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Exploring the Knowledge and Behavioural Responses of Tertiary Students towards Mental Health and Illnesses: A Cross-Sectional Study

Francis Awasighe Eremutha[1], Salem Iyorwuese Igyundu[2], Kafayah Adeola Jidda[3]

[1,2]Women Friendly Initiative (WFI), Plot 85A, AAI Employment Area, Off Funtaj College Road, Kuje. FCT, P.M.B. 15324, Wuse Post Office, Abuja, Nigeria
[1]Email: f.eremutha[at]wfi.org.ng
[2]Email: winitiative[at]wfi.org.ng

[3]Department of Health Promotion and Environmental Health Education, Faculty of Education, University of Ilorin, Nigeria
Email: *kafayahjidda[at]yahoo.com*

Abstract: ***The mental health and wellbeing of tertiary students is a concern around the world. The study explored the knowledge, attitudes and behavioural responses towards mental illnesses among undergraduates. A total of 450 students were selected using a 3-stage sampling technique. Data was collected using a self-administered semi-structured questionnaire. A total of 10 Focus Group Discussions was also conducted. The quantitative data were analyzed using descriptive and Chi-square statistics. Furthermore, Spearman rank correlation coefficient was utilized to evaluate the relationship between variables. The information from the FGDs were transcribed and analyzed for themes and contents. Respondents' mean age was 20.4 ± 2.4 years with the majority (52.4%) in the 20 and 24 years age group. The mean knowledge score for mental illness was 15.7 ± 3.3 indicative of an overall good knowledge about mental illness. The mean attitudinal score of respondents was 9.6 ± 2.7 indicative of an overall positive attitude towards mental illness. The mean perception score of respondents was 6.6 ± 1.7 indicative of an overall positive perception about mental illness. There was a significant association between class level of respondents and their knowledge about mental illness (p<0.05). There was also a significant association between age of respondents and their attitude towards mental illness (p<0.05). The correlation revealed significant positive correlations between knowledge and attitudes towards mental illness (r<0.0, p<0.01). Various derogatory words, phrases and slangs were used to describe individuals with mental illness by the participants. Reasons for stigmatization and discrimination against persons with mental illness were fear from lack of understanding about mental illness and fear of attack from such a person. The study recorded generally positive attitudes toward persons with mental illnesses; however, several stigmatizing perceptions were evident in the study findings. Increased mental health awareness and education can reduce the stigma toward mental illness.***

Keywords: mental illness, behavioural responses, stigma, undergraduates

1. Introduction

According to the World Health Organization, health is the state of complete physical, mental and social well-being and not merely the absence of diseases and infirmity [1]. The increasing prevalence of mental illness among young people is a major public health challenge in both developed and emerging countries. According to Esan et al [2], more than 4.5 million children aged 3 to 17 years are diagnosed with behavioural problems, 4.4 million are diagnosed with anxiety disorders, 1.9 million are diagnosed with depression, and more than 73% of college students have a mental health problem. The major health challenges identified among students in tertiary institutions are mental health, psychological problem, infectious diseases and emotional disorder [3]. University students are more vulnerable to various kinds of health problems, ranging from increased stresses to unhealthy lifestyle [4].

The mental health and wellbeing of students is a core concern for universities around the world. There have been several studies suggesting that a high proportion of students experience poor mental health while at university [5]-[7]. Some academic variables like poor learning atmosphere, student victimization, extortion, lack of social activities, huge academic workload, poor grades and relationship issues are common risk factors predisposing students to stress, anxiety, depression and other mild mental health conditions which can degenerate if not addressed early enough [8], [9].

According to Townsend [10], mental illness is a maladaptive response to stressors from the internal or external environment, manifested by thoughts, feelings, and behavioural disturbances. Consequently, people with mental illness are often seen to be aggressive, dangerous, violent, unpredictable in their behaviour, unable to handle too much responsibility, and more likely to commit offenses or harm themselves. These perceptions understandably cause fear and social distance [11]. It is widely accepted that mental health and mental well-being are critical to a happy, satisfactory and meaningful life [12].

Even though a lot of studies have been done on knowledge, attitude and perception towards mental illness, it has been reported that lack of accurate mental health knowledge may be one of the leading factors that may contribute to stereotyping people with mental disorders [13]. People with mental health problems can experience discrimination in all aspects of their lives. Stigma and discrimination are widely experienced by people with mental disorders in many domains of their daily life, such as in employment, schools,

social activities, personal relationships, housing, marriage, and so on. Stigmatization of mental illness has negative effects on the health-seeking behaviour of the victims. Prevailing misconceptions and stigma adversely affect mental health services utilization and it can discourage people who are either totally unaware of existence of services or are unwilling to seek out these services [14]. Stigmatising and discriminating behaviours of individuals are measured by proxy through estimation of their social distance towards those with mental illness [15].

This study therefore explored the knowledge, contact experiences and behavioural responses of young adults in the university setting about mental illness to form a basis for school-based mental health programmes which can help in reducing the burden of the illness.

2. Methods

2.1 Study Design and Setting

This was a cross-sectional descriptive study carried out within the University of Ilorin located at about 10 miles away from the city centre.

2.2 Study Population and Sample Size

The study population consisted of the undergraduates of the University of Ilorin admitted in the 15 faculties of the university. A 3-stage sampling procedure was adopted to identify the study population. The University was stratified into 15 faculties, and 30 students from each faculty were selected using a purposive sample technique. In the final stage, respondents were selected using an incidental sampling technique (students were approached about the study in lecture halls where they were present).

For the qualitative study, a total of 10 Focus Group Discussion Sessions were conducted with students (male and female sessions separately) selected by 5 categories. Each FGD session consisted of 8 participants who are undergraduates of the university and were willing to participate in the study.

2.3 Study Instruments

A self-administered, semi-structured questionnaire was used for the survey. There were a total of 57 questions and these were divided into six sections. The 8-question FGD guide also contained an introduction of the researcher and full disclosure of the research, ethical considerations as well as request for consent

2.4 Data Collection

The validated semi-structured questionnaire was administered to the students within their faculties in the study location by research assistants. Participants who were unwilling to participate were exempted from the survey and were replaced with other willing ones within the faculties. There was a 100% return rate. The FGDs were conducted by an interviewer and audio taped. The interviews lasted for a maximum of 50 minutes in line with the planned interview and follow up questions.

2.5 Statistical Analysis

Information gathered from the questionnaire was cleaned and coded for data entry. It was then entered and analyzed using IBM SPSS software version 29.0. The quantitative data were analyzed for frequency of occurrence. Both descriptive (means and standard deviations) and inferential (Chi-square and Correlations) statistics were used to analyze the data. For the statistical analysis, a p-value less than 0.05 were considered statistically significant. The information from the FGDs were transcribed verbatim and analyzed for themes and contents.

2.6 Ethical Considerations

Approval was obtained from the University Ethical Review Committee to conduct the study. The respondents were anonymous; this was done to ensure confidentiality and verbal informed consent was obtained from each of the respondent. This research did not in any way inflict harm on the respondents and every respondent was treated equally as much as possible. Respondents who refused to participate in the study were not coerced into the study.

3. Results

3.1 Findings from Quantitative Study

3.1.1 Socio-demographic Information

The age of respondents ranged from 17 to 30 years with a mean age of 20.4 ± 2.4 years. The class level of respondents ranged from 100 to 600 levels, majority (95.5%) fell in the range 100 to 400 levels. The major reported source of information was the social media (82.2%).

Table 1: Socio-demographic data of respondents

Socio-demographic variable	N (450)	%
Age		
15 - 19 years	190	42.2
20 - 24 years	236	52.4
25 years and above	24	5.3
Sex		
Male	211	46.9
Female	239	53.1
Marital Status		
Single	445	98.9
Married	4	0.9
Separated	1	0.2
Class level		
100 level	180	40.0
200 level	108	24.0
300 level	74	16.4
400 level	68	15.1
500 level	17	3.8
600 level	3	0.7

3.1.2 Knowledge about Mental illness

Knowledge score for mental illness was calculated for each respondent using a 22-point knowledge scale. Each correct answer had a score of 1 and an incorrect answer or a no

response had a score of 0. The scores were then summed up to give a composite knowledge score for each respondent.

The mean knowledge score for mental illness was 15.7 ± 3.3 which is indicative of an overall good knowledge about mental illness.

Table 2: Knowledge on the causes of Mental Illness

Causes of Mental Illness (N = 450)	Yes
Physical abnormalities in the brain	353 (78.4%)
Heredity	278 (61.8%)
Physical illnesses	260 (57.8%)
Possession of evil spirits	235 (52.2%)
Poor upbringing by parents	286 (63.6%)
Head injury	339 (75.3%)
Childhood illnesses	153 (34.0%)
Substance use	404 (89.8%)
Disturbance in relationship	341 (75.8%)
Stress	378 (84.0%)
Physical abuse	341 (75.8%)
Traumatic events or shock	412 (91.6%)
Poverty	254 (56.4%)

On the normalization of psychosocial problems and mental illnesses, majority (91.6%) of the respondents were of the view that exercise can help maintain mental health balance. On the treatment of mental illnesses, majority (93.8%) of the respondents knew that treatment of people with mental health disorders needs supportive psychological therapy (see Table 4 for details).

Table 3: Knowledge about Mental Illness

Variables	Correct Answers N = 450	%
Exercise can help maintain mental health balance **(True)**	412	91.6
Psychological or psychiatric services should be sought if one suspects the presence of psychological problems or mental disorders **(True)**	415	92.2
Psychological problems can occur at almost all ages **(True)**	386	85.8
Mental disorders and psychological problems cannot be prevented **(False)**	337	74.9
Individuals who have a family history of mental disorders have a higher risk of experiencing psychological problems and mental disorders **(True)**	299	66.4
Individuals with bad temperament are more likely to have psychiatric problems **(True)**	238	52.9
Feelings of sadness and depression are the same **(False)**	276	61.3
The treatment of people with mental health disorders is enough by giving antidepressants **(False)**	326	72.4
The treatment of people with mental health disorders needs supportive psychological therapy **(True)**	422	93.8

3.1.3 Attitude towards Mental Illness

The attitudinal score was calculated for each respondent using a 15-point attitudinal scale. Each positive attitudinal response had a score of 1 while a negative attitudinal response or a no response had a score of 0. The scores were then summed up to give a composite attitudinal score for each respondent. The higher the score, the more positive the attitude; conversely, the lower the score, the more negative the attitude. The mean attitudinal score of respondents was 9.6 ± 2.7 which is indicative of an overall positive attitude towards mental illness.

Table 4: Attitude towards Mental Illness

Variables	SA	A	SD	D	U
I would be afraid to talk to someone with mental illness	96 (21.3%)	139 (30.9%)	60 (13.3%)	117 (26.0%)	38 (8.4%)
I would be upset to be in the same class with someone who has mental illness	113 (25.1%)	134 (29.8%)	79 (17.6%)	86 (19.1%)	38 (8.4%)
I cannot make friends with someone who has mental illness	56 (12.4%)	81 (18.0%)	101 (22.4%)	125 (27.8%)	87 (19.3%)
I cannot render help to someone with mental illness	13 (2.9%)	17 (3.8%)	249 (55.3%)	150 (33.3%)	21 (4.7%)
People with mental illness might attack someone	105 (23.3%)	245 (54.4%)	40 (8.9%)	31 (6.9%)	29 (6.4%)
Mental illness is contagious	16 (3.6%)	45 (10.0%)	248 (55.1%)	116 (25.8%)	25 (5.6%)
If my boyfriend or girlfriend has mental illness, I should break the relationship	72 (16.0%)	83 (18.4%)	94 (20.9%)	115 (25.6%)	86 (19.1%)
I will feel ashamed if my friends found out that somebody in my family has mental illness	36 (8.0%)	130 (28.9%)	133 (29.6%)	106 (23.6%)	45 (10.0%)
People with mental illnesses deserve respect	164 (36.4%)	197 (43.8%)	19 (4.2%)	28 (6.2%)	42 (9.3%)
We must help people with mental illnesses for them to be better	283 (62.9%)	123 (27.3%)	22 (4.9%)	9 (2.0%)	13 (2.9%)
Avoiding people with mental illnesses is a good idea	31 (6.9%)	50 (11.1%)	218 (48.4%)	119 (26.4%)	32 (7.1%)
People with mental illnesses can help others	72 (16.0%)	163 (36.2%)	70 (15.6%)	77 (17.1%)	68 (15.1%)
If any of my friends suffer from mental illnesses, then I would advise them not to tell anyone	27 (6.0%)	54 (12.0%)	234 (52.0%)	98 (21.8%)	37 (8.2%)

Only people who are weak and overly sensitive let themselves be affected by mental illnesses	31 (6.9%)	55 (12.2%)	227 (50.4%)	100 (22.2%)	37 (8.2%)
Students with mental illnesses should not be in regular classes	57 (12.7%)	118 (26.2%)	124 (27.6%)	101 (22.4%)	50 (11.1%)

***Note: SA- Strongly Agree, A- Agree, SD- Strongly Disagree, D- Disagree, U- Undecided**

3.1.4 Perception about Mental Illness

The perception score was calculated for each respondent using a 10-point scale. Each positive perception response had a score of 1 while a negative attitudinal response or a no response had a score of 0. The scores were then summed up to give a composite perception score for each respondent. The higher the score, the more positive the perception; conversely, the lower the score, the more negative the perception. A score of 0 to 5 was categorized as a negative perception score while a score of 6 to10 was categorized as a positive perception score. The mean perception score of respondents was 6.6 ± 1.7 which is indicative of an overall positive perception about mental illness.

Table 5 illustrates the perception of respondents about mental illness.

Table 5: Respondents' Perception about Mental Illness

Variables (N = 450)	Agree	Disagree	Undecided
People with mental health are to be blamed for their conditions	15 (3.3%)	403 (89.6%)	32 (7.1%)
People with mental illnesses cannot work	90 (20.0%)	303 (67.3%)	57 (12.7%)
People with mental illnesses are dangerous	159 (35.3%)	167 (37.1%)	124 (27.6%)
One can tell whether an individual has a mental health disorder through his/her physical appearance	122 (27.1%)	262 (58.2%)	66 (14.7%)
People with mental illness are insane /mad	60 (13.3%)	318 (70.7%)	72 (16.0%)
People with mental illness should be locked up in a room	37 (8.2%)	376 (83.6%)	37 (8.2%)
People with mental illness usually need medication	336 (74.7%)	71 (15.8%)	43 (9.6%)
People with mental illness are often of lower intelligence	47 (10.4%)	354 (78.7%)	49 (10.9%)
People with mental illness cannot be successful in life	22 (4.9%)	389 (86.4%)	39 (8.7%)
Caring for people with mental illnesses in hospitals makes the community feel safer	366 (81.3%)	56 (12.4%)	28 (6.2%)

3.1.5 Mental Health Wellness and Social Connectedness among Respondents

Tables 6 and 7 illustrate the full details of the mental health awareness, wellness and social connectedness of the respondents.

Table 6: Experience of Mental Health Illness among Respondents

Variable	(N=450)	%
Experienced talking to someone with a mental illness		
Yes	228	50.7
No	218	48.4
No response	4	0.9
Ever diagnosed with a mental health disorder		
Yes	22	4.9
No	426	94.7
No response	2	0.4
Ever visited a psychologist or psychiatrist		
Yes	41	9.1
No	407	90.4
No response	2	0.4

Table 7: Mental Wellness and Social Connectedness

Variable	N(450)	%
Sleeping Habit		
8 hours	67	14.9
Below 8 hours	358	79.6
Above 8 hours	19	4.2
No response	6	1.3
Eating Habit		
At least 3 meals per day	194	43.1
Skip meals	207	46.0
Not always hungry	44	9.8
No response	5	1.1
Confidant when stressed or overwhelmed		
God	62	13.8
Family	131	29.1
Friends	93	20.7
Partners	10	2.2
Myself	58	12.9
No one	54	12.0
No response	42	9.3
Doing well in studies		
Yes	155	34.4
Need to improve	285	63.3
No response	10	2.2
Social connectedness		
Have friends	378	84.0
Lone ranger	61	13.6
No response	11	2.4
Full support of family in personal decisions		
Yes	377	83.8
No	64	14.2
No response	9	2.0
Mental Health Support System in school		
Yes	278	61.8
No	148	32.9
No response	24	5.3

3.1.6 Association between Respondents' Characteristics and Knowledge, Attitudes and Perceptions about Mental Illness

There was a significant association between class level of respondents and their knowledge about mental illness ($p<0.05$). Respondents in higher class level are more likely to have better knowledge about mental illness than those in lower class levels. The null hypothesis is therefore rejected for class level.

Table 8: Test of Association between Respondents' Age and Attitude towards Mental illness

Variables	Attitude towards mental illness		
	Negative	Positive	Total
Age			
15 - 19 years	46 (10.2%)	144 (32.0%)	190 (42.2%)
20 - 24 years	34 (7.6%)	202 (44.9%)	236 (52.4%)
≥25 years	11 (2.4%)	13 (2.9%)	24 (5.3%)
Total	91 (20.2%)	359 (79.8%)	450 (100%)

X^2 - 16.579, df - 2, p<0.05

There was a significant association between age of respondents and their attitude towards mental illness (p<0.05). Respondents in higher age group are more likely to have positive attitude towards mental illness than those in lower age groups.

Table 9: Test of Association between Respondents' previous consultation with Psychologist or Psychiatrist and Attitude towards Mental illness

Variables	Perception towards mental illness		
	Negative	Positive	Total
Ever visited a psychologist/ psychiatrist			
Yes	16 (3.6%)	25 (5.6%)	41 (9.1%)
No	75 (16.7%)	332 (73.8%)	407(90.4%)
No response	0 (0.0%)	2 (0.4%)	2 (0.4%)
Total	91 (20.2%)	359 (79.8%)	450 (100%)

X^2 - 10.304, df - 2, p<0.05

There was a significant association between respondents' previous consultation with Psychologist/Psychiatrist and their attitude towards mental illness (p<0.05). Respondents who have previously consulted a psychiatrist or a psychologist are more likely to have positive attitude towards mental illness than those who have not. The null hypothesis is therefore rejected.

The correlation test revealed significant positive correlations between knowledge and attitudes towards mental illness (r=0.23, p<0.01). This indicates a positive relationship between the two variables.

3.2 Findings from Focus Group Discussion

The FGD respondents' age ranged from 17 to 27 years with a mean age of 20.9 ± 2.6 years. There was a total of 10 FGD conducted and each group consisted of 8 participants selected based on their type of residence and departments (details in methodology).

3.2.1 Personal Descriptions of Mental Illness

Various definitions to mental illness were stated by the participants. These included: *'someone that is not okay', 'impairment of the brain', 'not in the right state of mind', 'defect in how the brain functions', 'emotional instability', 'form of illness that is disturbing the mind', 'inability to think straight', inability to concentrate or understand what normal people do', 'not being in your right mindset', 'the brain is not in proper working condition', 'a disrupt in the normal way that your mental health is supposed to be functioning', 'discomfort to the brain to the way you think and the way you do things' and 'a illness that is physical, it's something from the inner'.*

Other associated mental illness with their day to day academic activities: *'It is when my brain is being jam-packed with a lot of school work and assignments, and it causes frustration and depression. Before I don't even know about mental illness until I got to this school environment.'* - female participant

'Mental illness can be as a result of stress. It might be educational stress, may be student having problem listening to different lecturers or having different courses. Or it may be any issues, for instance the problem of transportation in the school, so a student might find it very difficult to cope with the situation and this can lead to mental illness' - male participant

Another participant stated that…*'there are levels to mental illnesses. I will say almost everybody has mental stress and what they are going through, not until it reaches a higher stage before we say this person is mentally ill. Everybody has problem mentally, it's just that it has stages'* - Female Participant

The reported types of mental illnesses included schizophrenia, depression, anxiety, bipolar disorder, obsessive compulsive disorder (OCD), postpartum depression, stress, personality disorder, autism, PTSD etc.

Another participant categorized mental illness types: *'from what I've heard there are 2 types; psychosis and neurosis. So psychosis, we can talk about what affect the psychological aspect, be it something like depression, anxiety, stress and then the neurosis that affect the body function. The psychosis doesn't affect the body functions but affect the behavioural attitude but neurosis affect the body functions because it deals with billions of neurons'* - Male Participant

The following were the reported signs and symptoms of mental illness by the participants: *'Unnecessary nagging', 'withdrawal', 'losing concentration', 'self isolation', 'loss of appetite', 'reacting negatively to things/over-reacting to things', 'mood swing', 'over-sensitivity', 'lack of sleep/Irregular sleeping', 'irrational behaviour/ thinking', 'laughing at things that are not funny' and 'social apathy'.*

Attitudes and Perceptions towards Mental Illness

Majority of the participants' reported first reaction to a mentally ill person was to distance themselves from such a person -*'I will firstly distant myself from the person so that the person won't affect me negatively'* - female participant. Another male participant stated that his first reaction will be *'I put myself into their shoes, I try to view what might cause this thing. My major concern is that I like to help if I see people in that condition'.* A female participant also reported a positive attitude towards a mentally ill person: *'I think the best thing to do is to give them attention, talk to them and provide support'*

There were also mixed feelings about mental illness from some of the participants. A female participant stated that feelings about mental illness *'are separated into positive and negative. For example now, if someone has been battling with mental illness, I have to just distance myself from him.*

On the other side, people may be like this person needs immediate attention, so we can report to maybe the school authority or any authority'.

Another participant reported that people feel it is a sign of weakness so you barely will know when someone has mental illness. Some of the participants stated that most people lack proper understanding on what mental illness truly is about and seemed to see it as a social trend. Others reported that mental illness is being trivialised by students: *'I feel most students tag everything as mentally stressed, especially when we are writing exams or tests, you tend to see it around their social media status, "I'm mentally stressed", "I'm mentally frustrated"'.*

A group of female participants stated that people are insensitive to the challenge faced by person with mental illness. One of them reported that *'some people don't even know what mental illness is, so when they see someone exhibiting some characters, they will say, 'you better hold her and take him to Yaba left' (*mental asylum*). Even the words that come out of their mouths will even add to the issue, because they will be like what's wrong with you, they will even say 'call his/her parents, this one will enter market'(*run wild*).*

Various derogatory words, phrases and slangs were used to describe individuals with mental illness by the participants. These included; '*were*', '*sconscon*', 'psycho', 'mad', 'mentally retarded person', 'out of his mind', 'introverts', 'less privileged', 'miserable', 'handicap', 'imbecile', 'mental', '*ogbaa'*, 'psychopath', 'deranged', '*gangangan*', 'crazy', 'nuisance', 'quack', 'idiots', '*alaganna'*, 'pervert'. Other common phrases used to describe students' frustration with academic stress reported by participants were: *'I'm going through a lot', 'My department is after my life'*

3.2.2 Experience Sharing about Mental Illness

At least 2 participants from each group shared their encounter with a mentally ill person. The seriousness of the experiences shared ranged from mild mental illness to severe mental illness.

Below are few selected and significant experiences shared:

Experience 1

'It was 2019, a friend of mine dissociated himself from everybody, and he isolated himself. If you are talking to him even with the funniest thing, he will just be looking with no reaction at all but he started with some counseling and now he is fine'. Male Participant

Experience 2

'My own encounter wasn't in school but the person is also a student. He got into taking hard drugs and after a while, he started misbehaving, that didn't make him stop though because he felt may be the drugs he takes makes him feel better and the more he took the drug, the more he got worse. He ran mad actually at the long run; that was in our neighbourhood'- male participant

Experience 3

'I came across someone recently with OCD, she was really depressed and has anxiety. So she came from a home that there wasn't peace. So we've been talking and I've been trying to be like a listening ear. She has gone to the therapist before but she says she hasn't seen any improvement in her therapy sessions and all that, so she just needed someone to talk to and open up about it. So I referred her to one of our counsellors in the department and she has been going to meet her ever since then' - Female participant

Experience 4

'A classmate slit her wrist because of the exam stress, she has to be rushed to UITH. Then there was also the speculation that from the house, she may have been put under pressure, maybe she didn't want to study the course, maybe she was forced to and now she felt she cannot do it' - Female participant

Experience 5

*'I have one of recent, actually the guy has been on drugs for a while but of recent he was unable to get those stuff; so he was like everybody is after him, they want kill him. So he's always like he doesn't have belief in anybody, even his roommate, he lost trust in them. If he wants to eat and even the food is cooked in his presence, he will not eat, he will say they've poison the food. To the extent that he was like let me kill myself; he bought sniper (*rat poison*) and drank it. So when that happened, they called me and we have to give him drip to neutralize the poison, then we called his parents and they took him home'* - male participant

Experience 6

*'There was a guy, I think his issue was very serious, the guy's friend is my roommate, the guy was saying that in their department, they don't like him, he's an outcast, he doesn't dress well, they just don't care about anything they put on, they don't care about people, they just do their things in their own way. So people use to neglect him, they don't talk to him, he has only one friend and that one only talk to him in class. So one day we just heard the news that the guy committed suicide. Later the friend told us that time a lecturer was calling the guy imbecile, the whole students joined, "he will not talk to people", "he is 'dindinrin" (*mentally retarded*),' stuff like that, he doesn't open up.' . That was why he killed himself-* male participant

3.2.3 Negativity and Causes of Discrimination against Persons with Mental Illness

The major reason attached to discrimination against persons with mental illness as reported by the participants was fear from lack of understanding about mental illness and fear of attack from such a person as it was generally believed that mentally ill persons have the tendency of causing harm both to themselves and others. Another reason stated by the participant was to avoid contracting the illness. Other reported causes of discrimination against mental illness were lack of empathy towards the mentally ill person and judgmental attitude especially towards those resulting from drug/substance abuse.

All the participants unanimously stated that discrimination against persons with mental illness has negative effect on

their health and well-being. Specifically it was reported that discrimination and stigmatization against mental illness worsens the situation and could lead to suicidal thoughts.

3.2.4 Responsibilities of Students towards Persons with Mental Illness

All participants stated that they would be supportive of any individual with mental illness.

'Assist them in speaking up, encourage them, try to interact with them, associate with them, don't bug them too much, give them the chance to speak up at their own convenient time but make yourself available, let them know they can confide in you when needed'- female participant

Other ways of rendering assistance to persons with mental illness as reported by the participant included: showing them kindness, being sensitive to their needs, not taking them for granted, paying close attention to them and giving them listening ears. Another reported responsibility of students towards their colleagues dealing with mental illness is to inform the parent and/or the school authority to ensure proper management of the individual. In addition, they are to be shown love and respect.

The reported benefits of rendering assistance to person with mental illness as highlighted by the participants are as follows: reduction in the prevalence of mental illness, increased self esteem, improved help-seeking behaviour, adherence to medication regimen, reduction in suicide rate and improved mental health and wellness.

Majority of the participants reported that they will want to be well taken care of should they develop mental illness. They also stated that they would not want to be discriminated or stigmatized. However a few of the participant reported they will choose to be left alone and would rather not inform anyone of their condition.

4. Discussion

This study demonstrated similar socio-demographic characteristics of respondents as other studies conducted on mental illness in the university setting [5]-[7]. The major source of information for the respondents was the social media/internet and also a large percentage of the study participants supported the proposed project intervention of electronic mental health course, this is indicative that mental health education can be made available to this group using the social media and the internet [8].

Study participants had a basic understanding of mental illnesses and recognized an assortment of mental illness causes, types and treatments. Knowledge about mental illness was remarkably good among the respondents. This is in line with the results from the study of Puspitasari [8] where students demonstrated good knowledge of mental health disorders in general. This study measured the knowledge of respondents on the normalization, prevention and treatment of mental illness; this is consistent with a study on mental health literacy measures [16] where similar measures were used to determine the level of knowledge among the study participants.

The study recorded generally positive attitudes toward persons with mental illnesses; however, several stigmatizing perceptions were evident in the study findings. Some respondents still demonstrated negative attitude and perceptions like avoiding people with mental illness and having the view that students with mental illness should be in separate classroom. This according to the respondents is due to the fear of being harmed or attacked by them. These assumptions are consistent with the findings from a qualitative study on medical students [17] where the participants stated that they would be fearful of their safety or would be uncomfortable around someone with a mental illness. It is also consistent with the submission of Bennett and Stennett [11] that fearful disposition often leads to social distancing and stigmatization. Still on stigmatization and discrimination against individuals with mental illness, study participants identified words like "psycho", "crazy" and "nuisance" as words used to describe people with mental illness. This is in accordance with a study conducted in China where similar words like “violent,” “crazy,” “strange” and “useless” were also used to describe people with mental disorders [18]. Health promotion and education campaigns about mental illness and its management are needed to address the stigma and discrimination against mental illness. Health promotion and education campaigns about mental illness and its management are needed to address the stigma and discrimination against mental illness.

Differences in age, sex and educational class level were associated with knowledge, attitude and perception, that is, participants who were in the higher age group, female participants and those who had attained a higher level of education had better knowledge of mental health illness. This is in similar to the study of Aruna [6] that reported insufficient knowledge in early year students in relation to mental health disorders. Also, this study reported a significant association in age and attitude, indicating that study participants in higher age group are more likely to have positive attitude towards mental illness than those in lower age groups.

It was expected that contact experience with mental illness would evoke some level of empathy towards individuals with mental illness but some participants rather attributed the fatality of some of the experiences shared as lack of communication on the part of the individuals with mental illness. However, others had sober reflections on their attitudes of negligence in providing psychosocial support for their classmates who were going through mental health challenges. Most participants also reported that the school system did not provide sufficient mental health education to adequately prepare them to provide appropriate support for individuals with mental illness.

This study also found an association between experience in visiting a psychologist or psychiatrist and attitude; implying that participants who have previously consulted/visited a psychiatrist or a psychologist are more likely to have positive attitude towards mental illness than those who have not. The possible reason for that could be that by having an experience of visiting a professional (psychologist or psychiatrist), students will have more understanding of

mental health issues from interaction with a professional and thereby shape their way of thinking and behaviour towards someone with mental health disorder.

The findings from this study validated a positive correlation between knowledge, attitudes and perceptions. The results further confirmed that students' knowledge about mental illness could affect their perception and behaviour towards individuals with mental health illness. Furthermore, the positive correlation between knowledge and attitudes in this study is in line with the study of Puspitasari et al [8] that showed a positive correlation between knowledge and attitudes among students in an Indonesian University towards mental illnesses.

This study also evaluated the mental health well-being and social connectedness of the participants. Participants had poor sleeping habits (below 8 hours per night) and also reported skipping meals; this is indicative of lack of self care and poor time management. Almost all the participants admitted the feeling of stress, being overwhelmed and the need for academic improvement. The possible explanations could also be as a result of academic workload and other stressors within the school environment (e.g. non-availability of basic amenities, inadequate mental health support system). There was increased awareness and readiness for mental health and psychosocial support among the participants for individuals with mental illness. This is due to the fact all the participants admitted to academic stress although few had personal mental health challenges bordering on financial and family issues.

5. Conclusion

Although the study recorded generally good knowledge and positive behaviours toward persons with mental illnesses; however, mental illness stigma was evident. Awareness programs and campaigns focusing on mental health and well-being should be implemented to increase students' knowledge and also dispel the stigma against individuals with mental illness. Mental health support systems focusing on peer influence and confidential counselling should be strengthened within institutions of higher learning.

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