

Assessment of the Effectiveness of Mental Health Support Services for Students in Nigerian Tertiary Institutions: Case Study Federal Polytechnic Bauchi

Aliyu Nafisa Bununu¹ Yunusa M. A.², Hajara Ibrahim³

^{1,3}Department of Mass communications Federal Polytechnic Bauchi +234 Nigeria

²Department of Electrical Electronics Engineering Technology Federal Polytechnic Bauchi +234 Nigeria
(nbaliyu.ma@fptb.edu.ng, yunusama@fptb.edu.ng, hibrahim.mac@fptb.edu.ng)

Corresponding Author: yunusama@fptb.edu.ng

Abstract— This study assessed the effectiveness of mental health support services for undergraduate students at the Federal Polytechnic Bauchi, Nigeria, using the Donabedian model as its evaluative framework. A descriptive cross-sectional mixed-methods design was employed with 717 students recruited through stratified random sampling. The GHQ-12 served as the primary screening instrument, administered via Google Forms and analyzed using IBM SPSS Statistics. Probable psychological morbidity was identified in 35.3% of respondents, with depressed mood, chronic strain and sleep disturbance as the most prevalent symptoms. Caseness rates did not differ significantly by gender, age or school of enrolment. Despite this substantial burden only 38.6% of students were aware of campus mental health services and service awareness showed no significant association with reduced morbidity. Distressed students were however, significantly more likely to desire professional support than their non-distressed peers (67.2% vs. 55.2%; $p = 0.002$). The findings reveal a critical misalignment between structural service provision and functional effectiveness challenging the assumption that awareness alone constitutes meaningful intervention. The study calls for outcome-oriented accreditation standards, investment in culturally responsive campus services and longitudinal multi-site research to better understand how institutional service quality shapes student psychological wellbeing in Nigerian tertiary education.

Keywords— mental health, GHQ-12, Nigerian tertiary institutions, psychological morbidity, help-seeking behaviour, campus mental health services, Donabedian model, Federal Polytechnic Bauchi.

I. INTRODUCTION

Mental health is not a peripheral concern in higher education it sits at the very centre of what it means for a student to learn, grow, and eventually succeed. The university years for many young people are the first sustained encounter with independence, academic pressure, social renegotiation and economic uncertainty often happens simultaneously. In a high functioning, well-resourced system, institutions recognise this vulnerability and build around it by providing counselling centres, psychiatric referral pathways, peer support networks and proactive mental health literacy campaigns. The expectation at least in principle, is that tertiary education does not merely transfer knowledge but protects the conditions under which knowledge can actually be absorbed. That expectation in the Nigerian context remains largely aspirational.

Nigeria operates one of the largest higher education systems on the African continent, with over 170 accredited universities and a combined tertiary enrolment exceeding four million students (National Universities Commission [NUC], 2022). The sheer scale of that population makes the mental health question urgent, not academic. Prevalence studies conducted across Nigerian campuses consistently report rates of depression, anxiety and psychological distress that rival, and in some cases exceed figures from institutions in higher income countries. Adewuya et al. (2006) found that approximately 22.6% of students at the Lagos State University College of Medicine met diagnostic criteria for depression a figure that has not meaningfully declined in the two decades

since. More recent work by Fatiregun et al. (2020) documented elevated anxiety symptoms in over a third of undergraduates sampled across southwestern Nigerian universities, with academic workload, financial strain and family pressure cited as dominant stressors. These numbers tell a story that institutional policy has been slow to hear.

The problem is not simply that mental illness exists among Nigerian students that would be true of students anywhere. The problem is the gap between the scale of need and the institutional response designed to meet it. The ideal scenario consistent with guidelines from the World Health Organization (2021) and frameworks endorsed by the Association of African Universities (2019), envisions tertiary institutions that integrate mental health services into core student welfare infrastructure i.e. providing staffed counselling units operating within accessible hours, trained professionals maintaining confidentiality, referral networks connecting campus services to community psychiatry and DE stigmatisation programmes embedded in the academic calendar. A handful of elite institutions in Nigeria notably the University of Ibadan and the University of Lagos maintain counselling centres that approximate this model, at least structurally. For the vast majority however, the reality is considerably thinner: understaffed units, counsellors carrying caseloads that would strain any professional, physical facilities that signal neglect rather than care and a campus culture in which seeking psychological help remains socially fraught (Lasebikan & Ayinde, 2013; Okonkwo et al., 2021).

Previous efforts to understand and address this situation have produced valuable but partial insights. Epidemiological

surveys, particularly those published between 2005 and 2020, have done important work in establishing that the burden of mental ill-health among Nigerian students is real and measurable (Adewuya et al., 2006; Gureje et al., 2010; Nweke et al., 2018). A smaller body of work has examined help-seeking behaviour, typically finding that stigma, cost, and distrust of formal services suppress utilisation even where services nominally exist (Abiodun, 1995; Bella-Awusah et al., 2014). What this literature has not adequately done is shift the analytical lens from the student to the service to ask not only whether students are mentally unwell, but whether the institutional mechanisms designed to support them are actually working, and by what measure we would know. Effectiveness, in this context, is not self-evident. A counselling unit that processes a *high volume of appointments is not necessarily providing care* that improves student outcomes; a unit that sees few students may reflect either low demand or high inaccessibility. Distinguishing between these possibilities requires a different kind of inquiry. The consequences of this analytical gap are both direct and systemic. At the individual level, students who do not receive timely, appropriate psychological support are more likely to experience academic disruption, withdrawal, repeated course failure, extended time to graduation and in severe cases, self-harm or suicide (Okolie et al., 2020; Oyelaran & Fakokunde, 2019). At the institutional level, unaddressed mental health problems inflate dropout rates and depress graduate productivity, outcomes with downstream implications for Nigeria's human capital development agenda. The indirect costs are harder to quantify but no less real: the erosion of campus communities when distress is normalised and help is stigmatised; the professional toll on the small number of counsellors attempting to absorb demand without adequate support; and the cumulative signal sent to students that their psychological wellbeing is not a legitimate institutional concern. These are not theoretical risks. They are documented outcomes of systemic underinvestment (Abdulmalik et al., 2014; Eaton et al., 2014). What remains absent from the literature is a systematic, evidence-based assessment of the effectiveness of mental health support services as they currently operate within Nigerian tertiary institutions not as they are designed on paper, but as students actually experience them. Prior studies have, with some exceptions, treated service availability as a proxy for service effectiveness, an assumption that deserves significant scrutiny. Availability says something about inputs; effectiveness is a question of outcomes. This study intervenes precisely at that gap. Drawing on a mixed-methods framework informed by the Donabedian model of health service evaluation which assesses quality across three dimensions: structure, process, and outcome (Donabedian, 1988) the research examines how institutional mental health services are constituted, how they are experienced by students who engage with them, and whether that engagement produces measurable improvements in psychological wellbeing, academic functioning, or help-seeking orientation. The Donabedian model is particularly well suited to this context because it does not presuppose that structural provision equals effective care it builds that question into the evaluative framework itself.

II. MATERIALS AND METHODS

The study population comprised undergraduate students enrolled at the Federal Polytechnic Bauchi, a public tertiary institution located in Bauchi State, north-eastern Nigeria. A total of 717 students participated in the study. The Federal Polytechnic Bauchi was selected as the study site because it represents a mid-sized Nigerian polytechnic with a diverse undergraduate population drawn from multiple geopolitical zones, making the findings relevant beyond a single institutional context. Participants were recruited using a stratified random sampling technique, with strata defined by academic department and level of study. This approach ensured proportional representation across the institution's faculties and prevented the overrepresentation of any single programme or cohort, thereby strengthening the generalisability of the findings within the study setting (Etikan & Bala, 2017).

Data were collected using Google Forms, an online survey platform that enabled efficient, paperless administration of the study instruments. The choice of Google Forms was deliberate and practical it's the platform that is accessible via both mobile devices and desktop computers which requires no institutional subscription and generates structured datasets that can be exported directly into statistical software without manual data entry, thereby minimising transcription error (Poirier et al., 2017). Given that a significant proportion of the target population accessed the internet primarily through mobile phones this mode of administration was considered more equitable than paper-based alternatives. A brief description of the study's purpose was included with each distribution message to orient potential respondents before they accessed the consent page. The survey remained open for four weeks, during which two reminder messages were sent at weekly intervals to departments where response rates appeared low, in accordance with established survey administration protocols for maximising completion (Sauermann & Roach, 2013). Respondents completed the survey independently at a time and location of their own choosing, which supported autonomy and reduced the social desirability effects that can arise in researcher-administered settings. The anonymity of the online platform further encouraged candid responses, particularly on items relating to mental health symptoms and help-seeking behavior, topics known to carry stigma within Nigerian campus cultures (Okonkwo et al., 2021). The primary instrument used was the General Health Questionnaire-12 (GHQ-12) it's a widely validated self-administered screening tool developed originally by Goldberg (1972) and subsequently refined for use in diverse cultural and linguistic contexts.

Quantitative data exported from Google Forms were analyzed using IBM SPSS Statistics and the results were presented in tables. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were calculated for all demographic variables and GHQ-12 scores to characterize the sample and the distribution of psychological morbidity. The bimodal GHQ-12 scoring method was applied consistently across all cases prior to analysis, and cases with more than 20% missing responses on

the GHQ-12 were excluded from the caseness analysis to preserve scoring validity.

III. ETHICAL CLEARANCE

All procedures were conducted in accordance with the ethical principles outlined in the Declaration of Helsinki (World Medical Association, 2013). Participation in the study was entirely voluntary and all prospective respondents received a written information sheet explaining the purpose of the research, the nature of their involvement, and their right to withdraw at any point without consequence. Written informed consent was obtained from each participant before they were enrolled in the study. To protect confidentiality, no personally identifying information was collected at any stage, and all data were stored securely with access restricted to the research team.

IV. RESULTS

Sociodemographic Characteristics of Respondents

A total of 717 undergraduate students participated in this study over the four-week data collection period. The sample was almost perfectly balanced by gender with females constituting a slight majority and over half of all respondents fell within the traditional undergraduate age range of 17 to 22 years. The School of General Studies contributed the largest proportion of participants, reflecting its broader enrolment base at the institution and most students depended wholly or partially on family financial support. Table 1 presents a full breakdown of the sample's sociodemographic profile.

TABLE 1: Sociodemographic Characteristics of Study Participants (N = 717)

Variable	Category	n	%
Gender	Female	365	50.9
	Male	352	49.1
Age Group	Between 17–22 years	415	57.9
	22 years and above	300	41.8
	Multiple/unspecified	2	0.3
Academic Year	First Year / ND I	310	43.2
	Second Year / ND II	335	46.7
	Third Year / HND I	57	8.0
	Fourth Year / HND II	11	1.5
	Multiple/unspecified	4	0.6
School	School of General Studies	508	70.9
	School of Engineering Technology	194	27.1
	School of Management Sciences / Business Studies	7	1.0
	School of Science and Technology	3	0.4
Source of Income	Support from Family only	422	58.9
	Personal Income & Family Support	204	28.5
	Personal Income only	84	11.7
	Multiple/other combinations	7	0.9

Prevalence of Psychological Morbidity: GHQ-12 Findings

The GHQ-12 bimodal scoring method produced a mean score of 2.45 (SD = 3.02) across the full sample, with scores spanning the entire possible range from 0 to 12. The distribution was right-skewed, reflected in a median of 1.0,

indicating that while the majority of students scored in the lower range, a meaningful minority registered clinically elevated scores. Using the standard caseness threshold of 3 or above, 253 students (35.3%) met criteria for probable psychological morbidity. Notably, 26 respondents (3.6%) achieved the maximum possible score of 12, pointing to a small but vulnerable subgroup experiencing pervasive distress across all GHQ-12 domains. Table 2 presents the full distribution of GHQ-12 scores alongside caseness classification.

TABLE 2: Distribution of GHQ-12 Scores and Caseness Classification (N = 717)

GHQ-12 Score	n	%	Cumulative %	Caseness Status
0	245	34.2	34.2	Non-case
1	128	17.9	52.0	Non-case
2	91	12.7	64.7	Non-case
3	64	8.9	73.6	Case
4	51	7.1	80.8	Case
5	39	5.4	86.2	Case
6	22	3.1	89.3	Case
7	24	3.3	92.6	Case
8	11	1.5	94.1	Case
9	8	1.1	95.3	Case
10	3	0.4	95.7	Case
11	5	0.7	96.4	Case
12	26	3.6	100.0	Case
Total Non-cases (0–2)	464	64.7		
Total Cases (≥ 3)	253	35.3		
Overall Mean (SD)	2.45 (3.02)			
Median	1.0			
Range	0–12			

Note. GHQ-12 bimodal scoring was applied throughout. Caseness threshold set at ≥ 3 , consistent with Goldberg et al. (1997).

Psychological Morbidity by Gender and Age

Gender, age, and school of enrolment were each tested as potential demographic correlates of GHQ-12 caseness using chi-square tests of independence.

TABLE 3: GHQ-12 Caseness by Demographic Characteristics (N = 717)

Variable	Category	n	Cases n (%)	Mean GHQ Score (SD)	χ^2 (df)	p
Gender	Female	365	133 (36.4%)	2.50 (3.03)	0.336 (1)	1.562
	Male	352	120 (34.1%)	2.40 (3.01)		
Age Group	17–22 years	415	140 (33.7%)	2.40 (—)	1.012 (1)	0.315
	22 years and above	300	113 (37.7%)	2.54 (—)		
School	School of General Studies	508	180 (35.4%)	2.55 (—)	0.000 (1)	1.995
	School of Engineering Technology	194	68 (35.1%)	2.25 (—)		

None of the three variables reached statistical significance, indicating that the prevalence of probable psychological morbidity was broadly comparable across the major demographic subgroups represented in the sample. Mean

GHQ-12 scores were also similar across gender and age groups, with differences of less than one point in each case. These findings suggest that psychological distress at FPTB is not a phenomenon confined to any particular demographic subgroup but is distributed across the student body as a whole. Table 3 presents caseness rates and test statistics for each demographic variable.

Item-Level Distress Profiles

Examining responses at the individual GHQ-12 item level reveals the specific psychological domains in which students reported the greatest difficulty. Feeling unhappy or depressed (Q9) attracted the highest proportion of distress-endorsed responses at 30.8%, followed by constant strain (Q5) at 29.0%, and sleep loss due to worry (Q2) at 25.7%. Difficulty overcoming problems (Q6) and reduced ability to enjoy daily activities (Q7) were also among the more prevalent symptoms. In contrast, items related to self-worth and cognitive functioning, such as feeling worthless (Q11) and difficulty concentrating (Q1), showed lower but still notable distress rates. The overall pattern points to an affective and stress-related profile rather than one dominated by cognitive or functional impairment. Table 4 summarizes the distress endorsement rates across all twelve items.

TABLE 4: GHQ-12 Item-Level Response Distribution: Proportion Endorsing Well-Functioning vs. Distress Responses (N = 717)

Item	GHQ-12 Domain	Item Type	Well / Normal Functioning n (%)	Distress Response n (%)
Q1	Able to concentrate	Positive	605 (84.4%)	112 (15.6%)
Q2	Sleep loss due to worry	Negative	533 (74.3%)	184 (25.7%)
Q3	Playing a useful role	Positive	614 (85.6%)	103 (14.4%)
Q4	Capable of making decisions	Positive	614 (85.6%)	103 (14.4%)
Q5	Feeling constantly under strain	Negative	509 (71.0%)	208 (29.0%)
Q6	Unable to overcome difficulties	Negative	539 (75.2%)	178 (24.8%)
Q7	Able to enjoy daily activities	Positive	566 (78.9%)	151 (21.1%)
Q8	Able to face up to problems	Positive	591 (82.4%)	126 (17.6%)
Q9	Feeling unhappy or depressed	Negative	496 (69.2%)	221 (30.8%)
Q10	Losing confidence in self	Negative	584 (81.5%)	133 (18.5%)
Q11	Feeling worthless	Negative	605 (84.4%)	112 (15.6%)
Q12	Feeling reasonably happy	Positive	590 (82.3%)	127 (17.7%)

Awareness of Mental Health and Campus Services

Awareness of mental health observances and campus-specific services was limited across the sample. Fewer than half of respondents had heard of World Mental Health Day, and awareness of World Sleep Day and World Suicide Prevention Day fell below one in four and one in five students respectively. Institutional service awareness was similarly constrained, with nearly two-thirds of the sample unaware of

campus mental health services and over six in ten reporting they had never been briefed on mental health matters within their school. Critically, chi-square tests confirmed that none of these awareness variables was statistically associated with GHQ-12 caseness, indicating that being aware of services was not translating into any measurable protective effect on psychological outcomes. Table 5 presents awareness rates and associated chi-square statistics.

TABLE 5: Awareness of Mental Health Observances and Campus Services, with Association with GHQ-12 Caseness (N = 717)

Awareness Variable	Yes n (%)	No n (%)	$\chi^2(df)$	p
Heard of World Mental Health Day	321 (44.8%)	396 (55.2%)	0.282 (1)	0.595
Heard of World Sleep Day	161 (22.5%)	556 (77.5%)	0.187 (1)	0.665
Heard of World Suicide Prevention Day	142 (19.8%)	575 (80.2%)	0.000 (1)	1.000
Know about campus mental health services	277 (38.6%)	440 (61.4%)	0.000 (1)	1.000
Briefed about mental health in school	249 (34.7%)	468 (65.3%)	0.188 (1)	0.665

Help-Seeking Behaviour and Unmet Need

Just over half of respondents (51.6%) had talked to someone about personal issues during their time at school, while 48.4% had not, a near-even distribution. Having previously talked to someone showed no statistically significant association with caseness ($\chi^2(1) = 0.000$, $p = 1.000$), likely reflecting the predominantly informal nature of those conversations. The most statistically consequential finding across the dataset was the relationship between current desire for professional support and GHQ-12 caseness: students meeting case criteria were meaningfully more likely to express a wish to speak with a health practitioner or trusted person (67.2%) compared to those who did not meet the caseness threshold (55.2%), a difference that reached statistical significance ($\chi^2(1) = 9.320$, $p = 0.002$, Cramer's $V = 0.114$). While the effect size was small, the direction of this association, combined with the finding from Table 5 that 61.4% of students do not know about campus services, *points to a substantive gap between expressed need and institutional capacity to respond*. Table 6 presents the full help-seeking findings including cross-tabulation of unmet need by caseness status.

TABLE 6: Help-Seeking Behaviour and Desire for Professional Support, by GHQ-12 Caseness Status (N = 717)

Variable	Category	Total n (%)	Non-Case n (%)	Case n (%)	$\chi^2(df)$	p	Cramer's V
Talked to someone about personal issues	Yes	370 (51.6%)	239 (51.5%)	131 (51.8%)	0.000 (1)	1.000	—
	No	347 (48.4%)	225 (48.5%)	122 (48.2%)			
Wish to speak with a health practitioner	Yes	426 (59.4%)	256 (55.2%)	170 (67.2%)	9.320 (1)	0.002	0.114
	No	291 (40.6%)	208 (44.8%)	83 (32.8%)			

V. DISCUSSION

The findings of this study paint a sobering picture of the mental health landscape within a Nigerian polytechnic, one that is simultaneously consistent with what prior research has documented and what is troubling is that it adds to that record. A caseness prevalence of 35.3% meaning that more than one in three students at the Federal Polytechnic Bauchi met the GHQ-12 threshold for probable psychological morbidity is not an outlier figure in the Nigerian tertiary education literature. Adewuya et al. (2006) reported a depression prevalence of 22.6% among medical students in Lagos, while Fatiregun et al. (2020) found anxiety symptoms in over a third of undergraduates across southwestern institutions. The current figure sits within and slightly above that range which is significant for two reasons. First, it demonstrates that the mental health burden documented predominantly in university settings is not confined to those institutions; polytechnics, which receive comparatively little research attention carry an equivalent or greater load. Secondly, a prevalence rate that has not meaningfully shifted across two decades of published literature is not a fluctuation on itself rather it is a structural feature of the Nigerian tertiary environment, its one that policy has repeatedly failed to address at scale.

The item-level analysis strengthens this interpretation. The three most frequently endorsed distress responses i.e. (I) feeling unhappy or depressed (30.8%), (II) feeling constantly under strain (29.0%) and (III) sleep loss due to worry (25.7%) this form a recognisable constellation of stress-reactive psychopathology, the kind that is shaped less by individual vulnerability than by environmental conditions: academic pressure, financial precarity and the chronic uncertainty that characterises student life in under-resourced institutions. This pattern aligns with what Nweke et al. (2018) and Oyelaran and Fakokunde (2019) identified as the dominant stressor profiles among Nigerian undergraduates, namely academic workload and economic strain, and it echoes findings from the broader sub-Saharan African literature where structural hardship consistently emerges as a more powerful predictor of student distress than demographic characteristics (Eaton et al., 2014). The absence of significant gender or age differences in caseness rates in the current study reinforces this point. Unlike findings from some Western contexts where female students and older undergraduates have shown elevated distress rates (Eisenberg et al., 2007), the uniform distribution of morbidity across demographic subgroups here suggests that the stressors generating distress at FPTB are not differentially distributed they are ambient conditions that affect most students regardless of who they are.

When viewed through the Donabedian (1988) framework that guided this study, these outcome-level findings become more analytically meaningful when read against the process and structural data captured in the awareness and help-seeking findings. The structural picture that emerges is one of near invisible provision: 61.4% of students did not know that campus mental health services existed and 65.3% had never received any briefing about mental health within their school. These figures are consistent with Okonkwo et al.'s (2021) characterisation of Nigerian campus mental health services as

structurally present but functionally inaccessible, and they extend that critique to a polytechnic context where the evidence base has been particularly thin. Critically, however, the current study adds a finding that prior awareness focused research has not examined with sufficient rigour: awareness, where it existed, made no statistically significant difference to caseness status. Students who knew about campus services were no less likely to be psychologically morbid than those who did not. This null finding challenges a widely held policy assumption that raising awareness of available services is itself a mental health intervention. The data suggest otherwise. Awareness without accessible, trusted and culturally resonant services is not protective; it is simply knowledge of something that is not working.

The help seeking findings deepen this critique. The statistically significant association between GHQ-12 caseness and expressed desire for professional support ($\chi^2(1) = 9.320$, $p = 0.002$, Cramer's $V = 0.114$) confirms a theoretically expected pattern i.e. students who are more distressed want more help. What the data cannot confirm because the services are largely unknown or unused is that this desire is being met. The near even split between those who had talked to someone (51.6%) and those who had not, combined with the absence of any caseness-protective effect from having talked. It further suggests that most help-seeking is occurring informally and without clinical benefit. Bella-Awusah et al. (2014) and Lasebikan and Ayinde (2013) documented similar patterns, noting that Nigerian students consistently prefer informal sources of support, partly because of stigma and partly because formal services lack the cultural legitimacy to attract engagement. The current findings do not merely replicate this; they suggest that even where students express a willingness to engage with professionals, the institutional conditions for that engagement do not consistently exist.

These findings carry meaningful implications for theory, policy and practice. Theoretically, they add empirical weight to critiques of narrow structural models of health service evaluation. The Donabedian framework's distinction between structure, process and outcome is analytically powerful precisely because it refuses to conflate resource allocation with effective care and this study demonstrates that distinction concretely. Institutions can have counselling units on paper without those units functioning in ways that reduce distress. For policy, the findings challenge the Nigerian regulatory ecosystem particularly the National Board for Technical Education and National Universities Commission, to move beyond compliance-oriented service mandates toward outcome linked quality standards. The data make a case not for the presence of mental health services, but for their measurable effectiveness, a distinction that current accreditation frameworks in Nigerian tertiary education do not adequately enforce. At the level of institutional practice, the most actionable implication concerns the design of mental health communication. If awareness is not translating into protection, then institutions must examine not merely whether students know that services exist but whether those services are trusted, destigmatised, physically accessible and staffed by

professionals with adequate time and cultural competence to engage meaningfully with presenting students.

VI. LIMITATIONS

Several methodological considerations temper the conclusions that can be drawn from this study. The cross-sectional design, while appropriate for prevalence estimation cannot establish causal directionality: whether low service awareness causes higher distress or whether distressed students are less able to engage with institutional information theses cannot be determined from these data alone. The reliance on self-report measures, including the GHQ-12, introduces response bias; social desirability effects may have led some students to underreport symptoms particularly given the documented stigma around mental health disclosure in Nigerian campus cultures. The restriction of the sample to a single polytechnic in Bauchi State limits geographic and institutional generalisability and the online administration via Google Forms, while practically efficient may have systematically excluded students with limited internet access or smartphone literacy therefore potentially biasing the sample toward more connected and therefore possibly less economically marginalised students. These limitations do not invalidate the findings, but they do suggest that the prevalence estimates reported here should be treated as conservative rather than comprehensive.

VII. CONCLUSION

This study assessed the effectiveness of mental health support services for undergraduate students at Federal Polytechnic Bauchi by examining psychological morbidity, service availability, awareness, access and help-seeking behaviour. The findings revealed that more than one-third of students experienced probable psychological distress, with depression, chronic stress and sleep difficulties being the most common symptoms. Despite this high prevalence, awareness and utilization of available mental health services were low. Most students were unaware that such services existed and less than two-fifths had received any form of mental health orientation. Importantly, students experiencing psychological distress were significantly more likely to desire professional support, highlighting a gap between student needs and institutional capacity.

The study demonstrated that the mere existence of mental health services does not guarantee their effectiveness. Drawing on the Donabedian framework, it showed that structural provision must be accompanied by accessibility, adequate staffing, cultural sensitivity and continuous evaluation to improve outcomes. The findings suggest a need for policy reforms that emphasize service effectiveness rather than simple service availability. Although limited by its cross-sectional design and single-institution focus, the study provides strong evidence that the mental health challenges in Nigerian tertiary institutions stem largely from inadequate institutional responses. Strengthening mental health support is therefore essential for student wellbeing and educational success.

ACKNOWLEDGMENT

This research work was made possible through the sponsorship of The Institutional Base Research Federal Polytechnic Bauchi by Tertiary Education Trust Fund (TET Fund) in Nigeria.

REFERENCES

- [1] Abdulmalik, J., Fadahunsi, W., Kola, L., Nwefoh, E., Minas, H., Eaton, J., & Gureje, O. (2014). The mental health leadership and advocacy program (mhLAP): A pioneering response to the neglect of mental health in Anglophone West Africa. *International Journal of Mental Health Systems*, 8(1), 1–9. <https://doi.org/10.1186/1752-4458-8-5>
- [2] Abiodun, O. A. (1995). A validity study of the Hospital Anxiety and Depression Scale in general hospital units and a community sample in Nigeria. *British Journal of Psychiatry*, 165(5), 669–672. <https://doi.org/10.1192/bjp.165.5.669>
- [3] Adewuya, A. O., Ola, B. A., Aloba, O. O., Mapayi, B. M., & Oginni, O. O. (2006). Depression amongst Nigerian university students: Prevalence and sociodemographic correlates. *Social Psychiatry and Psychiatric Epidemiology*, 41(8), 674–678. <https://doi.org/10.1007/s00127-006-0068-9>
- [4] Association of African Universities. (2019). *Mental health and wellbeing in African universities: A position statement*. AAU Secretariat.
- [5] Bella-Awusah, T., Ani, C., Ajuwon, A., & Omigbodun, O. (2014). Help-seeking behaviour of secondary school students in southwest Nigeria. *Child and Adolescent Psychiatry and Mental Health*, 8(1), 1–8. <https://doi.org/10.1186/1753-2000-8-18>
- [6] Donabedian, A. (1988). The quality of care: How can it be assessed? *JAMA*, 260(12), 1743–1748. <https://doi.org/10.1001/jama.1988.03410120089033>
- [7] Eaton, J., Kakuma, R., Wright, A., & Minas, H. (2014). A position statement on mental health in the post-2015 development agenda. *International Journal of Mental Health Systems*, 8(1), 28. <https://doi.org/10.1186/1752-4458-8-28>
- [8] Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry*, 77(4), 534–542. <https://doi.org/10.1037/0002-9432.77.4.534>
- [9] Etikan, I., & Bala, K. (2017). Sampling and sampling methods. *Biometrics and Biostatistics International Journal*, 5(6), 215–217. <https://doi.org/10.15406/bbij.2017.05.00149>
- [10] Fatiregun, O. A., Fatoye, F. O., Agidee, R., & Olagunju, A. T. (2020). Anxiety disorders in Nigerian university students: Prevalence and associated factors. *International Journal of Mental Health*, 49(2), 158–173. <https://doi.org/10.1080/00207411.2019.1683539>
- [11] Goldberg, D. P. (1972). *The detection of psychiatric illness by questionnaire*. Oxford University Press.
- [12] Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2010). Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, 186(5), 436–441. <https://doi.org/10.1192/bjp.186.5.436>
- [13] Lasebikan, V. O., & Ayinde, O. O. (2013). Family burden in caregivers of schizophrenia patients: Prevalence and socio-demographic correlates. *Indian Journal of Psychological Medicine*, 35(1), 60–66. <https://doi.org/10.4103/0253-7176.112205>
- [14] National Universities Commission. (2022). *List of approved universities in Nigeria*. Federal Republic of Nigeria. <https://www.nuc.edu.ng>
- [15] Nweke, P. C., Iroegbu, M. E., & Nwosu, A. A. (2018). Prevalence of mental health problems among university students in southeastern Nigeria. *Nigerian Journal of Clinical Practice*, 21(3), 349–355. https://doi.org/10.4103/njep.njep_153_17
- [16] Okonkwo, A. D., Okonkwo, U. P., & Awunor, N. S. (2021). Mental health services in Nigerian universities: Availability, access, and utilisation. *African Health Sciences*, 21(1), 1–9. <https://doi.org/10.4314/ahs.v21i1.2>
- [17] Okolie, C., Awojobi, O. N., & Ugwu, A. (2020). Student suicidality in Nigerian higher education: Epidemiology and institutional response. *Journal of Affective Disorders*, 272, 204–210. <https://doi.org/10.1016/j.jad.2020.03.111>

- [18] Oyelaran, O. T., & Fakokunde, J. B. (2019). Psychological distress and academic performance among undergraduates. *Ife Psychologia*, 27(1), 84–96.
- [19] Poirier, T. I., Behnen, E., & Bushwood, M. (2017). Google Forms as a practical tool for assessment. *Currents in Pharmacy Teaching and Learning*, 9(5), 929–931. <https://doi.org/10.1016/j.cptl.2017.05.014>
- [20] Sauermann, H., & Roach, M. (2013). Increasing web survey response rates in innovation research. *Research Policy*, 42(8), 1,372–1,386. <https://doi.org/10.1016/j.respol.2013.05.007>
- [21] World Health Organization. (2021). *Comprehensive mental health action plan 2013–2030*. WHO Press. <https://www.who.int/publications/i/item/9789240031029>
- [22] World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA*, 310(20), 2,191–2,194. <https://doi.org/10.1001/jama.2013.281053>