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EFFECT OF MENTAL HEALTH EDUCATION ON RISKY BEHAVIOURS AMONG IN-SCHOOL ADOLESCENTS IN KOGI STATE NIGERIA

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Abstract: **The study examined the effect of mental health education on risky behaviours among in-school adolescents in kogi state Nigeria. Adolescents are observed to be faced with challenges of ill-health and premature death worldwide because of their involvement in preventable risky behaviours which mental health education has been identified to have the potential to remedy. Mental Health Education Risky Behaviour Inventory - MHERBI (r- 0.81) pretest and posttest was administered among 436 participants before and after eight week mental health education training. Four hypothesis on effect of mental health education on risky behaviour, gender, religion and 3-way interaction effect on gender and religion among those exposed to treatment and control group) were tested at 0.05 level of significance. Data was tested with ANCOVA. There were no significant effect between treatment and control groups ($F_{(1,427)} = .83$; $p > .05$), but experimental group obtained higher score ($\bar{x} = 34.85$) than control group ($\bar{x} = 34.29$). Also 3-way interaction effect on treatment, gender and religion ($F_{(1,427)} = .09$; $p > .05$) is not significant but there were also slightly higher posttest score in both cases. The study concludes that mental health education is realised to have potential of effecting positive health behaviour and healthy lifestyle among in-school adolescents. Mental health education is recommended for inclusion in secondary school curriculum to inculcate positive mental health in in-school adolescents.**

Keywords: **Risky behaviour, In-school adolescents, Mental health education, Gender, Religion.**

1. INTRODUCTION

Adolescents are generally thought to be healthy because they are at the second decade of life when they have survived the diseases of early childhood, and the health problems associated with ageing are still many years away. Even then many adolescents die prematurely as a result of preventable risky behaviours such as substance use, risky sexual acts, unhealthy eating habits, unnecessary worry, and violence. Adolescents according to Amhad, Khalique, Khan and Amir (2007); and Britsch and Olson (2001), are those in the age group between childhood and adulthood, generally viewed as between ages 10 – 19 years. During this period, these young people experience puberty and psycho-social developments. This developmental process may make them to be faced with the problem of trying new experiences and activities that emphasize socializing with peers, and conforming to peers standards. These risky behaviours apply to specific form of inappropriate problem handling and they are understood to be behaviours with undesirable consequences that is accompanied by probability of harm or loss and also lead to enduring negative consequences at considerable costs to individuals, families, and the wider community (Amhad, Khalique, Khan and Amir 2007; Hurrdmann and Richter M 2005).

The World Bank Group Report (2007) postulated that more than a quarter of the world population is between the ages of 10 and 24. Most (86%) of the world's 1.7 billion young people live in the developing countries where they often constitute 30% or more of the population. And that young people (adolescents) account for 15% of the diseases and

injuries worldwide and over one million die each year, mainly from preventable causes. Further that, roughly 70% of premature deaths among adults can be linked to behaviour initiated during adolescence, such as tobacco use, poor eating habits, and risky sex. These place them at serious health challenges. The group revealed further that half of the HIV infections are in people under 25 years, one –third of women in the developing countries give birth from unplanned pregnancies before age 20 on the average, and between 2 and 4 million adolescents undergo unsafe abortion yearly. Also nutritional deficiencies such as anemia are wide spread in both young men and women, and millions of youths (adolescents) die tragically or suffer from ill health because of preventable health hazards such as substance abuse, violence, sexuality problem, road accidents, , suicide, infectious diseases and the over controlled, internalizing or emotional problems like anxiety, bulimia and anorexia nervosa (The World Bank Group Report 2007).

Similarly, Igwe and Ojinnaka (2010) in a cross-sectional study among 900 adolescents selected from 29 secondary schools in Enugu metropolis on the prevalence of psychosocial dysfunction and depressive symptoms among adolescents who abuse substance and the influence of socio-demographic factors and type of substance on the pattern of dysfunction found that a total of 290 students were current substance abusers. In this regard, National Institute on Drug Abuse (1998), declared that substances (alcohol drinking, cigarette smoking, marijuana smoking and illicit drug use) contain various agents that can detriment health and are also associated with an increasing morbidity and mortality among adolescents worldwide but remain the number one risky health behaviour among adolescents. Also many research findings revealed that contemporary adolescents are exposed to other greater health challenges than in their early years. Millions of them may be affected by the effect of inadequate nutrition and micronutrient deficiencies and poor eating habit Olanegan (1999); Kurtzweil (2007); Science Daily News (2011); infectious diseases, violence, anxiety, cultism, crime of different types, and the increased threat of living with HIV/AIDS STIs (National Center for Chronic Disease Prevention and Health Promotion 2010). They need to be equipped with the correct values and skills that will make them face these challenges and assist them in making healthy life-style choices as they grow. Also, Fagan (2006) attested that health behaviours are positively affected by religious practices. His review on religion and crime suggested that, compared with their less religious counterparts, religiously involved individuals are less likely to carry or use weapons, fight, or exhibit violent behaviours. Further to this Fagan (2006) in reference to Regnerus (2001) revealed that boys and girls react differently to same issues and there are consistent gender differences in health behaviours.

Meanwhile, mental health education through schools is expected to be able to contribute to and acceptance of positive change towards risky health behaviour. Mental health education programme is an aspect of the entire health education programme which deals with provision of professionally designed programme for better understanding of the importance of mental wellness and development and maintenance of desirable healthy lifestyles.

Mental health can refer to the ability to think rationally and logically, and to cope with the transitions, stresses, traumas, and losses that occur in all lives, in ways that allow emotional stability and growth. Eaton and Tilley-Gyado (2011) reported that World Health Organisation definition of health is all embracing and implies that the mental health of the citizens of a nation must be given urgent, necessary and desired attention for a nation to be wealthy. Mental health about a person's state of the mind that describes a person's level of cognitive or emotional well-being or an absence of mental disorder as well as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, can enjoy life and procure a balance between life activities and efforts to achieve psychological resilience and is able to make a contribution to his or her community (WHO, 2005). Mentally healthy individuals value themselves, perceive reality as it is, accept its limitations and possibilities, respond to its challenges, carry out their responsibilities, establish and maintain close relationships, deal reasonably with others, pursue work that suits their talent and training, and feel a sense of fulfillment that makes the efforts of daily living worthwhile. But this does not imply that there is absence of distress and suffering, or strict societal conformity (Gale Encyclopedia of Public Health 2011).

Mental health education is practical step towards achieving positive healthy habits and behavioural change among adolescent. Therefore providing students with a professionally designed programme in mental health education programme and activities will help them learn how to cope with all the influences around them, assist in addressing areas like healthy decision making, developing positive self-esteem, handling stress, bullying, and respecting and accepting differences (Susan Byrnes Health Education Center 2005-2011). Comprehensive Health Education (CSHE) is designed to enable students develop healthful behaviours that are based on valid health concepts and the application of skills related to health information literacy, health communication and healthful choices. This is because the focus of health education is ultimately on behaviour, and is balance between behaviour that prevents disease and promotes health and attainment of wellness.

Risky health behaviours among adolescents in Nigeria may lead to mental health problems. Poor mental health impedes an individual's capacity to realize his/her potentials, work productively, and contribute to the community. Mental health education that involves youth development programmes and activities like social youth organizations, clubs and societies, social recreational activities, counseling, role modeling, sex education, nutrition education and job training, and other livelihood programrmes are expected to be an empowerment for school adolescents. This can be done with the use of materials and aids that will break perceived barriers influencing and preventing the adolescents from adopting or maintaining a healthy lifestyle. Experiences from mental health education influence how adolescents feel about themselves, provides supportive and protective factor which adolescents assess for enhancing their health, human potential and provide the choices they make, which can affect their health now and in future. The development of positive attitudes should be emphasized through the teaching and learning process of adolescents to make them realize and utilize their adult potentials effectively. This study therefore, determines the effect of mental health education on risky behaviour among in-school adolescents in western senatorial district kogi state Nigeria.

Statement of the problem

Adolescents of secondary schools age in Western Senatorial District in Kogi State engage in risky behaviours. These behaviours may include substance use, violence, unsafe sexual acts, anxiety and poor dietary habits. The risky behaviours may be as result of inadequate understanding of the negative effects. Risky behaviours can predispose them to health problems such as infectious diseases, psychological problems, heart diseases and probably premature death. But then most of these adolescents' problems have been given little attention or completely ignored, with little understanding of the potential effects in adolescents' life, their society and the nation as a whole. Variables such as religion and gender were also examined in the study. Suggestions were provided on based on the findings on how to develop positive behavioural change among adolescents' towards positive health development in Kogi State, Nigeria.

2. SIGNIFICANCE OF THE STUDY

Most of the adolescents engage in these risky behaviours probably because of lack or inadequate mental health education. It is therefore believed that incidences of risky behaviour are likely to reduce when adolescents are exposed to mental health education. It is on this purpose that this study sought information on the effect of mental health education on in-school adolescents in the western senatorial district of kogi state Nigeria.

3. HYPOTHESES

The following seven hypotheses were generated and tested for the study:

1 There is no significant effect in the risky behaviour of in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

2 There is no significant effect in the risky behaviour of male and female (gender) in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor nutrition, anxiety, and multiple sex partners and those in the control group.

3 There is no significant effect in the risky behaviour of Christian and Muslim (religion) in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

4 There is no significant 3-way interaction effect of treatment on male/female (gender) and Christian/Muslim (religion) in-school adolescent exposed to mental health education risky behaviour on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

4. METHOD AND PROCEDURE

Pretest-posttest quasi-experimental design was used for the study. The population for this study comprised all coeducational (male and female) public Senior Secondary Schools in Lokoja Kogi State, Nigeria. Four hundred and thirty six (436) 69.64% out of six hundred and twenty six (626) students in senior secondary school II (SSS II) from the four (4) sampled schools were used. Simple random sampling technique was used to select the schools and Micro Soft Excel Rand Function was used to select the participants.

The instrument for the study was Mental Health Education Risky Behaviour Inventory (MHERBI) (r = 0.81) which was subjected to face, construct, and content validity. Also Cronbach alpha was used to determine the internal consistency and reliability coefficient at 0.05 alpha level. The reliability score ntal Health Education Risky Behaviour Inventory (MHERBI) was r = 0.81. Inter-rater and Scott's π reliability were used to determine the stimulus instrument and the reliability score was r = 0.69. Pretest and posttest were administered directly to the participants by the trained research assistants and data gathered were analyzed by inferential statistics of Analysis of Co-variance (ANCOVA). The decision to reject or to accept the hypotheses was set at 0.05 alpha level of significant.

5. RESULT AND ANALYSIS

Ho1: There is no significant effect in the risky behaviour of in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

Table 1: Summary of ANCOVA of Posttest Risky Behaviour Scores by Treatment, Gender and Religion.

Source of Variance			Hierarchical Method			
		Sum of Squares	Df	Mean square	F	Sig
Covariates	RISKY	3.198	1	3.198	.127	.722
Main Effects	BEHAVIOUR	93.403	3	31.134	1.233	.297
	(Combined)	20.875	1	20.875	.827	.364
	TREATMENT	.415	1	.415	.016	.898
	GENDER	72.114	1	72.114	2.856	.092
	RELIGION					
3-way Interactions	TREATMENT x GENDER x RELIGION	2.508	1	2.508	.099	.753
Model		247.437	8	30.930	1.225	.283
Residual		10782.911	427	25.253		
Total		11030.349	435	25.357		

Significant of p < .05

From Table 1, there is no significant effect of treatment on students' mental health education risky behaviour ($F_{(1,427)}$ = .83; p >.05). This means that there is no significant differences in the adjusted posttest of mental health education risky behaviour mean score of students exposed to the treatment and their counterparts in the control group. On this basis, hypothesis 1 is accepted.

Table 2: Multiple Classification Analysis of Posttest Risky Behaviour Scores by Treatment, Gender and Religion.

Grand mean = 34.58

Variable + Category		N	Predicted mean		Deviation		Eta	Beta
			Unadjusted	Adjusted for factor and covariates	Unadjusted	Adjusted for factors and covariates		
TREATMENT	Intervention	225	34.8044	34.8458	.2265	.2678	.04	.055
	Control	211	34.3365	34.2924	-.2415	-.2855	6	
GENDER	Male	209	34.5455	34.5434	-3.25E-02	-3.46E-02	.00	,007
	Female	227	34.6079	34.6099	2.995E-02	3.189E-02	6	
RELIGION	Christianity	281	34.8541	34.8843	.2761	.3063	.07	.082
	Islam	155	34.0774	34.0227	-.5006	-.5533	4	
R = .094								
R Squared = .009								

Table 2, shows that students in the treatment group obtained slightly higher mental health $= 34.85; adj.dev = .27)$

education risky behaviour adjusted posttest mean score ($\bar{x}$ than their control group counterparts ($\bar{\mathbf{x}}$ = 34.29; adj.dev =.29). However, this difference is not significant as shown in Table 1.

Ho2: There is no significant difference in the risky behaviour of male and female (gender) in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor nutrition, anxiety, and multiple sex partners and those in the control group.

From Table 1, there is no significant effect of gender on students' adjusted posttest mental health education risky behaviour scores ($F_{(1,427)} = .02$; $p > .05$). This means that male and female students adjusted posttest mean mental health education risky behaviour score do not differ significantly. Hypothesis 2 is therefore accepted. Table 2, however, shows that the female students obtained slightly higher adjusted posttest mean mental health education risky behaviour score ($\bar{\mathbf{x}} = 34.61; adj.dev. = 0.03$) than the male counterparts

($\bar{\mathbf{x}} = 34.54;; adj.dev. = -0.03$).

Ho 3: There is no significant difference in the risky behaviour of Christian and Muslim (religion) in-school adolescents' exposed to mental health education on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

From Table 1, there is no significant effect of religion on students' adjusted posttest mental health education risky behaviour scores ($F_{(1,427)} = 2.9$; $p > .05$). This means that Christian and Muslim students adjusted posttest mean mental health education risky behaviour score differ significantly. Hypothesis 3 is therefore accepted.

Table 2, however, shows that the Christian students obtained slightly higher adjusted posttest mean mental health education risky behaviour score ($\bar{x}$= 34.88; adj. dev. = .31) than the Muslim counterparts ($\bar{x}$= 34.02; adj. dev. =.55).

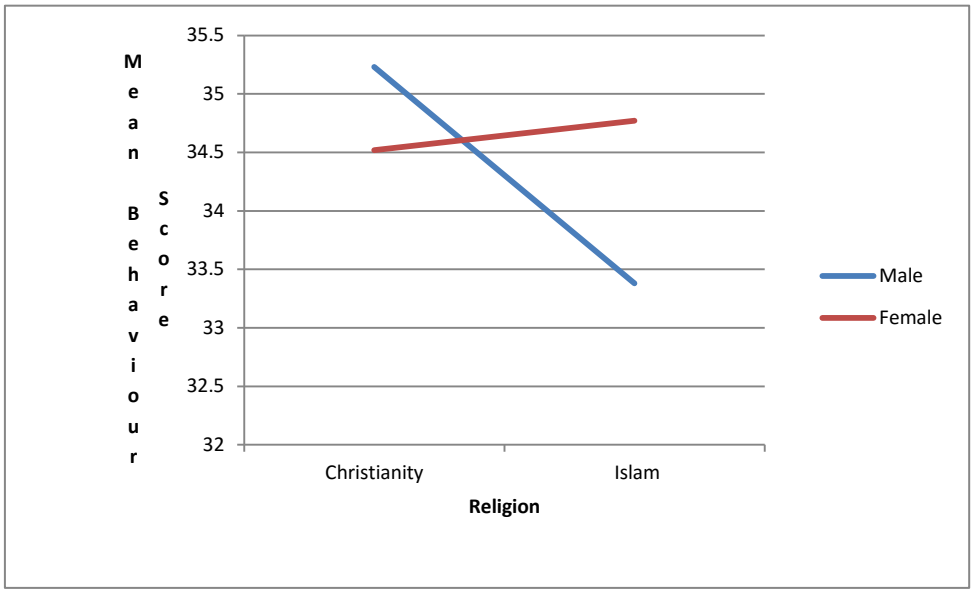

Figure 1; Interaction Effect of Gender and Religion on Mental Health Education Risky Behaviour of Participants.

Figure 1: shows that among the Christian participants, males had higher mean mental health education risky behaviour score ($\bar{\mathbf{x}} = 35.23$) than the females ($\bar{\mathbf{x}}$ 34.52) while the reverse is the case among Muslim where females obtained higher mental health education risky behaviour score ($\bar{\mathbf{x}} = 34.77$) than their male counterparts ($\bar{\mathbf{x}}$ 33.38). This gives a disordinal interaction.

Ho4: There is no significant 3-way interaction effect of treatment on male/female (gender) and Christian/Muslim (religion) in-school adolescent exposed to mental health education risky behaviour on cigarette smoking, alcohol consumption, marijuana smoking, interpersonal violence, poor eating habit, anxiety, and multiple sex partners and those in the control group.

Table 1 shows that there is no significant interaction effect of treatment, gender and religion on students' mental health risky behaviour ($F_{(1,427)} = .09$; $p > .05$). On this basis, hypothesis 7 is not rejected.

6. SUMMARY OF FINDINGS

The findings of the study are summarized as follows:

1. There is no significant difference in the adjusted posttest mental health education risky behaviour mean score of students exposed to treatment and their counterparts in the control group. However students in the treatment group obtained slightly higher mental health education risky behaviour adjusted posttest mean score than their control group counterparts.
2. There is no significant effect of gender on posttest mental health education risky behaviour. Female students obtained slightly higher adjusted posttest mean risky behaviour score than their male counterparts.
3. There is no significant effect on students' mental health education risky behaviour. The Christians in the study obtained slightly higher adjusted posttest scores than their Muslim counterparts.
4. There is no significant 3-way interaction effect of treatment, gender and religion on students' mental health risky behaviour.

7. DISCUSSION

Different educative materials such as prints, fliers, posters portraying some inscriptions and diagram showing the dangers of risky behaviours and their effects on man were used for mental health education the training programme on in-school adolescents. Also appropriate skills and effective teaching methods were adopted during the training programme. Despite that, there was no significance effect in the adjusted posttest mental health education risky behaviour mean score of students exposed to treatment and their counterparts in the control group. However students in the treatment group obtained slightly higher mental health education risky behaviour adjusted posttest mean score than their control group counterparts. Also, there was no significant effect on gender of posttest mental health education risky behaviour but female students obtained slightly higher adjusted posttest mean score than their male counterparts. Further there was no significant effect on religion of posttest mental health education risky behaviour but Christians obtained slightly higher adjusted posttest scores. The 3-way interaction effects of treatment, gender and religion on students' mental health education risky behaviour were not significant too but there were slight increase in the posttest scores than the pretest.

The insignificance differences may be because unhealthy behaviour could be a reflection of poor upbringing by parents and religious leaders. This is because adolescents could gain their health practices largely through family and religious influences which may continues for years in life time. The finding is in agreement with the expression by Awoniyi (2003) that "charity begins at home" and home is the oldest and most unique human institution and the cradle of discipline. Further that home should ensure adequate and effective development of adolescents from childhood beside the provision of care, protection and social skills for a better society. A healthy behaviour need to be developed early in a person's life because it is always difficult to stop once an attitude is formed. This does not mean that parents and religious leaders are pleased with the behaviours of some adolescents but they probably lack the tactics, time, mental health knowledge to handle such problems. It may also be that some parents feel the problems are solely the responsibility of the school teachers to handle the total educational training and most importantly the mental health education of students which may not be possible.

However, the insignificance may be because behavioural change is not an issue that can be sudden but gradual process and that the students will change after sometimes. This is in line with the theory of Prochaska and DiClemente as adapted by Glanz, Rimer, and Lewis (2002), who explained how individual 'readiness' to change or attempt to change from unhealthy behaviour is basically a gradual process and not a sudden event. The change can be achieved and be of great benefits if presented by means of different programmes that can match and interest the individual adolescents. Population Report (1998); Olanipekun (2006) complemented the opined that counseling faces the formidable challenge of changing behaviour which is an incremental process that entails provision of information, teaching new skills, eliciting emotional commitment, creating social support for safer behaviour, and providing services and supplies by helping another as they talk person to person, to help client make a decision or solve problems.

These findings implied that mental health education is important and necessary if adolescents are to live a healthy life that will be free sickness and early death. Also that parents and older adults in the society should be involved greatly in the life and training of adolescents since most of them constitute religious settings in the society. Gender differences should be given adequate attention to allow efficient and effective teaching.

8. CONCLUSION

The following conclusions were drawn based on the findings of the study Mental health education can be potent in successfully stemming risky behaviours among in-school adolescents in Kogi State Nigeria. Therefore it can be concluded that effective mental health education would bring about positive changes to the risky behaviour on interpersonal violence, poor eating habit, anxiety, multiple sex partners and substance use among in-school adolescents in Kogi State. This would help to reduce the rate of anti-social behaviour, ill-health that predetermined poor academic performance and early death among school adolescents which ravages our contemporary society at present and the nearest future. Also the expenses of medical bills and cost of fighting crimes and inadequate gainful employment by the nation will be reduced to the barest minimum.

9. RECOMMENDATIONS

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

1. Adolescents should be educated through mental health education programme in conjunction with teachers, school counselors, parents and religious groups. This will help develop, promote, evaluate and correct behaviours and desirable living against alternative destructive. The activities could be built into recreational, school counseling and devotional activities, or presented on prints, posters, and existing health services within the school system for the students.
2. Religious setting and elders should be sensitized on the need to be involved early in developing and training adolescents' towards healthy life through mental health education programme. They should be made to realize and understand that the younger a person involved in risky behaviour, the more likely the experience will last and continue to endanger his/her health. Mental health education activities can be carried out alongside with religious teachings during adolescents learning and developmental process to encourage and occupy adolescents positively and prevent them from having time for unhealthy negative behaviours that can detriment their health.
3. Government should provide and include vocational activities that can encourage positive mental health development in school programme early to engage students positively and constructively after school periods. This will serve as additional benefits for the students to earn a living and even contribute to the development of the nation as students and even in adulthood.
4. Curriculum planners should understand that mental education health education is mostly taught in disciplines like health education and so they should ensure that such discipline included among the core courses in the secondary school and accorded the same recognition as other core subjects like English and Mathematics.
5. Government should enact legislation to prevent advertisement of things that can promote risky behaviours such as handling of weapons at certain age, nude dressing and prostitution that may encourage risky sexual behaviours and engagement in behaviours like use of substances.

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