

Original Research Article

Knowledge, attitudes, stigma and appropriate referral toward mental illness among secondary school teachers in Southwestern Nigeria: a mixed method study

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Received: 14 August 2026

Revised: 23 September 2026

Accepted: 28 September 2026

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ABSTRACT

Background: Adolescent mental-health problems are important public-health and educational concerns. The ability of school teachers to respond appropriately to mental-health challenges may be affected by appropriate attitude, mental-health literacy, stigma, cultural and religious beliefs about mental illness. The study aimed to assess the knowledge, stigma and attitudes toward mental illness among secondary-school teachers.

Methods: The study employed a cross-sectional design involving mixed-methods of quantitative and qualitative approaches. A validated instrument; Community Attitudes towards Mental Illness (CAMI) scale divided into 4 priori subscales including: Authoritarianism, Benevolence, Social Restrictiveness and Community Mental Health Ideology and Sociodemographic Questionnaire were administered for 125 participants. Focus-group discussions (FGD) and key-informant interviews (KII) explored findings requiring deeper explanations. Data were analysed using SPSS version 20.

Results: The participants had a mean age of 42.05±8.99 years with female preponderance. Most had first degree in education with over 10years of teaching experience. Authoritarianism showed mixed but poor knowledge of mental health while the benevolence social restrictiveness and Community mental health ideology showed harsh reactions towards the mentally-ill. Key informant interview (KII) and focus group discussion (FGD) showed apparent knowledge-gap in description, causes and treatment modalities.

Conclusion: The study identified knowledge gaps as a key determinant of poor teacher mental-health literacy, stigma with poor referral intentions. Findings may inform teacher education, continuing professional development, school mental-health policies, anti-stigma programs and formal referral pathways between schools and mental-health services.

Keywords: Adolescent mental health, Teachers, Mental-health literacy, Stigma, Social distance, Help-seeking, Referral, South West Nigeria, Mixed methods

INTRODUCTION

Adolescence is a formative developmental period characterized by biological, psychological, social, and educational transitions. The world health organization

estimates that approximately one in seven adolescents aged 10–19 years experiences a mental disorder. Depression, anxiety, and behavioral disorders are among the leading causes of illness and disability during adolescence and untreated conditions may impair

educational, interpersonal, and occupational functioning later in life.¹ The WHO guidance recommends school and community platforms for promoting adolescent mental health, preventing mental disorders, and reducing self-harm and related risk behaviors.² Teachers are therefore important gatekeepers because they interact with students regularly and may observe changes in mood, academic performance, social interaction and behaviour. Their role is not to diagnose mental illness but to recognize possible distress, provide appropriate initial support and facilitate referral.

Mental-health literacy refers to knowledge and beliefs about mental disorders that facilitate their recognition, management, prevention and appropriate help-seeking for teachers, which includes recognition of warning signs, understanding of appropriate professional support and confidence in initiating referral.³ A mixed finding has been reported concerning gap in knowledge among teachers in Nigeria. Aluh et al reported low recognition of depression among secondary-school teachers while Atilola et al reported some improvements in teachers' knowledge and confidence about mental illness.^{4,5} Mental-health problems among adolescents are often wrongly interpreted as indiscipline, poor motivation, attention-seeking, spiritual problems or ordinary adolescent behavior which may delay appropriate support.²

The knowledge-gap hypothesis proposes that when information enters a social system, individuals with greater educational and socioeconomic resources may acquire information more rapidly than those with fewer resources. Teachers' mental-health knowledge may differ according to their educational qualification, professional exposure, access to information, training and school resources. The theory therefore provides a framework for examining inequalities in mental-health knowledge which is very crucial in implementing mental health literacy program.⁶ There is a need for a comprehensive mixed-methods investigation of knowledge, attitudes, stigma and appropriate referral intentions among secondary-school teachers in Southwestern Nigeria to reducing stigma around mental illness and to administer appropriate help to those who are mentally ill.

The aim of this study therefore is to assess knowledge, attitudes, stigma, referral intentions toward mental illness among secondary-school teachers in Southwestern Nigeria and to explore factors influencing teachers' responses to students with mental-health problems.

METHODS

Study design

The study employed a quantitative and qualitative design. This mixed method study was adopted because most studies on stigma in Nigeria had used quantitative methods only.

Sampling technique

Five participants from each local government were nominated to attend by the officers in charge making an expected 150 participants.

Using a convenient sampling technique, one hundred and twenty-five teachers were willing to participate drawn from the 30 local governments in Osun state who attended the Rotary international celebration of Mental Health Day program 2024 at Ata Oja secondary school, Osogbo, Nigeria.

Study duration

The study started in October 2024 and was completed in March 2025.

Study criteria

The criteria include mainly secondary school teachers in active public service, principal officers of the ministry of Education with background teaching experience, and teachers who consented to participate were recruited for the study.

While those that were unavailable at the program, available but not in teaching service, or not secondary school teachers were excluded.

Study instrument

Data collection was by 2-section self-administered questionnaires.

Section 1 comprised the socio-demographic characteristics of respondents, including number of years in teaching and cadres.

Section 2 a validated instrument, Community Attitudes towards Mental Illness (CAMI) scale developed by Taylor and Dear^{7,8} was used. This instrument comprises 40 items divided into 4 priori subscales of ten items each viz: Authoritarianism, Benevolence, Social Restrictiveness and Community Mental Health Ideology.

Procedure

For the quantitative data, Questionnaires (CAMI and Questionnaires for Sociodemographic) were distributed to the teachers who were willing to participate after due explanations were given and the questionnaires retrieved by the researcher before the end of the program. A total of 125 questionnaires were retrieved and analysed.

For the qualitative approach, detailed information to participants concerning participation and the consequences of the study was provided and thus participation was voluntary. With the consent of individual participants, all sessions were digitally

recorded and transcribed verbatim. Four In-depth interviews were held with 2 principals and 2 other senior officers of the Osun state ministry of Education while two focus group discussions for other teachers randomly selected of 12 members each.

Thus, for in-depth data, selections were purposively made of the Permanent Secretary of the ministry, a Local Inspector of education and 2 principals of secondary schools in the ministry of education. Focus-group discussions (FGD) and key-informant interviews (KII) explored findings requiring deeper explanation, particularly: reasons for particular attitudes, cultural explanations, religious beliefs, experiences with mentally ill students, barriers to referral, perceptions of psychiatric services and preferred approaches to how teachers can intervene.

Data analysis

The quantitative Data was analysed using the SPSS version 17 and results presented in tables while the qualitative data were transcribed using the traditional manual approach of handwriting before they were typed into Microsoft Word for storage. Also, through a manual approach, the research themes were identified and sorted into likely and unlikely opinions based on the research objectives and assigned to appropriate research objectives. Some of these opinions were presented verbatim in the report.

RESULTS

A total of 125 respondents were recruited for this study. Most respondents were aged 35–45 years 51(40.8%), with a mean age of 42.05 ± 8.99 years. Females constituted the majority 77(61.6%). Christianity was the predominant religion 77(61.6%). Regarding academic qualification, most participants held a BSc Ed 74(59.2%). A large proportion had formal training in education 112(89.6%). In terms of years of education, the majority had >10 years of experience 76(60.8%), with a mean of 13.38 ± 8.81 years Table 1.

From Table 2, the majority of respondents disagreed that large mental hospitals are outdated 71 (56.8%). Most agreed that there is something about the mentally ill that makes them easily distinguishable from normal people 69 (55.2%). A substantial proportion disagreed that less emphasis should be placed on protecting the public from the mentally ill 66 (52.8%). Half of the respondents agreed that mental patients need the same kind of control as young children 63(50.4%). More than half agreed that a person should be hospitalized once signs of mental illness are shown 68 (54.4%). The majority disagreed that mental illness is an illness like any other 71 (56.8%). Most agreed that lack of self-discipline and willpower is a main cause of mental illness 75 (60.0%). A similar proportion agreed that keeping the mentally ill behind locked doors is one of the best ways to manage them 78 (62.4%). The majority disagreed that virtually anyone can become mentally ill 76 (60.8%). Likewise, most disagreed that the mentally ill should not be treated as outcasts from society 75 (60.0%).

Table 1: Socio-demographic characteristics.

Variables	Categories	Frequency	Percentage
Age (years)	<25	3	2.4
	25-35	30	24.0
	35-45	51	40.8
	45-55	31	24.8
	>55	10	8.0
	Mean $\pm$ SD=42.05 $\pm$ 8.99		
Sex	Male	48	38.4
	Female	77	61.6
Religion	Christianity	77	61.6
	Islam	48	38.4
Highest Academic Qualification	B Tech Ed	6	4.8
	BSc Ed	74	59.2
	HND	3	2.4
	M.Sc. Ed	9	7.2
	NCE	29	23.2
	PDGE	4	3.2
Any training in education	Yes	112	89.6
	No	13	10.4
No of years of teaching	<5 years	20	16.0
	5-10 years	29	23.2
	>10 years	76	60.8
	Mean $\pm$ SD=13.38 $\pm$ 8.81		

Table 2: Authoritarianism

Variables	Categories	Frequency	Percentage
Large mental hospital are an outdated means of treating the mentally ill	Strongly disagree	52	41.6
	Disagree	71	56.8
There is something about the mentally ill that makes it easy to tell them from normal people	Strongly agree	53	42.4
	Agree	69	55.2
Less emphasis should be placed on protecting the public from the mentally ill	Strongly disagree	57	45.6
	Disagree	66	52.8
Mental patients need the same kind of control as young children	Strongly agree	62	49.6
	Agree	63	50.4
A person should be hospitalized once he shows signs of mental illness	Strongly agree	57	45.6
	Agree	68	54.4
Mental illness is an illness like any other	Strongly disagree	49	39.2
	Disagree	71	56.8
Lack of self-discipline and willpower is one of the main cause of mental illness	Strongly agree	46	36.8
	Agree	75	60.0
Keeping them behind locked doors is one of the best ways to handle the mentally ill	Strongly agree	41	32.8
	Agree	78	62.4
Virtually any one can become mentally ill	Strongly disagree	44	35.2
	Disagree	76	60.8
The mentally ill should not be treated as outcasts from society	Strongly disagree	46	36.8
	Disagree	75	60.0

Table 3: Benevolence.

Variables	Categories	Frequency	Percentage
The mentally ill are a burden on society	Strongly agree	63	50.4
	Agree	62	49.6
It is best to avoid anyone who has mental problems	Strongly agree	32	25.6
	Agree	91	72.8
Our mental hospitals seem more like prisons than like places where the mentally ill can be care for	Strongly agree	57	45.6
	Agree	64	51.2
More tax money should be spent on the care and treatment of the mentally ill	Strongly disagree	43	34.4
	Disagree	78	62.4
The mentally ill do not deserve our sympathy	Strongly agree	31	24.8
	Agree	87	69.6
The mentally ill have for too long been subject of ridicule	Strongly disagree	40	32.0
	Disagree	80	64.0
We have a responsibility to provide the best care for mentally ill	Strongly disagree	44	35.2
	Disagree	73	58.4
We need to adopt a more tolerant attitude towards the mentally ill in our society	Strongly disagree	41	32.8
	Disagree	78	62.4
Increased spending on mental health services is a waste of tax money	Strongly agree	39	31.2
	Agree	77	61.6
There are sufficient existing mental health services in Nigeria	Strongly agree	46	36.8
	Agree	77	61.6

Table 4: Social restrictiveness.

Variables	Categories	Frequency	Percentage
The mentally ill should be denied their individual rights	Strongly agree	32	25.6
	Agree	84	67.2
Women who were once patients in a mental hospital can be trusted as babysitters	Strongly disagree	61	48.8
	Disagree	58	46.4
The mentally ill should not be given any responsibility	Strongly agree	39	31.2

Continued.

Variables	Categories	Frequency	Percentage
	Agree	77	61.6
Anyone with a history of mental illness should be excluded from taking public office	Strongly agree	46	36.8
	Agree	71	56.8
The mentally ill are far less of a danger than most people suppose	Strongly disagree	32	25.6
	Disagree	83	66.4
I would not want to live next door to someone who has been mentally ill	Strongly agree	60	48.0
	Agree	57	45.6
The mentally ill should be isolated from the rest of the community	Strongly disagree	44	35.2
	Disagree	72	57.6
No one has the right to exclude the mentally ill from their neighborhood of normal life	Strongly disagree	45	36.0
	Disagree	70	56.0
Mentally ill Patients should be encouraged to assume the responsibility of normal life	Strongly disagree	55	44.0
	Disagree	61	48.8
A woman would be foolish to marry a man who has suffered from mental illness, though he seems fully recovered	Strongly agree	42	33.6
	Agree	70	56.0

Table 5: Community mental health ideology.

Variables	Categories	Frequency	Percentage
Having mental patients living in a residential area might be good therapy, but the risks are too great	Strongly agree	61	48.8
	Agree	57	45.6
It is frightening to think of people with mental problems living in residential neighborhood	Strongly agree	49	39.2
	Agree	67	53.6
Mental health centers should be kept out of residential areas	Strongly agree	59	47.2
	Agree	58	46.4
Locating mental health services in residential neighborhoods does not endanger local residents	Strongly disagree	49	39.2
	Disagree	66	52.8
Local residents have good reasons to resist the location of a mental hospital in their area	Strongly agree	49	39.2
	Agree	68	54.4
Residents have nothing to fear from people coming into their area to receive mental health treatment	Strongly disagree	51	40.8
	Disagree	64	51.2
The best therapy for many mental health problems is to be part of a normal community	Strongly disagree	42	33.6
	Disagree	71	56.8
As far as possible, mental health services should be provided through community-based facilities	Strongly disagree	37	29.6
	Disagree	77	61.6
Locating mental health facilities in residential areas downgrades the neighborhood	Strongly agree	45	36.0
	Agree	70	56.0
Residents should accept location of mental health facilities in their neighborhood to serve the needs of the local community	Strongly disagree	41	32.8

Table 3 shows that half of the respondents strongly agreed that the mentally ill are a burden on society 63 (50.4%). A large majority agreed that it is best to avoid anyone with mental problems 91 (72.8%). Most agreed that mental hospitals appear more like prisons than care facilities 64 (51.2%). The majority disagreed that more tax money should be spent on the care and treatment of the mentally ill 78(62.4%). Similarly, most agreed that the mentally ill do not deserve sympathy 87 (69.6%). A substantial proportion disagreed that the mentally ill have long been subjects of ridicule 80 (64.0%). Most respondents disagreed that society has a responsibility to provide the best care for the mentally ill 73 (58.4%).

Likewise, the majority disagreed that a more tolerant attitude should be adopted toward the mentally ill 78(62.4%). Most agreed that increased spending on mental health services is a waste of tax money 77 (61.6%). The majority agreed that there are sufficient existing mental health services in Nigeria 77 (61.6%).

Table 4 revealed that the majority of respondents agreed that the mentally ill should be denied their individual rights 84 (67.2%). Nearly half strongly disagreed that women who were once mental patients can be trusted as babysitters 61 (48.8%). Most agreed that the mentally ill should not be given any responsibility 77 (61.6%).

Similarly, the majority agreed that individuals with a history of mental illness should be excluded from public office 71 (56.8%). A substantial proportion disagreed that the mentally ill are less dangerous than supposed 83(66.4%). Almost half strongly agreed that they would not want to live next door to someone who has been mentally ill 60 (48.0%). The majority disagreed that the mentally ill should be isolated from the community 72 (57.6%). Most also disagreed that no one has the right to exclude the mentally ill from normal neighborhood life 70 (56.0%). Nearly half disagreed that mentally ill patients should be encouraged to assume normal life responsibilities 61 (48.8%). Also, the majority agreed that a woman would be foolish to marry a man who has suffered from mental illness, even if recovered 70(56.0%).

From Table 5, the majority of respondents strongly agreed that having mental patients living in residential areas poses excessive risks despite possible therapeutic benefits 61 (48.8%). Most agreed that it is frightening to have individuals with mental problems living in residential neighbourhoods 67 (53.6%). Similarly, a large proportion strongly agreed that mental health centers should be kept out of residential areas 59 (47.2%). The majority disagreed that locating mental health services in residential neighbourhoods does not endanger residents 66 (52.8%). Most agreed that local residents have good reasons to resist the siting of a mental hospital in their area 68 (54.4%).

A substantial proportion disagreed that residents have nothing to fear from people seeking mental health treatment 64 (51.2%). The majority also disagreed that the best therapy for many mental health problems is integration into a normal community 71 (56.8%). Most disagreed that mental health services should be provided through community-based facilities 77 (61.6%). Similarly, the majority agreed that locating mental health facilities in residential areas downgrades the neighbourhood 70 (56.0%). Also, most respondents disagreed that residents should accept the location of mental health facilities in their neighbourhood 74 (59.2%).

Description of mental illness

The respondents both at KII and FGD describe mental illness as any form of abnormal behaviour that is out of keeping with what is expected in the society. They also share the view that some folks could have been mentally ill for long before they are noticed only by experts and the spiritually gifted while some form of mental illnesses are easily noticed. Mental illness is viewed as being easily recognized while some hold the view that those that are not noticeable are not mental illness but mere personality traits which are not mental illnesses. This inability to recognize the less dramatic mental illnesses is due to the lack of training in mental health rather than a discriminatory attitude.

Causes of mental illness

Findings from the KII and FGD show that the respondents believe that all mental illnesses are caused by spiritual forces that could come in the guise of stresses of life. A good number of them believe that orthodox medical interventions only suppress the symptoms but can never get to the spiritual roots of the illnesses. They corroborated this spiritual etiological concept by referring to scriptural texts from the holy books, experiences of others and documentaries they have watched on the television. When I probed further on how does the attack take place; a pastor among them explained that spirits can attack the mind upturning the thought processes by generating anxiety and stress which invariably predisposes to mental illness. This was corroborated by the Muslims among the group by justifying exorcism. This belief has been established by previous studies in this environment and elsewhere in this cohort. However, they believe in the physical associated causes but basically engineered by spiritual forces.

Treatment modalities

The respondents believe that for the mentally ill to be wholly treated; there is a need for spiritual intervention in the form of exorcism. They claim that some are purely due to the spirits while majority may be caused by a combination of physical and spiritual factors and they canvassed for a medico-psycho-spiritual approach. However, they failed to spell out in clear terms the distinctive criteria to differentiate those caused by the spirit alone from those caused by a combination of the two forms. They are of the opinion that those that are due to spiritual causes can only be discerned by the gifted ones who will perform exorcism. They however believe that when folks are properly treated with kindness and consideration, they may not have mental illness and that folks struggling with challenges of life need counselling and support. They all agreed that patients can be referred to doctors to take medications but will definitely need spiritual support in terms of prayers.

The concept of cure

They do not believe that mental illness can be completely cured especially when it is due to spiritual attack. They are of the opinion that preventive strategies including spiritual armaments. Majority of them expressed opinions that they will not want their children and relatives to marry anyone that is mentally ill. This is definitely a gap in knowledge that mental health education can address.

Role of teachers in the care of the mentally ill

The respondents believe that they play a crucial role in preventing mental illness rather than curing it. They hold on quite strongly to the view that the mentally ill is a 'damaged person' that may not be restored to the previous state except through spiritual intervention. They are

aware of guidance and counselling training but they cannot link its usefulness to detecting early onset of mental illness and instituting appropriate referral.

Opinion about orthodox medical intervention for mental illness

They recognize the role of medical intervention in the treatment of mental illness but they do not see it as first line as they feel prayers and counselling may avert seeing a psychiatrist. They feel that medications only suppress symptoms but do not cure as they have frequent relapses. These are cogent issues that mental health literacy curriculum should address with case studies and lived experiences testimonials.

The role of teachers in community mental health

In one of the key informant interviews; a director in the ministry of education is of the opinion that teachers should play a crucial role in the prevention of mental illness especially the abuse of psycho active substances. The permanent secretary also corroborated this view by describing the teachers as gatekeepers of the adolescents who are in their turbulent years susceptible to mental illness. He is of the opinion that teachers have a vantage position of picking deviant behaviors early and calling the attention of parents to it so that appropriate referrals can be made.

DISCUSSION

The study revealed that there are more females' participants which increases the feasibility and appropriateness of mounting mental health literacy program as they can double as mothers and counsellors. Majority of the respondents have been in the teaching profession for more than ten years and have undergone training in education irrespective of their initial entry point. This could serve as template for mental health literacy training.

The value of this training in education became obvious as they expressed strong professional commitment to their students but only handicapped with the gap in appropriate knowledge. This gap should be the point of focus of training rather than an issue of disconnect for mental health literacy. Their definition of mental illness was closely linked to deviations from psychosocial benchmarks which may help them to detect even cases that may not be dramatic when properly trained.

The attitudes on the authoritarianism scale and elicited negative attitudes where about half feel that the mentally ill need the same kind of control and discipline as a child and others claimed that there is something about them that is easy to tell. These findings are reflective of the stigma concerning mental illness as more than half agree that anyone who shows a sign of mental illness should be promptly hospitalized. Reports have shown that negative

attitudes were mostly mediated by culture, stereotypes, causal explanations, and a lack of understanding about mental health.^{9,10}

From the FGD and KII; the respondents hold a profound spiritual paradigm as template for total recovery for the mentally ill. This they share in common with the traditional and spiritual healers deriving from the African culture which may reflect the finding on the authoritarian scale as negative.

The attitudes on the benevolence subscale and majority of the respondents strongly agreed that the mentally ill are a burden and to avoid anyone with mental health problems. The majority disagreed that more tax money should be spent on the care and treatment of the mentally ill and that they do not deserve sympathy but being subjects of ridicule. Also, most respondents disagreed that society has a responsibility to provide the best care for the mentally ill.

From the FGD and KII; Majority of the respondents do not share the view of their Permanent secretary who sees the school as an institution that can easily identify deviant behaviour, work with the parents and guide in the process of appropriate referral. The reason may be due to gap in appropriate knowledge or lack of exposure and experience on the part of those other teachers compared to the permanent secretary. The other director of education cited a personal professional experience where his timely intervention averted what could have been a mental health crisis in a friend's family.

Social restrictiveness subscale showed that the mentally ill are perceived to be dangerous and should be avoided through their unpredictable behaviour. The majority of respondents agreed that the mentally ill should be denied their individual rights, should not be given any responsibility and should be excluded from public office. This agrees with a study within the university student community, where there is a prevailing presence of negative and stigmatizing attitudes toward individuals with mental illness. These sentiments are characterized by authoritarian and socially restrictive perspectives, as well as a lack of benevolence, which persist despite a general acceptance of community-based mental health treatment.¹¹

From the KII and FGD; it appears the respondents' views that the mentally ill cannot be completely cured is a product of the prevailing sociocultural prescriptions against the mentally ill when they were interviewed on social restrictiveness.

On the community mental health ideology, findings from this study show that the respondents do not have a very robust understanding of their role in community health advocacy. This is because they are not aware that their training as educationists is precariously linked to mental health advocacy and care. The majority of respondents

strongly agreed that having mental patients living in residential areas poses excessive risks despite possible therapeutic benefits. Also, most agreed that it is frightening to have individuals with mental problems living in residential neighborhoods and that mental health centers should be kept out of residential areas.

From the KII and FGD, it's impressive to note that majority of the respondents could not understand that not all mental illnesses are dramatic and that there are some forms of mental illnesses that do not come with drama and violence. This gap in their knowledge also downplays their awareness of the role they can play in the care and advocacy for the mentally ill.

Studies have shown that improved knowledge positively influences attitudes towards mentally ill persons especially with regards to authoritarianism, discriminatory beliefs and social integration. It is obvious that the majority of respondents in this study have not had any form of mental health training although most of them have requisite training in education which should ordinarily serve as template for mental health literacy which is central to the present study.

Mental health literacy as a concept was initially developed from the broader health-literacy literature and encompasses knowledge and beliefs about mental disorders that facilitate recognition, management and prevention. It includes the ability to recognize disorders, knowledge of risk factors and causes, knowledge of self-help, knowledge of professional help, knowledge of effective treatments, attitudes facilitating recognition and help-seeking, knowledge about prevention. Thus, mental-health literacy is broader than simply knowing psychiatric terminology. A teacher may know the term "depression" but lack the ability to recognize depression in a student since a teacher may recognize symptoms but does not know where to refer the student. The present study therefore investigates the needs and emphasis of any mental health literacy in a teacher- population as a strategy of implementation.

Teachers are frequently exposed to students experiencing emotional and behavioural difficulties, yet teacher preparation programmes may devote limited attention to mental health. A Nigerian study of secondary-school teachers found considerable gaps in the recognition of depression and in appropriate professional help-seeking recommendations. Only 16.3% correctly identified the depression vignette, while only 13.5% recommended a psychiatrist or psychologist.¹² The findings in this study are significant because it demonstrates that being a teacher does not automatically confer adequate mental-health literacy.

A recent systematic review of mental-health literacy among secondary-school teachers reported substantial variability in teachers' knowledge and attitudes and found that educational interventions could improve knowledge

and attitudes and reduce stigma.¹³ This supports the argument that teacher mental-health literacy is modifiable rather than fixed. Efforts are required to identify myths and dispel them, educate the teachers on the common types of mental illness such as depression, acute stress disorders and anxiety and not just psychotic disorders to which they erroneously believe comprise the whole sphere of mental disorders. Specific interventions should be geared towards the factors that discourage hostility, social distancing and design strategies to minimize them.

Limitations

The study involved participants from southwestern region schools with good representation of different school types, local government areas, mixed-methods integration and use of interview techniques strengthened the study findings. Although it employed a cross-sectional design, self-report, interview bias, limited audience and requiring further multiregional study to improve the generalisability of these findings.

CONCLUSION

This study observed that insufficient or lack of training in mental health could explain a few hostile positions within the context of a cultural view point but the overall attitude is supportive of care for the mentally ill. This peculiarity may invariably serve as a template for the scaling up program of the WHO especially in a low-income country like Nigeria where spiritual healers are prominent on the pathways of care and prevent patients from having access to orthodox care as the teachers who are also close to the grassroot can serve as a formidable alternative.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Oyewole AO, Oyewole AO, Buhari ON, Ojedokun SA. Knowledge, attitudes, stigma and appropriate referral toward mental illness among secondary school teachers in Southwestern Nigeria: a mixed method study. *Int J Community Med Public Health* 2026;13:5527-35.