



Should Mental Health Be Addressed in Schools? Preliminary Views of In-School Adolescents in Ibadan, Nigeria

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Received 2018 October 31; Revised 2018 November 06; Accepted 2019 January 02.

Abstract

Background: School mental health programs have the potential to bridge the gap in mental health care for young people. There are limited data on the views of young people about these programs in developing countries.

Objectives: The study aimed to determine the views of school-going adolescents on addressing mental health issues in schools.

Methods: In this study, 379 students completed an open-ended semi-structured questionnaire on the suitability of addressing mental health concerns in schools. A subset of students who received a targeted school-based mental health intervention provided additional information on their experience. Data were analyzed using thematic analysis.

Results: The majority of the students indicated that school was not a suitable place for addressing mental health issues. Concerns cited included the deviation from the primary aims of the school system, lack of resources, and the potential for stigmatization. However, the subset of students who received a targeted mental health intervention found it helpful and wished the program could be made more widely available in schools.

Conclusions: This suggests that if well targeted and appropriately delivered, the school-based mental health interventions have the potential to reach Nigerian adolescents in need of mental health interventions, who would, otherwise, be without support.

Keywords: Adolescents, School Mental Health, Low and Middle Income, Nigeria

1. Background

Schools are identified as ideal places to provide comprehensive health services including mental health services to young people (1). This is because a wide range of health services such as promotional and preventive interventions, early identification of at-risk youth, and treatments can be carried out in schools (2, 3). Schools are also more readily accessible and potentially less stigmatizing compared to hospital settings. While school health programs are well developed in many high-income countries (HIC), such programs are yet to be established in many sub-Saharan African countries like Nigeria (4). Studies from Nigeria show that youth experience a wide range of psychosocial and mental health problems and there is potential to address these problems within the school setting (5, 6). While not all children attend and complete school, school enrolment is on the rise in many parts of sub-Saharan Africa (SSA) including Nigeria; the gross enrolment rate for secondary school education in Nigeria

was 41.98% in 2016 (7). This provides the opportunity to tackle the emotional wellbeing of young people within the school environment, which may contribute to greater school retention (8).

Globally, one of the challenges with providing mental health services in schools is a lack of adequate resources and structures within schools to carry out these activities (9). This is especially true for low resourced regions of the world (10, 11). However, most of the formative data for establishing school mental health programs across the world, especially in the SSA region, have been provided by adult policymakers, school administrators, school staff, and teachers (4, 12-14). There is limited information on the views of young people about these programs, especially in low and middle-income countries (LMIC) like Nigeria where availability and access to specialist mental health services are grossly limited (15, 16). Involving youth in these processes may help them to serve as pointers to priority issues to be addressed as the programs are developed (17).

2. Objectives

As part of a wider study that sought to determine the effectiveness of a targeted school mental health intervention for students with significant depressive symptoms in Nigeria (18), this paper reports on the preliminary views of in-school adolescents about providing mental health interventions in schools. The views of students who participated in the targeted intervention are also explored.

3. Methods

3.1. Study Location

This study was a mixed methods study conducted in two public secondary schools in Ibadan, South West Nigeria. Only are the qualitative survey data reported here. Nigeria is the most populous African country with a population of approximately 180 million people of whom 44% are children and adolescents below 14 years of age (7). Ibadan with a population of over five million is the third most populous city in Nigeria after Lagos and Kano and is inhabited predominantly by the Yoruba people. The educational system in the country is such that pupils spend six years in elementary (primary) school, three years in junior high (secondary) school, and three years in senior high (secondary) school (7). Basic education consists of six years of elementary school and three years of junior secondary school. The country has had a school health policy in place since 2006, which includes a small mental health component such as pre-entry psychological screening, as well as student counseling. However, awareness and implementation of the policy by schools have been poor (19). One urban local government area (LGA) (Ibadan North) out of the five urban and six rural LGAs in the city was chosen as the site for the study because of its proximity to the University College Hospital, Ibadan, where the study team was established to allow regular access during the intervention component of the study.

3.2. Sampling and Procedure

A two-stage sampling technique was used to recruit participants in the study. In the first stage, two public schools were randomly selected from a list of all public schools in the chosen LGA. Both were located in a low-density suburban area of the city, which is largely inhabited by the lower and middle-upper class. In the second stage, 200 students from each school were drawn at random from the list of students in the senior secondary classes one to three. Students who were reported

to have learning difficulties by their teachers were excluded because of potential problems with understanding and completing the questionnaires. The measures included a socio-demographic questionnaire (5) and a brief semi-structured open-ended questionnaire that was self-completed. It asked about the suitability of providing mental health interventions in schools, as well as the preferred mode of delivery of such interventions.

The selected students who scored above the cut-off for significant depressive symptoms on the Beck depression inventory (BDI) received a weekly cognitive behavioral therapy (CBT) intervention for five weeks in the wider study (18) and also completed an additional "client satisfaction questionnaire" (20), which was modified to include open-ended questions about their experiences such as what they liked most about the intervention, what they did not like, and how the intervention could be improved in the future.

3.3. Ethical Considerations

This study was approved by the Ethical Review Committee, Oyo State Ministry of Health, Ibadan, Nigeria. Official permission was also obtained from the Oyo State Ministry of Education, and the authorities of the selected schools. Written informed consent was obtained from the participants' parents and guardians, and the participants provided completed informed consent forms.

3.4. Data Analysis

Data were analyzed using thematic analysis (21). Participants' responses to the open-ended questions were entered into a spreadsheet. The responses were read and re-read to identify emergent themes. Initially, 20 participants' texts were coded and a framework for coding was developed for the remaining texts. The codes were critically reviewed and assigned under broader meaningful themes. To depict the main themes, the most expressive quotes of the participants were chosen and presented in the results section. The initial analysis was performed by TB-A and refined through iterative consultations with co-authors.

4. Results

4.1. Socio-Demographic Characteristics of Study Participants

A total of 379 students participated in the study (64.8% females and 35.2 % males). The age of the participants ranged from 13 to 19 years with a mean age of 15.4 years (SD =1.2). The majority of them (71.1%) were Christians and from monogamous families (65.5%).

4.2. Adolescents' Views About School Mental Health

4.2.1. Suitability of School as a Place to Receive Mental Health Interventions

A total of seven themes emerged from this question, four of which were in favor of addressing mental health issues in schools and three were not. They included the following:

4.2.1.1. Schools Are for Learning, Not for Health

The participants described the primary goals of schools as imparting knowledge and not healing, through the following statements:

'Schools are meant to impart formal education not to treat mentally deprived people.'

'Because it is not the duty of school but it is the duty of people in the hospital.'

'Because we learn in school, but we receive treatment at the hospital.'

4.2.1.2. Lack of Resources

The participants emphasized the lack of training of school personnel to help youth with mental health problems:

'Because in school, there are no experienced doctors and nurses to handle the problem.'

'Because teachers may not know the right thing to give the stressed or mentally ill student, teaching is different from doctoring.'

4.2.1.3. School Induces Stress

The participants' responses pointed to poor relationships with teachers, as well as harsh punitive discipline used by their teachers.

'Because the teachers are not ready to listen to your complaints.'

'Some teachers that are not merciful will flog which will lead to more stress.'

4.2.1.4. Stigma

The participants had concerns about other students being aware of their mental health issues if they received interventions in schools, and some thought that mental health problems could be contracted from others who already had the problems:

'Because it can affect other students in that school.'

'People will call the person a diseased person.'

4.2.1.5. Mental Health Is Part of What We Should Learn

Students mentioned that learning about mental health issues could be part of their informal curriculum.

'Because the school is not only for formal education but for all other things associated with it.'

'Clubs can be set up in school to educate students about stress or mental health problems.'

4.2.1.6. Social Support in School Helps Mental Health

The participants mentioned that enough support from teachers and peers in schools can improve mental well-being:

'Because teachers are always after both our physical and mental well-being.'

'Because there are good teachers and friends to make you feel happy and lively.'

4.2.1.7. Easier Access to Mental Health Interventions

The participants mentioned lower costs, reduced stress of traveling to a hospital, and familiarity with the environment as factors that could improve access to interventions.

'Because parents might not have enough money to treat the children and it will be free.'

'It reduces the stress associated with receiving it somewhere else and the student will not be shy.'

4.2.2. Mode of Delivery of Mental Health Interventions in Schools

Participants' responses on the mode of delivery of interventions were divided into three themes: Personnel providing interventions, location, and timing of interventions (Table 1).

4.3. Students' Perceptions of a Targeted School Mental Health Intervention

There were 20 students who received a CBT intervention. In addition to quantitative outcomes, these students completed three open-ended questions to assess their experiences and satisfaction with the program.

(1) What did you like most about the intervention?

Three themes emerged from the question: the content ('the thing I liked most is the information'), the process ('the coordinator of the program is kind and talks softly, so it makes the program easy to understand'), and accompanying refreshments ('the soft drinks provided').

(2) What did not you like about the intervention?

Most of the participants did not identify any issues in the intervention that they did not like. Only reported one participant that the number of sessions was too short ('the

Table 1. Participants Views on the Delivery of School Mental Health Interventions

Themes and Examples	Personnel	Location	Timing of Interventions
1	School principal and teachers	Sickbay, school clinic	Part of formal classes
2	Medical personnel	Private places	Weekends and holidays
3	Mental health specialists	Staff offices	Free periods
4	Ministry officials	Specially designated rooms	As needed
5	Any knowledgeable, caring and patient person	Clean, welcoming rooms	2 - 3 times weekly
6	Peers		

program was too short, I wanted more sessions so I could continue sharing with my mates’).

(3) Suggestions for improvement of the intervention

Two themes emerged from this question: to disseminate the program widely and to have alternate meeting places outside the school premises.

‘Maybe you should take this program to the school network or TV station so that many people that are not here will benefit from it’

‘To meet in a special place outside school’

5. Discussion

This paper reports on the preliminary views of in-school students about receiving mental health interventions in school in an urban LGA in Ibadan, Southwest Nigeria. Despite the fact that schools are globally identified as ideal places for young people to receive mental health services, the majority of the adolescents in this study felt otherwise. Most of them viewed school primarily as a place for learning and not for addressing mental health. This is in keeping with reports that the major challenges in getting schools to embrace mental health care are that schools pride themselves as institutions of learning and not health care institutions (9). It also appears that the students in this study majorly understood mental health interventions as giving treatments and seemed less aware of the promotive and preventive aspects of mental health.

The lack of support for school-based mental health interventions by the majority of the students in this study is in contrast to the Nigerian school health policy that has been in place since 2006 (22). The goals of the Nigerian school health policy are to enhance the quality of health in the school community, as well as create an enabling environment for the promotion of a child-friendly school environment for teaching and learning. Incidentally, recent surveys have found limited awareness of school personnel about this policy and its implementation, which may have limited the students’ understanding of addressing health issues in a school setting (23, 24).

It is also possible that the students were averse to addressing mental health in schools because of the high levels of stigma associated with mental health problems among both adults and children in the society, as in many other parts of the world (25, 26). Students who mentioned stigma talked about discrimination and labeling, as well as “fear of contamination”. These are similar to reports from other parts of Nigeria (27) and these findings indicate the huge need for increased mental health literacy among young people in this environment. A few mental health literacy programs carried out among in-school adolescents in this part of Nigeria have shown promising results with significant changes in mental health knowledge and attitudes using multiple learning methods including drama, which is helpful with dealing with attitudes and social distance (28).

Other reasons given by the participants for not addressing mental health issues in schools such as non-availability of resources are in keeping with the literature from all over the world (10, 29). Increasingly, it has been advocated that teachers can serve as a good resource base for school mental health services. However, there has been a lot of debate about this issue due to the fact that many teachers have little or no training in mental health and may already be overburdened by their teaching duties (6). Though in line with the task-shifting model of health care for poorer resourced regions of the world, having teachers take up mental health care may be overwhelming, especially in low resourced regions like Nigeria where remuneration and motivation for teachers are very poor (30). This may be linked to the poor teacher-student relationships reported by the participants in this study, which calls for more emphasis on mental health promotion training for teachers in this region.

It was encouraging to see that some students in this study found social support in schools and from peers as possible sources of mental health support. Peers are a potential resource to be explored although the challenges are likely to be substantial. Training peer counselors for mental health delivery has been found to be feasible and ef-

fective in changing knowledge and attitudes among college students in this region (31). It remains to see if the same could be done among secondary school students. Although some students mentioned qualified health professionals as possible providers of school mental health, it is unlikely that this group would be able to provide sustained mental health services to schools because of the grossly inadequate numbers of these professionals in the country (32). However, they can play a crucial role in training and supervising others such as peers, teachers, or lay health counselors using the model of task-shifting, which has been used successfully in low and middle-income countries (15, 33).

The range of responses to the locations for the delivery of interventions suggests that many schools do not have appropriate in-house health facilities. However, many participants clearly desired privacy. Suggestions as to the timing of these interventions showed that students would prefer that the interventions do not interfere with regular school activities. This would necessarily prove challenging. However, many schools have allocations for co-curricular activities into which mental health activities could be incorporated. The suggestion to incorporate mental health into routine classes would be an example of a universal mental health intervention. Although this would have the advantage of a wider reach, it is very expensive to run even in high-income countries (34).

For students who participated in the school-based CBT intervention, the quantitative feedback on the client satisfaction questionnaire was quite positive (18). Qualitatively, the participants mentioned the content of the intervention, the manner of the session leader, and the refreshments as what they liked most about the intervention. This particular intervention was carried out by a trained psychiatrist and it will be important to pay adequate attention to relational issues when training non-professionals to deliver this type of intervention in schools.

The views of the majority of the students that school is not a suitable place to receive mental health services are contrary to the positive feedback from participants who attended the intervention. However, the intervention was presented as a skill-building psycho-educational program to manage stress rather than a mental health intervention for depression. Positioning the intervention in this manner may have mitigated some of the student's concerns that such a program may lead to stigma. This should be kept in mind when planning future school interventions to ensure acceptability by students.

5.1. Strengths and Limitations

This study is one of the few to explore the views of young people regarding school-based mental health pro-

grams in a low and middle income countries. However, as students were sampled from only two urban public schools, these views may not be generalizable to all young people in the same region. In-depth interviews or focus groups would also have given greater insight into some of the beliefs and attitudes expressed by the students.

5.2. Conclusions

This study showed that while the majority of the in-school adolescents were not supportive of the idea of addressing mental health concerns in schools, students who were targeted and offered a school-based CBT intervention indicated that they found it helpful and wished such a program could be made more widely available in schools. This suggests that if well targeted and appropriately delivered, the school-based mental health interventions have the potential to reach needy Nigerian adolescents who would, otherwise, be without support.

Acknowledgments

The authors wish to thank the students and their parents for agreeing to participate in the study, and the school authorities for providing the necessary permissions for the study.

Footnotes

Authors' Contribution: All authors contributed to the conception and design of the study. Tolulope Bella-Awusah carried out the initial data analysis and wrote the first draft of the manuscript. All authors read and approved the final draft of the manuscript.

Conflict of Interests: All authors declare that they have no conflict of interests related to the material in the manuscript.

Ethical Considerations: This study was approved by the Ethical Review Committee, Oyo State Ministry of Health, Ibadan Nigeria. Official permission was also obtained from the Oyo State Ministry of Education (Ref. number AD 13/479/535).

Funding/Support: Funding support for this study was received from the John D. and Catherine T. MacArthur Foundation (grant number: 10-95902-000-INP) through the University of Ibadan Centre for Child and Adolescent Mental Health (CCAMH).

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