steps to take during subsequent meetings with the same clients.

The trained mental health peer counsellors indicated that there was pressing need to raise awareness and educate the community members about mental illness, as some of them are already experiencing some stigmatization based on the fact that they are involved with mental health care activities. They are however, very enthusiastic about getting on with peer counselling activities as soon as they settle down. They also plan to carry out awareness campaigns all around the campus. Supervision of their activities will continue at regular intervals throughout the session.

5.7 Conclusion

There is a huge burden of mental health problems globally and university students are significantly affected. With the existing wide treatment gap prevalent in low and middle-income countries, there is a need to increase the capacity of non-professionals to provide skilled help to those in need by training them. There is even greater need to train college/university students to provide skilled mental health services to their peers.

A major conclusion that can be drawn from the present study is that the mental health peer counselling training programme is feasible. The study has also shown that training programmes to increase the knowledge base, skills and attitudes of volunteer mental health peer counsellors are effective and would likely go a long way to complement global efforts aimed at reducing the contribution of mental health issues to the global disease burden. However, stigmatizing the trained mental health peer counsellors need to be addressed to prevent attrition.

5.8 Recommendations

Based on the findings from this study, the following recommendations were made:

- Going by the individual and collective levels of enthusiasm displayed by the volunteers, the mental health peer counselling programme should be made a university programme, and the volunteers given certificates of recognition upon graduation from the university.
- Volunteer peer counsellors should be trained and retrained annually, at the start of every academic session or when the need is identified.
- Adequate funding should be provided regularly by the Management of the University of Ibadan or other funding agencies to ensure sustainability of the programme.
- The opinions and contributions of key resource persons should be obtained and utilized.
- Adequate incentives should be provided, to ensure volunteer peer counsellors are motivated to remain in the programme. However, the trained peer counsellors were informed that their services are voluntary and no form of reimbursement is to be expected.

- The university should ensure all trained peer counsellors are given accommodation in their respective halls of residence, just like the hall executives, sports and press men, and others.

REFERENCES

Ajuwon A.J. (2008). Roles and Responsibilities of Peer Educators. In: Shokunbi W.A. and Ajuwon A.J. (eds). Training Workshop Manual on Peer Education for HIV-AIDS Prevention among University of Ibadan Students. Centre for HIV-AIDS Intervention, Nigeria. Pgs 297-300.

Ajuwon A., Fawole F., Oladepo O., Osungbade K. and Asuzu M. (2008). Effects of training programme on HIV/AIDS prevention among primary health care workers in Oyo State, Nigeria. *Health Education.* 108(6):463 – 474.

Ajuwon A.J., Brieger W.R. (2007).Evaluation of a school-based Reproductive Health Education Program in rural South Western, Nigeria. *African Journal of Reproductive Health; 11(2): 47-59*

Akanle F. (2010). Effect of Peer Education as a Key Strategy for Safe Sexual Behaviour among Female Sex Workers: Implication for HIV prevention in Nigeria. AIDS 2010 – XVIII International AIDS Conference. Abstract No. TUPE0467.

Allicock M., Carr C., Johnson L-S., Smith R., Lawrence M., Kaye L., Gellin M., Michelle Manning. (2014). Implementing a One-on-One Peer Support Program for Cancer Survivors Using a Motivational Interviewing Approach: Results and Lessons Learned. *J Cancer Educ.* 29(1): 91–98.

Aluede O., Imhonde H., Eguavoen A. (2006). Academic, Career and Personal Needs of Nigerian University Students. Journal of Instructional Psychology; 33(1): 50-57.

Atik G. and Yalcin I. (2010). Counselling Needs of Educational Science Students at the Ankara University. Procedia Social and Behavioural Sciences. 2:1520-1526.

Australian Institute of Health and Welfare. (2013). Burden of Disease. Retrieved from www.aihw.gov.au/burden-of-disease/ on 20th November, 2014.

Bella T.T. and Omigbodun O.O. (2009). Social phobia in Nigerian university students: prevalence, correlates and co-morbidity. *Social Psychiatry and Psychiatric Epidemiology*. 44 (6): 458-463

Blanco C, Okuda M, Wright C, Hasin D.S., Grant B.F., Liu, S-M, and Olfson M.(2008). Mental Health of College Students and Their Non-college-attending Peers: Results from the National Epidemiologic Study on Alcohol and Related Conditions. *Arch Gen Psychiatry*. 65(12): 1429–1437.

Brieger W.R., Delano G.E., Lane C.G., Oladepo O., Oyediran K.A. (2001). West African Youth Initiative: Outcome of a Reproductive Health Education Programme. *Journal of Adolescent Health*. 29(6): 436-446.

Bruckner T.A., Scheiffler R.M., Shen G., Yoon J., Chisolm D., Morris J., Fulton B., Dal Poz M.R., Saxena S. (2011). The Mental Health Workforce Gap in Low and Middle Income Countries: a Needs-Based Approach. Bulletin of the World Health Organization; 89:184-194.

Coulshed V. and Orme J. (2006). Counselling. In: Social Work Practice. 4th Edition. Pg 103-131. Palgrave Macmillan, New York.

Clarkson P (ed). (1998). Counselling Psychology: The Next Decade. In: Counselling Psychology: Integrating Theory, Research and Supervised Practice. Pg 4. Routledge Publishers. New Fetter Lane. London EC4P 4EE.

Colburn A.A.N.; Neale-Mcfall C.; Michel R.E.; Bayne H.B. (2012). Counseling Supervision: Exploring the Impact of Temperament on Supervisee Satisfaction. Ideas and Research You Can Use: Vistas. Article 29.

Dadwani R. S., Tintu T. A S. (2014). Mental Morbidities: Prevalence and Health Seeking Behavior. *Int J Biol Med Res*. 5(3): 4186-4189.

Djalalinia S., Tehrani F.R., Malekafzali H., Peykari N. (2013). Peer Education: Participatory Qualitative Educational Needs Assessment. Iranian J Publ Health; 42(12):1422-1429.

Gesinde A.M., Adejumo G.O., &Motunrayo A.A. (2013). Self-Reported Psychosexual Lifestyles of University Students in Southwestern Nigeria: Implication for Professional Counseling Practice. Global Journal of Human Social Science; 13(3):1-9.

Harvard University Health Service. Student to Student Support. Retrieved from www.huhs.harvard.edu on 30/08/2014.

Hunt J., Eisenberg D. (2010). Mental Health Problems and Help-Seeking Behavior among College Students. *Journal of Adolescent Health.* 46:3-10.

Huygens F.J.A. (1982). Cited in: McWhinney I.R. (1989). The Family in Health and Disease. A Textbook of Family Medicine. Oxford University Press, New York, United State of America. Pg 239.

Jaja Clinic, Universsity of Ibadan. (March 2013-September 2014). Unpublished data from the medical records.

Jegede A.S. (2008). Voluntary Confidential Counselling and Testing. In: Shokunbi W.A. and Ajuwon A.J. (eds). Training Workshop Manual on Peer Education for HIV-AIDS Prevention among University of Ibadan Students. Centre for HIV-AIDS Intervention, Nigeria. Pgs 196-218.

Joint United Nations Programme on HIV/AIDS. (1999). Peer Education and HIV/AIDS: Concepts, Uses and Challenges. UNAIDS Best Practice Collection. Joint United Nations Programme on HIV/AIDS, Geneva, Switzerland.

Karimi J., Muthaa G., Bururia D., Karimi V., Mburugu B. (2014). Assessment of Counselling Needs among Students in Kenyan Universities. Journal of Education and Practice; 5 (12):36.

Kitzrow M.A. (2003). The Mental Health Needs of Today's College Students: Challenges and Recommendations. *NASPA Journal*. 41 (1): 167-181.

Kracen A (ed). Peer Support Training Manual. (2003). Student Counselling Service. Trinity College, Dublin.

LaHaye Tim. (1984). Four Basic Temperaments Chart. In: Why You Act the Way You Do. Tyndale House Publishers Incorporated. USA.

Mastroleo N.R., Mallett K.A., Ray A.E., Urrisi R. (2008). The Process of Delivering Peer-Based Alcohol Intervention Programs in College Settings. *J Coll Stud Dev*. 49(3): 255–259.

McIntyre D.R., Thomas G.H., Borgen W.A. (1982). A Peer Counselling Model For Use in Secondary Schools Canadian Counsellor. 17(1): 29-36.

Medley A., Kennedy C., O'Reilly K., Sweat M. (2009). Effectiveness of Peer Education Interventions for HIV Prevention in Developing Countries: A Systematic Review and Meta-Analysis. AIDS Education and Prevention. 21 (3):181-206.

Merikangas K. R, He J-P, Burstein M, Swanson S.A, Avenevoli S, Cui L,Benjet C, Georgiades K, Swendsen J. (2010). Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Co-morbidity Study-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 49(10): 980–989.

Naushad S., Farooqui W., Sharma S., Rani M., Singh R., Verma S. (2014). Study of proportion and determinants of depression among college students in Mangalore city. Nigerian Medical Journal. 55(2):156-160.

Nelson-Jones R. (2005). Practical Counselling and Helping Skills. 5th Edition. Sage Publications Ltd. London. Pg 4.

Odirile L. (2012). The Role of Peer Counselling in a University Setting: The University of Botswana. Proceedings of the 2012 Summit of the African Educational Research Network, 18-20th May, 9 North Carolina State University & Double Tree Hilton, Raleigh Brownstone University Hotel.

O'Leary T., Borsari B., Colby S.M., Monti P.M. (2007). Peer Enhancement of a Brief Motivational Intervention with Mandated College Students. *Psychol Addict Behav*. 21(1): 114–119.

Ojedokun O. (2011). Psychological predictors of attitude towards seeking professional psychological help in a Nigerian university student population. *South African Journal of Psychology*; 41(3): 310-327.

Omigbodun O., Dogra N., Esan O., Adedokun B. (2008). Prevalence and Correlates of Suicidal Behaviour among Adolescents in South-West Nigeria. The International Journal of Social Psychiatry. 54 (1): 34-46.

Omigbodun OO, Onibokun AC, Yusuf BO, Odukogbe AA, Omigbodun AO. (2004). Stressors and counseling needs of undergraduate nursing students in Ibadan, Nigeria. The Journal of Nursing Education; 43(9):412-415.

OmigbodunO.O., OdukogbeA.O.,OmigbodunA.O., Yusuf B., Bella T.T., Olayemi O. (2006). Stressors and Psychological Symptoms in Students of Medicine and Allied Health Professions in Nigeria. *Social Psychiatry and Psychiatric Epidemiology.* 41(5):415-421.

Onyegegbu N. and Nwagbo C. (2009). Empowering the Nigerian Youths for HIV/AIDS Prevention through Training of the Trainers for Peer Education Programme: The National Youth Service Corps Experience. Journal of Curriculum and Experience. 7 (1&2):

Oladimeji B.Y. (2005). Eysenck Personality Inventory. In: Psychological Assessment Techniques in Health Care. Obafemi Awolowo University Press, Ile-Ife, Nigeria. Pg 131 – 133.

Pengpid S., Peltzer K., van der Heever H., Skaal L. (2013). Screening and Brief Interventions for Hazardous and Harmful Alcohol Use among University Students in South Africa: Results from a Randomized Controlled Trial. Int. J. Environ. Res. Public Health; 10: 2043-2057.

Pritchard M.E., Wilson G.S., and Yamnitz B. (2007). What Predicts Adjustment among College Students? A Longitudinal Panel Study. Journal of American College Health; 56: 15 – 21.

Rose D., Thornicroft G., Pinfold V., and Kassam A. (2007). 250 Labels used to Stigmatise People with Mental Illness. BMC Health Services Research; 7: 97.

Shokunbi W.A., Ajuwon A.J. (eds). (2008). Training Workshop Manual: Peer Education for HIV-AIDS Prevention among University of Ibadan Students. A Publication of the Centre for HIV-AIDS Intervention, Nigeria. College of Medicine, University of Ibadan.

Thorne, D.H., Ghorob, A., Hessler, D., De Vore, D., Chen, E.,Bodenheimer, T.A. (2013). Impact of Peer Health Coaching on Glycemic Control in Low-Income Patients with Diabetes: A Randomized Controlled Trial. *Ann Fam Med. 11(2): 137–144.*

Ti L., Hayashi K., Kaplan K., Suwannawong P., Wood E., Montaner J., Kerr T. (2012). Willingness to Access Peer-Delivered HIV Testing and Counseling among People Who Inject Drugs in Bangkok, Thailand. *J Community Health.* 38(3): 427–433.

Tilliman D.G. (2007). The Utilization of Counselling Services by the International Student Population on U.S. College and University Campuses. State University of New York: The College at Brockport. Counsellor Education Master's Theses. Paper 106.

Travis J., Roeder K., Walters H., Piette J., Heisler M., Ganoczy D., Valenstein M., Pfeiffer P. (2010). Telephone-based Mutual Peer Support for Depression: A Pilot Study. *Chronic Illn.* 6(3): 183–191.)

Trans4mind (2015). The Eysenck Personality Questionnaire. Retrieved from www.trans4mind.com.

Van der Maas F., Otte W.M. (2009). Evaluation of HIV/AIDS Secondary School Peer Education in Rural Nigeria. *Health Education Research*. 24 (4): 547-557.

Weckwerth A.C. (2010). Supporting University Students With Mental Health Issues: A Needs Assessment. Thesis Submitted to the Department of Psychology In partial fulfillment of the requirements For the Masters of Arts degree Wilfrid Laurier University.

World Health Organization(1997). Promoting Independence of People with Disabilities Due to Mental Disorders: A Guide for Rehabilitation in Primary Health Care. World Health Organization, Geneva, Switzerland.

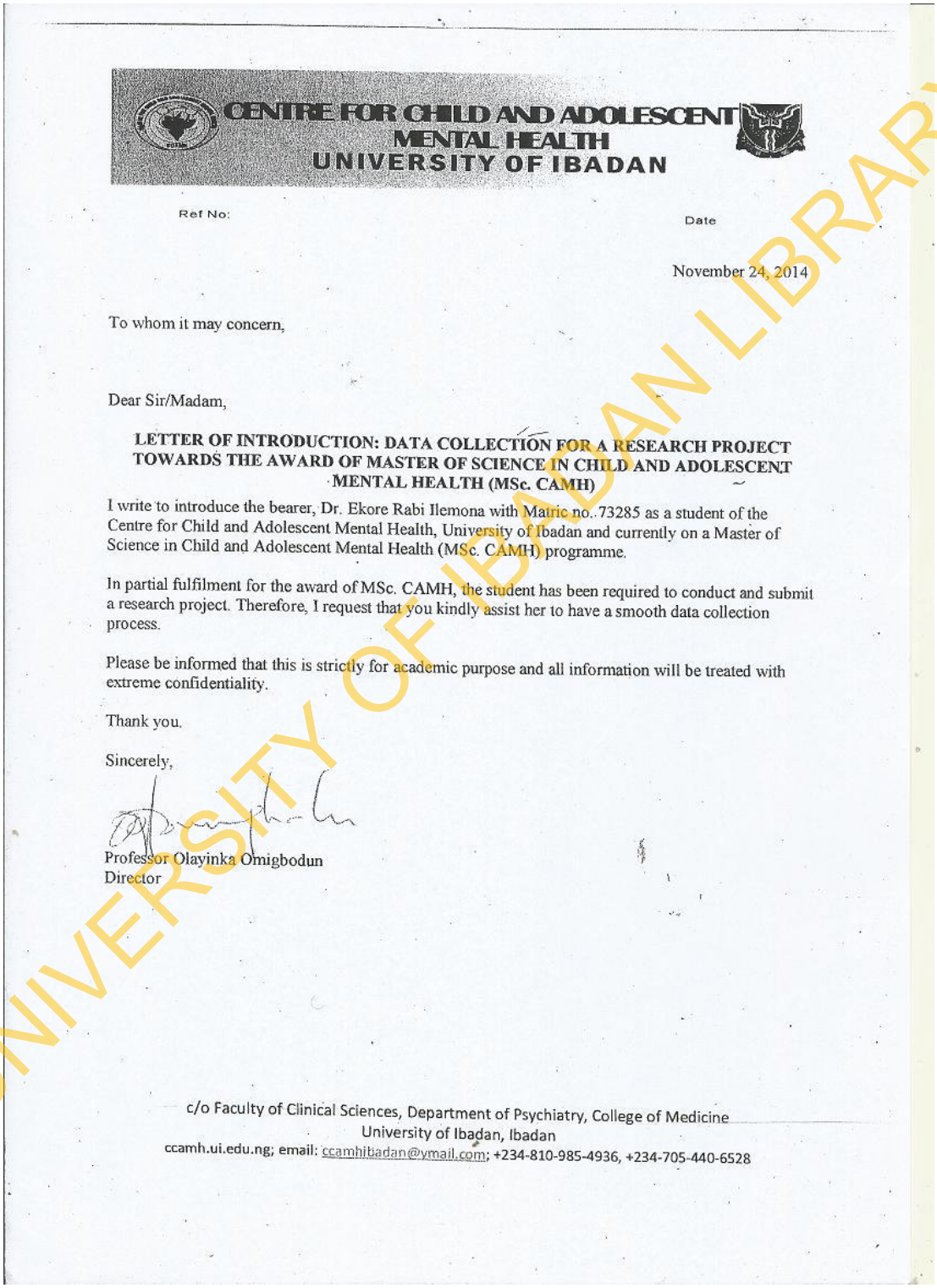
World Health Organization. (2008). Global Burden of Diseases Report. World Health Organization, Geneva, Switzerland.

World Health Organization. (2008). Mental Health Gap Action Programme Intervention Guide. World Health Organization, Geneva, Switzerland.

World Health Organization. (2013). Mental Health Action Plan, 2013-2020. World Health Organization, Geneva, Switzerland.

APPENDIX I

LETTER OF INTRODUCTION



CENTRE FOR CHILD AND ADOLESCENT MENTAL HEALTH
UNIVERSITY OF IBADAN

Ref No:

Date

November 24, 2014

To whom it may concern,

Dear Sir/Madam,

LETTER OF INTRODUCTION: DATA COLLECTION FOR A RESEARCH PROJECT TOWARDS THE AWARD OF MASTER OF SCIENCE IN CHILD AND ADOLESCENT MENTAL HEALTH (MSc. CAMH)

I write to introduce the bearer, Dr. Ekore Rabi Ilemona with Matric no. 73285 as a student of the Centre for Child and Adolescent Mental Health, University of Ibadan and currently on a Master of Science in Child and Adolescent Mental Health (MSc. CAMH) programme.

In partial fulfilment for the award of MSc. CAMH, the student has been required to conduct and submit a research project. Therefore, I request that you kindly assist her to have a smooth data collection process.

Please be informed that this is strictly for academic purpose and all information will be treated with extreme confidentiality.

Thank you.

Sincerely,

Professor Olayinka Omigbodun
Director

c/o Faculty of Clinical Sciences, Department of Psychiatry, College of Medicine
University of Ibadan, Ibadan
ccamh.ui.edu.ng; email: ccamhibadan@ymail.com; +234-810-985-4936, +234-705-440-6528

APPENDIX II

LETTER OF APPLICATION FOR ETHICAL REVIEW

Centre for Child and Adolescent Mental Health,

Department of Psychiatry,

University of Ibadan,

Ibadan,

Oyo State.

20th November, 2014.

The Secretary,

Oyo State Research Ethical Review Committee,

Ministry of Health,

Oyo State.

Dear Sir,

APPLICATION FOR ETHICAL APPROVAL FOR A PROPOSED RESEARCH

I hereby apply for ethical approval for my proposed M.Sc research work titled "**Development of Mental Health Peer Counselling Services for Students of the University of Ibadan: A Pilot Study**". The study aims to train undergraduate students to provide volunteer peer counselling and psychosocial support to their fellow students who are in need of such services. The effectiveness of such service shall be determined. The study shall take place at the University of Ibadan.

Attached is a copy of the proposed research protocol. Thank you for your anticipated cooperation.

Yours faithfully,

Dr. Rabi Ilemona Ekore, MBBS(Ib), MPE, FWACP

APPENDIX III

TENTATIVE ETHICAL APPROVAL

TELEGRAMS..... TELEPHONE.....

OYO STATE: THE PACESETTER

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/ 479/787

February, 2015

The Principal Investigator,
Centre for Child and Adolescent Mental Health,
Department of Psychiatry,
University of Ibadan,
Ibadan.

Attention: Ekore Rabi

Ethical Approval for the Implementation of your Research Proposal in Oyo State

This acknowledges the receipt of the corrected version of your Research Proposal titled: "Development of Mental Peer Counseling Services for students of the University of Ibadan: A Pilot Study."

2 I wish to inform you that the committee has reviewed the proposal and made the following observations and comments;

- *Summary is scanty and necessary information were not given.*
- *Acronym not completed.*
- *Method of collection of sample was not stated.*
- *The proposal is not clear and well explained.*
- *The conclusion is not accepted.*

Recommendation: ***Tentative Approval***

3. I am therefore directed to ask you to correct all the above observed ethical concerns and forward one (1) copy to the Ministry for final approval.

4. Thanks.

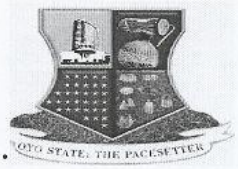
OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
Signature & Date

Sola Akande (Dr.)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee

APPENDIX IV

FINAL ETHICAL APPROVAL

TELEGRAMS..... TELEPHONE.....



MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to
the Honorable Commissioner quoting
Our Ref. No. AD 13/ 479/792 February, 2015

The Principal Investigator,
Department of Psychiatry,
University of Ibadan,
Ibadan.

Attention: Ekore Rabi

Ethical Approval for the Implementation of your Research Proposal in Oyo State

This acknowledges the receipt of the corrected version of your Research Proposal titled: "Development of Mental Health Peer Counseling Services for Students of the University of Ibadan: A Pilot Study."

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Sola Akande (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee

APPENDIX V

LETTER REQUESTING FOR PERMISSION TO CONDUCT STUDY IN THE UNIVERSITY

University Health Service (Jaja Clinic),
University of Ibadan,
Ibadan,
Oyo State.
5th January, 2015

The Dean,
Student Affairs Unit,
University of Ibadan,
Ibadan.

Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT RESEARCH PROJECT WITH STUDENTS

I hereby request for permission to conduct my MSc research project with students of the University of Ibadan. The research project is titled "DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN: A PILOT STUDY" and it aims to equip volunteers (students) with skills that will enable them identify fellow students with psychological or mental health issues and either refer them to the clinic for professional care at the University Health Service (Jaja Clinic), or provide them with psychosocial support. The project is a part of concerted efforts to reduce the treatment gap in mental health care globally.

Volunteers shall be recruited from the undergraduate halls of residence. With your approval, recruitment of volunteers for the project shall commence immediately, pending the resumption of academic activities next session during which the training shall commence. Ethical approval for the study has been applied for, and the research project proper shall commence only after the study has been approved by the Oyo State Ethical Review Board.

Thank you for your anticipated cooperation.

Yours faithfully,

Dr Rabi Ekore, MBBS(Ib), MPE, FWACP

CC: The Director, University Health Service
The Student Affairs Officer

APPENDIX VI

LETTER GRANTING PERMISSION TO CONDUCT STUDY IN THE UNIVERSITY

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

STUDENT AFFAIRS DIVISION

DEAN OF STUDENT AFFAIRS
PROFESSOR A.R.A. ALADA
B.Sc. (Hons (Cairo), M.Sc., Ph.D. (Ibadan)

DEPUTY DEAN OF STUDENT AFFAIRS
DR. I. A. ABIONA
B.A.(Hons), M.Ed., Ph.D. (Ibadan)

DEPUTY REGISTRAR (STUDENT AFFAIRS)
DR. F.I. ETADON
B.Ed., M.Ed., Ph.D. (Ibadan)

Tel: 08023291617
08054848778
E-mail: araalada@yahoo.com

Tel: 08023400362
08038492526
E-mail: keyeabiona@yahoo.com

Tel: 08050345420
07084868418
E-mail: fetadon@yahoo.com

14 January, 2014.

Dr. Ekore Rabi Ilemona,
Centre for Child and Adolescent,
Mental Health,
College of Medicine,
University of Ibadan.

Dear Dr. Ekore,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH PROJECT WITH STUDENTS

Your letter on the above subject dated on 5 January, 2015 refers.

I write to convey approval of your request as granted by the Office of the Dean of Students.

However, you are requested to ensure compliance with the following rules and regulations guiding the conduct of such activity in the University of Ibadan.

- The right of choice of the students must be respected.
- Student information must be treated with utmost confidentiality.
- Your activities must not, in anyway, constitute a breach of campus peace.
- Further to the above, as a subject of the University, other rules as contained in Chapter 5 of the Student Information Handbook are applicable.

Please note that acknowledgement of this approval signifies your obligation to full compliance for recruitment of volunteers for undergraduate students in their halls of residence for next academic session and any activity beyond your specific request stands unapproved and would be treated as such. In anticipation of a full compliance, you are hereby granted an official permission to conduct the experiment as scheduled.

Thank you.

14-01-15

Dr. F. I. Etadon, ***manupa***
Deputy Registrar (Students)

APPENDIX VII

TIMELINE FOR THE STUDY

Date	Activity
February 1st – March 26th , 2015	Placement of notice of recruitment in all halls of residence and faculties.
March 23rd – 26th, 2015	Personality Testing of all applicants.
March 30th and 31st, 2015	Pretest assessment and Focus Group Discussion (for training needs assessment).
April 1st – 3rd, 2015	Analysis of data from Focus Group Discussion.
April 8th and 9th, 2015	Training and Post-test assessment of Prospective Volunteer Peer Counsellors
April 10th – 23rd 2015	Supervision of all trained Volunteer Peer Counsellors.
April 10th – April 30th, 2015	Data Management and Analysis/Report Writing.

APPENDIX VIII:

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

INFORMED CONSENT FORM

My name is Dr Rabi Ilemona Ekore. I am a post-graduate student of the Centre for Child and Adolescent Mental Health, University of Ibadan, specifically undergoing a masters programme in Child and Adolescent Mental Health. I am carrying out a pilot study on the development of mental health peer counselling services for undergraduate students of the University of Ibadan. The study involves training interested volunteer students to be able to identify and refer students with mental health problems, and provide counselling and psychosocial support to students in need. There shall be individual personality test for each participant, focus group discussions and training sessions, after which the trained student will be expected to provide counselling services to students as well as keep records of all counselling activities.

Be rest assured that every information about you shall be kept confidential and you will have a unique identification. You are free to refuse to take part in this research, and you have a right to withdraw from the programme at any point in time if you so desire. Your refusal to take part in this research or your withdrawal at any time shall not be used against you in any way. However, I will greatly appreciate your full participation in the study.

CONSENT: Now that the study has been well-explained to me and I fully understand its content, I am willing to **participate** in the study.

_____ _____

Signature of participant/Date Signature of Interviewer/Date

APPENDIX IX

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

THE EYSENCK PERSONALITY QUESTIONNAIRE

The EPI Instructions

Here are some questions regarding the way you behave, feel and act. After each question is a space for answering YES or NO. Try to decide whether YES or NO represents your usual way of acting or feeling. Then put a tick in the box under the column headed YES or NO. Work quickly, and don't spend too much time over any question, we want your first reaction, not a long drawn-out thought process. The whole questionnaire shouldn't take more than a few minutes. Be sure not to omit any questions. Start now, work quickly and remember to answer every question. There are no right or wrong answers, and this isn't a test of intelligence or ability, but simply a measure of the way you behave.

S/NO		YES	NO
1	Do you often long for excitement?		
2	Do you often need understanding friends to cheer you up?		
3	Are you usually carefree?		
4	Do you find it very hard to take no for an answer?		
5	Do you stop and think things over before doing anything?		
6	If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so?		

7	Do your moods go up and down?		
8	Do you generally do and say things quickly without stopping to think?		
9	Do you ever feel 'just miserable' for no good reason?		
10	Would you do almost anything for a dare?		
11	Do you suddenly feel shy when you want to talk to an attractive stranger?		
12	Once in a while do you lose your temper and get angry?		
13	Do you often do things on the spur of the moment?		
14	Do you often worry about things you should have done or said?		
15	Generally do you prefer reading to meeting people?		
16	Are your feelings rather easily hurt?		
17	Do you like going out a lot?		
18	Do you occasionally have thoughts and ideas that you would not like other people to know about?		
19	Are you sometimes bubbling over with energy and sometimes very sluggish?		
20	Do you prefer to have few but special friends?		
21	Do you daydream a lot?		
22	When people shout at you do you shout back?		

23	Are you often troubled about feelings of guilt?		
24	Are all your habits good and desirable ones?		
25	Can you usually let yourself go and enjoy yourself a lot at a lively party?		
26	Would you call yourself tense or 'highly strung'?		
27	Do other people think of you as being very lively?		
28	After you have done something important, do you come away feeling you could have done better?		
29	Are you mostly quiet when you are with other people?		
30	Do you sometimes gossip?		
31	Do ideas run through your head so that you cannot sleep?		
32	If there is something you want to know about, would you rather look it up in a book than talk to someone about it?		
33	Do you get palpitations or thumping in your hear?		
34	Do you like the kind of work that you need to pay close attention to?		
35	Do you get attacks of shaking or trembling?		
36	Would you always declare everything at customs, even if you knew you could never be found out?		
37	Do you hate being with a crowd who play jokes on one another?		
38	Are you an irritable person?		

39	Do you like doing things in which you have to act quickly?		
40	Do you worry about awful things that might happen?		
41	Are you slow and unhurried in the way you move?		
42	Have you ever been late for an appointment or work?		
43	Do you have many nightmares?		
44	Do you like talking to people so much that you never miss a chance of talking to a stranger?		
45	Are you troubled by aches and pains?		
46	Would you be very unhappy if you could not see lots of people most of the time?		
47	Would you call yourself a nervous person?		
48	Of all the people you know, are there some whom you definitely do not like?		
49	Would you say that you were fairly self-confident?		
50	Are you easily hurt when people find fault with you or your work?		
51	Do you find it hard to really enjoy yourself at a lively party?		
52	Are you troubled by feelings of inferiority?		
53	Can you easily get some life into a dull party?		
54	Do you sometimes talk about things you know nothing		

	about?		
55	Do you worry about your health?		
56	Do you like playing pranks on others?		
57	Do you suffer from sleeplessness?		

APPENDIX X

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

MODIFIED SOCIODEMOGRAPHIC (SCHOOL HEALTH) QUESTIONNAIRE

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. Faculty/Department _____
2. Level _____
3. Hall of Residence _____

4. Date of Birth: _____ _____ _____

Day Month Year

5. How old are you (age last birthday)?

6. Sex: (a) Male (b) Female

7. Do you practise any religion? No Yes

8. Please write down your exact religion_____
_____

(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

11. What is your tribe? _____

Family Information

12. Family Type:

(a) Monogamous (b) Polygamous

13. Number of Mother's Children: _____

14. Number of Father's Children: _____

15. What is your position among your father's children? _____

16. What is your position among your mother's children? _____

17. Marital Status of Parents:

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

18. How many husbands has your mother had? _____

19. Who do you live with presently (when school is not in session)?

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

(f) Grandfather (g) Other [please specify] _____

20. Who brought you up from your childhood?

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

(f) Grandfather (g) Other [please specify] _____

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

____

22. 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)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

24. If yes, please describe what you do _____

25. Level of Father's Education

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

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

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

27. Level of Mother's Education

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

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

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

29. Do you like your family? Yes No

30a. If Yes, Why? _____

30b. If No, Why? _____

School-Related Questions

31. Do you like this university? Yes/ No

32. How many course-mates do you have? _____

33. Do you do well academically? Yes No

34a. If Yes, explain_____

34b. If No, explain_____

35. What is your current CGPA? _____

36. Are you having difficulties with any of your lecturers? Yes No

37. If yes, what sort of difficulties?

_____

38. Do you have guidance counsellors in your university? Yes No

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

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

_____

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

42a. If yes, why would you go?

_____

_____

42b. If no, why not?

_____

_____

APPENDIX XI

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

MODIFIED mhGAP KNOWLEDGE BASE QUESTIONNAIRE

Identification Number _____

Gender: Male [] Female [ ]

A. Put ✓ in the correct column.	True	False
1. Health is defined as a state of complete physical well-being characterized by the absence of disease or infirmity.		
2. Most mental disorders (about 50%) seen in adults have been shown to rarely begin in childhood, before the age of 14 years.		
3. Withdrawal from others, alcohol and/or drug abuse, eating problems, impaired judgment, poor sleep (insomnia), are complications that could result from stress.		
4. People with mental health issues should be cared for only in mental hospitals.		
5. Good interpersonal skills, good listening skills, friendliness and reliability are skills that a peer counsellor can do without.		
6. Providing brief advice to people who have alcohol problems is not effective.		
7. Mental health issues are not common in children, adolescents and young adults.		
8. The saliva of a person with epilepsy is contagious and you can develop epilepsy if it comes in contact with your body.		
9. Severe depression can adversely affect a person's academic performance.		
10. Peer educations entails using the knowledge and skills gained from a training to inform and educate one's friends or colleagues on a particular health issue.		
11. Mental health peer counsellors have a duty to identify and refer, or counsel their peers who need help.		
12. Mental health peer counsellors usually provide support for students with psychosocial issues such as relationship problems and acute stress.		
13. Alcohol and substance abuse is not a common cause of mental health problems among university students.		

14. Epilepsy is caused by witchcraft, demonic possession, or evil spirits		
15. Depression can present with recurrent or chronic vague physical pain and fatigue.		
16. Persons suffering from depression are advised to try to reduce their physical activities as much as possible, to avoid pain and fatigue.		
17. A 22 years old girl says that she hears voices (that no one else can hear) and is convinced that someone wants to hurt her. She is most likely suffering from psychosis.		
18. Once the diagnosis of epilepsy is made in a person with epilepsy, the person should stop schooling, and must not take up any job, marry or have children.		
19. During an epileptic seizure, remove any harmful object near the person and do not attempt to insert something in between the person's teeth.		
20. Alcohol use cannot cause seizures.		
21. De-escalation technique is an effective way of managing a mentally ill person with acute agitation/aggression.		
22. Using drugs to enhance reading while preparing for exams can boost academic performance.		
23. Imprisonment is the most effective intervention for the management of drug use disorders.		
24. Persons with mental health issues must take medications for the rest of their lives.		
25. Mobilizing and providing social support for persons with mental health issues will not make any difference to their recovery.		
26. In caring for persons with mental health issues, it is unnecessary to provide care that respects the dignity of the person in a culturally sensitive and appropriate manner, and that is free from discrimination in any form.		
27. It is okay to share patient identity or information with other people or on facebook, twitter, whatsapp, and other social media.		
28. Bipolar disorder is a mental health condition that tends to involve extreme moods, which may go from feeling very depressed and fatigued to feeling extremely energetic, irritated or overexcited.		
29. Empathy, respect, concreteness, self-knowledge and self-acceptance, are some of the qualities desirable in a peer counsellor.		
30. The 5 A's is a brief intervention method that has been shown not to be effective for modifying health risk behaviour.		

APPENDIX XII

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

FOCUS GROUP DISCUSSION GUIDE

Good day. My name is Dr Rabi Ilemona Ekore. I am a Masters' student of the Centre for Child and Adolescent Mental Health, University of Ibadan and I am currently doing my project which is focused on the development of mental health peer counselling services for undergraduate students of the University of Ibadan. In order to develop the contents for the training of peer counsellors, I would like to have your own opinion about mental health issues among students and specific areas of need as regards managing the problems. Your opinion matters a lot and would go a long way in ensuring that we provide a need-based training for you. Kindly be as honest and as frank as possible. Thank you.

1. What is your idea of the term "mental illness?" What are the mental illnesses that you know of?
2. What are the different names by which mental illness is referred to on campus?
3. What do you think are the causes of mental illness?
4. How can you tell that somebody is experiencing mental health issues?
5. What are the different resources available to treat students experiencing mental health issues on campus? Are such students being adequately treated?
6. What is your opinion about people with mental illness attending school?

7. In what ways do you think mental illness can affect a person?

8. How do you think students experiencing mental health issues can be assisted to cope better in school?

9. Do you know any person with a mental illness? Have you ever had a personal encounter with a person suffering from a mental Illness (family/friend)? What was your experience like?

10. How did you or do you feel about such a person?

11. What are your observations about the person?

12. What role do you think friends/peers/family can play in the development of mental illness?

13. What role do you think friends/peers/family can play in the treatment of a person with mental illness?

14. Would you like to be a friend/helper of a mentally ill person?

15. What kind of training/skills do you think you would need to enable you help those with mental illness?

We have come to the end of this discussion. Thank you so much for your honest and frank opinions. You are highly appreciated.

APPENDIX XIII

CLIENT ATTENDANCE RECORD

PEER COUNSELLOR ID: ……

S/NO	CLIENT ID	HALL	DEPARTMENT/LEVEL	EMAIL	PHONE #	Subject/Nature of Counselling

APPENDIX XIV

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

PEER COUNSELLING ACTIVITY LOG BOOK

CLIENT ID: ……..

SEX: …….

HALL OF RESIDENCE: …….

DEPARTMENT: ……

PEER COUNSELLOR ID: ……..

DATE	COMPLAINTS	INTERVENTION/REFERRAL

APPENDIX XV

MANAGEMENT INFORMATION SYSTEMS (MIS) FORM 1

CLASS ACTIVITIES

TEACHERS' NAME …….. CLASS ……..

DATE …….

NAME OF SCHOOL ……

TOPIC ……

S/N	NAME	SEX:M/F	REFERRAL YES/NO	REASON FOR REFERRAL

APPENDIX XVI

MANAGEMENT INFORMATION SYSTEM (MIS) FORM 2

GROUP EDUCATIONAL ACTIVITIES IN CLASS: EXTRA CURRICULAR ACTIVITIES

TEACHER'S NAME ……

NAME OF SCHOOL ……..

CLASS ……..

S/N	DATE	SEX M/F	ACTIVITIES TOPIC	GROUP DISCUSSION/ HEALTH TALK	'ENTER EDUCATE' (DANCE DRAMA)	DEBATE	TEACHER'S COMMENT

APPENDIX XVII

Training Opportunity for

Mental Health Peer Counsellors

Student Volunteers Needed (200, 300 & 400 Level)

Can a friend in need lean on you?

Are you interested in providing psychological and social support for fellow students?

Do you want to become a volunteer **mental health peer counsellor?**

Interested? Send your name, hall of residence and phone number to:

The Project Trainer
Jaja Clinic, University of Ibadan
Tel: 08055135312
Email: rabiekore@gmail.com

APPENDIX XVIII

TIME-TABLE FOR THE MENTAL HEALTH PEER COUNSELLORS' TRAINING PROGRAMME

FACILITATORS: DR RABI I. EKORE; DR JOHN EKORE; MR JAMES KOROMA & DR TOLU OLORUNTOBA

VENUE: JAJA CLINIC, UNIVERSITY OF IBADAN

DATE: 8TH& 9TH April, 2015

DAY 1: Wednesday 8TH April, 2015

Time	Topic	Facilitator
2.00 – 2.30 pm	Pretest/Introduction to mental health	Dr Rabi Ekore
2.30 – 3.00 pm	Depression	Dr Rabi Ekore
3.00 – 3.30 pm	Epilepsy/Role Play	Mr James Koroma
3.30 -3.45 pm	Lunch Break/Questions/Comments	All
3.45 – 4.15 pm	Psychosis/Bipolar Disorder	Dr Rabi Ekore
4.15 – 4.45 pm	Stress	Dr John Ekore
4.45-5.00 pm	Questions/Comments	Dr Rabi Ekore

DAY 2: THURSDAY 9TH APRIL, 2015

Time	Topic	Facilitator
2.00 – 2.10 pm	Creating Awareness (Practical Session)	All Participants
2.10 – 2.30 pm	Alcohol/Drug Use Disorders	Dr Rabi Ekore
2.30 – 3.00 pm	General principles of Care	Mr James Koroma
3.00 – 3.30 pm	Communication Skills	Dr Oloruntoba
3.30 – 3.45 pm	Lunch break/Questions/Comments	All
3.45 – 4.15 pm	Behavioural Emergencies	Dr Rabi Ekore
4.15 – 4.45 pm	Peer Counselling	Dr John Ekore
4.45 – 5.00 pm	Questions/Comments/Post-Test	All

APPENDIX XIX

EDUCATION/INFORMATION STICKERS

APPENDIX XX

MENTAL HEALTH PEER COUNSELLING REFERRAL CARD

MHPC Referral Card

Name	
Hall	
To see	Dr (Mrs) Rabi Ekore (08055135312)
Referred by	
Date	

MHPC Referral Card

Name	
Hall	
To see	Dr (Mrs) Rabi Ekore (08055135312)
Referred by	
Date	

APPENDIX XXI

PHOTOS FROM THE TRAINING PROGRAMME

APPENDIX XXII

ATTENDANCE SHEETS FOR THE TRAINING PROGRAMME

MENTAL HEALTH PEER COUNSELLORS' TRAINING PROGRAMME
(ATTENDANCE SHEET)

DATE: 08/04/2015

S/No	NAME	PHONE #	EMAIL	SIGNATURE
1	FRANCIS Chinyere E	08101672781	chinnyfrancis@yahoo.com	
2	Ogunmoye Ayokunle	08065278601	ayomoye001@yahoo.com	
3	ADELUYI BABATUNDE	07062802810	adeluyianthony56@gmail.com	
4	Idowu Oluwapamilayo .C	08168423389		
5	Olusola Rahmatullah Opeyemi	08187195036 ~~08191~~	rahmaldress3@gmail.com	
6	ATTAH OJOMA HANNAH	09037093887	anno78@yahoo.com	
	Oladay Abdulmalik	07031815199	[illegible]@gmail.com	
8	AFOLABI IBUKUN P.	08073051794	Oluwaibukunl@gmail.com	
9	Ayodele Samuel Oluwatoni	09050634724	sam-ayodele@yahoo.com	
10	Olotu Oluwanisola-O	08064888643	olotuoluwanisola@gmail	
11	Ilesanmi 'Damola G.	08031564521	pw132d@yahoo.com	
12	Olusoro Oluwaseun D	08064884844	seun.olusoro@aiesec.net	
13	Williams Damilola	08169170575	mamaniemi@gmail.com	
14	Nweze Amarachi F.	08109907624	amarachifaith@gmail	
15	AJAYI OLUWAYEMISI .T	08059611434	at4gail@yahoo.com	

MENTAL HEALTH PEER COUNSELLORS' TRAINING PROGRAMME
(ATTENDANCE SHEET)

DATE: 08/04/2015

S/No	NAME	PHONE #	EMAIL	SIGNATURE
1)	Olayeole Fyinfoluwa	08136412276	fyildemararose@gmail.com	
2)	FATUMBI TOBILOBA MOSES	08164859938	tobibeelorbah.081@gmail.com	
3)	ARE OLAJUMOKE T.	08164771743	jummiearee@gmail.com	
4)	OJELEYE Dasola	08102806966	ojeleye dasola@yahoo.com	
5	Obabiyi Paul O	08138982337	PSO.142a@gmail.com	
6	ADEYEMO Ifeoluwa C	08130298085	ifeoluwacomfort@yahoo.com	
7	Ajibade Anuoluwapo D.	08146829453	ajibadeadanuoluwa@yahoo.com	
8)	Olúfọwọ́kàn Israel	08089990986	Israeltosky@yahoo.com	

MENTAL HEALTH PEER COUNSELLORS' TRAINING PROGRAMME
(ATTENDANCE SHEET)

DATE: 09/04/2015

S/No	NAME	PHONE #	EMAIL	SIGNATURE
1	Williams Damilola. D	08169770575	mamanto mod@gmail.com	[signature]
2	Nwezo Amarachi F.	08109907624	amarachifaith3@gmail.com	[signature]
3	ADETEMO Ifeoluwa. C	08130298083	ifeoluwacomfort@yahoo.com	[signature]
4	Ajibade Anuoluwapo D.	08146829453	ajibadeadonyi128@yahoo.com	[signature]
5	Okon Daniel	08167455024	danielokon18@gmail.com	[signature]
6	Olayede Fiyinfoluwa	08136412276	hildemarqrose@gmail.com	[signature]
7	FATUNMBI TOBILOBA MOSES	08164455958	tobilobah081@gmail.com	[signature]
8	Ogunnye Ayooluwa	08065278601	ogunnye001@yahoo.com	[signature]
9	FRANCIS Chinyere E	08101672781	chinyerefrancise@gmail.com	[signature]
10	AJAYI YEMISI	08059611434	at4gail@yahoo.com	[signature]
11.	Are Olajumoke T.	08164771743	Jummie are @gmail.com	[signature]

MENTAL HEALTH PEER COUNSELLORS' TRAINING PROGRAMME
(ATTENDANCE SHEET)

DATE: 09/04/2015

S/No	NAME	PHONE #	EMAIL	SIGNATURE
01	ADEWUYI BABATUNDE	07062802810	adewuyiantony56@gmail.com	
02	Olusoto Oluwaseun	08028984192	Seun-Olusoto@aiesec.net	
03	Olotu Oluwunmisola O.	08066488643	olotuoluwanisola@gmail.com	
04	Ilesanmi Damola G.	08031564521	pw1328@yahoo.com	
05	Ousola Rahmatullah O	08187195036	rahmaldrees3@gmail.com	
06	Idowu Oluwaguwmibiyo	08168423389		
07	OJELEYE Dasola	08102806966	ojeleye dasola@yahoo.com	
08	MADUBUEZE ADA NKIRUKA	07039869505	yvee94@gmail.com	
09	Olúfúnsó Kín Israel	08098880986	israelbosky@yahoo.com	

APPENDIX XXIII

DEVELOPMENT OF MENTAL HEALTH PEER COUNSELLING SERVICES FOR STUDENTS OF THE UNIVERSITY OF IBADAN

THE FOUR TEMPERAMENTS

TEMPERAMENT	STRENGTHS	WEAKNESSES
SANGUINE	• Outgoing • Responsive • Warm/friendly • Talkative • Enthusiastic • Compassionate	• Undisciplined • Emotionally unstable • Unproductive • Egocentric • Exaggerates
PHLEGMATIC	• Calm/Quiet • Easy-going • Dependable • Objective • Diplomatic • Efficient • Organised • Practical • Humorous	• Unmotivated • Procrastinator • Selfish • Stingy • Self-protective • Indecisive • Fearful • Worrier
CHOLERIC	• Strong-willed • Independent • Visionary • Practical • Productive • Decisive • Leader	• Cold/unemotional • Self-sufficient • Impetuous • Domineering • Unforgiving • Sarcastic • Angry • Cruel
MELANCHOLY	• Gifted • Analytical • Aesthetic • Self-sacrificing • Industrious • Self-disciplined	• Moody • Self-centred • Persecution-prone • Revengeful • Touchy • Theoretical • Unsociable • Critical • Negative