








Original Research Article

Understanding knowledge gaps and determinants related to adolescent mental health issues among parents and teachers in Nigeria

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ABSTRACT

Objectives: Early detection of adolescents' mental health conditions is hindered by limited awareness among teachers and parents. This makes teachers' and parents' active involvement in mental health care even more critical, particularly in developing countries like Nigeria. This study, therefore, examines the level and determinants of parents' and teachers' knowledge of adolescent mental health in Nigeria.

Material and Methods: The study used a cross-sectional descriptive survey to assess parents' and teachers' knowledge of adolescent mental health in selected public and private secondary schools across urban and rural areas in the Nigerian Federal Capital Territory (FCT). Participants included 424 parents of enrolled students (selected systematically) and 50 guidance counsellors (purposively chosen) from each school. Data was collected via structured, interviewer-administered questionnaires. Data was analyzed using SPSS version 28.

Results: Among 424 parents, 96.7% were aware of common mental health issues, yet 71.5% felt uncomfortable discussing them with their children, and 75.9% lacked knowledge of warning signs. Older parents (41+ years) had significantly higher odds of good knowledge, while those with only primary education had lower odds. Common challenges identified were depression (35.1%), peer pressure (33.7%), and anxiety (21.2%). Among 50 teachers (guidance counsellors), 82.0% rated their knowledge as poor, with no significant association between knowledge and teaching experience, school type, or location. Only 28.0% had referred students to mental health professionals, with public school teachers making more referrals.

Conclusion: Despite high general awareness, both parents and teachers demonstrated limited practical knowledge, confidence, and engagement in adolescent mental health care. This underscores the urgent need for capacity-building, curriculum integration, and strengthened school-family-professional collaboration.

Keywords: Knowledge, Mental health, Parents and teachers

INTRODUCTION

Adolescence, generally occurring between the ages of 10 and 19 years, is a period of rapid growth marked by significant neurobiological, physical, social, emotional, and intellectual development.^[1] The way adolescents experience and cope with these developmental changes varies, and

difficulty in adapting to such physical, social, mental, and emotional transitions can increase the risk of mental health problems.^[1] Globally, the prevalence of mental health disorders among children and adolescents under 18 years is estimated at 10%–20% (5,6), with mental health conditions in adolescents accounting for 16% of the global burden of disease and injury, and suicide ranking as the

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second leading cause of death.^[2] Mental health is described as a state of well-being that enables individuals to manage everyday stress, realize their potential, learn effectively, work productively, and contribute to their communities.^[3] Students with mental health issues often struggle to fully benefit from academic instruction, resulting in lower achievement and reduced school engagement.^[4] Without timely support, such conditions can harm relationships, academic performance, and overall life outcomes. School-related factors such as fear of failure, parental and teacher pressure, academic workload, relationship breakdowns, and bullying can trigger psychological distress in adolescents. While academic demands aim to improve performance, poorly managed responsibilities may intensify stress and worsen mental health. Common adolescent mental health problems include depression, anxiety, eating disorders, psychosis, and self-harm.^[5] These conditions significantly contribute to the global disease burden among young people, with suicide now the third leading cause of adolescent death.^[6]

Knowledge of mental health encompasses an understanding of its signs, symptoms, causes, and consequences, as well as the ability to identify and categorize various mental disorders.^[7] Mental health knowledge, a subset of health literacy, remains particularly low in many developing nations, including Nigeria.

In Nigeria, studies across different regions have consistently shown that depression is common among children and adolescents, despite variations in prevalence. For example, Patel *et al.*^[8] found a 16.3% prevalence of depression among school-going adolescents in Ido-Ekiti. Similar high prevalence rates have been documented in other parts of the country.^[9,10] In Nigeria, the school health-education curriculum prioritizes hygiene and environmental health, with minimal mental-health content.^[11] Consequently, both students and teachers demonstrate limited knowledge of mental issues.^[12] Since teachers and parents play a vital role in the school environment, improving their mental health literacy, alongside that of students and parents, is considered crucial for effective school-based mental health promotion.^[13] Teachers are considered one of the most underutilized resources in mental health care.^[12] As frontline professionals with daily interaction with children, they are well-positioned to significantly influence students' mental health and overall development.^[14] Research has shown strong links between teacher characteristics and child outcomes, including mental health, behavior, school engagement, and academic achievement.^[15] Given that children spend considerable time in school, teachers have a unique opportunity to monitor various mental health indicators such as academic performance, peer relationships, and classroom conduct.^[12] The study is justified by the high burden of adolescent

mental health problems in Nigeria, coupled with evidence of low mental health literacy among parents and teachers who are key gatekeepers for early detection and support. Understanding their level of knowledge and its determinants is essential to inform targeted school- and family-based mental health interventions and policy planning.

MATERIAL & METHODS

Research design

This study adopted a cross-sectional descriptive survey design to examine the level and determinants of parents' and teachers' knowledge of adolescent mental health in Nigeria. The design was selected because it enables the collection of quantitative data at a single point in time, providing an effective means to assess awareness levels, attitudes, and related socio-demographic factors among the study population. Furthermore, the approach facilitated statistical analysis of associations between variables, including the identification of significant predictors of knowledge levels among parents and teachers.

Study area

The study was conducted in selected public and private secondary schools across the Federal Capital Territory (FCT), Abuja, Nigeria. The inclusion of schools from diverse locations ensured a representative sample of different socio-economic, educational, and cultural backgrounds, which are relevant factors influencing mental health knowledge and perceptions.

Study population

Parents of the selected students were invited to participate in the study. Two teachers, specifically guidance counsellors, were selected from each school, resulting in a total of 50 teachers. Their inclusion was intended to assess their role in supporting adolescent mental health.

Inclusion and exclusion criteria

Parents whose children were currently enrolled in the participating schools and teachers who served as guidance counsellors or were directly involved in student welfare and mental health-related activities were included in the study. Parents or teachers who were unwilling to provide informed consent were excluded, as were teachers who did not have direct responsibilities related to counselling or student welfare.

Sample size and sampling technique

A total of 424 parents and 50 teachers participated in the study. The sample size for parents was determined to provide adequate statistical power for subgroup analysis across

different socio-demographic categories. The teacher sample size was based on the availability of guidance counsellors in selected schools within the study area.

A multistage sampling technique was employed. In the first stage, schools were stratified into public and private categories, with representation from both urban and rural locations within each stratum. In the second stage, parents of students were selected through systematic random sampling from school enrolment lists, while teachers, specifically guidance counsellors, were purposively selected based on their roles in student guidance and counselling services.

Data collection instrument

Data were collected using a structured, interviewer-administered questionnaire developed to assess socio-demographic characteristics, awareness, attitudes, and knowledge related to adolescent mental health. The questionnaire captured information on age, gender, and education level for parents, as well as years of experience, school location, and school type for teachers. It assessed parents' awareness and involvement through questions on the frequency of mental health discussions, preparedness to support adolescents, and sources of mental health information. Attitudes and knowledge were explored by examining parents' comfort in discussing mental health, their ability to recognize warning signs, and awareness of professional help sources, alongside teachers' knowledge levels, curriculum coverage of mental health topics, frequency of classroom discussions, referral practices, and follow-up behavior.

The instrument also elicited parents' perceptions of common adolescent mental health issues, including depression, anxiety, stress, and peer pressure, and assessed teachers' views on available resources and support mechanisms such as workshops, counsellor engagement, and support groups. In addition, selected items were structured to enable logistic regression analysis to identify determinants of knowledge levels among both parents and teachers.

Conceptual framework

To clarify the construct of "knowledge" of adolescent mental health in this study, knowledge is conceptualized as a multidimensional construct encompassing three interrelated domains: awareness, attitudes, and action-oriented knowledge. Awareness refers to the ability of parents and teachers to recognize and understand common adolescent mental health issues, including depression, anxiety, peer pressure, and stress, as well as their prevalence and impact on adolescents' well-being. Attitudes capture the perceptions, comfort level, and willingness of parents and teachers to engage adolescents in discussions about mental

health, which are critical for fostering open communication, providing emotional support, and reducing stigma. Action-oriented knowledge extends beyond awareness and attitudes to include practical competencies, such as recognizing early warning signs of mental health problems, understanding referral pathways and available professional support services, and possessing the ability to offer appropriate guidance, ensure follow-up, or facilitate timely access to care.

Data collection procedure

Trained research assistants administered the questionnaires in participants' preferred language (English or local dialect) to ensure comprehension. Data collection took place within school premises and, for parents, during scheduled school meetings or community outreach events. Prior to data collection, the research assistants were briefed on ethical considerations and interview techniques to minimize bias.

Validity test

Validity is crucial for ensuring the study measures what it is intended to measure. In this study, subject matter experts reviewed the questionnaire to ensure that it accurately captured key concepts such as parental and teacher knowledge of adolescent mental health in low- and middle-income settings. Their feedback ensured that the tool was relevant and reliable for the study's objectives. Triangulation, which involved gathering data from multiple sources (parents and teachers), strengthened the internal validity of the study by providing a more comprehensive understanding of adolescent mental health from different perspectives. The inclusion of both rural and urban settings ensured external validity, as it allowed for generalizing findings across diverse contexts within the FCT. This study instrument consisted primarily of closed-ended questions (dichotomous Yes/No and categorical response options), with no open-ended items used for scoring. Scoring: Knowledge items were summed to generate a composite knowledge score. Respondents scoring $\geq 50\%$ of the total attainable score were categorized as having "good knowledge," while those scoring $< 50\%$ were categorized as having "poor knowledge." This dichotomization was used for descriptive analysis and logistic regression.

Reliability test

The study applied uniform methods during data collection to ensure consistency and dependability. Pilot testing of the questionnaire further enhanced reliability by identifying and addressing potential issues in question clarity, ensuring that the questions were understandable to the target population. This process helped refine the data collection tools to produce reliable results across diverse participant groups. Internal consistency reliability of the knowledge and attitude items was assessed using Cronbach's alpha.

The parental mental health knowledge scale demonstrated acceptable internal consistency (Cronbach's alpha ≥ 0.70), while the teachers' knowledge scale also showed satisfactory reliability (Cronbach's alpha ≥ 0.75), indicating good internal consistency for exploratory population-based research. The study did not require parents to clinically diagnose conditions such as depression or anxiety. Instead, parents were asked to identify commonly perceived mental health issues based on observable behaviors, emotional changes, and commonly recognized symptoms.

Statistical analysis

Data was coded and entered into the Statistical Package for Social Sciences version 28. Descriptive statistics, including frequencies, percentages, and cross-tabulations, were used to summarize socio-demographic characteristics, awareness, attitudes, and perceived challenges.

Bivariate analysis using chi-square tests was conducted to assess associations between categorical variables such as knowledge level and socio-demographic characteristics. Multivariate logistic regression analysis was used to determine the independent predictors of good knowledge among parents and teachers, adjusting for potential confounders. Adjusted odds ratios (AOR) with 95% confidence intervals (CI) were calculated, and statistical significance was set at $p < 0.05$.

Ethical considerations

Ethical approval for this study was sought from the Federal Capital Territory Health Research Ethics Committee with an approval number FHREC/2025/01/12/31-01-01-25. Also, approval was sought from the authorities of the schools before approaching participants. Written informed consent was obtained from all respondents, namely parents and teachers, after explaining the purpose, procedures, risks, and benefits of the study. Participation was voluntary, and respondents were assured of confidentiality and anonymity. Data were stored securely and used solely for research purposes.

RESULTS

Socio-demographic characteristics of parents

Table 1 presents the socio-demographic profile of the parents of adolescents surveyed. Nearly half of the parents (49.1%) were aged above 50 years, followed by 29.0% aged 41–50 years, indicating that most respondents' parents are middle-aged or older. In terms of gender, 56.1% of the parents were female, and 43.9% were male. Regarding educational background, the majority had either tertiary (42.9%) or secondary education (37.5%), while a smaller proportion had primary education (9.0%) or no formal education (10.6%).

Table 1: Socio-demographic characteristics of parents

Parameter	Frequency (N=424)	Percentage (%)
Age		
20 - 30 years	22	5.2
31 - 40 years	71	16.7
41 - 50 years	123	29.0
Above 50 years	208	49.1
Gender		
Male	186	43.9
Female	238	56.1
Education Level		
No formal education	45	10.6
Primary	38	9.0
Secondary	159	37.5
Tertiary	182	42.9

Parental attitudes and knowledge regarding adolescent mental health

Table 2 presents the distribution of parental attitudes and knowledge regarding adolescents' mental health among a sample of 424 parents. A large majority of parents, 303 (71.5%), reported feeling uncomfortable discussing mental health with their children, compared to only 121 (28.5%) who felt comfortable having such conversations. Furthermore, 322 (75.9%) parents indicated they were not well-informed about the warning signs of mental health issues in adolescents, while just 102 (24.1%) considered themselves well-informed. Regarding awareness of professional help sources for adolescent mental health, 354 (83.5%) parents reported knowing such resources, whereas 70 (16.5%) did not.

Table 2: Parental attitudes, knowledge, and awareness regarding adolescents' mental health

Parameter	Frequency (N=424)	Percentage (%)
Awareness of common adolescent mental health issues		
No	14	3.3
Yes	410	96.7
Comfort level in discussing mental health with a child		
Uncomfortable	303	71.5
Comfortable	121	28.5
Well-informed knowledge of mental health warning signs in adolescents		
Not well-informed knowledge	322	75.9
Well-informed knowledge	102	24.1
Knowledge of professional help sources for adolescents' mental health		
No	70	16.5
Yes	354	83.5

Factors associated with parents' knowledge of adolescent mental health

Table 3 illustrates the bivariate and multivariate logistic regression analysis of factors associated with parents' knowledge of adolescent mental health. The results show that parents aged 41–50 years (AOR = 4.205, p = 0.007) and those above 50 years (AOR = 8.306, p < 0.001) had significantly higher odds of having good knowledge compared to those aged 20–30 years. Additionally, parents with a primary education level showed a significantly lower odds ratio (AOR = 0.227, p = 0.041) of having good knowledge compared to those with no formal education. Other variables were not statistically significant.

Common adolescent mental health issues as perceived by parents

Figure 1 demonstrates that depressive symptoms constitute the most prevalent mental health challenge, affecting 149 (35.1%) of adolescents. Closely following is peer pressure, reported by 143 (33.7%). These two issues collectively account for nearly seven out of every ten cases, establishing them as the predominant concerns in adolescent mental health. Anxiety disorders emerge as the third most common challenge, impacting 90 (21.2%). While less prevalent than depression or peer pressure, anxiety still affects more than one-fifth of the adolescent population studied, warranting considerable clinical attention. Other mental health issues show relatively lower prevalence rates. Stress-related symptoms were reported by 37 (8.7%), while miscellaneous

concerns categorized as "other" accounted for only 5 (1.2%).

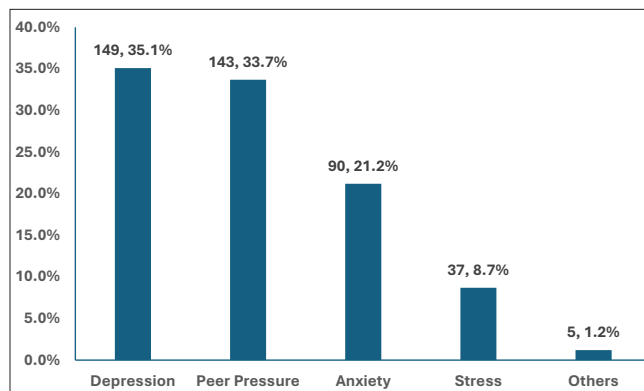


Figure 1: Common adolescent mental health issues as perceived by parents

Teachers (guidance counsellors)

Distribution of teachers' socio-demographic characteristics by school type

Table 4 illustrates the distribution of teachers' socio-demographic characteristics by school type. The table shows that a higher proportion of private school teachers have 1–10 years of experience (62.1%) compared to public school teachers (23.8%), while more public-school teachers have over 10 years of experience (76.2%). Regarding location, most private school teachers are from rural areas (72.4%), whereas public school teachers are more evenly distributed between urban (47.6%) and rural (52.4%) settings. Overall,

Variables	Poor	Good	COR (95% CI)	P-value	AOR (95% CI)	P-value
Parents' knowledge of adolescent mental health	59 (13.9%)	365 (86.1%)	-	-	-	-
Age						
20 - 30 years	8 (13.6%)	14 (3.8%)			Ref.	-
31 - 40 years	20 (33.9%)	51 (14.0%)	1.457 [0.530-4.004]	0.465	1.435 [0.515-4.001]	0.490
41 - 50 years	15 (25.4%)	108 (29.6%)	4.114 [1.479-11.442]	0.007*	4.205 [1.484-11.915]	0.007*
Above 50 years	16 (27.1%)	192 (52.6%)	6.857 [2.504-18.776]	<0.001*	8.306 [2.844-24.257]	<0.001*
Parents Gender						
Male	23 (39.0%)	163 (44.7%)			Ref.	
-	-	-				
Female	36 (61.0%)	202 (55.3%)	0.792 [0.451-1.389]	0.416	1.049 [0.576-1.912]	0.875
Parents education level						
No formal Education	3 (5.1%)	42 (11.5%)		-	Ref.	-
Primary	9 (15.3%)	29 (7.9%)	0.230 [0.057-0.924]	0.038*	0.227 [0.055-0.940]	0.041*
Secondary	23 (39.0%)	136 (37.3%)	0.422 [0.121-1.477]	0.177	0.770 [0.209-2.830]	0.693
Tertiary	24 (40.7%)	158 (43.3%)	0.470 [0.135-1.637]	0.236	0.797 [0.219-2.900]	0.731

Source: Field Survey *Significant at p<0.05 COR: Crude odds ratio, AOR: Adjusted odds ratio CI: Confidence intervals, Ref. = Reference category.

64% of all teachers are from rural areas, and 54% have more than 10 years of teaching experience.

Table 4: Distribution of teachers' socio-demographic characteristics by school type

Parameter	School type		Overall n (%) (N=50)
	Private	Public	
	n (%) (N=29)	n (%) (N=21)	
Years of teaching experience			
1 – 10 years	18 (62.1%)	5 (23.8%)	23 (46.0%)
Above 10 years	11 (37.9%)	16 (76.2%)	27 (54.0%)
Location			
Urban	8 (27.6%)	10 (47.6%)	18 (36.0%)
Rural	21 (72.4%)	11 (52.4%)	32 (64.0%)

Adolescent mental health knowledge among teachers (guidance counsellors)

Table 5 presents the distribution of teachers' (guidance counsellors') knowledge and attitudes regarding adolescent mental health across private and public schools, with a total of 50 participants. A large majority of teachers rated their knowledge of mental health issues in adolescents as poor, with 22 (75.9%) from private schools, 19 (90.5%) from public schools, and 41 (82.0%) overall indicating this perception. Only a small proportion reported having good knowledge, including 7 (24.1%) from private schools, 2 (9.5%) from public schools, and 9 (18.0%) overall. The chi-square test showed no significant difference between school types in this regard ($X^2 = 1.762, p = 0.184$). When asked whether mental health is given enough attention in the school curriculum, 14 (48.3%) private school teachers and 12 (57.1%) public school teachers responded "no," resulting in an overall dissatisfaction rate of 26 (52.0%). The difference between school types was not statistically significant ($X^2 = 0.384, p = 0.536$). Additionally, most teachers reported discussing mental health with students not frequently, 22 (75.9%) from private schools, 18 (85.7%) from public schools, and 40 (80.0%) overall, showing no significant variation by school type ($\chi^2 = 0.739, p = 0.390$). Regarding involvement in mental health support, 24 (82.8%) private school teachers and 12 (57.1%) public school teachers reported never referring a student to a mental health professional, with 36 (72.0%) overall indicating the same. However, among those who had made referrals (14 or 28.0%), a significantly higher proportion were from public schools: 9 (42.9%) compared to 5 (17.2%) from private schools ($X^2 = 3.964, p = 0.046^*$). Among these 14 teachers, half (50.0%) reported following up with students either frequently or not frequently, with no significant difference observed in follow-up behavior between school types ($X^2 = 0.311, p = 0.577$).

Table 5: Adolescent mental health knowledge among teachers (guidance counsellors)

Parameter	School type		Overall n (%) (N=50)
	Private n (%) (N=29)	Public n (%) (N=29)	
How would you rate your knowledge of mental health issues in adolescents?			
Poor	7(24.1%)	2 (9.5%)	9 (18.0%)
Good	22 (75.9%)	19 (90.5%)	41 (82.0%)
X2	1.762		-
P-value	0.184		-
Do you feel that mental health is given enough attention in your school's curriculum?			
No	14 (48.3%)	12 (57.1%)	26 (52.0%)
Yes	15 (51.7%)	9 (42.9%)	24 (48.0%)
X2	0.384		-
P-value	0.536		-
How often do you discuss mental health with your students?			
Not frequently	22 (75.9%)	18 (85.7%)	40 (80.0%)
Frequently	7 (24.1%)	3 (14.3%)	10 (20.0%)
X2	0.739		-
P-value	0.390		-
Role of teachers (guidance counsellors) in mental health support			
Have you ever referred a student to a mental health professional?			
No	24 (82.8%)	12 (57.1%)	36 (72.0%)
Yes	5 (17.2%)	9 (42.9%)	14 (28.0%)
X2	3.964		-
P-value	0.046*		-
If yes, how often do you follow up with the student afterward? (n = 14)			
Not frequently	2 (40.0%)	5 (55.6%)	7 (50.0%)
Frequently	3 (60.0%)	4 (44.4%)	7 (50.0%)
X2	0.311		-
P-value	0.577		-

Source: Field Survey *Significant at p<0.05

Resources to support student mental health among the teachers

Figure 2 illustrates the distribution of respondents' identification of various indicators associated with students' mental health issues, categorized by school type (Private, Public). The most identified indicator was participation in mental health workshops, recognized by 42% of all respondents (24% private, 18% public), followed closely by engagement with counsellors, which was reported by

37% overall (20% private, 17% public). Access to external resources was also cited by 26% of respondents overall (12% private, 14% public), while support groups were the least frequently recognized sign, with only 26% overall (15% private, 11% public) identifying it as such.

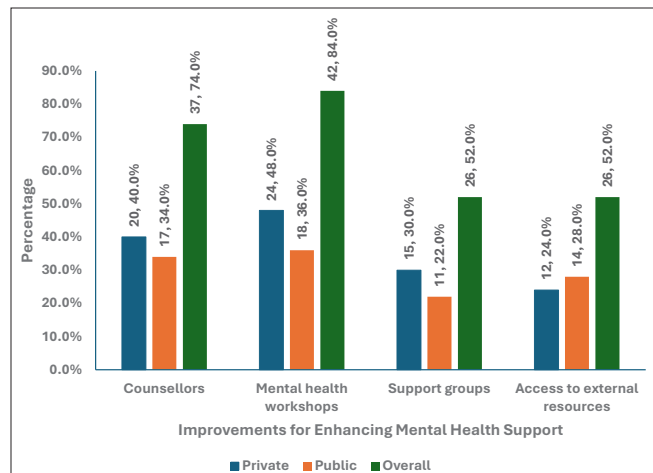


Figure 2: Resources to Support Students' Mental Health among the Teachers

Factors associated with teachers' knowledge of adolescent mental health

Table 6 presents the bivariate and multivariate logistic regression analysis of factors associated with teachers' knowledge of adolescent mental health. Most teachers demonstrated good knowledge of adolescent mental health (82%). However, years of teaching experience, school location, and school type were not significantly associated with teachers' knowledge, as none of the crude or AOR were

statistically significant (all $p > 0.05$). This indicates that these factors did not independently predict teachers' mental health knowledge in this study.

DISCUSSION

Although an overwhelming majority of parents reported being aware of common adolescent mental health issues, only a few engaged in daily conversations with their children about mental health. Alarmingly, nearly a third admitted to never discussing mental health at all. This disconnect between awareness and active engagement may be due to deep-rooted cultural stigma, discomfort with psychological terminology, or a lack of training on how to initiate such conversations. Additionally, most parents expressed discomfort in discussing mental health with their adolescent children. These indicators reinforce the notion that awareness without adequate understanding or communication skills remains superficial. Comparable studies, such as those by Corrigan *et al.*^[16], found that misconceptions about mental issues often contribute to poor detection, delayed treatment, and increased adolescent vulnerability.

When asked to identify common adolescent mental health issues, parents pointed to depressive symptoms, peer pressure, and anxiety as the top concerns. These align with global literature and support findings that list depression and anxiety as leading causes of illness and disability among adolescents.^[17,18] However, parental emphasis on emotional support and resource facilitation, without corresponding emphasis on open dialogue, raises concerns about whether adolescents feel emotionally safe and heard. This is particularly important because emotional validation and safe spaces are critical components of resilience-building among youth.

Variables	Poor	Good	COR (95% CI)	P-value	AOR (95% CI)	P-value
Teachers' knowledge of adolescent mental health	9 (18.0%)	41 (82.0%)	-	-	-	-
Years of teaching experience						
1 – 10 years	4 (44.4%)	19 (46.3%)		-	Ref.	-
Above 10 years	5 (55.6%)	22 (53.7%)	0.926 [0.217-3.953]	0.918	0.498 [0.099-2.502]	0.398
School location gender						
Urban	2 (22.2%)	16 (39.0%)		-	Ref.	-
Rural	7 (77.8%)	25 (61.0%)	0.446 [0.082-2.425]	0.350	3.358 [0.556-20.262]	0.187
School type						
Private	7 (77.8%)	22 (53.7%)		-	Ref.	-
Public	2 (22.2%)	19 (46.3%)	3.023 [0.559-16.334]	0.199	0.447 [0.074-2.686]	0.379

Source: Field Survey Significant at $p < 0.05$ COR: crude odds ratio, AOR: adjusted odds ratio, CI: confidence intervals, Ref. = Reference category.

The regression analysis highlights key demographic predictors of parental knowledge. Parental age and education level were statistically significant. Older parents aged 41 and above were significantly more likely to possess good knowledge of adolescent mental health, suggesting accumulated life experience or increased exposure to mental health information over time. This finding contradicts some assumptions that younger parents, who typically have more years of internet use and higher education levels, demonstrate greater digital parenting awareness, which includes both protecting children from online risks and encouraging efficient, positive use of digital tools.^[19] Surprisingly, higher levels of formal education did not show a significant correlation with increased knowledge in the multivariate analysis, except for parents with primary education, who were significantly less likely to possess adequate mental health knowledge compared to those with no formal education. This unexpected result may suggest either limitations in the type of education received or that those with no formal schooling rely more on community-based knowledge systems or religious and traditional structures that incorporate practical awareness of emotional distress, albeit outside formal diagnostic frameworks.

This study's findings also showed that only a small number of guidance counsellors rated their knowledge of adolescent mental health as "good," with a significant percentage reporting poor knowledge. Public school teachers, in particular, showed the highest proportion of poor knowledge. This deficiency was statistically consistent across both school types, with no significant difference observed. Such findings reveal a critical gap in mental health literacy among school staff. This is consistent with international research showing that even when counsellors are well-positioned to support adolescents, they often lack adequate training in assessment, referral, and intervention for mental health issues.^[20] Findings from Atilola *et al.*^[21] and Oduguwa *et al.*^[22] show that quality training programs significantly improve the knowledge and skills of guidance counsellors and peer counsellors, enabling earlier identification and intervention for students experiencing psychological distress. While 48.0% of respondents feel that mental health is given enough attention in the school curriculum, only 20% frequently discuss mental health with students, underscoring the gap between perceived importance and real engagement.

Teachers across both private and public schools overwhelmingly identified mental health workshops and access to counsellors as top priorities for improving adolescent mental health support in schools. Multi-tiered systems that combine universal programs (like workshops), targeted interventions, and individualized counselling have been shown to improve academic and psychosocial outcomes for adolescents.^[23,24] However, successful implementation requires adequate training for staff, involvement

of students in program design, and strong leadership to foster a culture that prioritizes mental well-being.^[25,26]

Referrals of students to mental health professionals were markedly low, with less than half of counsellors having ever made such referrals. Even when referrals were made, only half of these professionals reported consistent follow-up practices. Even when referrals are made, consistent follow-up is frequently lacking, which can undermine the effectiveness of the support provided and reduce the likelihood of positive outcomes for students.^[27] Studies suggest that improving mental health literacy among school staff and fostering stronger collaboration between schools and mental health professionals can increase both the frequency and quality of referrals, as well as ensure better follow-up and continuity of care.^[27,28]

Regression analysis did not show statistically significant associations between years of teaching experience and mental health knowledge, nor between school location and knowledge. This suggests that experiential learning alone is not sufficient to build competence in adolescent mental health. This shows that structured and ongoing professional development remains critical. While one might expect urban teachers or those in private schools to be more knowledgeable due to exposure or better facilities, the data reflect a more complex reality, revealing that access to information does not equate to understanding or preparedness.

Although awareness of adolescent mental health was high among parents, the widespread discomfort in discussing mental health reflects persistent cultural stigma, moral interpretations of psychological distress, and norms that discourage open parent-child communication on emotional issues in Nigeria. The strong association between parental education and knowledge underscores enduring curriculum gaps, where mental health remains marginal in both formal education and adult health promotion. Among teachers, poor knowledge and low referral practices are further explained by limited pre-service and in-service training, minimal mental health content in the school curriculum, and the severe scarcity of child and adolescent mental health services in Nigeria, which constrains referral pathways even when problems are recognized. These contextual factors highlight that improving adolescent mental health outcomes requires not only awareness campaigns, but also curriculum reform, stigma-reduction strategies, teacher capacity-building, and strengthened school-health system linkages tailored to the Nigerian setting.

LIMITATIONS

This study employed a cross-sectional design, which limits the ability to establish causal relationships between socio-demographic factors and knowledge of adolescent mental

health. The reliance on self-reported data from parents and teachers may have introduced social desirability and recall biases, potentially leading to over- or underestimation of knowledge levels and practices. Additionally, the teacher sample was relatively small and limited to guidance counsellors in selected schools within the FCT, which may affect the generalizability of the findings to other regions of Nigeria or to teachers without counselling roles.

Mitigation strategies

To reduce response bias, trained interviewers administered structured questionnaires in participants' preferred language, ensuring clarity and consistency. The inclusion of both public and private schools across urban and rural settings improved representativeness. Future studies could adopt longitudinal or mixed-method designs, include larger and more diverse samples of teachers, and incorporate objective knowledge assessments or qualitative interviews to strengthen validity and enhance the generalizability of findings.

Implication of the findings

The findings underscore the need for stronger interprofessional collaboration between the education, healthcare, and public health sectors. Specifically, the low practical knowledge and referral practices among teachers highlight the importance of structured partnerships between schools and mental health professionals to support early identification and continuity of care. For educators and school counsellors, the results support integrating targeted mental health literacy training and clear referral pathways within the school system. For public health planners, the identified gaps among parents and teachers point to the need for community- and school-based mental health promotion programs that align educational interventions with public health strategies. Policymakers can use these findings to inform policies that strengthen school health programs, embed mental health content into national curricula, and promote coordinated frameworks linking schools with primary healthcare and mental health services. Collectively, these implications enhance the manuscript's relevance to a multidisciplinary readership by demonstrating how evidence can inform collaborative, system-level responses to adolescent mental health needs.

CONCLUSION

The study reveals significant gaps in practical mental health knowledge, confidence, and engagement among Nigerian parents and teachers, despite generally high awareness. Parents, particularly those with lower educational attainment, often lack comfort discussing mental health and have limited ability to recognize warning signs, while teachers and guidance counsellors demonstrate low mental

health literacy, minimal classroom engagement, and weak referral and follow-up practices. These findings point to systemic shortcomings in school-based mental health support. Addressing these gaps requires targeted, evidence-informed interventions, including integrating mental health literacy into secondary school curricula through structured teacher training, delivering parent-focused psychoeducation via school-parent platforms to improve communication and reduce stigma, and establishing formal school-to-health referral pathways to strengthen continuity and effectiveness of adolescent mental health care.

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