

A survey of the implementation of participation strategies to enhance inclusive workplaces in the public and private educational systems in Lagos State

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Abstract

This survey examined the implementation of participation strategies to enhance inclusiveness of workplaces in the public and private educational systems in Lagos State, Nigeria for mental health service users. The study employed a multistage sampling technique to select 346 school administrators. The survey was largely quantitative, but three open-ended questions subjected to qualitative analysis were included to add depth to the analysis. Data were analyzed using descriptive, bivariate inferential and multivariate statistical methods. The results described only a minimal adoption of a collaborative strategy in schools. Private and public schools minimally engage in networking and cooperative structures. It was revealed that anti-stigma programs for prevention and intervention were in place in both private and public schools. A discrepancy in the government level of support was observed in private and public schools as governments tend to focus more on public schools. The findings established that information, psychoeducation, advocacy and referral/treatment significantly predicted inclusive outcomes in the two settings. However, school-type was significant in explaining variations in treatment/referral. Public schools have a higher treatment rate than private schools in the three study areas. More so, the hypothesis test results established a statistically significant mean difference between the networking and cooperative structures adopted by private and public schools with public schools dominating. Only the presence of cooperative structures accounted for the difference. Overall, it was found that the implementation of the inclusive framework (collaborative strategy) does not meet the objectives stipulated by the Federal Ministry of Health (FMOH, 2019) Human Resources Health (HRH) guidelines because the necessary structures and programs are lacking. There seems to be a power imbalance between mental health agencies and schools in program execution, with schools being a more passive consumer of mental health services as revealed in the qualitative data. It was recommended that both government and citizens have a role to play in fostering inclusion. The study highlighted the

need for schools' active involvement in programs planning for the effectiveness and continuity of this initiative.

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Table of Contents

Abstract	ii-iii
Acknowledgments	iv-v
Table of Contents	vi-x
Acronyms	xi-xiv
List of Tables	xv-xvi
List of Figures	xvii
1.0. CHAPTER ONE: INTRODUCTION	20
1.1. Background to the Study	20-24
1.2. Governance of Educational Affairs in Lagos State	25-26
1.3. Mental Health (MH) Services in Lagos State	26-27
1.4. Dual Roles of Schools	27-28
1.5. Rationale for this Study	28-30
1.6. Significance of the Study	30-31
CHAPTER TWO: REVIEW OF RELATED LITERATURE	32
2.0. Introduction	32-33
2.1.0. Operational Definition of Concepts	33
2.1.1. Mental Health	33
2.1.2. Public Sector	33
2.1.3. Private Sector	33
2.1.4. Voluntary Organizations	33=34
2.1.5. Strategic Alliance	34
2.1.6. Participation	34-35
2.17. Concept of Inclusion	35-36
2.1.8. Concept of Stigma	36-38
2.2.0. Theoretical Frameworks: Labelling Theory, Social Capital Theory, Principal Agent Theory, Collaboratory Theory	38
2.2.1. Labelling Theory: Contextual Issue Affecting Mental Health Inclusion	38-42
2.2.2. Impact of Stigma on Workplace Inclusion	43-45
2.2.3. Empirical Studies on Link between Personal and Public Stigma	45-49
2.2.4. Empirical Studies on Social Intervention for Stigma Reduction Programs	49-55
2.2.5. Summary of Empirical Findings on Stigma and Discrimination	55-57
2.3.0. Theories Related to Relationship Building for Facilitating Inclusion	57

2.3.1. Social Capital Theory: Contextualizing Social Capital within the Institution	57
2.3.2. Social Capital Outcomes	58-59
2.3.3. Assumptions about Measures of Quality of Social Capital	59-60
2.3.4. Four Constructs for Measuring Social Capital Outcomes	60-62
a. Measures of Cooperative Support	62
b. Actual Organizational Support	62-64
c. Motive for Commitment to Mental Health Programs	64-66
d. Procedure for Evaluating Social Interventions (Intra-agency)	64-66
2.3.5. Strategies for Promoting Inclusive Policy Schools	67-69
2.3.6. Empirical Studies on Effect of Social Capital in Promoting Inclusion	69-73
2.3.7. Facilitators of Social Inclusion in Schools	73
a. Community Healthcare Expected Roles in School's Inclusive Promotion	73-75
b. Non-governmental Organizations' Roles in School's inclusive Promotion	75-83
2.3.8. Summary of Empirical Findings on Social Capital	83-84
2.4.0. Integration Theory/ Strategic Alliances	85-86
2.4.1. Five Levels of Relationship Building in Strategic Alliance	87-90
2.4.2. Challenges in Mental Health Collaboration	90-91
2.4.3. Gagne's Four Components of Quality of Collaborations	91-98
2.4.4. Empirical Studies on Insurance Coverage for Mental Health Service Users	98-99
2.4.5. Empirical Studies on Community Engagement in Mental Health	99-104
2.4.6. Involvement of MHSUs and Family Caregivers	104-107
2.4.7. Integration of Mental Health Services in Community Healthcare System	107-111
2.4.8. Facilities variables	111-113
2.4.9. Summary of the Empirical Findings on the Relationship Building	113-114
2.5.0. Principal Agent Theory	114-116
2.5.1. The Impact of Principal Agent Relationships in Policy Cycle	116-117
2.5.2. Federal Ministry of Health Roles in Health Promotion at the Grassroots	117-119
2.5.3. Federal Ministry of Health guidelines on mental health promotion	120-121
2.5.4. Promotion of Inclusive Agenda in Private and Public Sectors	122-125

2.5.5. Mental Health Alliance between International NGOs and Federal Government.	125
a. The Nigerian Mental Health Leadership Advocacy Programs	125-126
b. Non-governmental Support (WHO_MHGAP)	126-127
2.5.6. The Review of Related Policies:	127
a. Review of National Mental Health Policy	127
b. National Health Policy 2014	127-128
c. National Discriminatory (Prohibition) Act 2018	128-129
d. National Human Resources for Health Strategic Plan 2008	130
2.5.7. An appraisal of Collaborative Framework in FMOH's Guidelines	130-135
2.5.8. Human Resources Health Guidelines for Mental Health Inclusion	135
a. Provision of Framework for Objective Policy Analysis	135-136
b. Alignment of Healthcare to the Public and Private Sector's Demands	136
c. Applications of the Best Practice for Mental Health Initiatives	136
2.6.0. FMOH's Arrangements Roles and Responsibilities	136-139
2.6.1. Key Assumptions in the Implementation of the Strategies	139-140
2.6.2. Empirical Research on Agencies Roles in Policy Implementation	141-144
2.6.3. Summary of the Empirical Findings on Integration of Anti-stigma Programs	144-147
2.7.0. Evaluation of Literature	147
2.8.0. Contextualization of Relevant Concepts to Mental Health Promotion	147
CHAPTER THREE: RESEARCH METHOD	148
3.0. Introduction	148
3.1, Research Purpose and Rationale	148
3.1.1. Research Objectives	148-149
3.1.2. Research Questions	149
3.1.3. Hypothesis	149
3.2. Research Design	149-150
3.2.1. Research Settings	150-151
3.2.2. Research Participants and Eligibility Criteria	151
3.2.3. Target Population	151
3.3. Sample and Sampling Technique	152

3.3.1 The Multi-Stage Sampling	152
3.3.2. Choice of Education Districts	152-153
3.3.3. Rationale for Cluster Sampling	153-154
3.3.4. Pilot-testing	154-155
3.3.5. Sampling Procedure and Justification of the choice	155-156
3.3.6. Procedure for Sampling Allocation	156-160
3.4. Description of the Instruments and Validity	161-162
3.5. Validity of the Instrument	162-163
3.5.1. CFA Model Fit	163-164
3.6. Procedure for Data Collection	164
3.7. Method of Data Analysis	165
3.8. Hypothesized Structure of Relationships and Anti-stigma Strategies	172
3.9. Ethical Related Issues from the Field	172-174
CHAPTER FOUR: FINDINGS	175
4.0. Introduction	175-178
4.1. Demographic Characteristics of the Study	178-197
4.2. Analyses of the Quantitative Research Questions	197
4.3. Testing Hypothesis	197-203
4.4. Summary of the Findings	203
4.5. Analyses of the Qualitative Data	203-217
4.6. Other Emerged Issues Related to Students' Mental Health	217-218
4.7. Similarities and Differences in the Integration of Mental Health	218-220
CHAPTER FIVE: DISCUSSION OF FINDINGS, CONCEPTUAL MODEL, CONCLUSIONS & RECOMMENDATIONS	221
5.0. Discussion of Findings	221-222
5.1. Key Findings and Conceptual Model of Structure of Relationships	222-223
5.1.2. The Structures of Mental Health Relationships in Private & Public Schools	223-225
5.1.3. Measures of Government's Support to Schools's Mental Health Promotion	225-227
5.1.4. Available Anti-Stigma Programs in Schools	227-229
5.1.5. Commitment to Schools' Preventive and Interventions Programs	229-231
5.1.6. Associations between Students and Workers' Experience of Mental Health Promotion in Schools	231-232

5.1.7. Key Findings from the Hypothesis: Differences in the structures and Strategies for MH Promotions in Schools' Settings	233-239
5.2. Contribution to Knowledge	239-244
5.3. Findings Implications & Recommendations	244-252
5.4 Study's Implications	252-257
5.5. Suggestions for Future Research	257
5.6. Strengths of the Study	258-260
5.7. Limitation of the Study	260-264
5.8. Conclusion	265-266
5.8.1. Generalizability of the Study	266-267
5.9. Recommendations	267-272
References	273-339

APPENDICES

Appendix A- Initial Research Instruments	340-349
Appendix B- Validated Research Instruments	350-357
Appendix C- Coding Book	358-371
Appendix D- Population distribution of the Public Schools	371-372
Appendix E- Formula for Calculating Study Sample Size	372-375
Appendix F- Research Implementation Timetable	376
Appendix G (i)- University of Manitoba Ethics Board Approval	377
Appendix G(ii)- Approval Letter from the State Secretariat, Ikeja	378
Appendix H- Consent Form	379-381
Appendix I -Advertisement for Research Participants	382
Appendix J- Letter of Authorization	383
Appendix K- Research Budgets and Expenditure	384-385
Appendix L- Descriptive Analysis of the Response to the Discrimination Scale	386
Appendix M- Descriptive Analysis of the Items on Policy	387
Appendix N- Descriptive Analysis of the Response to Organization Values	387-389
Appendix O1-Assumptions Testing: Research Question Four/& Hypothesis	390-408
Appendix O2- SPSS V. 21 Output: Regression Analysis for Research 4	409-441
Appendix P- Output of the Key Variable in the Study (Pre-test)	442-447

Appendix Q1-Data Screening Pre-test CFA Output of the Key Variables	448-495
Appendix Q 2- Hypothesized Structure of Five-Factor CFA Modelling Strategic Alliance (Mental Health relationship)	496-497
Appendix Q3- Tested Five Factor CFA Modelling Strategic Alliance (Mental Health relationship)	497-500
Appendix Q4- Hypothesized Structure of Anti-Stigma Constructs	501
Appendix Q5- Four Factor Modelling (CFA) Anti-Stigma Constructs	502-505
Appendix R- Table of Reliability	506
Appendix S -Test of Variance for the Two Sample	508
Appendix T1-Results of the T-test of Individual Strategic Alliance Construct	509-510
Appendix T2- Differences in Networking Structure for promoting MH	511
Appendix T3- Differences in Cooperative Structure for promoting MH	513
Appendix T4- Differences in Coordination Structure for promoting MH	515
Appendix T5- Differences in Coalition Structure for promoting MH	517
Appendix T6- Differences in Collaborative Structure for promoting MH	519-520
Appendix U-Copyright Permissions	521-523

ACRONYMS

ADVOC- Advocacy

ANOVA- Analysis of Variance

ANTISTIG- Anti-Stigma

APA- American Psychiatric Association

ASH- African Strategies for Health

CDV- Construct Design Validity

CE- Collective Efficacy

CFA- Confirmatory Factor Analysis

CMO- Chief Medical Officers

CHW- Community Mental Health Workers

CMAC- Chief Medical Advisory Committee

CMD- Chief Medical Director

CMHES- Community Mental Health Engagement Scale

CMHF-Community Mental Health Forum

CMV- Construct Measurement Validity

COAL- Coalition

COLB- Collaboration

CORD- Coordination

CPT- Cooperation

CSR- Corporate social Responsibility

CRS- Community Request System

DESA- Department of Economic and Social Affairs

DV- Dependent Variable

EU- European Union

EkoSHA- Eko Social Health Alliance

FA- Factor Analysis

FHPP- Federal Health Policy Promotion

FME- Federal Ministry of Education

FMOH- Federal Ministry of Health

GCC- Grand Challenges Canada

HM- Human Resources

HMO- Human Resources Organization

HRGS- Human Resources Guidelines and Strategies

HRH- Human Resources for Health

ICD- International Classification of Diseases

IEC- Information, Education, and Communication Strategies

INFO- Information

IPS- Implementation Participation Strategy

IV- Independent Variables

IVF- Variance Equation Factors

LGA- Local Government Areas

LSHS- Lagos State Health Scheme

MANCOVA- Multivariate Analysis of Co-variance

MANI-Mentally Aware Nigeria Initiative

MAR- Missing at Random

MCAR- Missing Completely at Random

MD- Medical Director

MDG- Millennium Development Goal

MH- Mental Health

MHCC- Mental Health Commission of Canada

MHLAP- The Nigerian Mental Health Leadership Advocacy Program

MHLS- Mental Health Literacy Scale

MHPHD- The Ministry of Health, Public Health Department

MHQMS- Mental Health Quality Measures Scale

MHS- Mental Health Services

MHSUs- Mental Health Service Users

MI- Multiple Imputation

MNS- Mental, Neurological and Substance Abuse

MLR- Multiple Linear Regression

NBS- National Bureau of Statistics

NCPD- National Commission for Persons with Disabilities

NCPD-National Commission for Persons with Disabilities

NDA National Discriminatory (Prohibition) Act,

NGO- Non-governmental Organizations

NHA- National Health Act

HSDF- Health Strategy and Delivery Foundation.

NMAR- Not Missing at Random

NMHC - National Mental Health Commission

NMHP- National Mental Health Policy

NPEC- National Primary Education Commission

NR- No Response

NSEC- National Secondary Education Commission

NT- Networking

OCB- Organizational Citizenship Behaviour

OE- Occupational Efficacy

OECD- Organization for Economic Cooperation and Development

OMS-WA-Opening Minds Scale for Workplace Attitudes

PA- Principal Agent

PCP - Primary Care Providers

PHC- Primary Health Care

PI- Principal Investigator

PIR- Australia's Partners in Recovery

PSU- Primary Sampling Units

PSYED- Psychoeducation

PTSD- Post traumatic stress disorder

PWLD- People with Learning Disability

RA- Research Assistant

SD- Standard Deviation

SMC- Squared Multiple Correlation

SPIDER- Sample, Phenomenon of Interest, Design, Evaluation, and Research

SPSS- IBM Statistical Package for Social Sciences version 21

SSSEC- Senior Secondary School Education Commission

SSU- Secondary Sampling Units

STATA- Data Analysis and Statistical Software

SUBEB- State Universal Basic Education Board

TSU- Tertiary Sampling Units

UNDP- United Nations Development Programme,

UNICEF- United Nations International Children's Emergency Fund

UN-United Nations

WHO- World Health Organization

LIST OF TABLES

Table	Name	Page
1.	The School Population for the Selected Local Government	154
2.	Probability Proportionate Mean Sample to Size from the Study Population	159
3.	Estimated Sample Size from the Selected LGA	160
4.	Variables Description for Research Question 4	165
5.	Variables that Measure the Null Hypothesis	168
6.	Demographic Characteristics of the Study Participants	175
7.	Differences in Collaborative Structure for MH Inclusion in Public and Private School Administrative Systems in Lagos State.	179
8.	Level of Support Received by Schools in the Implementation of Anti-Stigma Program(s) in Private and Public-Schools	182
9a.	Descriptive Analysis of Participants' Responses to Items Measuring Information Aspect of Anti-Stigma Interventions by the Public and Private School Administrative Systems in Lagos State	185
9b.	Descriptive Analysis of Participants' Responses to Items Measuring Psycho-education Aspect of Anti-Stigma Interventions by the Public and Private School Administrative Systems in Lagos State	187
9c.	Descriptive Analysis of Participants' Responses to Items Measuring Advocacy Aspect of Anti-Stigma Interventions by the Public and Private School Administrative Systems in Lagos State	189
9d.	Descriptive Analysis of Participants' Responses to Items Measuring Treatment Aspect of Anti-Stigma Interventions by the Public and Private School Administrative Systems in Lagos State	191
9e.	Available Service Systems for Anti-Stigma that School Provides through Collaborative Strategies in the Private and Public Education Sectors in	

	Lagos State	193
10a.	Indices of Normality for the Variables in the Regression Analysis	194
10b.	Intercorrelations among Variables in the Regression Analysis	195
11.	Summary of Regression Analyses for Effectiveness of Workplace Supportive Measures in Promoting Anti-stigma Program in Private and public Schools in Lagos State	195
12a.	Multivariate Tests of Difference in the Structures and Strategies Adopted by Private and Public Schools to Promote Mental Health Inclusion	199
12b.	Univariate Tests of Between-Subjects Difference in Collaborative Structures Adopted by Private and Public Schools to Promote Mental Health Inclusion	201
12c.	Univariate Tests of Between Subjects Difference in Collaborative Structures Adopted by Private and Public Schools to Promote Mental Health Inclusion	202
13.	Summary of the Findings, Contributions, Implications for Policy Implementation/ MH Social Work Practice and Future Study	244

LIST OF FIGURES

Figure	Name	Page
1.	Structural Equation Modelling showing a Link Between Self-Stigma and Public Stigma.	47
1.	Model of Adverse Effect of Stigma and Protective Mechanisms.	47
	Theoretical Formulation of Formal Strategic Alliance Phase.	97
4.	Concepts of mental health strategic alliance/relationship building	147
5.	Hypothesized Structures of Schools' Relationship Model & Anti-stigma Strategies	172
6.	A Summary of the Participants Response to the Question on Greatest Challenges to Mental Health Inclusive Promotions in Schools	209
7.	The Observed Conceptual Model of Structure of Relationships (Strategic Alliance) in Private and Public Schools in Lagos State	239

“The federal Ministry of Health should collaborate with the State Ministry of Health thus encouraging synergy between the two ministries.”

Research participant’s view.

CHAPTER ONE

INTRODUCTION

1.1. Background to the Study

Mental Health Service Users (MHSUs) are defined as those with lived experience and utilize their knowledge and experience to decide on their health plan -what works and how best to be supported (Song et al. 2023; Nohr et al. 2021). They represent one of the most vulnerable, stigmatized, marginalized, and underutilized sources of labour (Gaunt, & Lengnick-Hall, 2014; World Bank, 2015, Pinals et al., 2022); factors that hinder their acceptance are attributed to public and personal stigma (Ebuenyi et al., 2020a; Ebuenyi et al., 2020c). Also, studies by Henderson et al. (2012), Vornholt et al. (2013), and Lindsay et al. (2022) categorized the determinants of MHSUs exclusion into four variables: (a) lack of policy and programs, (b) self-stigma, and anticipated stigma from colleagues at work, (c) the demographic characteristics of MHSUs, (d) and employers' lack of commitment.

In addition, a series of interventions across the world have been designed to alleviate these problems. These include legislation and policy on stigma reduction, entrance to work programs that aim at reducing dependency for those on social security benefits, the use of quota systems and supported employment, among others (Agovino et al. 2019; Waghorn et al., 2017; Mik-Meyer, 2017; Moreno-Poyato et al. 2021), and Nigeria is no exception. In recent years, The Federal Government of Nigeria has embarked on a series of initiatives such as advocacy programs, work interventions and changes in policy (Adebowale et al., 2014; Abubakar, 2016; World Health Organisation, 2016) to promote an inclusive organizational climate for MHSUs. These initiatives are reflected in policy planning and emphasize collaboration across the three tiers of government to promote inclusivity as stipulated in the federal government's policy

statement of (i) promoting awareness to reduce stigma and (ii) supporting economic participation of MHSUs (FMoH, 2013).

Nonetheless, little is known about the success or otherwise of this strategic relationship in fostering inclusion. The adoption of this administrative collaborative framework as articulated in the Constitution of the Federal Republic of Nigeria (1999 as amended) describes the concurrent power and roles of the three tiers of government and addresses their shared responsibilities. In principle, the emphasis is on fostering relationship among these three levels of government in policy implementation. In practice, the policy has not been effectively implemented in Nigeria due to the complexity inherent in the Nigerian policy environment, where personal interest is often prioritized over the needs of the majority, as described by Okonofua (2013) and Babalola (2019). Divergent views, inconsistency in practice, lack of continuity, fund misappropriation, and lack of commitment, among others, have contributed to the policy's failure in Nigeria (Omoaregba, et al., 2015; Afegbuai et al., 2018).

In Nigeria, mental health lacks functional institutional frameworks, and the service management is excluded from the health governance system, as revealed by Abdulmalik et al. (2016; 2019), hinders any major development in this area. Fundamentally, the shift from a regional mode of governance in 1946 laid a foundation for federalism, and in 1954 it began as a full-fledged mode of governance. Its expressive purpose is to unify the country, redistribute resources, strengthen regional and ethnic relationships, and reduce discrimination and cultural barriers. However, the adoption of federalism in Nigeria centralizes power resulting in weakening the state's autonomy (Aluu, 2018; Okorie et al., 2022) and hindering efficiency in policy implementation (Oyelaran-Oyeyinka & Lai, 2016; Babalola, 2019). The Nigerian constitution recognizes power-sharing arrangements among the three tiers of government. The exclusive power belongs solely to the federal government, the concurrent power is shared

between the federal and the state governments, while the residual power is reserved for the state governments.

As expressed in Chapter II of the Constitution, under sub-sections (16) and (17), the relationship and exclusive roles in policy administration include legislation and policy, the criminal justice system, national defence, and macroeconomic policies. These are considered the federal government's roles. The concurrent responsibilities between the federal and the states comprise taxation, job creation, citizens' rights, business regulations, labour protection, reduction of workplace discrimination, economic development, social and health care services, creating enabling business environments, and maintaining law and order.

Also, federal agencies can regulate or give directives to state agencies. In this arrangement, the notion of collaboration at the state level is premised upon the cooperation between the two bodies. Both operate in the major sectors of the economy, such as healthcare and education. The federal government is responsible for macroeconomic policies and regulates ownership and control of private and public organizations through the National Assembly by sponsoring economic and climate bills that protect citizens' welfare. Local government areas (LGAs) hold delegated power and is accountable to the communities (The Constitution of the Federal Republic of Nigeria Constitution, 1999 as amended).

The concern for proper management and accountability which led to the 1976 reforms allows LGAs to act autonomously as the third tier of government. The federal government reinforces the LGAs' fiscal and administrative capacities either to work directly with the local stakeholders or the states. The goal is to aid social integration and unity across the federation (Adeyemi, 2013). Thus, mental health governance was premised on fostering partnership between the state and sundry stakeholders (FMoH, 2013). In this arrangement, the LGAs become an integral part of mental health policy and service delivery (Abdulmalik et al., 2019). However, the proliferation of LGAs has undermined manpower and finance, and corrupt

practices have reduced their efficiency in program delivery (Oviasuyi et al., 2010; Afegbua et al., 2018).

The integration of LGAs, ideally, should promote community participation (Adeyemo, 2005; WHO, 2015); however, the inconsistency in governance and the lack of a mental health system of governance have reduced their efficiency in mental health policy delivery (Wada et al., 2021). Also, policy failure is intricately linked to structural changes in the use of veto power in policy planning and delivery, either in military or civilian rules (Adeyemi, 2013; Aregbesola & Khan, 2018b; Babalola, 2019). Also, low input from experts, a lack of empirical evidence, and the absence of public opinion to shape policy direction hamper policy delivery (Aluko & Arowolo, 2010; Bolaji et al., 2015). Challenges in economic, social and health planning have been linked to these structural problems (Mbemba et al., 2016; Afegbua et al., 2018), and their effects are more pronounced on the vulnerable groups.

Policy planning and implementation in Nigeria do not represent the social characteristics, ethnic cleavage, will, and economic well-being of the people because of the use of veto; even when claiming the use of decentralized structures, most key decisions still come from the top (Bienen, 1978; Johnston, 2005; Arowolo & Aluko, 2010). For example, the 1976 reform allows the federal government to regulate and control public service delivery at the grassroots as specified in Section 16 (1c) of the 1999 Constitution, "...that participation will involve rendering services and supplying of foods". This is also evident in the National Health Policy of 2014, which stresses the local, state, and federal roles in coordinating the healthcare, education, and welfare sectors as well as the federal government's direct participation at the grassroots to protect Nigerian labour's physical and psychological needs. This policy statement is similar to the 1999 Constitutional declaration of provisions for people with disabilities at the federal and state levels. Nonetheless, past studies have established that mental healthcare governance is not well addressed in the healthcare governance system (Abdumalik et al. 2016;

Aregbesola & Khan, 2018a), and this might cause a major setback in the inclusion of MHSUs in communities.

In relation to the above, the introduction of the National Healthcare Insurance Scheme (NHIS) under Act 35 of the Federal Republic of Nigeria Constitution (1999 as amended) follows this same strategic pattern of rules. The design is expected to cover all Nigerians, but its execution has structurally removed the vulnerable (the unemployed and aged populations). Only 4% of the more than 200 million Nigerian population who are mostly federal government workers are covered (Ude, 2015; Aregbesola & Khan, 2017); the design of the scheme has structurally excluded MHSUs and other vulnerable people. According to the Federal Ministry of Health's (2019a) Human Resources for Health (HRH) Strategic Plan report, 90% of Nigerians are without healthcare coverage and pay out of pocket. The National Bureau of Statistics (2020) also reported that at least, about 17.5 million Nigerian youth are jobless, which means MHSUs who fall under this category are likely to be without insurance coverage and rely on family support.

As articulated in the Act, the concurrent government roles do not diminish the constitutional power of each tier of government to pursue distinctive state and local interests. Constitutionally, the federal government manages its administrative system through political appointees, such as the Ministers of Health, Commerce and Trade, and Education, among others. The state also has state commissioners in each sector of its economy. Therefore, the notion of collaboration between 774 LGAs across the country and the federal government is to bring services closer to the people (Adeyemo, 2005). The LGAs work directly with the state government by sharing power in executing government responsibilities such as the protection of citizens' welfare, tax collection, advocacy roles, providing a home for the destitute and the sick, promoting community engagement in mental health and MHSUs' social integration (Adamolekun, 2005; Adeyemi, 2013).

1.2. Governance of educational affairs in Lagos State

Essentially, for administrative convenience, the education sector is governed by both the state and federal governments through the Federal Ministry of Education (FME). Thus, the FME's responsibilities involve policy formulation, monitoring, and recommendation, and management of secondary schools. The Ministry is expected to liaise with the LGAs for educational development or monitoring of the State Universal Basic Education Board (SUBEB) roles in managing primary schools. SUBEB manages the primary and junior secondary system, while the senior secondary education system is coordinated by the Basic and Senior Secondary School Education Commission (SSSEC).

In July 2008, Lagos State restructured the mode of governing the pre-primary, primary and secondary schools to ease the governance of educational affairs. Schools in Lagos State are grouped into six distinct educational districts, and these districts span the 20 LGAs (Lagos School Census Board, 2019); see appendix "D" for more details. These districts are expected to implement and monitor policy and program delivery under their jurisdiction. The LGA plays a vital role in executing and monitoring the national inclusive agenda process and outcomes.

Thus, LGAs play an important role in facilitating the execution of the Discriminatory (Prohibition) Act, introduced on the 23rd of January 2018, to fulfil one aspect of the National Mental Health Policy (NMHP, 2013) statement. Page [7] of the policy statement addresses stigma reduction at all levels of government and in the labour market. This means that by taking a rational and incremental approach in policy promotion, the participatory role of the state at the grassroots has increased through partnerships with other agencies [healthcare system, NGOs: the World Health Organization, (WHO); the United Nations International Children's Emergency Fund, (UNICEF); Clinton Foundation]. The emphasis is on advocating for inclusion and stigma reduction (WHO, 2012, 2016, 2017; 2019a; Murphy et al., 2020) and increasing access to care.

However, as noted in the National Human Resources Strategies and Guidelines (2008), the complexity in policy implementation in Nigeria is due to human failures. Many facilities are understaffed and underserved. There is ample evidence from the literature about the poor condition of health centres, lack of personnel, and medical equipment across the country (Adebayo & Sanni, 2014; Ude, 2015; Abubakar, 2016; WHO, 2016; Ode, 2017; Timothy et al., 2018). Thus, policy implementation by the state and local governments suffers due to inequitable distribution of resources, which may affect the capacity of the healthcare system to fulfil the objective of NMHP of 2013. The criticism against the 1991 NMHP led to its amendment in 2013, the promotion of an inclusive organizational climate, and the reduction in mental health discrimination as one of its goals. Also, National Mental Health Act 2021 was signed into law on January 5th, 2023, emphasising community-based approach, increasing funding and public awareness to facilitate recovery and social integration.

1.3. Mental Health (MH) Services in Lagos State

Both federal and state government provide comprehensive healthcare insurance covering MH healthcare. National Health Insurance Scheme (NHIS, 1999) represents the most robust and comprehensive healthcare insurance planning in Nigeria and is provided by the federal government; the package includes Medicare from the general consultation fee to emergency services and management of chronic ailments. Essentially, it covers psychiatric services such as consultation services for MH diagnosis, treatment, medications, psychological treatment, hospitalizations, and rehabilitation service fees (NHIS, 1999). However, this federal coverage only supports 4% of the population who are federal employees (Aregbesola & Khan, 2018). Lagos State provision covers all its employees, and non-governmental employees are expected to purchase insurance coverage either from the state government or private insurance MH services. Unfortunately, most private insurance packages are not as robust and comprehensive as that of the federal government. Individual households can buy premiums directly from either the federal or the state governments or pay out of pocket. It is important to highlight that many

private insurance premiums do not cover hospitalization and rehabilitation services for MH (Lagos State Science and Technology, 2024).

Schools are supported by NGOs and state-owned facilities to provide valuable resources for residents and ensure access to a wide range of healthcare services. NGOs in particular offer different social support services (counselling, advocacy, seminars, and workshops) and fund MH programs in schools and communities (Ryan et al. 2020; Atilola et al. 2022). Lagos State offers health insurance which covers mild to severe mental illness. Lagos State PHC centres treat minor cases, offer initial consultation, and refer patients to specialized services such as Federal Neuropsychiatric and Specialised State Hospital (Lagos State University Teaching Hospital) for severe cases (Lagos State Science and Technology, 2024). Thus, educators in schools are expected to be trained by healthcare professionals at PHC's level to identify crisis and make appropriate referrals either to the nearby mental health resources in the community or a specialized mental institution (FMoH, 2019b).

Specifically, state insurance coverages include the Lagos State Health Scheme (LSHS) which covers a range of mental health conditions, particularly minor mental ailments. Conditions categorised as minor under LSHS are mild depression, anxiety, and stress-related disorders. Major mental health coverage primarily focuses on both minor and severe mental illnesses. The premium for a single-person to a four-person household is between eight thousand and five hundred (\$5.47) to forty thousand naira (\$24) per annum (Canadian \$ rate as at 10/11/2024) which includes the cost of treatments and medications. In addition, Eko Social Health Alliance (EkoSHA) provides free health insurance coverage to MHSUs and other vulnerable groups (Lagos State Science and Technology, 2024).

1.4. Dual Roles of Schools in Mental Health Services

The Federal Ministry of Health and Social Welfare (2024) articulates the roles of schools in mental health programs. The Nigerian education system performs a dual mandate role in mental

health provision, prevention, and intervention (which include counselling, referrals, and collaboration with mental health agencies). The schools significantly contribute to the mental health well-being of students and the schools' workforce by integrating mental health education, training educators, providing counseling services, and collaborating with health services.

Preventive services, awareness creation, training schools' educators, and promoting supportive environments for both learners and staff are essential services, while treatment covers crisis intervention by having a specialised individual on the ground till help arrives. Such specialized intervention entails counselling services and collaboration-either for referral to primary healthcare centres or specialized hospitals and community support group services (NMHP, 2013). However, resource limitations and sociocultural influences hinder the success of these initiatives (Fadele et al. 2024), re-emphasising the significance of collaboration in fulfilling this objective. Thus, this study aims to investigate the strategic approach adopted for collaboration and the effectiveness of the inclusive programs offered under this framework.

1.5. Study's Rationale

Employment is a constitutional right of all, including MHSUs. However, work integration of the MHSUs is largely confined to personal networks. Cultural bias, public discrimination, self-doubt, and lack of government support are attributed to the low economic participation of the group (Oshodi et al. 2014; Drake et al. 2020; Ebuenyi et al. 2020; 2021). In recent years, social integration of MHSUs has garnered government's attention in Nigeria. This is observed in the recent update to the National Mental Health Policy (Federal Ministry of Health, 2013; National Mental Health Act, 2021). Emphasis is now on relationship building as a mechanism for fostering inclusion. This federal government's initiative articulates alliance formation between the government and workplaces. Such relationships extend to other stakeholders and stresses that interventions should target social and economic participation of

MHSUs (FMoH, 2013). Subsection [7] of the policy recognizes that the framework requires massive investment to achieve its goals: (a) awareness creation and (b) integration of MHSUs into the labour market.

Therefore, stakeholders' involvement plays a key role in the success of this approach (WHO, 2003; 2016; 2019b; Anyebe et al. 2012; Ryan et al. 2020). Identified key stakeholders in this arrangement are the Federal Ministry of Health, the states, LGAs, NGOs, education systems, religious organization, community leaders, among others. The FMoH (2019a) guided the execution of this process and anti-stigma programs that are offered at the grassroots to promote inclusion.

Although education systems are viewed as part of the key actors in this arrangement, their role in the literature seems less articulated, where defined, it is more of a consumer of social interventions (WHO, 2013; 2016; Cavioni et al. 2020; Weist et al. 2023). More so, the focus of schools' interventions have consistently been on MH promotion and the prevention of behavioural problems directed at students (Cavioni et al. 2020; Bachman et al. 2024). Only a few studies have examined resilience and adaptive coping skills that promote work inclusion (Owadara, 2021; Imran et al. 2022; Weist et al. 2023). In Nigeria, the FMoH's (2008) guidance expected support from community healthcare and NGOs for the success of its implementation in schools.

Also, schools' adoption of inclusivity in Nigeria has consistently been silent on social integration of MHSUs, to focus on MH promotion (Gureje et al. 2015; WHO, 2016; Timothy et al., 2018; Waqas et al. 2020). It limits our understanding of the success of the relationship building framework in fulfilling policy objectives to facilitate socioeconomic inclusion for MHSUs' employees.

Thus, these gaps are the rationale for this study. Similarly, given the alignment of education values with the National Mental Health Policy's goal to support a more inclusive

and harmonious environment, it remains unclear how the profit-driven goals of private education system impact this framework leading to differential outcome. Hence the objectives of the present study are to examine (i) the adoption of the collaborative framework in private and public schools in Lagos, (ii) the available support that aids its implementation in schools and (iii) the extent of its performance in fostering MHSUs' socioeconomic integration.

1.6. Significance of the study

The federal government's intervention to reduce stigma has led to a change in policy and the development of macroeconomic initiatives to integrate mental health service users and other disability groups into the mainstream labour market. One of the strategies articulated in the policy is a collaborative approach. Thus, the education systems are recognized as a part of this mechanism. The motives are to promote mental health awareness, facilitate access to healthcare, and increase the social integration and economic participation of MHSUs.

This research believes that putting this knowledge into practice could increase our understanding of this framework's efficacy in reducing stigma. This study will be beneficial to private and public schools' management and MH workers, redefining their roles as both partners and consumers of services in facilitating MH inclusion for their workers. Also, by utilizing available MH resources that school management and staff can access, this study is informative to schools and MHSUs. It is also beneficial to both HR and school social workers/psychologists in reconceptualizing their roles in relationship building to increase their knowledge and liaise with experts at the MH office in the community or education district level. It is equally useful to NGOs in reconceptualizing their services and dialoguing with school management for service improvement.

The federal and state ministries of education can benefit from this study too. This study reinforces their cardinal roles in MH policy planning and implementation, and it stimulates their working directly with NGOs. State ministries of education can liaise with FMOH to

support flexibility in accessing MH resources and provide update and periodic training to school administrators, HR personnel and MH workers for service improvement.

The theory of strategic alliance has provided insightful details about stakeholders' relationships in mental health promotion. An examination of it within the Nigerian sociocultural environment can help generate knowledge around complexities involved in promotion of mental health in schools. It can also inform us on nature of relationships in public and private primary and secondary education system in Lagos state. Thereby improve the knowledge base.

Lastly, the study may have practical implication for social work engagement by offering practical strategies to the development of more inclusive programs that are culturally sensitive and adaptable. It can also be informative to educators on how to address diverse needs of the schools' populations. The study can foster more understanding of interconnectedness approach in promoting inclusion and reducing existing harmful sociocultural practice that hinders social and economic participation of MHSUs.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0. INTRODUCTION

This chapter delineates the conceptual definitions of terms and expounds the relevant theories that underpin this study, from organizational, sociological, to political science theories. The review was organized and discussed in the following manner: (a) the operational definition of some terms used in this study (b), stigma related theory, (c) other theories that are directly linked to relationship building and supportive measures to promote MH inclusion namely social capital and integration theory and principal agent theory. This chapter also reviews empirical research on stigma, agencies' roles (within the ministries of health and education) and NGOs' roles in promoting inclusion. Lastly, key findings, gaps in the body of knowledge, and contextual concepts studied were discussed.

The rationale for including labeling theory was to examine the sociocultural context in which MH interventions occur to understand hindrances to inclusivity. The theory of social capital was also reviewed as outcomes of social capital which reinforce commitment and trust in collaborative relationships. It provided an explanatory model to justify why organizations participate in inclusive programs and the extent of their commitment. It also crystalized shared values in integration theory. Thus, integration theory helped in portraying existing relationships in MH interventions and the motivations of diverse groups to take active roles in this arrangement.

Lastly, the principal-agent theory was reviewed to theorize the role of government agencies in promoting inclusion. The theory provides a good explanatory model to understand human behaviour in policy outcomes, especially when implementing a policy like inclusion that does not directly profit the organization. By examining these theoretical frameworks, they

helped uncover the gaps in the existing literature about the strengths and weaknesses of implementing inclusive policy.

2.1.0 Operational definition of concepts

2.1.1. Mental health

The World Health Organization's (WHO, 1986) definition of mental health sees mental health beyond absence of disorders to suggest optimal functionality in coping with daily stressors, working productively, and contributing to the community. This definition is adopted throughout the study.

2.1.2. Public sector

The public sector is a state-owned parastatal or a portion of the economy that is government controlled. As part of macroeconomic policies, the government often undertakes essential services (Marland & Wesley, 2019). Such services include healthcare, education, and the power sector, among others. This definition excludes private companies, voluntary organizations, and households (Howlett et al., 2009). Therefore, this study adopted this definition and described the public sector as all government-owned or controlled institutions, coordinating public affairs and policy delivery.

2.1.3 Private sector

The private sector refers to all sectors of the economy that are profit-oriented, privately owned, controlled, and managed by individuals or enterprises. They may be relatively small or large organizations or corporate bodies (Howlett et al., 2009). This definition will be adopted throughout the study.

2.1.4. Voluntary Organizations

Voluntary organizations, as defined by Brown (2010), often perform civic roles and operate independently. Such organizations are not profit-driven, but they dedicate time and resources

to serve and benefit society. In this study, voluntary organizations such as the WHO, Clinton Foundation, religious organizations, and local support groups that promote mental health inclusion are referred to as NGOs.

2.1.5. *Strategic alliances*

Strategies are planned effort, well-integrated and coordinated step-by-step guides to fulfill an organizational objective or establish programs or services; they are dynamic, goal-oriented, and action-driven and may be a long-term plan (Terra & Passador, 2016; Hitt et al., 2019). Thus, the WHO (2019a) defines strategic alliance as a framework that guides the national health care system in jointly responding to the planning and development of the healthcare agenda. The emphasis is on the identified set of areas where the organization has a comparative advantage to enhance healthcare impact. These areas are jointly agreed as priorities for collaboration. Therefore, this study adopts this description and defines mental health strategic alliance as all agreed procedures undertaken to promote an inclusive organizational climate for MHSUs.

2.1.6. *Participation*

Participation as a collective creativity emerges from two different perspectives; at the community level, the concept is portrayed as disruptive and interventive, and at the organizational level, it is viewed as constructive and ameliorative. At both levels, participation becomes indistinguishable from political commitment (Gary & Dufwenberg 2011). The authors opined that when people are invited to get involved, it is not about asking for help but to aid collaboration on important issues, thereby benefiting from such commitments. Thus, active participation can lead to greater commitment to a cause.

Participation is, therefore, a strategy for restoring or re-enacting social bonds through a collective elaboration of meaning. Within the public domain, participation is often categorized as voluntary roles and can be portrayed as contractual obligations in the business arena (Jena

et al., 2018). Promoting inclusive policy for MHSUs requires collective participation, the involvement of mental health stakeholders, government agencies and the labour market in its implementation, and the involvement of MHSUs and their families in stigma reduction programs.

Although Gary and Dufwenberg's conceptualization of participation is adopted in this study, this research does not assume that it is a path that is uniformly and actively pursued in Nigeria as findings from North and Southeast Nigeria have shown the lack of self-representation among families and community members in leadership programs (Ode, 2017; Adebisi et al., 2019).

2.1.7. The concept of inclusion

The concept of inclusion at macro and micro levels focuses on active policy or political engagement (Brodie, 2018). It systematically identifies a multifaceted group of actors: the state, voluntary organizations, political and administrative actors, healthcare and education sectors, and other companies involved in policy circles (Berkel & Møller, 2000). Both Szymańska & Aldighieri (2017) and Human Rights (1948) consider the concept as functional and constitutive aspects of a policy and part of a human rights agenda that promotes acceptance, respect, value, dignity, diversity, marginality, and equity in society. It means acceptance without prejudice, an equitable access to quality healthcare and social services (Berkel, Moller, & William, 2002).

Nonetheless, the concept transcends having equal access to treatment but includes full economic participation or access to a basic income. In the view of Frankel and Mulvane (2014), basic income is vital for reducing poverty and promoting citizens' welfare and can be promoted through effective participation of the government, workplace, and NGOs. Thus, equity promotion as a means of reducing poverty is a government's constitutional role and can be termed an inclusive agenda.

More so, the United Nations Department of Economic and Social Affairs (UN, DESA, 2009) avers that inclusion includes respect for diversity and the promotion of a sense of belonging. Thus, inclusion policy as a framework fosters equality by standardizing employment conditions such as setting predefined and unified criteria by the government that focus on individual strength rather than a disease to evaluate the mode of entry or of accepting MHSUs into specific organizations. It also encompasses the encouragement given to organizations to promote enabling workplaces through awareness programs and guidelines (Brown & Townley, 2015). Inclusion ensures the prioritization and protection of workers to promote a culture of belonging through active contribution and participation by all workers (Hodkinson, 2011). In Nigeria, the design of inclusion policy and programs offers guidance and principles to organizations, families, MHSUs, NGOs, and other stakeholders in stigma reduction (NMHP, 2013). The federal government also recognizes its strategic position in capacity building by partnering with employers to promote the social integration of MHSUs. Some of these measures are explored under integration theory.

2.1.8. Concept of stigma

Stigma emanates from the Greek word ‘stigmata’ (a plural form of stigma), a branding mark on the body like Christ’s crucifixion wounds, and a discredited identity (Grinker, 2022). In the modern era, stigma connotes a deeper meaning. It represents a flawed identity such as the stigma of mental illness: a person’s psychological state defines an individual’s identity as incompetent, invisible and marginal due to discriminatory norms and culture (Scheff, 1999). Thus, Scheff argued that stigma makes an individual become secretive or deny emotional hardship to conform to the ideal.

Hence, culture becomes an illusion of innate differences that sustains all forms of discrimination (Jegede et al., 1985). From a historical perspective cultural lens preserves mental illness stigma because the biological model has been unable to fully account for some

psychological impairments outside genetic dysfunctions which may explain why stigma associated with mental diseases remains unabated (Scheff, 1999). Unlike HIV/AIDS and cancer, which were highly stigmatized in the early 1980s, and with the scientific discovery in the early twentieth century, evidence of their cause, drug development and new treatment plan have made these illnesses less stigmatized (Kohn, 2011).

Furthermore, Grinker (2022) discussed people's perception of stigma by asserting that asylum embodies shame while the war era reduces it. People with psychological problems enlisted for the war and gained respect as opposed to being looked down upon in the asylum, depicted as unfit, imbecilic, or lazy. Grinker opined that post-traumatic stress disorder (PTSD) after World War II in the United States in the early 1950s led to huge investment in research and development that culminated in the first diagnostic tool "The Diagnostic Statistical Manual of Mental Disorder (DSM-I)" by the American Psychiatric Association (1952) to understand the cause of mental illness, reduce stigma and design a treatment plan for military men after the war. However, an economic definition of an ideal person such as being responsible, productive, capable, and educated pathologized the sufferer as unfit or incompetent (Peter, 2004). Thus, employment equates to competence (Gold et al. 2012). The individual who does not meet these criteria is, therefore, unfit for work. Findings by Hernandez and McDonald concluded that mental illness equates to managers bias, lack of promotion judgemental attitude about their competence and cost counting due to absenteeism. Again, the lack of a scientific explanation for some ailments like neurotic behaviour, or anxiety disorders, and the unavailability of drugs to cure mental illness have continued to make medicalization thrive (Grinker, 2022).

In sub-Saharan Africa, mental illness is associated with spirituality or witchcraft, a taboo that often leads to shame, fear, denial, and secrecy, even among close relations (Jegede et al., 1985; Stefanovic et al., 2016). This conceptualization affects how and when people seek

help and negatively impact their recovery and other social roles like marriage, and employment (Larkings & Brown, 2018). From the foregoing, stigma is better understood as a cultural or social phenomenon that imposes additional labels or identities of shame, fear, and secrecy on the bearer. Thus, the description of mental illness as a “double illness” as offered by Grinker (2022) first portrays the ailment itself, and second, evinces the marginalization of the sufferer which stresses cultural and social forces as barriers to the eradication of mental health stigmatization. Therefore, this definition is very relevant to this present study in the description of the internalized and public stigma associated with mental illness, and to examine insights associated with inclusion policy and programs.

2. 2.0. Theoretical frameworks: Labelling theory, social capital theory, integration theory (strategic alliance) and principal agent.

2.2.1. Labelling theory: Theory related to contextual factors affecting inclusion

From the sociological perspective, labelling theory is an identity theory which posits that individuals become who they are because of how society portrays and treats them (Scheff, 1974). Therefore, the cause of internalized stigma is closely associated with a cultural stigma that often triggers nervousness, feelings of shame, and worthlessness (Michalak et al., 2011; Ma et al., 2020). According to Goffman (1963), stigma constitutes a mark of disgrace; or a degrading attitude toward an individual or a group because of their personality, traits, or attributes such as illness, deformity, colour, race, nationality, or religion. The discrediting attitude could result from social discrimination influenced by the socio-cultural and etiological interpretation of the disease.

Culture serves as an underlying mechanism that fosters stigma; it depicts self-stigma as an internal representation of cultural prejudice (Vogel et al., 2013). The authors suggest that self-stigma is complicated due to the intolerance that exists in internal cognition that is manifested in our daily social lives through verbal or nonverbal responses. It decreases a person’s self-worth, and can also manifest in community attitudes, law, and organizational

policy. The general conceptualization of mental illness results in an individual possessing different identities, marking the person as the other (Goffman, 1963). Underpinning this assumption is the idea that any form of maladaptive behaviour can make a person vulnerable and open to other people's judgmental attitudes.

The nature and degree of anticipated public stigma often trigger associated self-stigma or negative emotional responses (Corrigan, 2006; Jones et al., 2016). Thus, labelling theory and its variants assume that classifying persons with derogatory names can alter their self-concept and social identity, inflaming self-stigma, and diminishing self-efficacy and social life functioning (Jon, 2009; Huggett et al. 2018). Labelling theory connects how a society's norms can influence individuals' behaviour and actions. It theorizes stigma as a strong negative label that alters individuals' self-esteem, self-concept, and social identity; that is, how people react to those who are labeled deviant often influences the behaviour of the labeled individual, arousing the sense of inadequacy, incompetence, hopelessness, and helplessness (Scheff, 1999).

In explaining a psychological problem as a socio-cultural phenomenon, Scheff (1974, p. 445) portrayed primary deviance as a violation of norms and "residual deviance" as violating norms that are not explicitly defined or stated but its violations are still seriously considered as crimes or norm violations. Scheff's construction of secondary deviance suggests that when an individual who is being labeled assumes and practises the structurally transferred attributes, it becomes a permanent label. It emphasizes that deviance is not about a person breaking the norms but about others considering the person as having done so. Thus, labelling is often described as a self-fulfilling prophecy. Scheff (1999), in an experiment, observed that labeling a person as pseudo-psychiatric even after completing the test still affects the participants.

In addition, underperformance and self-stigmatization have been associated with the threat of stereotyping. A person or group that is negatively stereotyped can feel threatened or

anxious when exposed to a stereotype threat or when the risk confirms a negative stereotype about their group (Steele & Aronson, 1995). Thus, discrimination is situation-dependent. When one is in a particular circumstance, others can judge one according to self-fulfilling negative stereotypes of the prescribed group (Spencer et al., 1999).

Research findings have examined and confirmed workplace judgemental attitudes towards MHSUs, revealing employers' skepticism about MHSUs' employees competence and colleagues' hostility towards the group (Hand et al. 2016; Chong et al., 2013; Hing & Russell, 2017). The studies linked stereotypical labelling to underperformance because the fear induced when salient stereotypes are primed alters or distracts from the intellectual task at hand. The longer-term effects of stereotypical threat remain elusive.

However, Steele (1990) hypothesized that the resulting anxiety could lead to the internalization of inferiority (self-stigma) and manifest as adopting a victim's identity, assigning blame to others, or underutilizing available opportunities. Caza et al. (2018) explored the significance of an individual's self-identity among minority groups in the workplace and affirmed that a person's subjective interpretation of who she/or he is, is shaped by roles, group relationships, socio-demographic and personal characteristics, among others. For minority groups like MHSUs whose illness can be invisible, self-identity may be problematic because institutional and organizational factors such as the lack of a policy, a manager's attitude or an unsupportive work environment can increase a sense of insecurity. Even when programs are in place, a manager's or director's attitude can threaten disclosure (Lyons et al 2017; Leonard 2019) and increase anxiety and social distance. Mattei et al. (2020) established that such negative attitudes can lead to underutilization of workplace supportive resources or misconceptions about the reason behind an organization's supportive measures.

Internalized stigma can escalate due to negative workplace attitudes and impact well-being and acceptance. As revealed in previous studies, MHSUs employees' persistent absence

from work can strain relationships with their co-workers (Ebuenyi et al., 2018b; Lindsay et al., 2019a). Those who manage to gain employment tend to hide their mental health status (Goldberg et al., 2005) because stigma exacerbates undue tension and resentment among colleagues and supervisors (Wahl, 1999; Owadara, 2015). Co-workers often struggle to understand or accept the reality of the symptoms, especially when the psychological ailment is manifested in behavioural issues and not physical disabilities. Thus, they are likely to be less sympathetic and feel used by colleagues living with mental illness (Lindsay et al., 2019a; Bonaccio, et al., 2020). The incessant absences may be interpreted as laziness and may breed hostility when colleagues are mandated to share the responsibilities of the absent employees (OECD, 2018). Therefore, self-stigma can arise due to discrimination, a hostile social environment, thereby impacting social adjustment and the entire life of MHSUs.

In addition, Levy et al. (2014) relate mental illness discrimination to chronic social stressors, which can provoke psychiatric symptoms and limit adjustment, suggesting that aversive socio-cultural factors exacerbate the diseases. This aversive social environment can severely limit the effective utilization of social work interventions (counselling, support services or programs both in and out of the workplace) because clients may be reluctant to seek support or use available services. The removal of these social barriers often results in better social relations and positive clinical outcomes. Also, literature has shown that an inclusive organizational climate decreases psychiatric symptoms, reduces hospitalization, and increases social and economic participation (Williams-Whitt & Taras, 2010; Lindsay et al., 2019a, 2019b).

Alternatively, internalized stigma is viewed as cognitive as opposed to behavioural issue; depicted as a result of prejudice which means one is cognitively impacted by the stereotypes about mental diseases (Blais & Renshaw, 2013). It subsequently influences one's beliefs and actions. One of the negative responses to internalized stigma is the reduction in

social activity or psychosocial growth, such as striving for self-actualization (seeking better employment or higher education) (Blais & Renshaw, 2013; Vogel et al., 2013). Hence, internalized stigma is one of the barriers to full economic participation of the group which may not necessarily be the consequence of psychotic or mood symptoms but of the perceived judgemental attitude of the public.

In addition, employers often weigh the cost-benefit of economic decisions, such as the risk involved in engaging MHSUs as employees (OECD, 2018). Thus, employers' preconceived notions of incompetence and loss of profits can outweigh their consideration to embark on social care programs. Consequently, MHSUs are likely to hide their symptoms, which could further aggravate feelings of worthlessness and increase anxiety (Owadara, 2015; Ma et al., 2020). The fear of disclosure in the workplace is real, consistent with past studies. Exposure, or disclosure of one's mental health condition can be the cause of demotion and job termination (Sunghee et al., 2011; Bonaccio et al., 2020; Owadara 2021). Stigma reduces opportunities and confines MHSUs to menial jobs. The sufferers may experience wage differentials incommensurate with their educational qualifications, experience, skill, and performance (Baldwin & Marcus, 2006, 2007; Baldrige et al., 2018, Lindsay et al. 2019b). A multivariate analysis by Hing and Russell (2017) established that anticipated stigma strongly predicts self-stigma when all demographic variables are controlled. The degree to which MHSUs internalize discrimination, stereotyping and rejection heightens the severity of their psychological problems. Thus, stigma is detrimental to social functioning. It creates chronic psychosocial stress that can preclude consistency at work or cause a complete withdrawal from the labour force (Yanos et al., 2008; Michalak et al., 2011) due to intense shame and anticipatory anxiety. MHSUs are often in a dilemma about disclosing their medical status for fear of the consequences but not reporting may worsen the condition (Corrigan et al., 2009; Owadara, 2015).

2.2.2. Impact of stigma on exclusion in workplace

The social and economic consequences of self-stigma are experienced by the individual, family, and society because it increases dependence, stagnation, and social marginalization, and the individual may permanently develop a mental illness identity (Weich & Lewis, 1998). MHSUs are affected by stigma resulting from public judgemental attitudes, cultural influences, and the lack of support from the government and, it has significant implications for their integration (Waghorn et a;, 2015; Waghorn et al. 2017; Ma et al., 2020). The diseases impact government resources due to overreliance on the welfare system for MHSUs basic needs (Poremski et al., 2015).

Essentially, the deprivation model by Jahoda (1981) argues that the adverse effects of underemployment, unemployment, and job loss on mental health, and the benefits of full economic participation of MHSUs need to be seen beyond monetary compensation. Having a job helps structure their time, enhances their social networks, increases their sense of purpose, and social status, and provides them growth opportunities (Jahoda, 1981, 1982). The lack of earnings can result in psychosocial loss, poor quality of life, and poverty (World Bank, 2014, 2019). Assessing the impact of lack of opportunity on MHSUs may be significantly challenging due to the inability to differentiate diseases arising from the loss of jobs and those originating from biological pathogens such as genetic diseases leading to developmental disabilities since the sufferers are stigmatized in the same manner and both experience discrimination with the same intensity.

Furthermore, MHSUs are less likely to participate in the workforce due to practical challenges such as the degree of variability and sensitivity of their mental health symptoms due to individual cultural backgrounds, policy issues, and low access to care (Sunghhee et al. 2011). Often, the cause of their underemployment exceeds psychiatric disability (Beatty & Kirby, 2006). It includes employers' judgmental attitudes and the insensitivity of the government to

socio-cultural issues and hostile economic policy towards the group (Baldwin & Marcus, 2011; Beatty et al, 2019).

The enormity of the burden of mental diseases was the focus of a study by Nohr et al. (2021). These researchers compared the impact of cultural discrimination and poor knowledge of professional help-seeking behaviour in two countries. Nohr et al. investigated MH stigma and help-seeking attitudes, using a convenience sampling technique to select 195 and 165 participants from Cuba and Germany respectively. Cultural context was found to be associated with MH stigma and the help seeking behaviour of the patients. Cuban participants reported less mental health stigma and are more willing to seek help. Also, community attitudes towards the sufferer significantly predicted help-seeking attitudes among the Cuban sample. Among the German sample, individuals' negative beliefs about mental illness predicted self-stigma which impacted and lowered help-seeking behaviour. Also, cultural context was found to moderate the association between mental health stigma and help-seeking attitudes with a stronger association between the measures among the German participants. Neither gender nor its interaction with community attitudes, and cultural context predicted the help-seeking attitudes of the German participants.

The study concluded that sociocultural factors contribute to MH stigma. Even within healthcare settings where the expectation for a better understanding of mental illness is high, the knowledge and attitudes of healthcare workers still affect the working environment. They influence relationships among health workers and their attitudes toward MHSUs (Ebuenyi et al., 2019; Kato et al., 2021). A correlational study in two Japanese mental health hospitals by Kato et al. (2021) revealed the link between professional, ethical values, and social factors in responding to stigma in the workplace. The study examined the relationship between having control over practice and stigma towards mental health service users in the workplace. A

significant difference exists between social workers and nurses in handling discrimination cases because psychiatric social workers have a greater knowledge of recovery than nurses.

Thus, the occupational characteristic and educational backgrounds of the professionals differed substantially and were associated with attitudes and responses to the needs of mental health service users. Kato et al. highly recommended the efficient use of intra-agency resources like human resources management to prioritize roles, mechanisms, and strategies that can enhance adequate knowledge of mental health among workers. This is a reminder that sometimes an institution can become an enabler of mental health stigma when consideration is not given to the sensitive nature of stigma-related issues in the workplace to provide adequate and appropriate expertise and other resources that meet the needs and expectations of the service users.

In addition, the study revealed that being an expert in a health-related field has a profound effect on an individual's attitudes. As indicated, it is the degree of an individual's professional attitude that reduces stigma. Nevertheless, the extent to which personal characteristics and organizational practices can lead to differential outcomes, either in not providing the required support or due to negligence on the part of the management team, needs more clarity. In addition, given the specific nature of healthcare settings in comparison to other workplaces, further analysis is vital to determine why organizations may act differently in advocating for inclusion under different circumstances.

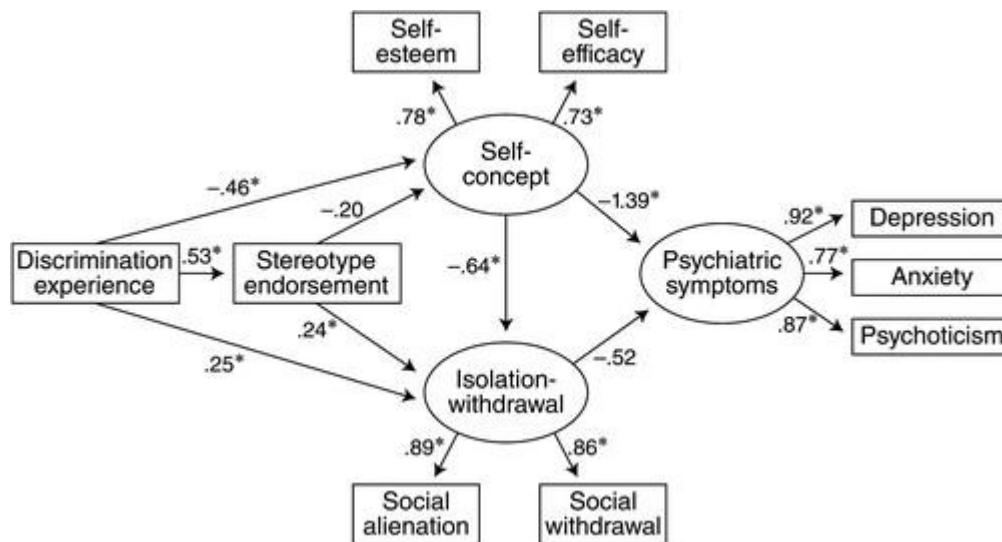
2.2.3. Empirical evidence on links between self-stigma and public stigma.

The outcome of a cross-sectional study by Oshodi et al. (2014) on the experience of stigma in Nigeria among 103 patients (adults) revealed a connection between self-stigma and public stigma. The study specifically focused on patients that had been diagnosed with a major depressive disorder with an episode within the past 12 months. They selected a sample from four tertiary psychiatric facilities located in different regions in Nigeria. A self-developed

socio-demographic instrument, the Discrimination and Stigma Scale by Brohan et al. (2013), the Internalized Stigma of Mental Illness Scale by James et al. (2016), the Boston University Self-Empowerment Scale by Roger et al. (1997), and the Rosenberg Self Esteem Scale (Rosenberg, 1965) were administered to collect the data. The study showed that being unfairly treated in dating or intimate relationships was the most frequent form of discrimination experienced, while concealment of mental illness was the most common form of anticipated discrimination. The study also revealed that people under the age of 40 and who have a higher level of education are exposed to a higher risk of discrimination. Thus, age and educational level may increase exposure to mental illness and self-concealment.

Similarly, a comprehensive model by Drapalski et al. (2013) deployed structural equation modeling to link public stigma to self-stigma as revealed in figure 1. The model provides a framework through which targeted behaviour could be studied for intervention. The constructs in the rectangles refer to the observable variables which can be targeted during the intervention, and those in ovals are latent variables. The arrows indicate directional effects, which specify the relationship between the observed and latent variables. The free parameters are depicted with asterisks, and arrows between isolation, withdrawal and psychiatric symptoms represent the path co-efficient relationships indicating the relationship between exogenous variables and an endogenous variable. As indicated below, 12 parameters were specified to be estimated from the model. This comprised three path coefficients and nine factor' loadings.

Fig1. Structural equation modelling showing the links between self-stigma and public stigma.



Adapted from Dopelaski et al. (2013, p. 268).

Figure 1 represents stigma as a multifaceted concept which can hinder social lives. It suggests an inter-relationship among self-concept, social isolation, and psychiatric symptoms. Therefore, two crucial issues are raised and worth further exploration: (a) government strategies/measures that can help reduce or prevent stigma and (b) effectiveness/or challenges of such measures in the workplace. These will be discussed under integration theory.

Figure 2: Model of adverse effect of stigma and protective mechanisms

- **Individual attributes**
 - *Adverse Effects:* Low self-esteem, communication difficulties, cognitive/emotional problems, medical/or substance abuse.

 - *Protective Mechanisms:* Self-esteem, physical health/fitness, confidence, ability to manage stress, & solve problems, communication skills.
-
- **Socioeconomic factors**
 - *Adverse Effects:* Loneliness, bereavement, low income, & poverty, family conflicts, exposure to violence, unemployment, school failure, work related stress and neglect.

 - *Protective Mechanisms:* social support (family & friends). Economic security, family interaction, scholastic achievement, success at work, life satisfaction.

- **Environmental factors**

- *Adverse Effects*: Social & gender inequality, social injustice & discrimination, lack of access to basic services, instability (exposure to war)

- *Protective Mechanisms*: Social justice, tolerance, social integration, social & gender equality, access to basic service, physical safety & security.

Ritchie, and Roser (2018) Official Data on adverse effect of stigma and protective mechanism.

Adapted from <https://ourworldindata.org/mental-health#prevalence-of-mental-health-and-substance-use-disorders>

Figure 2 provides a broader approach for conceptualizing the impact of stigma and mechanisms that can reduce this impact. It connects the personal to the social, economic, and political contexts. The WHO (2015) provides an explanation of how these factors are connected. Individual attributes are personal characteristics that make individuals more susceptible to mental illness such as medical illness, physical inactivity, low self-esteem, among others. In addition, having good health and high self-esteem, are characterized as personal protective mechanisms which have been linked to better mental health.

The socioeconomic factors directly impact a person's financial status or independence as well as social position. They include individual financial viability, education, social support, class, and gender. Empirical studies have linked economic factors to high self-esteem among MHSUs; however, due to internalized and public stigma, they are often at a disadvantage in the labor market, and this can even impact their help-seeking behaviour and access to mental health care (Dobson et al., 2016; Nohr et al., 2021). Environmental factors are characterized as the effect of human harmful practices and consequences on human beings such as lack of access to community space which may be the result of marginalization and social exclusion, living in a hostile neighbourhood, or war affected area. According to the WHO's (2015) findings, maintaining a balance among these factors – such as living a healthy lifestyle, access to

communal space, supportive family, colleagues, and friends – can promote better mental health. This approach draws attention to the effect of stigma and the need to design policy that foster protective mechanism in the workplace environment to promote an enabling environment for MHSUs.

Thus, Johnson (2017) made a case for national policy, social research, and social activism to focus on the root of mental diseases. This researcher argued that more investment in social work research at the national level may prove supportive where psychiatric and psychological research have been unable to gain more ground. Thus, Johnson advocated national policy reforms to address the growing social, political, and economic inequality among MHSUs. The researcher affirmed that such directions should prioritize employment, parenting and education, social support, political advocacy, and activism to increase acceptance and reduce discrimination against MHSUs. This study links low acceptance of MHSUs to lack of government support to shape social programs. However, the study did not explicitly state the procedure for implementing stigma reduction and acceptance of MHSUs. A deeper understanding of strategies for promoting inclusion and reducing stigma at the grassroots is therefore necessary.

2.2.4. Empirical evidence on social intervention for stigma reduction in workplaces

Inclusive programs such as anti-stigma interventions are designed to change behaviour and attitudes toward MH problems in workplaces. Successful delivery of such training in workplaces begins with the management. Empirical studies have identified the head of department, the supervisor and human resource (HR) managers as part of the strategic plan for stigma reduction because of their understanding of workplace practices and the importance of such programs (Szeto et al., 2019; Waqas et al. 2020). However, convincing the senior executives to build a partnership on this premise is often difficult due to erroneous beliefs of

protecting an organization's image and the misconceptions about what the program represents (Szeto et al., 2019). Essentially, influential figures in the public have significant roles to play in the acceptance of anti-stigma programs to change behaviour and attitudes toward mental health issues in a workplace and community (Shahwan et al., 2022).

Considering the notion that MHSUs have much to contribute to strengthening anti-stigma campaigns, Shahwan et al. (2022) examined the views and the suggestions of MHSUs and their informal caregivers on effective strategies to combat stigma in Singapore. Each focus group comprised six participants (People with Learning Disability, PWLD) and five informal caregivers in each group. The total samples for the study was 73 comprised of 42 PWLD and 31 caregivers. The study established four themes of strategies: raising mental health awareness, social contact, advocacy by influential figures or groups, and the legislation of anti-discrimination laws. The findings emphasize the importance of relationship building in changing attitudes and behaviours toward acceptance of MHSUs, which raises the significance of examining this concept within the Nigerian labour market.

Similarly, a meta-analysis by Dobson et al. (2019) focused on evaluation of mindfulness and stigma reduction programs among frontline workers and managers in Canadian workplaces. Eight replicated anti-stigma program evaluation studies, self-report resilience scale and coping studies that took place between 2012 and 2015. The researchers conducted a pooled analysis of 1292 respondents, however, only 1155 matched those who completed both the pre-and-post-surveys. In the follow-up assessment phase, out of 564 follow-up surveys completed, only 414 surveys matched with the pre-post-test. The Cronbach α results for "Opening Minds Scale for Workplace Attitudes (OMS-WA)" at pre-, post- and follow-up test were .91, .92, and .90, respectively. For the resiliency scale, the α level results at pre-, post- and follow-up phases were .81, .86 and .84 respectively.

The study did not explicitly discuss test validity, but it can be inferred that construct validity was assured with the use of different scales, which yielded similar results. The scales included are: “the Opening Mind Scale for Workplace with 22 items,” (Mental Health Commission of Canada, MHCC, 2019) and “a Self-developed Resiliency Scale with five items”. Using a linear mixed-model analysis, the primary outcome (a priori measures set to measure direct outcomes of the programs) and the secondary outcomes (additional outcomes to assess change over the time) for the pre- and post-test showed a significant difference in stigma for the total scale with coefficient $R = .167$, $SE = .08$, $z = 20.72$, $P < 0.001$, and other subscales (P s < 0.001). Analysis of the respondents’ personal and demographic characteristics showed no differences in the outcomes based on the participants’ “self-rated mental health” as frontline staff vs. supervisory workers, organization type, gender, age, education, marital status, job status, and self-rated health.

For improvement in resiliency skills, between the pre- and post-test, the mean (SD) scores were 3.50 (.64) and 3.81 (.61) respectively, showing an overall mean improvement of .31 between the scale points for the program’s outcome. The result of the mixed-model analysis for the pre- to post-change on the resiliency skills scale indicated a significant improvement ($P < 0.001$). However, participant factors when tested were not significant predictors of resiliency skill improvement. The follow-up phase was after three months. The results of the 414 follow-ups out of 564 surveys which were matched with the corresponding pre- and post-test for those that completed the three surveys revealed a lower but more positive baseline stigma score compared to those who did not complete the study (1.72 and 1.81, $P = 0.002$) for the OMS-WA total scale and subscales (Dobson et al. 2019).

The results of the two subscales showed the scores for the pre-test to follow-up phase ($R = .201$; $SE = .025$; $z = 7.90$; $P < 0.001$). It suggested a stability in stigma reduction up to the follow-up in reducing perceived danger or unpredictability; however, no changes were

observed for the helping subscale (coefficient = $-.023$; SE = $.035$; $z = -0.66$; $P = 0.510$). The overall mean (SD) scores at times 1 to 3 indicated baseline = $1.72 (.43)$, post-test = $1.53 (.41)$, and follow-up = $1.62 (.42)$ ($n = 415$). The results indicated a better retention of resilience skills among respondents from the private sector compared to the public sector. Regardless of the programs adopted across the study centres, from the pre-to-post and follow-up assessment, there is a significant improvement over the baseline level. This suggests that despite differences in stigma reduction programs adopted, noticeable behavioural and attitudinal changes were observed throughout the sites. In addition, an increased retention of resiliency skills was observed in the private sector when participant characteristics were examined. Participants in the private sector were able to develop and retain skills that helped them overcome problems.

Hence, people with great resilience abilities can manage disappointments because they do not allow setbacks to prevent them from growing professionally. Application of the same instrument in different sociocultural settings might have a varied outcome due to cultural problems that may impact organizational behaviours and attitudes.

More so, a systematic review by Hanisch et al. (2016) on the effectiveness of workplace anti-stigma intervention strategies examined 16 studies. Changes in knowledge of mental disorders, their treatment and recognition of signs of mental illness; attitudes towards individuals with mental-health challenges; and supportive behaviour were the selected criteria for examining the effectiveness of the interventions. Out of the 16 studies explored, five were randomized controlled trials while 11 were quasi-experimental studies. The intervention strategies comprised mental health first aid, role plays, online training/group discussions, trauma risk management, anti-stigma workshop, psychoeducation, and crisis intervention training. It was reported that workplace anti-stigma interventions can improve employee knowledge and supportive behaviour towards individuals with a mental-health crisis. The effects of the intervention were generally reported as positive but mixed on changes in

employees' attitudes and the quality of evidence varied across studies. The study appears to have focused on the stigma reduction programs with less emphasis on services that are beneficial to MHSUs and structures that aid the success of these programs per se. Thus, more clarity on factors that aid the success of these initiatives is needed. Such a study might need to closely examine the structure of relationships with the community, its values, and cultures that embrace diversity.

Waqas et al. (2020) reviewed the effectiveness of various educational institution- based anti-stigma interventions. Out of the initial 104 articles selected for review, 44 randomized controlled trials were selected as meeting the inclusion criteria. In these selected articles, education through lectures and case scenarios, contact-based interventions, and role-plays were adopted as strategies to tackle the stigma of mental illness. The review revealed that a high proportion of trials reported that there was a significant improvement for stigma reduction (76%), attitudes (72%), help-seeking (72%), knowledge of mental health (78%), and social distancing (57%). These interventions were also effective in reducing both public and self-stigma. Knowledge of these anti-stigma programs might help in evaluating how private and public schools in Nigeria promote stigma reduction programs, the efficacy of the interventions and the structure through which they are delivered.

In collaboration with the Canadian Mental Health Commission, Szeto et al. (2019) examined evidence-based anti-stigma programs adopted in Canadian workplaces. The study evaluated management experiences on implementation of two programs, "Road to Mental Health Readiness" and "The Working Mind", using online survey questionnaires at the pre and post stages. For anonymity purposes, the study adopted a permanent code generation for all 100 organizations. The outcomes of the evaluation revealed challenges and barriers to anti-stigma programs at the adoption, implementation, and evaluation phases. During the participants' recruitment and implementation phase, challenges encountered are from the top

management, especially the executive and HR personnel, who exhibited different perceptions about mental health in the workplace. Their cultural backgrounds affected their perceptions of the anti-stigma program, and they are more doubtful about the potential benefit of stigma reduction to the workplace. The fear of increasing an organization's vulnerability, the misconceptions that the anti-stigma program could portray a negative image of an organization, a change in the leadership structure that hindered collaboration, and delay in program endorsement processes are all part of the barriers.

At the implementation and evaluation phases the observed barriers include low support for anti-stigma interventions, which was attributed to managements' lack of commitment, scepticism about the evaluation's purpose, and lack of continuity. The researchers concluded that organizational support and values are essential ingredients for the success of anti-stigma programs. This raises the significance of examining these contexts and how they can hinder collaborative relationships in promoting the required training, program continuity, consistency in the on-site evaluation, and response time.

Furthermore, Mascayano et al. (2020) believed that stigma reduction interventions must be culturally sensitive. In a study carried out to investigate the effectiveness and how culturally sensitive the various MH stigma reduction interventions were in low- and middle-income countries, findings evinced that majority of the interventions focused on improving knowledge and attitudes through education of healthcare professionals, community members, or consumers. Out of the 25 interventions, 20 involved short training programs, most especially for health professionals, students or consumers, and families. Practice-based skills, exposure through direct patient contact, support for people with mental disorders and their relatives, treatment adherence management, referrals to community agencies, viewing films depicting individuals with schizophrenia positively for discussion were utilized for healthcare workers. For consumers and their families, art activities, training for caregivers, and needs-based

interventions were implemented to promote positive attitudes and reduce self-stigma. The study further reported that only 20 percent of the interventions considered cultural values, meanings, and practices. Though the findings emphasized the importance of comprehending cultural values and meaning for positive interventions, a better understanding of the nexus between organizational cultures and values is crucial to determine the direction of interventions not just for the low management team but also for the top executive officials who are often sceptical of anti-stigma interventions.

Similarly, Taghva et al. (2017) qualitatively explored strategies effective in combating stigma toward people with mental disorders in Iran using a purposive sampling technique; participants were mental health stakeholders. They include mental health providers, advocacy groups, community organization, service users, NGOs. The data were collected via eight individual interviews, two focus group discussions, and six written narratives. The major themes that emerged in the study were: (i) emphasis on education and changing attitudes, (ii) changing culture, (iii) promoting supportive services, (iv) the role of various organizations and institutions, (v) integrated reform of structures and policies to improve the performance of custodians, and (vi) evidence-based actions. In the study, the effectiveness of these strategies was not evaluated. Drake et al. (2020) argued that to rebuild self-reliance and confidence among MHSUs, integrated employment plays a vital role as it possesses both short and long-term benefits to the group. Thus, reducing stigma in the workplace perhaps can lessen dependence and encourage active participation of MHSUs in the labour market.

2.2.5. Summary of empirical findings on stigma and discrimination in the workplaces

The review of related literature in this chapter showed that stigma reduces the social integration of MHSUs. Investigation about the prevalence of mental health problems, their nature, and their prognosis indicated stigma as the bane of employers'/managers' indecision in promoting an inclusive policy. This has led to different outcomes (Chong et al., 2013). In

addition, Vornholt et al. (2013) established that poor knowledge of the diseases sometimes leads to employers'/managers' indecision and delay in intervention. Other findings shared similar outcomes, attributing employers' indecision to lack of awareness and underestimation of the percentage of the affected population in workplaces (Hemphill & Kulik, 2016; Ebuenyi et al., 2018; Lindsay et al., 2019b). From the preceding literature, five interrelated conclusions can be drawn about stigma and organizations' responses to the promotion of an inclusive policy.

(a). The unresponsive attitude of an organization may be due to inability to broadly relates with variety of ways in which mental health affect its workforces. This may be linked to a lack of transparency on both sides (employees and managers).

(b). The episodic nature of some illnesses may make it challenging for employers to appraise, understand, and respond to employees' MH needs because organizations may lack experts to interpret mental health reports. This suggests the need for workplaces and healthcare systems to collaborate in the promotion of inclusive goals.

(c). Personal attributes such as manager experiences and those of other decision-makers may constrain organizational responses or act as a catalyst for punitive measures.

(d). The invisible nature of some disabilities can influence how organizations process and prioritize needs.

(e). An organization's perception of its role concerning institutional responses and perceived government commitment may define how and when an organization promotes inclusion.

Three major issues can be drawn from this discussion; (a) knowledge of people and attitudes in the construction of mental illness is deeply rooted in the socialization process. Therefore, designing approach for stigma reduction have to consider individual culture which influences their perceptions. This leads us to the second issue which has to do with the context in which policies are developed and implemented. For a successful MH policy implementation, it is

design need to build knowledge around sociocultural background in which the policy is to be implemented. Third, the fear attached to MH issues have significant impact on users' readiness to access and utilize MH programs regardless of its accessibility and availability. Thus, individuals' readiness to seek help might be hindered due to fear and judgmental attitude of the people.

2.3.0. Theory related to relationship building for facilitating inclusion

2.3.1. Social Capital Theory

In social work and epidemiological research, social capital is sometimes used interchangeably with social support or social network (Webber et al. 2014; Webber & Fendt-Newlin, 2017). Thus, social network constructs are used to measure the quality of support from the close network of MHSUs. Similarly, Veenstra (2007) and Veenstra and Abel (2019) adopted this concept as a social determinant of health in measuring health inequality. There seems to be a consensus in health and social work studies that social capital moderates support, promotes well-being, increases strong attachment at a personal level, and brings social development and equity when adopted at the community level. For this present study, services that promote inclusion are treated as outcomes of social capital which developed through relationship to promote mental health (MH) and acceptance of disability groups (MHSUs). Preventive care and interventions as identified by FMOH (2019b) are outcomes of social capital and include: preventive care- information accessibility, advocacy and psychoeducation, for interventions- they include treatment (counselling) and referral. Thus, the concept of trust as opined by Fukuyama (1995) fosters commitment in this arrangement and relevant in the context of MH promotion in schools because it is expected to enhance personal and interpersonal relationships that support MH inclusion.

2.3.2a. Contextualizing social capital within the institution

Social capital resources that are helpful to communities are attributed to information about local resources, psychosocial and political resources (Carpiano, 2006). Vyshka et al. (2018) explored government's involvement in providing informational resources on mental health in Albania. Specifically, the study examined the state resources and the extent of the state's involvement in policy delivery, the availability of human and material resources and the polarization of mental health issues in relation to the nation's understanding of the diseases. The study's outcomes revealed the absence of the state's coordination and support in raising awareness and sharing information and resources which reduces public trust in the state and its agency.

Thus, the commitment of governments, organizations, and the public remain essential to facilitate better participation in promoting inclusion. According to the Department of Health's (1999) report in the United Kingdom, social capital can engender social inclusion because it entails participation, reciprocity, a sense of trust and safety, social power, social connections, and community perceptions. The opportunity for MHSUs and other vulnerable groups to feel included, connected and be able to actively participate in social and economic activities, and make friends, without living in a segregated sheltered workshop or feeling ostracized, largely depends on the type and quality of social capital available in the community which may be different from region to another.

Corporate organizations often engage in diverse social responsibilities such as support for local development, scholarship, health information, security, and environmental protection to strengthen their relationship with their host communities, as opined by Brown (2010). Also, Yamatani et al. (2015) sampled 1,988 Canadian workers and concluded that people with disabilities are at a higher risk of exposure to hazards in the workplace. They affirmed that sharing of health information and security provision are vital to maintain safety in the

workplace. Collaboration, therefore, becomes one of the mechanisms of building social capital, sharing information, and fostering good relationships within and outside organizations. Essentially, an organization's participatory potential, perception of civic responsibilities, and interpersonal and institutional trust are necessary conditions that facilitate cooperative relationships (Putnam, 2000).

An organization often builds social capital through a shared understanding, norms, values, interpersonal relationships, cooperation, reciprocity, and a common sense of identity. It can offer tangible resources such as inclusive policy, material incentives and physical development (Zhai, & Du, 2020). A good example is when a space for a wellness program is created or when an accessibility problem is resolved. Psychological or emotional supports are also examples of intangible resources (Warren et al., 2015; Zhai, & Du, 2020). In addition, Johanson (2000) revealed the importance of structural social capital in facilitating information sharing. Structural social capital is the configuration of connections within the social system that acts as a source of support for individuals such as established protocols organizational chart, information channels in the workplaces that facilitate collaboration. Johanson differentiated between structural and cognitive capital in measuring the health status of a country. According to Johanson, the effect of macrostructures is significant in facilitating or disabling social capital. A similar observation was reported by Rossler (2016) on the impact of political interventions such as economic restructuring or a change in policy which are designed to increase positive outcomes. The author affirmed that the influence of important figures supporting a cause and positive attitudes from the media increased social capital in the community.

2.3.2b. Social capital outcomes

As observed by Johanson (2000), reasons for corporate organizations' involvement in fulfilling corporate responsibilities vary. Some intentions are secretive to avoid

counterproductive or negative reciprocity, and their purpose can be simple or complex. However, social work and health-related studies have incorporated health determinants and network analysis to ease some of these complexities in studying the spread of diseases (the negative side of social capital) as observed during the Covid-19 pandemic (Rajkumar, 2020). Social capital has also been employed to examine differential access to material resources (for example, the use of a virtual community as a means of social networking or spreading information), and social benefits as well as healthcare services have been conceptualized as constructs to measure social capital (Wong & Kohler, 2020; Kuguyo et al., 2020). Also, quality of the relationship and the impact that such a relationship has on resources at the individual level or group level when measuring social capital outcomes may be the focus (Proikaki et al., 2018, Friehe & Utika, 2018). This study embraces the latter aspect of social capital outcomes.

An experimental study by Thompson (2018) examined the level of interpersonal trust in organizations and established that social capital acts as a stimulant to innovative ideas and development in organizations. Six leadership behaviours are listening skills, openness, receptiveness to diverse opinions, trusting in collective wisdom, acceptance of alternative views, and a shared sense of collective responsibility were identified as facilitating attitudinal change. The study established that leaders' ability to build relationships increased economic growth and the employees' work output. However, it is often challenging to determine organizational intentions in collaborating or engaging in social responsibility because the social relationship is not devoid of rational and self-motivated goals, which Granovetter (1985) referred to as embeddedness in social relations.

2.3.3. Assumptions about the measure of quality of social capital

Four additional constructs for measuring the quality of social capital outcomes were proposed by Carpiano (2006): the extent of social support, the quality of such support, and the actual activities/initiatives in informal and formal organizations. These activities may include

block clubs, community boards and community-based organizations or organized community social care services. There is a concern in using these variables to measure organizational involvement in/out of the workplace because the outcome of social capital may be entirely different for the organization, staff, and community. Thus, to reduce the risk of disengagement from values that organizations attach to corporate social responsibilities to the staff and community, it may be more appropriate to tie such responsibility to the mission and vision of organizations, especially when projects do not directly benefit organizations. Thus, in this present study, education inclusive goals are tied to the mission statement of the selected schools to examine outcomes of inclusion programs.

In addition, Carpiano suggests the need to specify the actions and goals for which social capital can be utilized. The nature of the relationships (formal or informal) should be defined to explain the intention of an organization. In this study, organizational promotion of mental health awareness programs and policy in the workplace is the goal, and government agencies and workplace relationships can be defined as formal in terms of policy and legislation that guide mental health promotion. The actual practice, persuasion, may be described as informal. Additionally, the framework that an organization adopts in promoting social capital needs to be specified. Collaborative strategies and information, education, and communication strategies (IEC) remain dominant strategies employed in promoting and sensitizing the public about mental health issues (Chukwuani et al., 2006; Hann et al., 2015; Abimbola et al., 2020).

There is recognition of the need for greater involvement of all stakeholders in awareness creation and care service for MHSUs. As articulated in the NMHP (2013), cooperation remains a crucial component of addressing inequality, discrimination, and the integration of MHSUs. WHO (2019a, p. 31) states that such “a relationship should be built between PHC, local schools, NGOs and individuals from communities in implementing programmes” to promote mental health and prevent mental disorders. This study examined four constructs to model the

degree of an organization's participation in mental health promotion and integration of MHSUs. They are (a) measures that directly explain the reported the structures of cooperation between schools and the government, or NGOs (b) measures that explain actual organizational support such as material and informational resources that promote inclusion in the workplace, (c) measures that explain strategies for promoting inclusive policy, and (d). measures that explain management's motivation for commitment.

2.3.4. Four constructs for measuring social capital

2.3.4.(a). Measures of cooperative structures

The WHO (2016) defines collaboration in MH as a mutually beneficial arrangement between two or more entities that jointly work towards a common purpose. Carpiano (2006) conceptualized it as social integration that measures social diversity through social networks and the degree of involvement. Collaborative strategy is purposely designed to improve citizens' mental health and wellbeing by increasing their access to preventive care, health promotion, treatment, and rehabilitation services. Its strength lies in relationship building among health care providers, workplaces, consumers, families, and caregivers (Gagne, 2005). In the assessment of community-based or participatory action studies, several measures have been adopted to investigate health behaviours/outcomes and social development programs. These assessment scales include nine or more items, and the items often focus on the spread and size of the network, group membership, and the frequency of interaction (Wellman, 1979; Wellman & Frank, 2001).

(b) Actual organizational support

Organizational support theory (OST) by Eisenberger et al. (1986) opines that employees tend to attach human-like behaviour to the organization. Often, organizations justify rewarding their workers' socioemotional needs based on their performance. Employees uses the quality of support provided by organizations to gauge organization's valuation of their contributions

and how they care about their wellbeing (Eisenberger et al., 1986). Theorizing social exchange between employers and employees has generated different arguments about its process and outcome. Castillo et al. (2012) argued that the variability in the degree to which traditional hierarchical and mechanistic structures, such as inflexible bureaucracies and power centrality, exist can influence organizations' support of their workers.

Similarly, the nature of an organization – whether non-profit, family-oriented, a private corporation or a public institution – plays an important role in its support for its workers. Studies on the Covid-19 pandemic revealed that hospitals are more inclined towards health promotion, preventive care and more concerned about its staff members' wellbeing (Xiao et al., 2020; Tomlin et al. 2020; Brender et al, 2021). Though, the nature of organizations may to an extent define how they respond to staff. Utilization of such service may depend on how staff interpret the motive behind it and what it means to them (Tomlin et al. 2020). Previous scales that focus on perceived support from workplace and families are Zimet et al's. (1988) multidimensional scales which contain 12 items with item coding scores from one to seven, while Eisenberger et al.'s (1986) scale was developed using a principal component analysis of individual responses with an original 36 items, and later they were reduced to 17 items. They were further reduced to 8 items with a similar reliability coefficient of 0.96 (Worley et al., 2009) to validate the assumption of treating the scale as a unidimensional scale.

More so, in an interview session with 12 female and male coaches in voluntary and part-time jobs in the UK, Norris et al. (2020) investigated participants' experience of support networks when they most needed this support and the type of support they received. They found it useful and reliable to explain how cooperative relationships helped in building their careers. The outcomes revealed four types of social support that are found among participants' support networks which are instrumental, informational, emotional, and appraisal. However, only informational support was found most useful in a semi-informal relationship. This could be

associated with the nature of a job, that is, a job technicality may require information from experienced colleagues or the superior. In a career-oriented relationship, informational support and active communication proved helpful between coaches and their teams, and participants also found inclusion of peer, family, and friends in social interventions very useful.

Therefore, the technicality involved in structuring and adapting semi-informal support in a strictly formal relationship may be an issue of concern in a workplace. It seems to pose a very challenging situation in the choice of whose professional expertise is best applied to navigate this process. Also, under what conditions might the knowledge of such support in semi-formal relationship be helpful in a formal relationship such as the relationship between MHSUs and employers or between colleagues? How can organizations tap into employees' support networks or work with families and communities without jeopardizing the emotional stability of the MHSUs? Though these questions can be helpful in shaping the course of interventions, they are however unexplored in this study.

(c). Motives for commitment to inclusive programs

Organizational cultures and values have also been linked to motives for commitment to an action plan (Vannette, 2016; Nelissen et al., 2017). For example, healthcare studies attached the mission and values to why the healthcare system is more receptive towards inclusive policy (Berwick et al., 1997, Erasmus et al., 2017; Thompson, 2020).

Education sectors share similar values in their pursuit of inclusivity (UN, DESA, 2009). School's programs target preventive care- provision of safe place, building leadership skills, resilience, encouraging peer support, and promoting community of learning (WHO, 2016, 2019b; Link et al. 2020). However, a few empirical studies have shown that inclusivity in the education sectors tailored anti-stigma programs towards learners as opposed to employees and are more receptive through a lecture-based approach (Link et al. 2020, Song et al. 2023). Similarly, post-secondary and secondary schools' participation have consistently been

targeting drug abuse, awareness creation and theoretical guidelines on MH promotion in schools (Bachman et al. 2024; Bbus et al. 2019; Cavioni et al. 2020). Consequently, when schools' programs target learners alone, the concept of inclusion seems derailed from its broad objective and perhaps constitutes hidden stigma in its execution. The idea that schools' commitment are often students-based suggest the need to extend schools' motives for social support beyond organizational goals and values. Perhaps, due to profit-driven motive of private sector, investing in workforces' wellbeing might hinder such a motive.

Inclusive promotion requires massive investment (WHO, 2013; 2019d) which may not be readily available to schools. Thus, fostering relationship between the PHC and schools, and NGOs and schools (FMoH, 2019b) can help bridge this gap. However, Anyebe et al (2019) established that there is an absence of leadership collaboration in mental health (MH) programs at PHC in Benue state, Nigeria. That MH promotion (such as drug enlightenment program) is occasionally advocated in schools. The study affirmed that there is a dearth of assessment for early detection of mental health problems. They concluded that the Federal government of Nigeria still concentrated on long-term care, and that none of the guidelines specified in the policy framework (mental health accessibility, assessment form, community leadership, advocacy) exist in the researched settings. Thus, complexity is inherent in the description and practice of MH inclusion in Nigeria, and the extent of its support for schools' workforce.

Other empirical evidence affirmed that organizations differ in the value of resources they are willing to invest in employees and are determined by management's discretion (Adu-Gyamfi et al. 2021; Arizkuren-Eleta et al., 2015). Top managers are more likely to invest heavily in developmental training opportunities and other resources that will enhance employees' productivity because employees' skills, knowledge, and decisional autonomy are to be fostered continuously (Tsui et al. 1995).

Nevertheless, Adeyemo (2005) affirmed that readiness to adopt a policy might not actually lead to desirable outcomes due to the discrepancy between policy statements and practices or oversights in policy planning. On the part of employees, school's instrumental or socioemotional resources can influence perceived organizational support and promote employees' commitment (Ng & Sorensen, 2008). Organizational support motivates altruism, workers' solidarity, cooperativeness, interpersonal trust, and collective action (Abou-Moghli, 2015). However, countries with high levels of individualism have lower social embeddedness, resulting in negative side effects of social capital such as disloyalty and selfishness (Sorensen, 2011). A better conceptualization of how national context, cultural variations such as power distance (social hierarchy) and avoidance of uncertainty can impact social capital, or limit social embeddedness is essential but are beyond the scope of this present study.

(d) *Procedures for evaluating social interventions: Intra-agency trust*

Management's perception of the importance of a conducive organizational climate has been tied to its short-term and long-term goals (Amadi et al. 2017; WHO, 2018; World Bank, 2020). Since the success of interventions largely depends on management's ability to establish and promote cooperative behaviour, DESA (2009) asserted that the primary focus in evaluating organizational interventions should begin at the planning and implementation phases. Appraisal should include guidelines or strategies to foster unity, eliminate barriers, eradicate stigma, and promote strategies that can alleviate health disparities in workplace settings.

Furthermore, Gagné (2005) affirmed that concern should include challenges that come with relationship building when appraising organizational support such as unequal relations between business owners and government when promoting inclusive programs. Unequal relations can adversely affect the degree of participation or loyalty. In work relations, Uzzi, (1999, p.483-484) argued that the embedded instrumental exchange in strong social relationships enhances supportive exchanges by enacting "expectations of trust and reciprocal

obligation that actors espouse as the right and proper protocols for governing exchange with persons they know well".

Building on this extrapolation, at the core of organizational support theory as noted by Eisenberger et al. (1986) and Levinson (1965) is that expectations could promote inclusiveness and enhance workers' output. Consistent with this argument, the network of multiplex, reciprocal exchanges in which employees are embedded within the workplace has been theorized and empirically proven as having an influence on their perceived organizational support (Kossek et al., 2011; Myeong & Seo, 2016; Yani et al., 2020). Integrating the concept of social embeddedness within an organizational support framework provides evidence that the effect of social embeddedness has far-reaching impact than previously conceived. Therefore, this thesis asserts that the effects of social embeddedness can be extended beyond interpersonal relations to study relationships between the actors (bureaucrats) and the labour market. It can also be extended to study relationships between schools and NGOs in mental health promotion.

2.3.5. Strategies for promoting inclusive policy in education systems

As entrenched in the FMOH (2109b), preventive care encapsulates information accessibility, advocacy and psychoeducation. A number of studies have examined strategies for promoting MH at organizational level and information are consistently identified as parts of the key component of MH promotion (Yaakoobi & Weisberg, 2020; Ryan et al. 2020). Thus, communication, relationship building, and education remain critical components of facilitating inclusive policy (Hayes & Bulat, 2017; Brimhall & Mor Barak 2018; Qi et al. 2019; Yaakoobi & Weisberg 2020). They have been strongly connected to the outcome of support. When utilizing lean (concise and brief information) communication support networks, such information must be brief, timely, useful and encourage active listening (Pai & Harsha-Kumar, 2015; Xiao et al. 2020). Studies have shown that individuals' health and education are tied

together, MH problems are disruptive to social integration success in schools and challenge economic participation (WHO, 2003c; 2019).

However, Asgari et al.'s (2020) study touched on the contribution of leadership styles (transformational and transactional leadership) to inclusive promotion in schools and the mediating roles of perceived organizational support and job satisfaction in workplace relationship. This study was conducted among 250 respondents who were employees of the University of Birjand, Iran. The findings showed that transformational leadership, employees' job satisfaction and perceived organizational support positively and significantly influence employees perceived organizational civic engagement. Employees' job satisfaction and employees perceived organizational support were found to mediate the association between transformational and transactional leadership and employees' OCB. The relevance of the findings cannot be overemphasized in building an understanding around the subject of inclusion. It connects schools' administrative roles to the implementation of inclusive policy and the criteria through which employees might judge the adequacy of such involvement.

In a review of schools' participation in MH, Margaretha et al. (2023) revealed the healthcare domain utilizes the concept of MH often, while educational systems sometimes refer to it as social, economic and education wellbeing. The difference in nomenclature creates challenges in defining expectations and defining schools' interventions that tailor toward specific MH needs. It becomes increasingly challenging to partner with healthcare systems. Thus, this study suggested a unified MH manual between schools and healthcare providers.

Similarly, the WHO (2003c) provided eight standard indicators of MH promotion in schools among which social support and interagency alliances are stressed. It has further developed into Mental Health Gap Action (mhGAP) to train, offer guidelines, monitor, and evaluate program effectiveness in stigma reduction (WHO, 2013). For students, such intervention aims at providing peer support and mentorship, led by student support groups and

establishing local partnerships with healthcare providers, community and NGOs. On the part of workforces, the program aims at training educators, providing professional support network, establishing collaborative structure between schools and external mental health professionals to foster supportive work environment. Most importantly, WHO advocates for recognition of workplace stressors and promotion of team building in wellness promotion. In evaluating MH intervention programs two theoretical frameworks have been consistently deployed, competence-based actions and resourced-based model, to determine internal and external resources for MH inclusion (Nelissen et al. 2017; Ludwick et al. 2018; Margaretha, 2023). The resource-based approach has continued to focus on measuring needs, available resources and systems that offers support services.

Ludwick et al's study in Uganda ties the success of schools' inclusive programs to community Healthcare Workers. They are expected to act as a guardian, perform supervisory roles and link schools to available resources near them. The study confines schools' participatory roles in inter-agency collaboration to that of consumer which limits its functional role in MH inclusion. In Nigeria, FMoH (2019a) portrays schools as parts of MH policy implementer teams. Schools as MH team recognize directors, teachers, mental health staff in school roles. Other partners in the community comprise NGOs, religious organizations, and policymakers. From the review MH inclusion in education sectors are rather broad, targeting school community as a whole. However, for the purpose of this thesis, MHSUs' employees are targeted to examine effectiveness of school preventive strategies and interventions in reducing stigma and facilitating economic participation of MHSUs' employees..

2.3.6. Empirical studies on the effects of social capital in promoting inclusion.

Myeong and Seo (2016) examined the relationship between trust in government and, bonding and bridging social capital in South Korea. They hypothesized that the level of trust in government might increase with growth in social capital; and that the impact of social capital

on the level of trust in government might differ based on its type. Their classification of social capital was based on Putnam's (2000) bridging and bonding social capital. Bridging social capital describes the network among people with heterogeneous social backgrounds and socio-demographic characteristics, among others. Bonding describes networks among people with homogeneous social backgrounds and socio-demographic characteristics.

Bridging social capital measures the quantity, rather than the quality of relationships, while bonding explains the quality of relationships. The findings revealed that bonding social capital has a negative relationship with trust in government ($B = -0.112, p < 0.05$). Specifically, the result showed ($B = 0.311, p < 0.001$) and ($B = 0.501, p < 0.001$) for active and passive bridging social capital respectively, indicating that both have a positive relationship with trust in government. The differences in the perception of trust in government between the two types of social capital showed that people with high level of social standing are likely to rely on government actions and believe in state policies the most within their bonding (close-knit) social groups. In relation to bridging social capital, the high-status group also showed the highest level of trust in government, and there exist differences in perception among middle and low status groups and these differences among bridging social capital groups were significant ($F = 32.474, p < 0.001$).

The result of a Scheffe post hoc comparison further showed that all the three groups (high, middle, and low) had significantly different perception of trust in government. As revealed in the study, while bonding social capital had no significant influence on trust in government, bridging social capital significantly influenced trust in government and it can be taken as a determinant factor that accounts for the difference in trust in government. The outcome of these findings influences the framing of the proposed study since trust remains a key issue that researchers have identified affecting policy planning and outcomes in Nigeria

(Adeyemo, 2005; Bolaji et al., 2015; Anyebe et al. 2019). An imperative question is how schools evaluate government MH advocacy roles to participate in inclusive promotion.

In relation to organizations, Yani et al. (2020) conducted a survey to determine the impact of social capital on entrepreneurship competence in business performance among 315 entrepreneurs in Bekasi city, Indonesia. The results showed a significant effect of social capital on entrepreneurial competence and business performance with a significant effect on knowledge sharing via entrepreneurial competence. This result perhaps raises the significance of social capital to organizations' commitment to a cause, especially when the cause is measurable and justifiable. However, when the concept is tied to competence, it is unclear how the organization defines parameters for measuring its outcome when the social capital goal is a long-term investment, such as when embarking on inclusive programs. The extent of the organizational commitment may need more empirical evidence because of uncertainty in the world. Issues of importance may include the size of an organization, years of operation, the nature of the organization (whether private or public), and its types of service to decide its level of commitment.

A similar outcome was observed in the findings by Lyu and Ji's (2020) meta-analysis. The researchers explored the impact of social capital on firms' performance in China's transitional economy based on 106 independent studies carried out between 2008 and 2018. The findings showed that each dimension and type of social capital; structure of social capital; business networks of relationships; and cognitive dimensions significantly affected firms' performance. Likewise, social capital types such as internal, external, institutional, and business significantly affected firms' performance. The result shows that social capital is positively related to firms' performance in transitional economies. It was also related to the business relationship in private and state-owned firms in China's transitional economies. They discovered that the positive effect size of social capital is higher for private enterprises

(correlational coefficient “ R_c ” = 0.169) than state-owned enterprises (R_c = 0.159), however; the difference was not significant. This implies that in terms of performance, it cannot be said that social capital is more positive for private firms than state-owned firms in China's transition economies. However, the effect sizes of social capital were significantly larger for high-tech industries (R_c = 0.312) compared with low-tech industries (R_c = 0.236). Similarly, the positive effect size of social capital is more prominent and significant in regions with a low level of marketization (R_c = 0.448) than high-level marketization (R_c = 0.237). The effect size for each construct is significant because none of its confidence intervals include zero, since multiple studies are involved the p-values range between < 0.05 and < 0.10 .

These findings showed that while social capital performance depends on specific performance measures and dimensions, specific social capital is required at different points in different industries and market areas. It implies that in relation to performance, social capital is positively influenced by the nature of an organization, that is, profit-oriented organizations may be eager to support initiatives that can lead to higher returns and may be unlikely to pursue an initiative that has little or no direct benefit to the organization. Thus, how the organization perceived inclusive policy and the values that the organization pursues may influence acceptance and commitment towards the government's inclusive agenda. However, this explanation has not been able to proffer clarity on whether the years in operation or business sector may impact on how the organization defines its civic engagement to employees and the community. This is crucial to a better understanding of why private and public schools may be willing to promote the government inclusive agenda.

Jung (2020) investigated the influence of social capital on personal happiness among 281 respondents (employees) in service industries in South-Korea. The study examined social networks, social norms, and social trust. The social network is measured as satisfaction in social relations and the degree of social exchange; social norms are measured in relation to

reciprocity, participation, belonging, and solidarity. Social trust measures the degree to which trust is maintained in the community. It was found that social networks, social norms, and social trust jointly, significantly predict the well-being of employees and accounted for 64.1 percent of the observed variance in their personal well-being. However, while social networks and social norms individually contributed significantly to personal well-being at the 0.05 level of confidence, the contribution of social trust independently was not significant. Given the outcome of these findings, perhaps, it is safe to suggest that the extent to which these constructs, when combined influence employees' mental wellbeing maybe subject to what the organization prioritizes as its values.

The idea that social trust when singularly tested did not predict employees' well-being may depend on how employees perceive the availability and quality of support services and the management's sincerity. For MHSUs, trust remains a key component to promote a feeling of workplace acceptance, but it is often difficult to measure because of mental illness' invisibility. Perhaps, the extent to which MHSUs perceive organizational support as sincere and the quality may influence their feeling of workplace acceptance.

2.3.7. Facilitators in schools' inclusive promotion

According to the World Bank's (2021) report, there is a possibility of variation from country to country in how people experience social exclusion due to how each society views and responds to MHSUs' needs. Persons with a disability are classified as an at-risk group because they are often denied full participation in society's socio-economic and cultural system. Deprivation experienced by this group has been attributed to physical and social barriers due to ignorance, indifference, and fear. According to the report, the global percentage of persons living with one form of disability, or another was approximately 15 percent of the global population. One-fifth of the estimated global population, between 110 and 190 million people, experience significant disabilities. Therefore, the World Bank suggested that the social

integration of the at-risk group starts with creating an enabling environment with equal opportunity for their inclusion and full economic participation.

Notwithstanding, the concept of social integration has been equated to creating an inclusive society to promote social development, and it is considered indispensable for attaining Sustainable Development (SDG) Goal 1, which centres on eradicating extreme poverty, but dovetailed into other goals, including achieving universal education, promoting gender equality, stigma reduction, reducing mortality rates, and access to health and mental healthcare (UN, DESA, 2009). The positive outcome of an inclusive society raises a question that requires a pragmatic answer. How can social inclusion be made operational in the face of the resistance to change? An inclusive society premised on social integration is based on upholding fundamental human rights of freedom for all and equality in dignity and rights. It envisions a society where individuals are not hindered by their background to participate in civic, social, economic, and political activities (UN, (DESA, 2009). These regulatory policy frameworks need to be entrenched to promote MH inclusive processes in all areas.

As noted earlier in the study by Margaretha et al. (2023) and Ludwick et al. (2018), primary and secondary schools are more of consumers in MH promotion while community healthcare and NGOs are important facilitators in collaborative arrangements. However, with the constant changes in the political economy, the healthcare system is becoming a pure business entity, and new directives and new governance approaches are required to enhance performance. Responsibility and conformity to inclusive policy may become perfunctory when a hospital operates in such a manner (Porter, 1996). In addition, McCrickerd (2000) argued that when healthcare runs on a corporate model with several administrative components, staff treatment, patients, and social services may not be taken as priorities, since the organization commodifies the service of care. Therefore, supporting national objective of promoting mental

health, such as building relationship with schools or communities to offer preventive care and interventions may be secondary and hinder schools' commitment.

a. Healthcare supportive roles to schools' inclusive promotion

Schools' promotion of inclusion requires support from community healthcare system (CHS), families, community members, NGOs, healthcare workforce (African Strategies for Health, ASH, 2014, Pour et al., 2014; WHO, 2016). This review examines preventive care-information, psychoeducation, and advocacy and interventions- referral and treatment adopted by the healthcare system to promote inclusive initiatives. ASH (2014) emphasizes the importance of corporate organizations' supportive roles in promoting an inclusive agenda in healthcare settings. However, the study did not explain the process of determining how such alliance and support unfold nor disentangle how changing in hospitals' priority such as the need for cutting cost and maximizing allocative efficiency may impact on inclusive programs. Despite FMOH's (2019a) articulation of supportive roles of CHS in supporting schools' inclusive promotion, it is hard to come-by research that delineates what constitutes such support in the school systems. Thus, schools' sustainability of MH services (promotion of preventive care and interventions) and the conditions involved to receive support from hospitals appears to have consistently been neglected.

As observed by Brandão et al. (2013), social responsibility in the context of health care delivery signifies a new paradigm in hospital governance. Though social responsibility falls in the purview of moral obligations as suggested by the Report of the International Bioethics Committee of UNESCO (2018), citizen request system (CRS) is for the enhancement of community engagement, efficiency and transparency. However, it cannot be imposed by others or by the state, nor is there any legal coercion to fulfill such obligations. Nonetheless, the existence of a right to health care as a positive social right emphasizes the need for hospitals to practice active social responsibility. Brandão et al. (2013) opined that the scope of socially

responsible behaviour requires hospitals to fulfil their social and market objectives within the law and ethical standards, while its social responsibility should include aspects such as abstention from harm to the environment or the protection of all stakeholders' interests in healthcare delivery. As earlier noted, the healthcare system is becoming more completely composed of corporate organizations that treat healthcare services as products, which may have serious implications on its social responsibilities and service delivery.

Therefore, given the lack of statutory compulsion, even when incentives are introduced, it is safe to hypothesize that the outcome of an inclusive program (preventive care and interventions) in the workplace may be less impactful since the motive for participating in an inclusive program can differ across organizations. It raises a crucial question about whether the use of incentives by the state is sufficient to motivate organizations to invest in an inclusive policy. Also, in a profit-driven economy, when an organization promotes inclusive programs, are there any parameters to measure its processes and outcomes? And, if such measures exist, do they extend to mental health services, and how well do the programs meet the needs of mental health service users in both private and public settings?

In relation to healthcare settings, Aysola et al. (2018) acknowledged that for health care organizations to reduce disparities in care, there is a need to diversify the health care workforce. The outcome of their study revealed six broad factors affecting inclusiveness within health care organizations. These factors are discrimination, the silent witness to abuse (those who witness the abuse without acting to denounce or report it), bullying, the interplay of hierarchy, recognition, and civility, organizational leadership, and mentors; support for work-life balance; and perception of inclusive efforts. It was concluded that challenges to inclusion have adverse effects on well-being and job performance of the marginalized groups. The lack of preventive care and interventions increase reports of stress, anxiety, and feelings of hopelessness. The study highlights the significance of understanding and exploring diverse areas and minute

details in which supervisor, manager, employees' network family/or friends, health officers/ health managers/ and safety manager can collaborate both within and outside the workplace to contribute to inclusive environments for MHSUs' employees.

Findings by Qi et al. (2019) on the influence of inclusive leadership on employees' innovative behaviour used perceived organizational support as a mediator. Data were collected from employees and supervisors from 15 service-based organizations in six cities in China. After controlling gender, age, education, and tenure (demographic variables), inclusive leadership was positively related to employee innovative behaviour ($\beta = .339$, $SE = .081$, $p < .01$). The outcome suggests that the more inclusive the employees perceive the leadership; the more innovative behaviour they exhibit. Inclusive leadership was also found to be positively related to perceived organizational support ($\beta = .843$, $SE = .068$, $p < .01$); and perceived organizational support was positively related to employee innovative behaviour ($\beta = .244$, $SE = .068$, $p < .01$). Also, inclusive leadership was positively related to employee innovative behaviour via perceived organizational support ($\beta = .206$, $SE = .059$, $p < .01$), which confirms the mediating power of perceived organizational support in the relationship between inclusive leadership and employee innovative behaviour. The study highlighted the significance of leadership style and attitude in promoting an inclusive organizational climate for diverse employees. A challenge to inclusive promotion is about how to bridge the gap between what the organization pursues as inclusion and what the manager prioritizes as important, and how to align the national inclusive agenda with organizational goals without creating conflicts of interest among managers and supervisors. If there are divergent views about organizational interests, are they amenable to meet the national inclusion goal? These are vital concerns to determine the extent of the readiness and commitment of the management team towards promoting inclusion in the workplace.

Ashikali et al. (2021) examined how inclusive leadership fosters inclusiveness in diverse teams by sampling 293 employees in the Dutch public sector. The multiple structural equation modelling results showed that teams that work for the Dutch Central Government organizations tend to experience greater inclusiveness than those in local government organizations ($\beta = .28, p < .05$). A negative association was found between team ethnic-cultural diversity and an inclusive climate ($\beta = -0.19, p < .01$). The interaction of inclusive leadership with the association between team diversity and inclusion was significant ($\beta = .11, p < .01$). Therefore, this outcome suggests that inclusive leadership reduces the strength of the negative association between team ethnic-cultural diversity and an inclusive climate. It can be deduced from the study that constructs that aid an inclusive agenda need to be made broader in scope, to include the dynamism of the workplace, interactions among colleagues and those between workers and employer/manager/ immediate supervisor. These interactions are of importance to this study. Possibly, by focusing on these interactions in the workplace, it can improve our knowledge of how differences in sociocultural understanding of mental diseases among colleagues, diverse teams, and management needs can be managed, to reduce hindrances to the promotion of the national inclusive agenda and hence help determine a more appropriate strategy to plan both preventive care includes as described in the policy guidelines (FMoH, 2019b) information accessibility means removal of all forms of barriers to mental health information and services, and MH awareness creation in the workplaces. While psychoeducation as part of preventive care includes provision of knowledge, information, and coping skills to manage mental health conditions. Employees are expected to be well-informed about available treatment options or diagnosis, symptoms, and other available therapeutic resources. Advocacy- address the role of peer support and educators in receiving appropriate training on how to support, educate, and advocate for the school community mental health. Specifically, FMoH (2019b) describes interventions access to medication, hospitalizations and

counselling while referral service includes training the educators to identify crisis and knowing where to refer the individual to, either to the MH community resources nearby or a specialized mental healthcare.

Similarly, Szymanska and Aldighieri's (2017) study established that organizational support encourages diversity in the workplace. Thus, management support of good governance in removing stereotypical attitudes and language barriers was identified as vital to the acceptance of diversity in the workplace. Gender was also revealed as influencing organizational decisions toward promoting inclusion. More so, the study narrowed the concept of inclusion to organizational output. However, MH promotion in workplaces needs to move beyond the description of organizational responsibilities to encapsulating features of inclusive policy such as acceptance, equity, access to healthcare, and stigma reduction, among others, as well as involvement of other stakeholders to comprehend its adequacy.

In a study by Lubis (2018) on the evaluation of the impact of corporate social responsibility (CSR) on government hospitals, the author administered questionnaires to 200 patients selected from four government hospitals in Medan, Indonesia. The result showed mixed reactions among the inpatients regarding their perception of the level of implementation of CRS at government hospitals. First the hypothesis that government's social responsibility in the hospital influenced positive reactions from the service users was sustained with a critical ratio (C.R) of 3.282 and p-value of 0.001. Second, the effect of CRS was found to influence hospital values negatively and significantly (C.R -2.905), suggesting that CSR activities might be detrimental to whatever the hospital constitutes as values. However, when a hospital's reputation, loyalty and values are combined, CSR represents a significant positive impact on service users' reactions towards the hospital.

Also, the overall mean value indicated that CSR is minimally implemented across the four hospitals. The overall model showed that CSR positively and jointly affects the hospital's

reputation, patients' loyalty, and hospital value. Although a direct negative effect of CSR was found on hospital value, nonetheless, the larger influence of indirect effects reported in the study occurs through the mediating role of reputation. Also, loyalty variables indicated that CSR could increase the hospital value. The findings raised a few concerns about ambiguity in the use of the term values in the study. It is unclear whether the concept of values is defined from a patient perspective or healthcare perspective, which might help in explaining the negative effect of CSR on hospital values. It is even problematic to measure patients' perspective objectively if the measure is based on healthcare outcomes- patient health improvement. Or how do we objectively quantify subjective experience of patients' evaluation of healthcare competence, commitment, and efficiency in the quality of service received. If the value-based entails collaboration and transformation, are they measured in terms of cost? Also, consistency in the use of values to describe how an organization meets public expectations is of equal importance. Since value is at the core of organizational practice, how inclusivity and equality are promoted (either in liaising with the government or other organizations) may be subjected to what the organization deems as important. Hypothetically, it can be suggested that the extent to which a collaborative strategy meets the needs of each organization will predict program continuity in the organization.

In Nigeria, the unethical attitudes of health practitioners reduce the promotion of an inclusive policy as observed by Ngwu and Ogande (2017). The authors contended that public hospitals and healthcare centres in Nigeria exist to provide healthcare services for the public and profit for the government. These practices reduce the efficiency of their functions and contribute to the low utilization of public healthcare facilities. The authors affirmed that management's good reputation is imperative and suggested that public hospitals should maintain a good reputation not just for the sake of their corporate social responsibility but also for continued patronage and public satisfaction in the use of public health facilities. The

complex environment in which hospitals operate in Nigeria needs to be taken into cognizance when appraising the readiness to promote inclusion. However, since hospitals are expected to be self-reliant and generate income for the government, the practice of inclusion at organizational levels and between hospital staff and patients, especially for MHSUs, may be compromised greatly.

This also raises a concern about how hospitals manage this complexity in relation to employees' engagement, patients' relationships with care management teams, and hospital engagement at the community level (such as relationship building with other agencies). Ngwu and Ogande contend that the extent to which the patient, staff and community value a hospital's commitment is vital to the sustainability of the inclusive agenda. There is also a methodological constraint about what modality to employ to appraise hospital relationships. Should it be patient-centered, or from management/frontline workers' perspectives, or a combination of both? The study posed a challenge about how to conceptualize a hospital's response to MHSUs' needs when viewing MHSUs as staff (core personnel/ casual workers) and patients, or when viewing them as patients and community members. Perhaps, it an avenue worth exploring to draw attention to how conceptualizations of dual role of a patient as an employee and a patient affect how hospitals perform their social responsibility and its implication on the concept of inclusion.

A cross-sectional study by Liu et al. (2016) examined how patients viewed hospital social responsibility and explored factors influencing patients' perception of it. They administered structured questionnaires to a sample of 5385 patients at 48 public hospitals in three regions of China. They adopted a multilevel regression model in identifying factors influencing patients' assessments of hospital social responsibility. The hospital's performance was examined under four sub-variables: service quality, appropriateness, accessibility, and

professional ethics. The scores on these four indicators were reported as positively associated with patients' assessments of hospital social responsibility.

The results showed that patients had great satisfaction in public hospitals' performance of their social responsibility. Conversely, older outpatients gave low assessment scores when compared to larger hospitals' inpatients who gave higher assessment scores. It can be deduced that access to quality healthcare without prejudice and with law-abiding behaviour is instrumental to acceptance and patients' satisfaction. The paper concluded that the size of the hospital increases patients' satisfaction. But does physical structure equate patients' satisfaction and efficient delivery of hospitals' social responsibility? Perhaps a large hospital may have resources to improve the service quality by hiring competent workers and initiate programs that can promote inclusion diverse groups of patients. Healthcare systems are part of the agencies that promote national inclusive agenda in Nigeria and are expected to work directly with schools. Contrarily, evidence of this inclusive role is scarce in literature.

Again, a cross-sectional study by Pai and Harsha-Kumar (2015) has shown that private hospitals in Mangalore are very selective in the type of CSR they provided. At least, 66.7% of the hospitals engaged in some free or subsidized services, while only 29.2% provided free services such as health check-up camps and subsidized medical and surgical treatment. Their findings revealed that most of the hospitals failed to provide information on specific criteria for selecting the patients for CSR. They concluded that most of these private hospitals did not provide free or subsidized healthcare services that is consonance with their self-driven CSR initiatives. The possible explanation for this outcome perhaps may be due to the ineffectiveness of some government measures in promoting inclusion, and there may be fewer directives from the government on how organizations can support both their workers and consumers. As observed by the WHO's (2014) report, governments in the developing world are less active in

promoting welfare policies and programs that can reduce poverty and inequality among their populations, especially the vulnerable groups.

Thus, an organization's motive in accepting government's social welfare program may be crucial to understand the success or failure of any social intervention on mental health inclusion. The absence of a template to evaluate workplace's participatory roles as often articulated in FMoH (2013) mental health policy raises a concern about how social intervention on relationship building is perceived, determined, implemented and evaluated. To further this discussion, integration theory is explored to crystalize the concept of relationship building, specifically, to provide a credible template for answering the null hypothesis of whether the structures of these interventions will be statistically different in private and public education sector.

b. Non-governmental Organization (NGOs) inclusive promotion in schools

The WHO (2003b) observed the nature of relationships between NGOs and governments (federal, state and LGA) in mental health leadership advocacy programs and detailed the roles of NGOs in this arrangement. NGOs are involved in the provision of human and material resources (experts, grants/funds, and equipment), managing databases on health and social-related issues for proper disease monitoring and control, performing advisory roles to the government in policy and program planning, and offering support for best practices.

Governments (federal and state) on the other hand are expected to provide human resources, space, and capital, and to nurture the growth of the program, among other functions. Community leaders are expected to sensitize and mobilize their subjects and liaise with state governments in the provision of additional local resources. A systematic review by Alber et al. (2020) drew attention to how challenging fulfilling diverse stakeholders' needs in program delivery and interventions has become, and the impact it has on trust when executing collaborative relationships. The researchers proposed that individual support plans (which

embrace individual knowledge, skills and attitudes) may be helpful to overcome such challenges to motivate diverse stakeholders' support and sustain their interests for program continuity. However, they concluded that these do not equate short cut to program delivery.

Local NGOs are expected to participate in grassroots policy/program initiatives in Nigeria to offer preventive care- advocacy, psychoeducation and provide information on MH to schools (FMoH (2019b)). Thus, as part of local NGOs roles in MH promotion, Mentally Awareness Nigeria Initiative (MANI) have continued to offer education and advocacy in schools and communities. Also, AIDS Preventive Initiatives (APIN), Health Strategic and Delivery Foundation (HSDF), and Mental Health Foundation (MHF), Nigeria, among others also provide education and create MH awareness. Importantly, they provide support services such as counselling, stress management, and referral services (WHO, 2003a; Health Emergency Initiative, 2023). Furthermore, NGOs' roles in Nigeria are much more diversified than their specific MH interventions. For example, APIN covers a range of social services outside MH. Thus, assessment of the effectiveness of these inclusive programs has received less focus outside the healthcare settings (Gureje et al. 2015).

2.3.8. Summary of the empirical studies on effect of social capital

From these empirical studies, it can be deduced that social capital facilitates an inclusive workplace and its application in different organizations can become complex due to what organization prioritizes and how the concept is contextualized (Margaretha 2023). Most importantly, attention is drawn to influence of social capital in promoting collaboration which is vital to the promotion of mental health in schools. Yani et al. (2020), Yaakobi and Weisberg (2020) and Ashakali (2020) identified not only the types of social capital that can be adapted to foster inclusive work environment but also the type of leadership structure that are helpful in fostering inclusive goal. Other findings emphasized the functional role of social capital such as enhancement of employee retention because employees' network can help create a sense of

belonging and purpose. Others dwell more on how social capital can encourage innovative ideas through strategic relationships, hence fostering greater career advancement and sense of belonging. Such advantage is not limited to knowledge improvement but also stressor reduction, and promotion of employee's wellbeing. In particular, this essential role of social capital in promoting collaboration suggest the need to examine how strategic alliances are built either theoretically or in practice within the workplace (school).

2.4.0. Integration theory/strategic alliances

A strategic alliance emphasizes a holistic approach that encompasses temporary and long-term organizational structures, the network of organizations, and the people involved (Tuckman, 1965). There is disagreement about whether strategic alliance should be viewed as a concept or a theory (Gagné, 2005). Strategic alliance as a theory covers four major aspects namely rationale, formation, structural preferences for governance, and performance (Peterson, 1991; Das & Teng, 2000; Todeval & Knoke, 2005). However, when treated as a concept, the performance aspect of strategic alliance is often stressed. The concept is value driven and is evaluated based on cost-effectiveness. Thus, the success or effectiveness of strategic alliances is measured by evaluating the process of their formation, operation, and outcomes (Das, 2013). Strategic alliance as a theory takes a rational approach to justify that strategic alliances are resource-based and suggests that people collaborate for value-creation purposes, to generate resources. Such alliances coalesce resources for a common cause. The characteristics of resources such as program substitutability, accessibility, and accentuated value-creation, among others, often justify alliance formation (Das & Teng, 2000).

Theorists like Tuckman (1965) denote strategic alliance as a theory which focuses on strategic association both at macro and micro levels. Tuckman categorizes this approach as a process through which collaborative structures form and develop performance. It is assumed

that collaborative effort is determined by the level of a network's integration from low to high integration. Thus, the degree of partners' involvement/commitment in the areas of motivation and trust in forming an alliance, the purpose of forming the alliance, and structural preferences for governing the alliance can impact the integration level. When interaction is at the phase of seeking information or exploring interests, the process and structure of collaboration are limited. The coalition is termed moderate when it is closer to the other end of the spectrum. The ultimate goal is to enhance trust and commitment among the individuals involved. Participation is seen as strategic and purposeful because even though all the entities may maintain separate identities, the mutual goal, and the plan to work together is limited.

Collaborative efforts, according to Peterson (1991), can receive support at the macro level (national level, which indicates moderate or medium integration) and micro-level (group level, which indicates low integration). Peterson opines that cooperation, coordination, and collaboration that form the three-point continuum of reciprocity for strategic alliances, exist for the following reasons. First, the alliance begins with cooperation between or among fully independent groups offering information for outcomes of mutual benefits. Second, there is the coordination phase – the phase in which these independent parties unanimously sponsor programs or services that mutually benefit the goals of each organization. Collaboration is the third phase in which parties relinquish some degree of autonomy for a common goal.

However, Hogue's (1993) analysis of integration theory reiterates five levels of connection- namely community linkage, choice and networking, alliance/cooperation, coordination, coalition, and collaboration. These five levels are employed in this study to explain strategic alliances and the contributory role of social capital in fostering relationship building to promote inclusive policy.

2.4.1. Five levels of relationship building in strategic alliance

a. Choice and Networking

Choice and networking involve sharing information and communication among independent people and organizations for mutual benefit (Hogue, 1993). For example, given the geographic location or distance among independent members, the entities involved can choose to share experiences through a specific tool, for example, a computer network. Networking represents the lowest level of integration and does not involve any common goal or structure that can influence the form and timing of member contributions. Hence, common values “agreed values by entities involved” are not generated (Camarinha-Matos & Afsarmanesh, 2014). Activities engaged in at this low end of the spectrum include searching for information, discussion and brainstorming for ideas.

b. Alliance/Cooperation

In this phase, Hogue (1993) emphasized that the division of labour (which may not be wide in scope) among participants is mapped out to achieve cooperation. The overall value generated in this exchange is the outcome of the added "components" of value developed by all participants in a quasi-autonomous manner. The constitutional roles of the three tiers of government are examples of the cooperative process. Although, the hierarchical structure of power may lead to power imbalance, it nevertheless, diminishes specific role of each level in such arrangement. The relationship is defined and coordinated, but each tier or agency performs its role in a quasi-autonomous manner. A shared plan is not often collectively defined but can be designed by one entity which suggests the low level of integration at this point, and, at least, connection occurs when one partner's activities (plans and outcomes) are delivered to the next partner. Cooperation at this level is about sharing information, adjusting activities, and sharing resources for achieving MH goals. The most significant issue at this point is that members' goals are compatible and can result in value generation. That is, the inclusivity approach often

leads to members finding common ground to create compatible or common values to guide the relationships (Camarinha-Matos & Afsarmanesh, 2010). Such goals may be instrumental to the development of a definite and concrete supportive relationship.

c. Coordination

Coordination involves centering (designing and setting operation) or altering activities as well as sharing information to achieve effectiveness. The deliberate adjustment of partners' activities to achieve a common goal is termed coordination and it is one of the primary components of collaboration (Hogue, 1993). A good example of the coordination phase involves group participation in activities (such as lobbying) when it is beneficial. Some heterogeneous entities may share some common information and adjust the timing of a new topic or project to maximize their impact (Castañer & Oliveira, 2020). Goals might be different for each entity involved, even the degree to which each entity is ready to utilize personnel, resources and strategies, and the impact created may be different. Often, values are not collective but created at an individual organizational level (Hogue, 1993).

d. Coalition

In Hogue's (1993) description of coalition, it is a phase where entities unanimously agreed to pursue and achieve common objectives that may be unattainable independently. Roles and expectations in this phase include strategic decision-making and joint action (planning and sharing complimentary resources, reaching agreement). Activity in this stage is not static but continues to evolve to reach new goals or respond to a new perspective. The emphasis is on combined effort to encourage resources sharing. Frey et al.'s (2006) survey listed components that participants addressed under coalition to include having a representative to vote or make decisions, sharing of resources, sharing ideas, promote inclusion, in constant communication, presence of emotional connection among partners. In school-based interventions. Cavioni et al. (2020) added emotional-resilience as a variable for promoting coalition between teachers

and students in reducing the effect of depression. Coalition phase leads to greater advocacy among members (Hogue, 1993).

e. Collaboration

The concept of collaboration derived its name from the Latin word "collaborare," which denotes cooperating for a common outcome (Hogue, 1993). It is a process of sharing information and allocating resources and responsibilities to make a collective plan, and implementing, and evaluating a service or program of activities (WHO, 2016). This process of shared-value creation involves the procedures undertaken by a group of entities to enhance each other's capabilities (Hogue, 2003). For example, in collaboration with NGOs and other stakeholders, a state's ministry of health is expected to share risks and resources and designate responsibilities and benefits as articulated in the FMoH (2019b) guideline.

When implementing an inclusive program, although values among the entities involved may differ, collaboration could be beneficial to all, by promoting good images of the organizations and the state to the public (WHO, 2018; 2019b). Mutual engagement (trust) of all stakeholders to resolve a particular problem such as collective stigma reduction often takes time, effort, and dedication as findings by Zugai (2015) demonstrated. However, studies by Fitts et al. (2020) and Leung et al. (2018) at PHC levels in Sierra Leone and California respectively showed that at this level, individual contributions to value creation may be cumbersome to determine because partners may be reserved, unwilling to fully share data or experience, misrepresent ideas, be unwilling to dedicate time, or contribute equal time and resources. More specifically, in Nigeria, a collaboration process in the healthcare sector (PHC level) involves concurrent role sharing in healthcare services, as affirmed by Anyebe (2012). This author asserted that in program delivery, there is constantly an element of uncertainty in the level of commitment between the state and the federal governments. It is either that needed

funds are not made available or are insufficiently provided, or that the roles are not explicitly delineated to allow proper integration.

In addition, Leung et al. (2018; 2019) affirmed that either of the parties involved may maintain a complete silence over the operation of the program. The state may be unwilling to provide manpower and the necessary integral components (e.g., offices/branches, insurance coverage and communication structures), such reluctance often leads to projects' failure. Theoretically, collaboration at PHC levels is about the integration of mental health programs, and each state and federal agency is expected to jointly team up to create more accessible care and promote an inclusive atmosphere for social and economic participation of MHSUs. At this level, some coordination may be needed, thus, collaboration is more of an (involving) term because it involves sourcing divergent ideas, knowledge, and spontaneity.

f. Coadunation

Bailey and Koney (2000) theorized an additional concept, "coadunation," which is the point at which one of the partners in this social arrangement fully relinquishes its power to strengthen an organization's survival. Coadunation is located at the farthest end of the integration spectrum to depict collaboration as a journey and not an end or a destination. The value at this phase is continuity which also hinges on the commitment of other partners.

2.4.2. Challenges in mental health collaboration

Scholars have debated why the evaluation of strategic relationships in mental health is often challenging. Wallerstein et al. (2002) argued that expectations related to healthcare differ from person to person and are sometimes unrealistic. Resources can pose a challenge; skills required for specific tasks may be difficult to acquire, and complexity in building relationships can occur due to sociocultural diversity. Therefore, the evaluation of a collaborative or participatory approach needs to center on the negotiated cooperative relationship among stakeholders, an active coalition process, feedback, and adherence to traditional evaluation

principles, that emphasize accuracy, feasibility and credibility (Chelimsky & Shadish, 1997). Nonetheless, in mental health, recent literature amplifies the relevance of policies, legislation, fund sufficiency, regulations, program monitoring, among other factors, to promote an inclusive agenda (WHO, 2015; 2019d; Fuller et al., 2011; Fitts et al., 2020). Essentially, MH collaboration is built on healthcare principles (accessibility, efficiency, portability, comprehensiveness, among others) to promote an inclusive policy (WHO, 2003b; 2017). Since collaboration aims at inclusion of MHSUs, it prioritizes accessibility, efficiency in program delivery, and consumer-centeredness. These are considered as principles of collaboration required for effective service delivery (Gagné, 2005). A collaborative strategy is different at all levels of participation and location. Challenges at the policy level can be in the form of enforcement of legislation or the scope of liability, recruitment, and remuneration in human resource practices. At the community level, designing the program to meet people's needs is important to its success, without which the process can suffer a failure (Federal Ministry of Health Planning, 2008). Recognition is given to the roles of mental health specialists in providing direct care in primary health care settings which includes scheduling visits and offering indirect care by supporting the primary health care system either formally or informally and liaising with the workplace to create awareness (Gagné, 2005). Four components of collaboration are identified and modelled to examine agency relationships within the workplace in the promotion of inclusive policy:

2.4.3. Gagné's four components of collaboration

i. Accessibility

Collaborative strategy is not restricted to mental health settings. It simply represents a means through which mental health services are extended to other sectors to increase access to services. It aims at mental health promotion, preventive care, early disease detection, and treatment in PHC settings, among other elements (Perrin et al., 2014; Ryan, 2020). The

strategic alliance involves schools, prisons, homes, health care providers' offices, community health centers, and shelter houses as stipulated in the FMOH's (2019) guidelines. All needs are prioritized, as well as the training, knowledge, and skills of the service providers. The evaluation of the outcomes requires a joint assessment that involves several stakeholders, including employers, community organizations, service users, families, and caregivers.

According to the National Centre for Chronic Diseases Prevention and Health Promotion (2018), employers as mental health providers can promote mental health in workplaces by liaising with PHC organizations, and supporting workers and their immediate families, while ensuring that mental health programs/services are unified and in accordance with the relevant policy template. Employers can provide communication structures and encourage their utilization, network with other mental health providers, government and NGOs, and encourage healthy behaviour by offering incentives. Employers can utilize data to monitor the progress or effectiveness of these services.

BBus et al. (2019) theorized that first-hand experience enriches treatment/intervention and asserted that different service users experience treatment differently, making a strong case for the co-production model that involves MHSUs in forming a strategic alliance in the promotion of inclusion of MHSUs. BBus et al. conceptualized four categories of integrated approach for viewing mental health. Advocacy prioritizes (i) a humanist perspective that aims at psychological adjustment and self-development of the MHSUs, (ii) a facilitator's perspective that targets the experience and wisdom of MHSUs and encourages sharing of their experience and knowledge in an informed manner, (iii) an activist perspective which sees MHSUs as advocates for social justice, so that their collective efforts can facilitate change in social, political and economic domains, and (iv) a transformer perspective which goes beyond self-actualization, as it sees MHSUs' engagement as a grassroots movement, embracing dialogue, collectively acting for a change in societal attitudes while encouraging personal growth of the

individual MHSUs. The authors also argued that the preferred choice of language in such a relationship is consumer discourse because it makes consumers' roles in mental health collaboration more relevant. MHSUs have first-hand knowledge or experience with mental illness, and they can therefore be of great help when their views are prioritized in programs. Thus, MHSUs become powerful tools in program planning and program outcomes.

Castillo et al. (2019) studied stakeholders' participatory roles in this arrangement. The roles of community entities were noted as enhancing multi-sector coalitions to fund research, plan and develop mental health programs, and encourage community leaders' involvement in awareness creation and stigma reduction programs to change attitudes, beliefs, and practices. The introduction of psychoeducation to reduce stigma or increase MH literacy and skill acquisition programs (screening and diagnosis for early MH detection to plan interventions), and family members' and MHSUs' participation is crucial. They can become advocates, act as referral agents, provide peer support, or offer system navigation (Norris et al., 2020). When appropriate, no limitation is placed on physical location as contact can occur via telephone or online (Gagné, 2005). Therefore, measures of the actual efficiency of these programs, when implemented, may be unrealistic due to distance. Users live in remote areas, as well as poverty-stricken areas with low access to a communication network or means of accessing the necessary financial support to obtain basic needs (communication technology). Again, therapeutic effects may be lost due to the absence of physical contact which may affect the outcome of the program.

ii. Collaborative structures

According to Bruner (1991), successful collaboration as a mental health care initiative is premised on a unified approach between systems and structures that aid collaboration. First, it is assumed that providers are likely to create or join an organizational structure that explicitly includes both formal (rules and regulations) and informal components for collaboration.

Examples of formal components are service agreements, coordinating centres, and collaborative networks.

Bruner (1991) opined that informal structures can be verbal agreements between providers. Second, providers can organize or create procedures and activities to define how they agree to accomplish certain collaborative mental health care functions. These may include referral strategies such as the provision of forms, the use of referral networks, the harnessing of information technology such as a computerized methods of documenting clients' records, electronic or web-based information exchanges, teleconferencing, videoconferencing, e-mail, and/or listservs. It also includes evaluation processes. Mental health providers can decide how to develop or adopt specific evaluation instruments and/or methodologies or use common software.

iii. Richness of collaboration

The richness of collaboration is a vital feature of a mental health strategy among other entities involved such as primary healthcare systems and mental health care providers, workplaces, MHSUs, and caregivers (Ness et al., 2014). Characteristics of the richness of collaboration are relationship building, sharing information, experience, joint effort through a negotiated dialogue, establishing human relationships, and shaping and maintaining relationships (Ness et al., 2014; Yaakobi & Weisberg, 2020). They also include knowledge transfer among mental health care partners through various educational initiatives. Tools adopted may include courses, lectures, tutorials, seminars, and symposia (WHO, 2003a, 2017, 2019b). As noted by the WHO (2017) educational materials such as research papers, studies, books, guides, manuals, and the involvement of healthcare partners are more holistic because they enrich the effectiveness of the initiative by developing not just the knowledge of the psychological factors but also of the social and biological factors.

According to the Centers for Disease Control & Prevention's (2019) report, researchers' participatory role is crucial in providing data that can inform mental health practitioners about diseases and suggest new directions or intervention programs. It is therefore suggested that joint participation is essential in enriching a collaborative strategy. Hence, experts in these relationships span across different disciplines: nurses, social workers, dieticians, family physicians, psychologists, psychiatrists, pharmacists, occupational therapists, and peer support workers (Gagné, 2005). Graham and Barter (1999) offered that social workers' role in such relationships is to provide support, facilitate continuity and sustainability. Thus, the absence of experts in schools may hinder such alliances.

iv. Consumer-centeredness

MHSUs' needs are at the core of collaborative mental healthcare. Consumer-centeredness calls for MHSUs to be involved in all aspects of their care, from treatment choices to program evaluation. Hence, the development of initiatives should address a specific need of each group, especially those who are often underserved or critically in need of mental health services (Agovino et al 2019; Ryan et al., 2017a) level. Collaborative mental health care initiatives emphasize the roles of MHSUs in proving first-hand experience and becoming knowledge co-producers, and they stress the need to allocate time and resources to them. They also offer caregivers information support, such as educational materials, sessions, or information centres.

Additionally, a systematic review by Pomare et al. (2020) examined the context of interprofessional alliances in community healthcare; only thirty-four papers met the inclusion criteria out of 4,776 studies generated by a search engine. They discovered inconsistency in the methodological approaches of some of the studies reviewed. Nevertheless, the findings revealed a moderate benefit of interprofessional relationships on patients' social adjustment and recovery. They also suggested that both staff and workplace can benefit from such

alliances. Moreso, the findings emphasized cultural sensitivity in the application of strategic alliances in healthcare services and suggested a mixed method design (quantitative and qualitative methods) in approaching evaluation research.

Collaborative strategy also emphasizes peer support roles in developing collaborative mental health care initiatives through focus groups and the establishment of committees. It develops and implements program evaluations (for example, instrument design, articulation of actors' roles such as interviewers or respondents), participation in adapting MH promotion, and treatment interventions to meet individual needs, including cultural experiences (Adebayo, & Sanni, 2014; WHO 2017b). Complexity arises in what constitute constructs of this framework because goals and values in forming a relationship dictate its focus. Thus, Frey et al (2006) suggested that constructs should be closely related to members' objectives. In relation to FMOH's (2019a) guidelines, development of and implement program evaluations (e.g., instrument design, articulation of actors' roles such as interviewers or respondents), participation in adapting MH promotion, and treatment interventions to meet individual needs, including cultural experiences are specified. This is closely related to the WHO (2013) MHLAP framework with emphasis on inter-agency alliance in MH promotion. Castillo et al.s' (2019) review concluded that evaluation should be on what works for the service users, and should start from knowing MHSUs' needs, and nurturing them with evidence-based interventions. Thus, when designing the programs, MHSUs' participation at the outset is crucial to increase accessibility and utility and promote the acceptability of the mental health service among peers. It encourages building positive relationships with community health workers (CHW), thereby providing a means of setting goals and expectations (WHO, 2003b). This thesis usage of collaborative strategy emphasizes peer support and members' roles in developing collaborative mental health care initiatives.

Figure 3: Theoretical formulation of formal strategic alliance phases

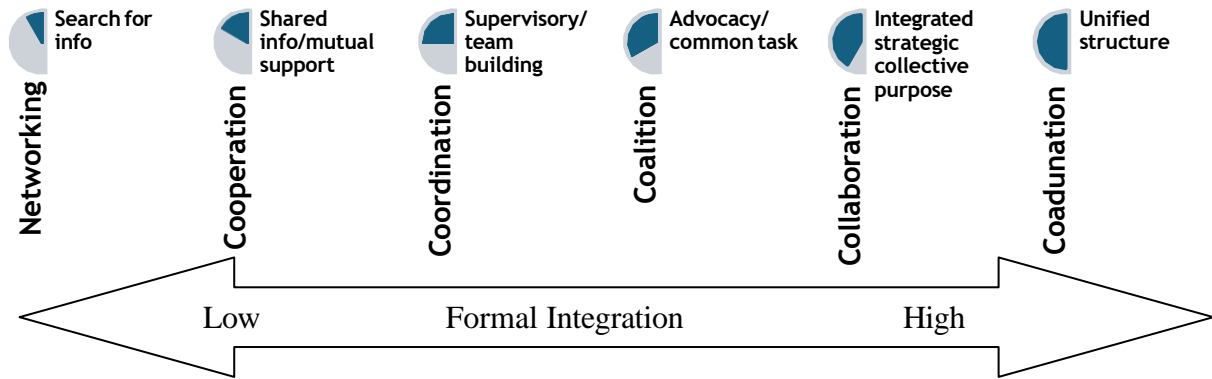


Figure 3 shows strategic alliance phases as a journey from the left (low) to the right (high), suggesting the level of integration. Adapted from “Strategic alliances among health and human services organizations: From affiliations to consolidations” by Bailey, D., Koney, K., 2000. (Abridged). Thousand Oaks, CA: Sage. p. 71.

Fig. 3. shows the level of strategic integration from low to high integration. The lowest level of integration starts from the left side of this spectrum, indicating networking as the lowest form of integration. It involves the search for information at the outset of the program, and therefore, at this phase, project planning and objectives may not be explicitly defined. The second phase depicts cooperation where members’ focus centres around sharing information, finding common purposes, and defining the objectives, as well as cooperation, also on the left side, which denotes low integration on this spectrum.

The next phase is coordination. It is a little higher than the cooperation phase. It is assumed that the objectives have been clearly defined and planned, and activities have been well developed, emphasis is on supervision. The next phase is coalition and focuses on strategic planning, mapping out activities and sharing tasks based on members’ preferences for further coordination. The collaboration phase is towards the high integration side of this spectrum. The main activities here are about pooling resources for collective purpose and assessing the

progress and outcome of the shared activities. The last phase is coadunation. It is located at the end of this spectrum, and it simply depicts long-term commitment and continuity because of the unified model of its structure. Coadunation phase is not examined in this study based on the outcome of the past studies; it appears Nigeria has not reached the phase.

2.4.4. Empirical research on insurance coverage for MHSUs

Universal health coverage is set to achieve specific goals such as improvements in health status, equitable access to health care, affordable financing, service quality, and protection of human rights (National Healthcare Insurance Scheme, 1991). Service fees (amount paid to the service provider for services completed) and “capitation fees” (payment received by health providers whether the clients seek a service or not) are reported in this study to explain factors that promote program sustainability or continuity.

There is a wide gap between healthcare insurance and the in-service MH coverage such as emergency service, treatment services for MH and substance use disorders, and behavioural health. The percentage of MHSUs who need treatments/services but are unable to access it is between 76% and 85% in low and middle-income countries and represents the treatment gaps (Ude, 2015; Khan & Aregbesola, 2018b; Abimbola et al. 2020). A study by Aregbesola and Khan (2018a) revealed that the unavailability of MH services limits MHSUs’ access to MH services, that poverty also hinders service utilization when unemployed MHSUs are expected to pay. Only 4% of the over 200 million Nigerian population are covered by healthcare insurance. They are mostly federal government workers (Khan & Aregbesola, 2018b). This emphasizes the shortcoming of the federal and state governments in providing healthcare coverage for all citizens. The findings depict how the struggle for inclusion may lose its footing before it even commences.

Abdulmalik et al. (2019) examined macro-fiscal economic activities and socio-political profiles and provided an insight into the Nigerian situation in relation to financial risk

protection and access to healthcare services. They conducted a qualitative study by purposively sampling 12 expert stakeholders from the healthcare policy arena, healthcare system, and economic sectors. Using a multi-level method, the authors conducted a situation analysis of the Nigerian healthcare system, established that poor funding and low access to care are responsible for the observed vast treatment gap, and linked the reduction in access to quality care to the increase in poverty rates because low-income earners are incapable of personally paying for health services. The authors recommended comprehensive coverage of mental health conditions and suggests supporting the ongoing discussion of health insurance reforms as key to inclusion for all Nigerians.

4.4.5. Empirical studies on community engagement in MH promotion

Recently, there is a call for a major reform in this area. However, it is an ongoing discussion and expected to consider diverse stakeholders' views from the economic, healthcare, and education sectors (Muritala, 2021). The international organizations' (WHO and the Clinton Foundation) roles are highlighted as key observers in MH policy discussion, but there is concern about the success of this arrangement because of the precarious policy environment in Nigeria (Abdumalik et al, 2019). Divergent views of diverse ethnic groups in Nigeria can impact on such arrangement and its outcomes. Thus, it is important to be mindful of the cultural context of a policy and how it may hamper promoting inclusion.

Consequently, Adam et al. (2020) conducted a focus group and interview study to identify factors that impact mental healthcare interventions, service provision, and utilization in Sierra Leone to improve community mental health programmes. Participants' experiences were incorporated in identifying factors contributing to the successful delivery of community mental health programs in Sierra Leone. The researchers adopted one-to-one semi-structured interviews and focus group discussions to collect the data. Semi-structured interviews were conducted with 10 mental health nurses, while focus group discussions were adopted to collect

data from the 52 forum attendees (which included religious leaders, counsellors, youth leaders, and community leaders). The results showed that traditional beliefs and culture and the nature of healthcare systems (program accessibility, the nature of the service rendered, or availability of the program, and service affordability) affected the inclusive approach.

It was established that participation in the community mental health forums contributed to awareness, and changes in beliefs and behaviour towards mental illness. Hence, participation seemed to have contributed to relationship building between formal and informal mental health practitioners because participants affirmed that relationship building is the key driver toward the success of the program. The success of the program was also related to respect and acceptance among members in the community forum, in that members were able to collaborate and cooperate. The collective effort of the community forum in caring for persons with mental disorders reduced drastically the burden of care shouldered by family members.

In recent times, interagency collaboration seems to be a *sine qua non* in providing adequate and effective MH healthcare (Fuller et al., 2011; Henderson et al., 2019). Interagency collaboration provides a means of improving PHC systems (Henderson et al., 2019). Other advantages include improvement of access to services, reducing service gaps (Petrich et al., 2013), a reduction in healthcare cost through efficient use of existing resources and prevention of service duplication (Tseng et al., 2011), and enhancement of equity in service provision (Cooper et al., 2016).

In the same vein, Henderson et al. (2019) carried out a longitudinal study between 2014 and 2017 to investigate the enabling factors and hindrances to collaboration in Australia's Partners in Recovery (PIR) programs using focus groups and interviews. PIR is a program established in Australia in 2012 to coordinate service delivery for individuals with severe mental illness. The interview involves fifty senior staff (community MH officers, peers, social and welfare officers) at local community healthcare centres (PHC programs operated directly

by the national government). Also, eight focus groups with 51 mental health stakeholders were conducted (which included service users, community leaders, community mental health workers, traditional healers) in different jurisdictions in the country. A content analysis was conducted, and the outcomes of the study showed that effective collaboration that involves first-hand experience is not limited to advocacy, crisis intervention, but also includes individualized support plans, family support and care coordination to facilitate knowledge sharing and adequate information about various health and social support and referral contributed to the success of the programs.

Adam et al. (2020, p. 9) reported “changes in the number of referralsas a result of the community mental health forum (CMHF).” The study identified some factors that aided the collaboration process which include dedicated funding, a shared understanding of program aims, joint planning, strong networking management, mutual respect, effective communication, local knowledge, and the population health planning roles of community-based hospitals. However, political interests, program inflexibility, poor financing, poor communication, and service delivery problems (distance jurisdictional boundaries and funding discontinuity) were reported as the main barriers to collaboration.

Murphy et al. (2021) carried out a qualitative study funded by Grand Challenges Canada (GCC), a Canadian government initiative to reduce poverty gap and promote people’s psychological wellbeing in low-middle income countries and in Canada through collaborative efforts at local and international levels. Participants were drawn from different locations which include Latin America, the Caribbean, South America, West Africa, East Africa, South Asia, Southeast Asia, and Australia. The study examined the challenges and drivers of stakeholders’ engagement in global mental health implementation, using both secondary and primary data (online surveys, individual interviews, stakeholders’ focus groups and interviews with Medicare local senior executive members). Altogether, 51 senior executive members and 210

participants from 52 community-based healthcare centers were purposively selected for telephone interview sessions and online surveys, respectively.

The audiotapes from the interviews and focus groups were transcribed and analyzed deductively and inductively. The results revealed comprehensive barriers and categorized drivers of stakeholders' engagement under four major themes: contextual considerations (sociocultural differences, differences in states and countries' policies and development, local knowledge, differences in organizational settings and values, knowledge of health planning, distribution of and gaps in mental health services), resources (dedicated funding, local knowledge, information and electronic record sharing), relationships (respect for service providers, partnership between community healthcare, and NGO), as well as participation, uptake and empowerment (joint planning, centralized intake, and knowledge of mental health).

Barriers to stakeholder engagement under contextual considerations are complex environments, fragile relationships among collaborators, emerging or under-resourced healthcare systems, competing priorities, among other factors. The drivers under this theme are comprehensive contextual understanding, realistic demands, supportive structure, and streamlined services. Barriers to engagement identified under participation as a theme include competition, lack of reciprocity, time, capacity, and trust. The driver is leveraging existing resources and relationships. In relation to the participation, uptake and empowerment theme, the barriers enumerated are achieving active engagement and diverging expectations, while drivers of practical and successful engagement are empowerment, opportunities, and bottom-up advocacy and communication. Stigma is more of a barrier than a driver, and barriers under this theme include the low status of MHSUs and the negative perception of MHSUs.

Wakida et al. (2018) conducted a systematic review to synthesize evidence of barriers and facilitators to incorporating mental health services into primary health care. The SPIDER framework (Cooke et al., 2012) was adopted for inclusion criteria (sample, phenomenon of

interest, design, evaluation, and research type) to select articles whose sample focused on primary care providers (PCP), community mental workers (CHW), healthcare managers, and policy makers involved in mental health integration into PHC, general health care, collaborative care, or specialized health care around the world. Out of the 3,353 search results, 20 studies met the inclusion criteria for the study. The outcomes for both barriers and facilitators were presented under five domains which included attitudes towards programme acceptability, appropriateness and credibility, knowledge and skills, motivation to change, management/leadership, and financial resources.

For the attitudes toward programme acceptability, appropriateness, and credibility domain, some of the barriers identified included misconceptions about the diseases that mental illness is strange behaviour, more challenging to diagnose than other illnesses, that traditional healers were more effective than modern medicine, that anyone who had mental health problems should be avoided, and being uncomfortable attending to mentally ill people, among others. Facilitators under this domain agreed that MH problems are common and need to be attended to, accepted that mental disorders are a problem, and that care is essential. They supported MH integration in healthcare settings, and that treating mental illness in the community is a feasible way of integrating patients into community life. The barriers under the knowledge and skills domain were the inability to diagnose and treat mental illnesses, inability to identify either an antipsychotic or antidepressant medication, lack of knowledge regarding psychosocial interventions, and inadequate training in the use of mental health screening tools.

Facilitators in the knowledge and skills domain included perceived competence in mental health care, knowledge of mental disorder symptoms, and prior training in mental health. The barriers to motivation to change were low interest in delivering mental healthcare services, increased workload and limited time, lack of resources for service delivery, and client's patronage of many clinics often leading to inconsistent management of health

problems. Facilitators under this theme included improved psychotropic medicines, trust from clients, ability to understand the patients more holistically, the convenience of service provision, and willingness to screen for mental health problems. Under the management/leadership domain, some of the barriers identified were no in-service training in mental health care, no formal discussions about mental health disorders with higher-level supervisors, inadequate coordination between general health workers and mental health specialists, restriction on the prescription of psychotropic medicines, and uncoordinated care planning.

In contrast, facilitators included connected primary care and mental health services, improved training and recruitment of specialized and other allied health workers, and communication among services providers. In the domain of financial resources, barriers reported included inequalities in funding; lack of employee benefits; lack of reimbursement for services, mental health budget cuts, insufficient insurance coverage to meet treatment options, and the high cost of hiring nursing and support staff. A separate mental health budget line within the Ministry of Health budget was reported as the only facilitator. Some of these findings provide broader views about the concept of inclusion and the assessment of the strategic alliance adequacy to promote the national inclusive agenda both within and outside the healthcare system in Nigeria.

2.4.6. Involvement of MHSUs and family caregivers

The growing concern for improvement of care has made the first-hand knowledge and experience of MHSUs vital for program development and treatment planning. Service users' engagement is a continuous process, and systems, providers, and service users influence this process and outcomes (Ellis et al., 2013; Baker-Ericze'n et al., 2013; Buckingham et al., 2016). Therefore, it can be assumed that the involvement of MHSUs can be nurtured to grow or can wane depending on how this process is managed.

Furthermore, a systematic review by Zugai et al. (2015) of 52 selected articles on the concept of therapeutic alliance covers the therapeutic relationship in divergent areas such as education, emergency service, and outpatient care. Forty-one of the articles focus on mental health care settings. The author examined MHSUs' roles and relationship building between community mental health nurses and MHSUs in shaping the course of treatment. The findings linked MHSUs' involvement in intervention decision-making to improvement in treatment outcomes. Zugai et al. (2015) established that an understanding and application of the knowledge of the following themes – attributes, interpersonal partnerships, mutual trust, consumer focus, consumer empowerment, and interpersonal healthcare culture – are crucial to MHSUs' integration into collaborative care. In addition, collaboration between mental health teams and MHSUs is depicted as a therapeutic alliance, associated with an improvement in treatment outcomes and caring experiences. It was concluded that MHSUs' involvement in treatment should be viewed as important because they are expected to have a better understanding of the problem, the required support and motivation. Therefore, they should be empowered.

Similarly, using a constructivist qualitative research method, Buckingham et al. (2016) purposively selected 20 caregivers and 11 service users and conducted two focus-groups on caregivers, former service users, and those currently utilizing mental health services in the Mid-Atlantic States in the USA. The authors explored consumers' perspectives on collaboration and utilized an interview guide and follow-up questions that covered a series of topics. The discussion covered family involvement in caring roles, previous experience, challenges, views on the quality of interventions/treatments and expectations from the therapist to increase family involvement. The findings revealed four themes: attitudinal and behavioural engagement, aspirational versus actual engagement, barriers, and strategies to reduce barriers and facilitate consumers' collaboration.

These themes were further elaborated, it showed that attitudinal and behavioural engagement embody trust in service providers for service continuity. Behavioural engagement is described as adequate support for service provider, MHSUs and caregivers which are conceptualized as indirect actions that influence positive attitude towards treatment. Such a description does not portray non-adherence, itself in a non-negative way, but a result of lack of trust to establish deeper involvement in the intervention process. However, family caregivers' devotion to the therapists' roles, intervention plans and medication, to monitor their loved ones' journey and assess what works best or poses a threat to their loved ones' recovery are construed as vitals in facilitating treatment continuity. Services that are helpful are encouraged, valued, and retained, while those that pose a threat are dissuaded. Barriers to engagement with service providers were described as practical barriers for both caregivers and service users such as attitudinal barriers which include stigma, social norms, and cultural differences.

System problems were also noted as the cause of disengagement from the service. It also increased mistrust between service providers and service users due to service providers' negative behaviour (such as lack of empathy and caregivers' perception that the service provider is not well equipped to manage the treatment plan effectively). Strategies for facilitating service users' engagement included improving trust among service users, family, and service providers, encouragement in promoting a collaborative approach in planning interventions, promoting rapport, empowering service users to establish collaborative relationships, and psycho-education about services.

Again, Stomski et al. (2017) focused on MHSUs' advocacy role while studying factors that drive MHSUs advocacy groups. The authors purposively extracted 60 clients' data from the Health Consumers Council database in Australia (a non-governmental program) and adopted a thematic analysis approach. Four themes were developed: problems with prescription, fear about involuntary detainment, engaging in an advocacy role for clarification

of health-related information, and insensitivity of some health practitioners towards service users. As noted, the concern about drug prescription was the fear of compulsory prescription or an enforcement of the community treatment order which was part of the Australia government policy in 2014 to offer antipsychotic drugs/intervention to people in the community without their consent (National Mental Health Commission, NMHC, 2014).

In addition, fear of misdiagnosis, frequent changes in medication, over-medication or increased dosages often lead to health deterioration. These factors encouraged MHSUs' advocacy roles to seek social justice. Essentially, Stomki et al. linked MHSUs' involvement in advocating social justice and seeking support to protecting MHSUs from persuasive behaviour and coercive treatment by the state and attitudes of some MH practitioners' indifferences to MHSUs' plight and that of their loved ones. Although these findings might have shown how MHSUs' engagement is central to the success of the collaborative strategy, they nevertheless unravel additional constraints which concern how MHSUs interpret the programs and the description of commitment at the planning and implementation phase. They equally suggest how vital the nature of the service provided the role of government are in driving the success of the collaborative strategy.

2.4.7. Integration of mental health services in community healthcare systems

The integration of mental health to the community healthcare system fulfils some aspects of the core principles of healthcare policy delivery which are accessibility, comprehensiveness, and efficiency (WHO, 2017; Happell et al., 2020). Research studies globally have shown that there are variations in the implementation of mental health integrated models and MH practitioners' involvement and expectations in PHC systems (Perrin & Sheldrick, 2011; Brown, & Wissow, 2012; Perrin et al., 2014; Zugai et al., 2018). For example, Brown and Wissow (2012) argued that the integration of mental health in PHC should incorporate engagement of physicians, medical assistants, nurses, receptionists, and

paraprofessionals, among others. According to these authors, paraprofessionals are not adequately equipped with the required training to manage mental health crises. Thus, it was suggested that initial screening, escorting patients for examination, and referral services are best provided by social workers. Other findings emphasized the active roles of caregivers and MHSUs in sharing experience and advocacy at the community level (Perrin et al., 2014; Johnson, 2017). The integration could take a person-centred or collaborative approach where professional caregivers are seen as part of a team in nurturing trust in intervention.

Happell et al. (2020) reviewed several intervention studies on the integration of mental health into primary healthcare settings as alternative models for implementing behavioural health care within comprehensive pediatric care. Although the review did not mention the method of selecting the articles or the number of articles selected, it however stated that only evaluative research studies in this area were selected. Happell et al. summarized the reasons for service integration and the various integrated approaches in community healthcare systems. The reasons for service integration are: (a) prevalent and burdensome behavioural problems and (b) the limitation of specialty mental health services such as treatment limitations, limited resources, prolonged delays for service, lack of appropriate service providers, the high cost of care, stigma, and communication gaps between mental health practitioners and physicians.

Models for service integration include the chronic model, an approach that offers a crucial treatment direction for designing comprehensive care for pediatric patients, which is successful in treating depression and bipolar disorder. The flexibility of the approach makes it useful for educators, social workers, and consultants and essentially for those working collaboratively in primary healthcare systems. Another approach to mental health integration is consultation with external coordination. The treatment plan is jointly coordinated by social workers, nurses, and psychiatrists and focuses on a specific issue such as initial assessment and referral. The goal is to allow information sharing and collaboration in designing interventions

to improve psychosocial adjustment and reduce the severity of symptoms voluntarily. The interventions include on-site treatment (without primary care providers “PCP”), on-site treatment with PCP, and training clinicians for collaborative care. They also involved trained clinicians not only in coordinating the collaborative process but also in delivering treatment. This process is supported by brief screening and continuous monitoring as a routine check on mental health. Social worker/behavioural therapist healthcare manager, occupational therapist, etc. can offer these brief intervention services. These services encouraged consulting with service providers, modelling to develop mutual trust and dedication, and fostering improvements in the quality of care. The study seems to confine the integrative approach to the healthcare system in the delivery of care, suggesting the need to extend the applicability of this model to other settings.

Again, Leung et al. (2017) conducted a longitudinal cohort study with a sample of 66,638 patients in 29 sites (four hospital-based and 25 community healthcare) in the Southern California Veterans Affairs clinics between 2008 and 2013. The researchers hypothesized that the integration of mental health services in PHC would lower the rate of general mental health service use without reducing the use of specialized services. Leung et al. also examined the proportion of mental health related problems diagnosed in each PHC. For covariates, the characteristics of patients utilizing the facilities such as age, gender, race/ethnicity, income, marital status, insurance coverage, distance to the clinic, and homelessness were included. The ICD9 mental health diagnostic code (International Classification of Diseases, 1979) was used to categorize service users’ needs and the clinic’s engagement.

Leung et al. (2017) performed a t-test to compare the mean score of types of psychiatric symptoms and specific interventions requested in each type of clinic and utilized regression analysis to predict whether there is an association between PHC engagement and the outcome of the mental health services. The authors estimated the effect of PHCs’ engagement on

hospital utilization outcomes and adjusted for the year, clinical fixed effects, and the type of intervention. They also focused on sub-group characteristics of (depression/psychosis, personality disorder, anxiety/somatoform disorders, acute reaction to stress) problems related to patients' hospitalization to determine whether each diagnosis had an interactive effect with mental health engagement in PHCs. Their findings revealed significant differences in the characteristics of patients' health and their commitment from low to high collaboration in mental health at the PHC levels. The results of the hypothesis predicting relative rates of visiting general MHS in comparison to the specialized MHS are as follows: patients with substance use disorders minimally utilized specialized service in comparison with patients with anxiety disorders and schizophrenia. The use of community mental health resources was relatively high for patients with depression and alcohol use disorders. This outcome suggests that patients' willingness to utilize services or receive treatment in general MHS may be attributed to the availability of service, proximity of patients' house to the mental healthcare setting, and the way symptoms influence acceptance of a particular treatment. These factors encouraged active engagement and more willingness to promote mental health integration in PHC clinics.

The results also established that the proportion of targeted psychiatric diagnoses among patients using PHCs was higher in the past five years compared to those utilizing the general MHS system. These differences remained significant even after the results were stratified by high versus low PHC clinic engagement. Although the study revealed a decrease in reported mental health symptoms, PHC facility utilization continued to increase by at least one percent yearly, and this remained the same through the study period, compared to a 1.2 percent reduction in the use of general MH facilities. The results are significant and of importance to the study conducted as they indicated that MH diagnosis determined the success of MH integration into the community healthcare system. For patients with mild depression, substance

use disorder and anxiety disorder, mental health integration into PHC proved supportive. The study stressed that proximity to the PHC may explain the increased differences in patients' use of collaborative care. Alternatively, the cost-effectiveness of using PHC maybe an explanatory factor that motivates the integration of mental health services in PHCs on the part of the government, and MHSUs' readiness to utilize the service

2.4.8. Facilities variables

Government institutions that promote MH care in Nigeria are few. According to the WHO's (2006, 2007) reports, there are eight federally owned psychiatric hospitals in Nigeria. They are listed as follows: Aro Neuropsychiatric Hospital Abeokuta, Ogun State (which remains the headquarters of the WHO since 1979); Yaba Psychiatric Hospital, Lagos State (the first, founded as Yaba Asylum in 1907); The Federal Neuro-psychiatric, Kaduna; Federal Psychiatric Hospital, Calabar (it remains the national and regional resource centre); Federal Psychiatric Hospital; Sokoto Federal Psychiatric Hospital; Maiduguri and Federal Psychiatric Hospital, Enugu. Based on reported data by the FMOH (2019b), about 36,534 hospitals are in Nigeria, out of which 950 are public hospitals with the inclusion of twenty federal government multi-specialist hospitals (teaching hospitals) with independent psychiatric units.

The reports also include 54 federal tertiary hospitals, 22 federal medical centres, and primary healthcare facilities in 774 LGAs. MHS providers and a coordinator at the community level are expected to manage MH services with the support of the federal government and the WHO. However, variations in the states' involvement are linked to the discrepancy in the quality of services (Anyebe, 2012). Although the exact number of private health care facilities could not be ascertained, the agency estimated about 2,600 in Lagos state (FMOH, 2019b). There is no report on private investment in mental healthcare and little is known about private facilities' active involvement in incorporating MH programs at the PHC level. This represents a gap in extant literature.

The lack of policy to manage recruitment and staff transfer in the PHC setting was reviewed by Abimbola et al (2017). They employed four demographic variables in their analysis namely decision-makers' education qualifications, number of years spent in services, present work setting, and gender. They concluded that accommodation problems, lack of supervision, lack of social amenities, lack of financial incentives, and lack of staff retention at PHCs hinder effective service delivery. The authors observed that such neglect might continue due to the absence of a national framework to manage PHCs. They suggested bottom-up interventions in recruiting personnel which would prioritize committee roles (planning and monitoring) in personnel selection. Each designated PHC is expected to have a functioning committee to plan, manage, monitor, and evaluate its services. The committee includes the village leader, the ward officer, PHC technical and LG PHC management committees (Chukwuani et al., 2006; WHO, 2011, 2018). PHCs provide three types of healthcare centers. Type I (basic health care clinic) uses voluntary health workers to offer advice, and the agency collaborates in resource sharing. The community provides the space for consultation and the agency offers personnel (Abimbola et al., 2015).

Primary healthcare centers (Type II) offer services to inpatients with at least ten beds in the facility. Staffing includes an experienced nurse acting as head of the community health office. Type III (comprehensive healthcare centers) has more than 30 beds manned by a doctor. It renders preventive and promotive health care services. Although the policy statement articulates the incorporation of mental health preventive and promotive care in the PHC sector, the situation analysis reviewed did not indicate a change in this direction (Abimbola et al., 2017).

Again, the Health Market Insights Nigeria Medical Health (2019) projects PHCs' roles in inclusive promotion to include prevention, health education, and community health mobilization. Thus, FMoH as a governing body monitors PHCs' roles and provides

information, education, and communication (IEC) strategy at PHC level (FMOH, 2019). This is to support inclusive policy's goals of practice and behavioural change, by raising public awareness and support through effective communication. It was observed that policy implementation is saddled with human and capital resources limitations such as low funding, lack of political will, poor coordination, low community involvement, and lack of human resources planning.

Chukwuani et al. (2006) administered questionnaires in 53 PHC facilities and conducted focus groups in 42 communities to draw attention to poor service and low utilization of PHC in 17 LGAs in the South-east Nigeria. They concluded that facilities are poorly managed, lack skilled workers and run without budgets. The researchers suggested that building a strategic alliance between the private and public sectors could enhance care at the community level. In all the articles reviewed, there seems to be an absence of information at the PHC levels in Nigeria about the operation of MH care, and inter-agency alliances which seem to be at the core of strategic alliances in MH program delivery. Available literature seems to have focused on maternal and child related issues (Adeyemo, 2005; Chukwuani, et al., 2006; Adeyemi, 2013; Aregbesola & Khan, 2018a; 2018b; Abimbola et al., 2017). Thus, the supportive role of PHCs in providing expertise to support MH inclusion in schools as indicated in the FMOH policy guidelines remains vague.

2.4.9. Summary of empirical findings on collaboration/ strategic alliances

In summary, past studies highlighted success of collaborative strategy in mental health production, changing attitude towards seeking treatment and social support. Most importantly in addressing public negative attitude. Some of these findings also revealed diverse structures of relationship that promote mental health from community-based approach to hospital settings, and the nature of supportive roles from communication service, training, to treatment that are supported through this framework (Brown & Wissow, 2012, Buckingham et al. 2016).

Also, availability of resources- funding, experts' coordination, facilities and locations are part of the identified factors that lead to success of this framework. Such service coordination can be a patient-centred or group-based. However, facilitating internal and external coordination to support mental health collaboration has consistently been reported as challenging (Happell et al 2020). Thus, program continuity can become very challenging even with such alliances is formed. This hindrance is not limited to organization's commitment but also public and bureaucratic roles in program execution and monitoring.

2.5.0 Principal-agent theory

The adoption of principal-agent (PA) theory in this study is to discuss FMOH and Ministry of Education roles at the grassroots in fostering collaboration between PHC and schools to execute inclusive programs. PA encapsulates the rational choice model in decision making; actors (principals) in a competitive world use whatever means they have to offer incentives to other actors (agents) to achieve the result they most prefer (Weingast & Moran, 1983; Oden, 2018). Importantly, Oden (2018) surmised that the responsiveness of the agents to the principal's goals and how these actors come to terms to collaborate through their actions within the institution in which they act is crucial to understanding success or otherwise of a program. PA theory provides a framework for evaluating accountability in a political economy, like Nigeria. Bureaucrats' accountability to the top-level political actors greatly impacts accountability towards the public in policy planning and delivery (Oden, 2018). Bureaucrats are experts equipped with the knowledge and training to fulfil the assigned roles by the government. Weingast & Moran (1983) opined that bureaucrats possess informational advantages over politicians which makes their roles indispensable in policy cycles, and they last longer in office than their employers (elected politicians) due to the process of their engagement. Their roles are crucial in the enforcement of policy and its implementation because of their bureaucratic position; they can act contrary to higher-level politicians'

expectations either in over or underplaying their roles. There seems to be a consensus that this imperfection in the control of hierarchical relationships could result in a gap between directives from the top and the government agencies' functions (Weingast & Moran, 1983; Howlett et al., 2009; Oden, 2018).

Thus, the federal and the state ministry of education and ministry of health are arms of government through which policy related to education and health are implemented, monitored, and evaluated, and in this study, they are treated as government's representatives. Also, there are other government appointees like commissioners of health and of education, the Chief Medical Directors (CMDs), Chief Medical Advisory Committees (CMACs) in public hospitals, school principals, vice principals. They are considered as government agents and, to a certain extent, have autonomous power due to the strategic positions they occupy to act contrary to the expectations of the elected officials in government. Principal-agent theory focuses on policies to explain practical necessities leading to the delegation of authority and issues arising at the administrative level. It emphasizes the role of incentives and institutional structures as crucial in understanding problems inherent in meeting the goals of a policy (Mitnick, 2013).

There is a shared recognition that granting power to bureaucrats can be risky because initiatives can be sapped, risk taking can be inhibited, and creativity crushed. Administrative size can also increase rigidity or delay in policy processes or inhibit policy execution. Lack of proper directives from the federal to state bureaucrats and the use of different measures such as facilitative health policy or coercion (law) can affect policy outcomes (Licari, 2001). Thus, the author assumed that the total elimination of bureaucrats would lead to the insurmountable task of designating procedures for every situation and dictating guidelines for every circumstance. Weingast and Moran (1983) opined that politicians know that assigning roles could weaken their power but see bureaucrats as indispensable. The authors also noted that

government often expands bureaucrats' discretion, making bureaucracies function in a complex structure and specialized manner.

Nevertheless, in research, it has been established that the impact of bureaucrats on people outside this hierarchical relationship can be consistently undermined because different policy planners often present broader perspectives which can hinder acceptance of policy at the grassroots, open it to different interpretation, and lack of funding may limit its impact, hence affecting the end users (Luca, 2016; Puustinen et al., 2017; Nevile et al., 2018). For analytical purposes, in the study conducted, the roles of the ministries of health and education in fulfilling policy objectives at both the state and federal levels were taken as the unit of analysis because the officials occupying these strategic offices were considered as representatives of elected politicians' appointees. They were expected to represent the government, fulfil policy objectives, and provide accountability to the public in the delivery of their assignments.

2.5.1. The impact of Principal-agent relationships in the policy cycle

Theoretically, agents' independence is to harness the technocratic expertise and reduce the impact of uncertainty in the economic environment (Beazer, 2012). The efficiency of an agency can lessen the negative impact resulting from allowing fewer officials that use their authority irresponsibly (Brehm & Gates, 1997; Rauch & Evans, 1999). The competence of the bureaucracy puts it in a strategic position to prevent derailment from public policy's goals (Rauch,1995).

However, studies have shown that the policy environment can be so volatile. Instead of bureaucrats acting in the interest of the society, their ideology, personal interests, and interests of various units in the policy cycle may undermine the success of policies and programs (Adeyemo, 2005; Petrick et al., 2011; Nguyen, 2011; Petrich et al. 2013; Bolaji et al., 2015). According to Bolaji et al., public policy operates in a multifaceted and complex context, from policy initiatives to sourcing for needed resources to implement them. Different issues

such as the economic situation, stakeholders' levels of commitment, public opinions, changes in administration as well as technological changes. The rest of the discussion focuses on government agencies' roles in MH inclusion.

2.5.2. Federal Ministry of Health roles in health policy promotion at grassroots

In Nigeria, the Federal Ministry of Health (FMOH) serves as the authorized agent of the government; the FMOH is the inspector and regulator that defends the guiding principles of health policy. It is responsible for initiating decisions in ever-changing circumstances within the healthcare system (FMOH, 2016). The Department of Health Research Planning and Statistics Unit, Abuja manages relationships with local and international agencies through collaborative efforts (FMOH, 2018). The Ministry of Health, Public Health Department, (MHPHD) contemplates the long-term effects of inflation on investments for other actors such as the health investors (big pharmaceutical companies, public and private hospitals), Health Maintenance Organisation (HMO), and advocacy groups. The uncertainty in how policies are regulated becomes a salient issue. Policy statements act as codified knowledge (written guidelines).

Written guidelines are crucial to the operation of mental health policy. They define specific expectations (action, behaviour, and processes) and create consistency to meet a policy's primary goal. The use of discretion (tacit knowledge) cannot be underestimated in mental health policy delivery (Cangiani, 2011). Therefore, tacit knowledge is "any knowledge possessed by a social actor which may not be articulated but enables the person to perform competently within a general or specific social context" (Jary & Jary, 1991). For Cangiani, it is an implicit knowledge not directly learned but transmitted through informal learning and can influence performance.

This informal understanding is sustained through social interactions, history, and societal culture. Essentially, Robertson et al. (2016) opined that tacit knowledge helps one to

be familiar with what works in MH policy delivery across geographical location, with sensitivity to language and gender descriptions, procedures for balancing emotion and values, development of social engagement, and building trusting relationship to shape its delivery. Edmondson et al.'s (2003) findings revealed that accumulated codified knowledge can improve policy implementation, and it also requires tacit knowledge for improvement and better performance.

More importantly, Sanford et al.'s (2020) study offered an insight into this codified knowledge. The researchers interviewed 26 heads of department, physicians, and officials from the emergency public health department to investigate strategies applied by the health agency- chief medical officers (CMO) and frontline workers (physicians) in program delivery in Ontario. Both tacit (informal) and codified (formal) knowledge are useful. Relationship building is important to establish rapport and trust such as when Medical Directors (MDs) or public health officers officially meet frontline workers to deliberate certain issues. In this process, both formal and informal networking can also be established. A good example of codified knowledge is when an official email or telephone contact is established, or an opportunity is granted to call or drop in to talk at any time regarding a program. Direct communication is also useful when there are doubts or attending unknown cases. However, in emergency cases, tacit knowledge is mostly applied because it is practical and originates from experience, especially where there is no formal guideline. Nonetheless, it comes with challenges; it becomes problematic when there are no clear directives between the state health agencies and hospitals to run a program or attend to a crisis in the community.

Other past research outcomes like those by Beazer (2012) further corroborated Sanford et al.'s (2020) conclusions on the use of tacit knowledge. Beazer investigated 600 enterprises in Russia to establish that indiscretion in the political and economic institution is due to the use of tacit (implicit) knowledge which encouraged misconduct. Thus, tacit knowledge is less

mobile and open to appraisal compared to the codified knowledge of policy. Tacit knowledge can impact policy implementation and may become very challenging to elicit in Nigeria and elsewhere.

As explained above, the use of tacit knowledge in policy or program delivery comes with difficulty because most innovations in policy and programs come from tacit knowledge. It often deviates from traditional guidelines or the specified protocol, which may impose constraints and uncertainty in policy delivery because the greater the discretion required, the greater the risk it may impose on the success of its outcomes (Howell & Jackman, 2013). For instance, Sanford et al. (2020) observed that when new programs or directives are implemented, uncertainty and ambiguity may impede their delivery due to limited information or low support for the new policy. It may cause the delivery of a policy to differ substantially from the stated guidelines. If public reaction towards such policy is unfavourable, and if at the initial phase, the policy impact is weighed against the nation's economy, these conditions may open the policy to different interpretations from different social actors.

In Nigeria, studies on the Eastern and Northern parts of the country established that acceptance and delivery of policies differed in their outcomes, and these differences are associated with poor coordination between the federal and the state governments. The lack of consistency in policy delivery and program discontinuity are attributed to this poor performance (Anyebe, 2012; Jack-Ide & Uys, 2013, Ude, 2015; Anyebe et al., 2019; Owadara, 2020). Readiness of the community healthcare system and other MH agencies to support education systems' inclusive goals may be hindered due to these challenges. It is not even clear if such opportunity to collaborate extends to private education system when there is no clarity on the existence of such partnership between the public school and PHCs.

2.5.3. Federal Ministry of Health (FMoH) guidelines on mental health promotion 2019b

Mental health promotion is often defined as positive MH, not in terms of mental ill-health (WHO, 1986), but as an enabling mechanism that helps people increase control over their psychological functioning and improve their mental health (WHO, 2013). Collaborative framework is a key component of the Federal Ministry of Health for promoting inclusion in Nigeria. The agency references the participation of NGOs, civic societies, healthcare providers, schools, and other stakeholders as crucial to the success of MH program. The goal of this initiative is to promote efficiency and affordability in service delivery for all while maintaining accountability. In leading healthcare service delivery, the Federal Government of Nigeria maintains autonomy through its agency. The FMoH provides guidance to the private healthcare sector to prevent unethical behaviour while protecting quality healthcare service delivery to the people (FMoH, 2019b).

The quality of this initiative will be determined by the MHSUs, healthcare providers or practitioners, and policy makers. MHSUs are concerned about receiving quality and affordable services when needed. Mental health providers prioritized availability of both material and human resources for efficiency in service delivery. For decision makers, accountability and value for money are crucial. Guidelines for evaluating available support at the grassroots are “(a) the level and quality of the services and resources, (b) the capacity of the hospital to provide safe and quality services. (c) the level of process capabilities (d) key drivers of quality and service users’ satisfaction in a strategic plan, (e) the competency level of clinical and non-clinical support staff and (f) areas for improvement” (FMoH, 2019b, p., 173). The federal ministry of health provided these specifications for evaluating workplaces’ roles in collaborative arrangement.

A Health Maintenance Organization (HMO) plays essential roles in fulfilling federal government mandates on access to healthcare and inclusion of disability groups in Nigeria.

They are expected to collaborate with stakeholders comprising end-users (mental health service providers), MHSUs, donors/NGOs, public-sector health care payers (organizations), and community (HRH Strategies and Guidelines, 2008). The National Health Act of Nigeria (2014) articulates the concurrent roles (health coordination) of the Nigerian government in health and MH delivery. It defines the role of the Federal Ministry of Health and the State Ministry of Health across the nation. The Federal Ministry of Health sponsors research and training and regulates healthcare affairs and other parastatals' safety issues under the jurisdiction of both the Federal and the State governments. Also, the Federal Ministry of Health is expected to have representatives at all local governments to collaborate with the State Ministry of Health and coordinate ward health committees, village health committees, private health care providers, traditional healthcare providers, and alternative healthcare providers. Gureje et al. (2015) described the relationship as crucial to promote mental health because the traditional healers are usually the first point of contact in mental healthcare service for families and MHSUs.

For the effectiveness of healthcare service delivery, the policy also stipulated that the basic health care provision fund should be set aside from the annual grant of the Federal Government and is not expected to be less than one percent of its consolidated revenue fund, grants by international donor partners, and funds from other sources. The Federal Ministry of Health (2016) links the goal of healthcare service delivery to inclusion; it equates inclusion to access to care, and the use of high-quality and equitable healthcare services for all, especially at the PHC level. The HRH policy and guidelines (2008) are expected to offer a road map to an organization and encourage its participation in promoting equity for marginalized groups, essentially people with disabilities. Even though there are no explicit guidelines in the National Health Act (2014) regarding the protection of MHSUs and employees, the notion of inclusion encompasses access for all citizens regardless of race, religious practice, gender, and disability.

2.5.4. Promotion of inclusive agenda in public and private education sectors

The concurrent power of government also reflects in the educational sector. Both the federal and state ministries of education regulate funds and decide on personnel recruitment. They take active leadership roles in initiating and promoting the alliance of stakeholders for effective service delivery. At the LGA level, the National Primary Education Commission (NPEC) and the National Secondary Education Commission (NSEC) oversee the affairs of primary education and the implementation of state-controlled policy at the secondary level respectively (World Bank, 2015; Federal Ministry of Education, 2016). Private schools are strictly for business and have diffused the educational objective of education for all. This arouses suspicion and criticism of the system because of the less stringent rules to regulate private school operations (Timothy, 2018). In addition, Omede (2015) pointed out that the lack of uniformity in service and poor regulation of its activities by the government can hinder the promotion of an inclusive policy in the education system. The HR shortcomings in promoting an inclusive workplace are attributed to failure to address material and human problems and the unpredictability of the Nigerian economy. The need for a concrete and workable strategy to reduce these problems has been acknowledged in the HR guidelines as well as Human Resources (HR) policy and guidelines (2008). Nonetheless, no specific solution is offered.

In practice, what inclusion represents within the education sector seems elusive for staff and students. The lack of training and uniformity of service, different remuneration scales, and incessant teacher transfers hinder the system's output and require constant psychological adjustment of workers. Also, the Human Resource Management (HMO) team plays a minimal role in the education sectors (Omebe, 2014).

The HMO attributed the challenges in fulfilling the HRH policy objectives across diverse spheres to low management support for HR practice, lack of support for staff welfare, and quality of life programs, low periodic updates of HR policy and guidelines, poor

understanding of the HR roles as a career counsellor, and protection of a quota system in employment of vulnerable groups. Additionally, constant changes in employers' demands, technological changes, changes in workers' values or workers' dissatisfaction, use of outsourcing in engaging workers and the absence of a legal framework for social and labour practice are part of the problems (National HRH Policy and Guidelines, 2008).

Ezenwaji et al.'s (2018) survey of public primary schools' recruitment revealed that standardization of hiring procedures only exists in theory; the system suffers from the lack of uniformity. Ezenwaji et al. revealed that recruitment into the Nigerian primary schools is replete with nepotism, favouritism, and corrupt practice. This type of recruitment hinders HR inclusive practice. Poor educational service conditions, lack of coordination, and low standards of practice in the public education system are linked to HR policies' complex interaction with an organization and employees and incompatibility of the policy with organizations' needs and employees' needs.

The complexity in the Nigerian work environment raises concern about the process and outcome of a policy when it does not offer direct incentives to benefit the parties involved. Acceptance of an inclusive policy and the level of commitment by the schools may wane when HR practices are undermined in a workplace. Evaluating education systems' adoption of collaborative strategic framework for implementing MH programs may become challenging in the absence of the procedure for enforcing compliance. Also, if there is any enforcement, does compliance equate to deeper commitment for the organization to provide the necessary human and material resources for the success of the program?

Furthermore, the description of governments' concurrent roles in the national framework for education also reflects in the government's promotion of social inclusion of all citizens. This is further articulated in the National Policy on Education (2013), stressing an integrated approach, effective coordination, concurrent implementation, quality assurance, and

cooperation. It articulates inclusion of workers and students. The Federal, State and LGA governments are responsible for all citizens' education and making provisions for MHSUs. The Ministry of Education's involvement at the grassroots level is expected to strengthen the relationship between the Federal Government and the LGAs in entrenching inclusion. The Federal Government coordinates services and provides for special classes and builds units in special schools for individuals.

The passing of the Discrimination (Prohibition) Act (2018) is expected to strengthen commitment towards MH inclusion and other disability groups. Even though the unfettered right of this group to education and economic participation was highlighted in the Act, it may not necessarily mean acceptance at all levels of society. The policy statement is often different from the actual practice, as shown the situational analyses of persons with disabilities in Nigeria (Thompson, 2020). The study examined various legal frameworks that promote inclusive policy in Nigeria to show that there is no significant change in promoting inclusion in the education sector over the course of its implementation. Participation rate in the education of children with disabilities is 12 percent compared to the 57 percent participation rates of those without disabilities. Twenty-five percent was reported for youth with disabilities compared to 55% for youth without a disability. Adults with disabilities participation in education/training was put at 0.5% compared to 4.5% for those without disabilities.

Regarding literacy rates, youths with disabilities were at 36 percent compared to 64% of youths without a disability. Challenges to inclusion in the education sector are closely connected to poor coordination, complexity in accessing funds whenever needed, negative attitudes, lack of accessible infrastructure and long and arduous journeys to school, lack of clear and supportive policies and legislation; lack of support services; poverty and high school fees; inadequate deployment of trained professionals, and various bureaucratic obstacles (Thompson, 2020). Although the study did not offer a breakdown of the disabilities nor did it

emphasize concrete supportive measures for staff wellbeing, nonetheless, it amplifies the need to narrow down the research focus in a way that the project indicates the needs of a specific vulnerable group. Thus, both physical and psychological supportive measures need to be investigated to determine what works, to identify those that need revision, and to improve measures for supporting MHSUs in the workplace and community.

2.5.5. Mental health strategic partnership between international NGOs and Federal Government

a. The Nigerian Mental Health Leadership Advocacy Program (MHLAP)

This program is a Federal Government of Nigeria initiative, designed by the Department of Psychiatry, University of Ibadan, Nigeria. The Department of Public Health now monitors it. The Federal Ministry of Health, Abuja, and the Centre for International Health Melbourne, Australia partly funded the initiative which involves 137 stakeholders across five African Countries (Gureje et al., 2015).

Findings by Hann et al. (2015) linked the goal of MHLAP to the promotion of an inclusive agenda through awareness creation, stigma reduction, and training programs. The key to its successful implementation is prioritizing local languages and adapting measures that meet the local context and needs in manuals and training tools. The WHO is one of the leading international agencies that offers specific training and workshops to stakeholders and community members in this area (Ryan, 2020). Active community participation, collaboration among federal and state ministry of health, local government, PHC, and independent bodies are vital to its success. The program offers policies and guidelines for promoting mental health awareness and positively utilizes the media to spread objective information. Thus, collaboration remains an essential component of promoting an inclusive policy (WHO, 2003a; 2016; 2019b).

The MHLAP specified two goals: first, building leadership and advocacy groups for mental health; second, development of stakeholder groups that can identify and pursue specific mental health services that target each country's needs. The mental health training includes advocacy skills, mental health leadership and mental health service development. Nigeria is among the five countries in which stakeholders' councils are situated. The success of this approach lies in its ability to stimulate non-governmental organizations' support across African countries (WHO, 2013; Ryan et al., 2020).

Again, Hann et al. (2015) evaluated the successes and barriers to this program in Sierra Leone using focus-group and interview methods with 15 participants. Their findings revealed the use of effective communication strategies such as awareness creation (where members act as peer advocates, grassroots initiators to champion mental health in their local communities and networks), and these are considered as an enabling factor. However, the strategy does not equate to effective change but serves as a stage setting process for more initiatives. Issues affecting the success of the program are management problems and stigma at the decision-making level, which have led to poor planning on the part of the government, low awareness, poor coordination, limited resources, and limited resource mobilization (poor funding and competitiveness in sourcing for funds), and networking problems (low grassroots involvement), among others. These are areas of investigation reported in the current study to develop an understanding of the available strategies to implement inclusive measures.

b. *Non-governmental support: WHO's Mental Health Gap Action Programme (MHGAP)*

WHO's Mental Health Gap Action Programme (MHGAP) initiative is an evidence-based approach guided by data from the field to offer technical guidance, practical tools, and training packages to promote awareness and facilitate access to services in Nigeria. It was first launched in 2003 and formally acknowledged by the Nigerian Federal Government in 2013 to promote MH initiatives and programs in rural or poor settings (WHO, 2013). Collaboration

(integrated approach) is vital to its operation for capacity building by training non-specialized healthcare providers to promote mental health services at all levels of care. It embraces an effective leadership style and governance in delivering mental healthcare. Second, it provides comprehensive, integrated social and mental health care services by utilizing community resources such as human resources and local space. Third, it implements strategies for promoting and preventing mental diseases. Fourth, it strengthens information systems with evidence from the field and research studies (WHO, 2016).

2.5.6. The review of related policies on mental health

a. Review of National Mental health Policy (2013)

The National Mental Health Policy (2013) represents the Federal Government of Nigeria's initiative to tackle structural discrimination and promote social integration of MHSUs. The policy addresses stigma and discrimination against MH diseases by promoting access to care and psychotropic drugs and facilitating social justice for the group. Essentially, collaboration is identified as one of the critical strategies for stigma reduction by working with employers and utilizing the tripartite of care for early intervention. The tripartite of care, according to Livneh (1995), is a three-level therapeutic measure developed from a broad range of therapeutic interventions. It centers on preventive care, crisis intervention, and providing tertiary therapeutic interventions. Given the diverse functional limitations in healthcare finance (for example, cuts in operational cost which includes cuts in routine finance, and unanticipated cost), it is designed to focus on specific goals. It also promotes compulsory national healthcare coverage and residual programs for those in dire need.

b. National Health Policy 2014

The National Health Policy (2014) objectives are improving access and making available affordable, quality health services. It aims at expanding healthcare coverage to all citizens and offering sustainable funds for healthcare services, among other initiatives. The

Federal Ministry of Health (2019a) proposed the National Healthcare Guide in its pursuit of fulfilling these objectives. It prioritizes the concurrent roles of the three tiers of government, as stipulated in the Constitution of the Federal Republic of Nigeria (1999). It categorizes the roles of healthcare service delivery into three levels namely primary, secondary, and tertiary care. The Federal Ministry of Health is responsible for formulating policies, strategies, guidelines, plans, and initiating programmes that provide direction for all healthcare system service delivery. The Federal Ministry of Health governs all tertiary healthcare institutions across Nigeria. It is the responsibility of the Local Government Councils to coordinate services at the primary care level and PHCs receive fund allocations directly from the Federal Government of Nigeria. States, on the other hand, are expected to provide secondary care and services, and are overseen by the State Ministry of Health.

c. National Discriminatory (Prohibition) Act 2018

Nigeria passed the National Discriminatory (Prohibition) Act January 23, 2018, as part of the agenda to promote the inclusion of MHSUs and other disability groups. It is difficult to evaluate its impact in Nigeria due to its newness. The goal and the measures articulated in the Act could serve as a means of assessing its effectiveness. The Act stipulates a fine of approximately Can \$156 as well as Can. \$777.66 fines (current market rate as of May 26, 2024) for small and large organizations respectively to dissuade organizations from discriminating against MHSUs. In addition, a minimum of six months' imprisonment was stipulated for individuals or employers that breach this law. It remains unclear whether this measure is practicable in Nigeria. If practicable, the modality for implementing it still remains vague as there is little or no empirical evidence to affirm the measures to execute it.

In accordance with the Constitution of the Federal Republic of Nigeria 1999 as amended, in Chapter (IV), it stipulates penalties to reduce structural discrimination in the labour market and improve access to care. Thus, both the Nigerian Constitution and the

National Discriminatory [Prohibition] Acts 2018 perform parallel functions in prohibiting discrimination against persons with disabilities and imposing sanctions. However, the fines and prison terms stipulated in the Discriminatory Act are not articulated in the Constitution. Likewise, Act stipulates five years for the modification of public buildings and structures to accommodate people with disabilities and recommends the establishment of a National Commission for Persons with Disabilities (NCPD) – an agency responsible for overseeing housing, healthcare, and education. It requires that five percent of employment be reserved for the group and addresses the violation of the rights of the group. These are new specifications articulated in the Discriminatory Act, but they are absent in the Nigerian Constitution.

However, the adoption of this Act in workplaces remains unclear (Etieyibo & Omiegbe, 2020; Suleiman & Umeakuekwe, 2023; Eniola, 2024) because of the persistence discrimination and the imbalance power and the lack of representations of the affected populace in policy discourse. These studies highlighted implementation gaps in policy delivery which often led to varied outcomes in response to government interventions. Challenges comprise of bureaucracy's roles, funding problems at the macro level, incompatibility of the national and the state goals and lack of timely intervention. These are noted as problems affecting federal government interventions. Although this Act could be considered as recent, however, there is a reason to believe that the indifference attitude of both the state and the federal to the micro-level initiatives has become a norm of practice which has reduced people's participation, as past studies have consistently demonstrated (Obayi et al. 2017; Abdumalik et al. 2019, Eniola, 2024). Essentially, this indifference has been linked to low staffing and inadequate funding for research and resources. Hence the functional capacity of these measures at the PHC level may be minimal.

d. National Human Resources for Health Strategic Plan 2008

As earlier observed and articulated in the National Human Resources Health Strategic Plan (2008), the healthcare sector is bedeviled with numerous challenges, such as low recruitment of health workers, variability in the utilization and quality of services provided, inefficiency in the operation of health systems, low motivation and high attrition among healthcare workers, and low attainment of healthcare goals. The Federal Ministry of Health Planning (2019) itemizes the following objectives and strategies to strengthen and evaluate the healthcare system.

The articulated objectives aims at enhancing health governance, increasing funding, promoting public health, this aspect specifically focuses on preventive measure and mental health campaigns and improvement in healthcare delivery. The strategies addressed community engagement, partnerships with local and international NGOs, implementing, monitoring and evaluating health information system, training and retraining practitioners, while strengthening PHC.

2.5.7. An appraisal of the collaborative framework in the FMOH's guidelines

In addressing the poor state of MH service, the FMOH harnesses the notion of good practice, which implies offering guidelines that are evidenced-based practice to guide mental health policy delivery. Emphasis is on collaboration between the healthcare system and other sectors to incorporate the Mental, Neurological and Substance Abuse (MNS) strategy (FMOH, 2013). Also, the National Health Policy (2014) stresses the need for health sector reform to remove conflicts that can hinder healthcare and MNS reform. As part of the Federal Government of Nigeria's developmental goal, MH intervention is expected to cover poverty reduction, stigma reduction and effective treatment of mental disorders. Therefore, in planning collaborative strategy, the FMOH (2019b) articulates that MH is inseparable from general health

interventions at the PHC level. The healthcare sector is expected to build a strategic position by collaborating with other sectors:

- a. **Education sector:** The healthcare system is expected to establish a relationship with the schools' educators to equip them with a basic knowledge of mental health and preventive measure. The strategic approach should be designed to address suicide prevention, early detection and speedy assessment, referral, treatment, and rehabilitation. It should also include promoting MH information in primary, secondary and tertiary institutions and offering support for those whose education is disrupted due to mental illness. It is expected to provide early education support for adolescents that are living with mental illness to prevent interruptions to their studies due to illness. Literacy that leads to skills acquisition and employment should be harnessed. Although the broad objective encompasses the school's populace, the subsequent explanations seem to focus on students.
- b. **Social welfare sector:** The policy also stresses the need for collaboration between the healthcare and social care sectors. Social workers play indispensable roles in assessing and managing mental health problems within a community and collaborating with healthcare workers for the provision of social welfare services.
- c. **Collaborating with Accreditation, Training and Registration Agencies:** This collaboration also includes physicians at the PCH level, social welfare agencies, occupational therapists, and others who work directly with MHSUs. This is to ensure employees are adequately trained to care for MHSUs or respond to their needs.
- d. **NGOs:** The role of NGOs is fundamental to mental health promotion in Nigeria. They channel resources into funding mental health promotion. This guideline on multisectoral collaborative approach articulates NGOs' participatory roles either at the

international or local level. For example, the bilateral aid agencies between overseas donors and local NGOs or foundations represent two-third of all foreign aids to mental health promotion (Ryan et al. 2020). Religious organizations, and private philanthropic organizations are categorized under NGOs, and their services is not limited to awareness creation, but also provide economic and social support for examples medications subsidy and referral services.

- e. Other areas of involvement comprise the traditional health sector, the police, and the prison systems, among others. Such mechanism should facilitate dialoguing and sharing ideas, removal of harmful practice, collaboration in early assessment, treatment planning, making referrals, building the standard of practice, and consideration for research work for knowledge production.

In a nutshell, PHCs are expected collaborate with other agencies to address the public intervention program, build human resource planning, offer basic training and continuity in professional development, and provide health management information on suicide and MHS. They are also expected to offer service providers' basic benefit incentives for social and health interventions, funding mechanisms (budgets and healthcare coverage), and provision for psychotropic drugs.

However, Abdumalik et al. (2016) conducted a multi-level analysis on the national mental health policy (2013) and institutional framework for MH in Nigeria and ascertained that there is an absence of MH programs in most key sectors. The authors suggested the development of strategies that consider personal, sociocultural, and environmental challenges confronting MH programs. Findings from other countries like the United States and Mexico emphasized better funding systems, accountability, increased access to national health insurance coverage, the inclusion of other sectors, and prison reforms as means of encouraging and promoting multisectoral coalitions and inclusion (Ryan et al., 2017a; Ryan et al., 2017b;

Castillo et al. 2018). Although the current NMHP (2013) of the Federal Republic of Nigeria articulates this multisectoral approach to promote inclusion, the extent to which this strategic approach is embraced at the micro level in the education sector or the success of it in stigma reduction seemed undetermined.

As part of the measure to ensure the collaboration of all national agencies and LGA, the NMHP (2013) articulates under the governance and accountability sub-unit of the guiding principles that the implementation of the policy statements will require cooperation among the federal, state, and local governments to enhance the effectiveness of implementing the intention. A Mental, Neurological and Substance Abuse (MNS) policy team will equally be set up in the Federal Ministry of Health. Also, to ensure effective use of allocated human and financial resources, the team is expected to be led by an officer in the Federal Ministry of Health of no less than the rank of Deputy Director. In recognition of the need for inter-sectoral partnerships for successful implementation, it was stated that many sectors of the economy, agencies, and individuals' contributions would be enlisted.

This partnership is expected to be fostered by the Minister of Health. The Minister is expected to establish a National Mental and Neurological Health Advisory Committee/Council in which members would be drawn from all key sectors, and decentralised mental and neurological health inter-sectoral committees will be formed and managed at the state and the local government levels.

In terms of supports for MHSUs, the policy acknowledges the need to strengthen the basic services and provide training for PHC teams to address the diverse needs of citizens. It emphasizes improving experts' knowledge in the assessment, diagnosis, and management of mental disorders, as well as establishing criteria for referral. The government should integrate MNS into PHC for easier accessibility, make provision for acute inpatient care for persons with mental and neurological disorders at every teaching and general hospital – as well as at every

federal medical centre, provide outpatient care in all healthcare settings; and provide rehabilitation services – including occupational, social, and clinical psychological services at every facility where persons with MNS problems are treated. While hospitalization should be provided for those in need, the policy statement does not specify the duration, although a short period of hospitalization is considered essential.

As part of efforts to ensure effective partnerships with the health sector, the policy statement stated that the MNS will be linked and integrated with overall health policy and the health sector. This linkage and integration are required to prevent potential friction between general mental health and MNS reforms, as such friction can militate against the full implementation and contribution of MNS towards the achievement of Nigeria’s physical health targets.

The policy reiterates that people with mental disorders in the prisons are better cared for in a therapeutic rather than a punitive environment. As a result, prisoners with psychosis are expected to be transferred to hospitals. It is expected that health teams liaise with prison staff to care for inmates with less severe disorders, educate the prison staff about modalities for recognizing mental disorders and criteria for referral to hospitals, and sensitize them about identifying and managing depression and suicidal risks within prison settings. Partnerships between the health staff and police that would ensure that people with mental illness receive speedy assessment and treatment are also emphasized. The expected partnerships should include developing training and a locally agreed guideline for the police in recognizing and handling people with mental illness that aligns with the Nigeria MH legislation.

Partnerships between the healthcare and education sectors will address a wide range of issues within education settings. Schools’ administrators and teachers will be trained to promote MNS in the schools and universities, early detection, treatment, and rehabilitation of disorders, and prevention of suicide. The partnership is also expedient to ensure that sick

children and adolescents do not interrupt their studies for a long time. The care plans for young people always include attention to their education needs and that the individuals with forensic issues who are hospitalised for a long period of time have an educational programme to enhance their literacy and numeracy skills for future employment. The need for partnerships between the health and social welfare sectors is premised upon the critical roles of social welfare for all clients.

Social welfare services, most especially, in assessment and management in communities and hospitals, are valued as an essential component of the strategies to deliver the inclusive agenda. Partnerships with accreditation, training and registration bodies were also emphasized, and such partnerships become inevitable when aiming at ensuring that practitioners involved are adequately trained to care for service users. As part of being sensitive to the help-seeking behaviour of the people, the policy acknowledges the need to partner with the traditional health sector, without compromising the standardized guidelines for health practices. As noted in the policy, some patients suffering from anxiety may recover well with support from traditional healers. This further engenders continuous dialogue and exchange of ideas, where possible, within the context of the overall government approach to regulate traditional health practitioners. The call for the integration of mental health service into the overall national healthcare plan necessitates examining the National Health Policy of 2014 to develop an understanding of its process and outcome in fulfilling this goal.

2.5.8. Human Resource Health (HRH) guidelines for MH inclusion

a. Provision of a framework for objective policy analysis

Broadly, the Human Resources for Health document (HRH, 2019b) itemizes three strategies for implementing and monitoring measures that target HRH problems in policy delivery. They include (i) an approach that focuses on up-to-date long, medium, and short-term measures to guide practice at all three levels of government; (ii) capacity building and enhanced

structures and systems to facilitate effective planning, management, and development; (iii) setting up and strengthening HR research as a mechanism for analyzing management performance in the public and private sectors.

b). *Alignment of the health workforce to the public and private sectors' demand*

Strategies adopted to achieve this objective include the enhancement of training capacity and output (service delivery) of health care. They also include quality assurance of institutional pre-service training programmes, skill development through re-orientation of postgraduate and post-basic training programmes to prioritize the health and social needs of all Nigerians (FMoH, 2019a).

c). *Application of best practices of HRH for management and health development initiatives*

This goal is expedient to promote equity in the distribution and retention of the necessary quality and quantity of both human and material resources for universal access to quality care (FMoH, 2019b). Applicable strategies include establishing mechanisms to strengthen and monitor the performances of health workers at all levels and recruiting and deploying of staff in line with an organization's objectives.

2.6.0. *FMoH's arrangements, roles, and responsibilities*

The FMoH is responsible for developing applicable strategies for an institutionalized forum to review policy and supervise and monitor support frameworks for practitioners in both the public and private sectors at all care levels (FMoH, 2019a). The collaboration strategy is expected to include government representatives from the federal and the state levels to recruit adequate and qualified healthcare staff in line with policies and plans. Such expectations require greater commitment. In this regard, Castillo et al. (2019) propose a change in institutional policies and program direction to support MHSUs' social and community emotional wellbeing. Castillo et al. (2019) established that the encouragement of community leaders' participation in MH programs is crucial to the success of such an initiative. Also, government can make changes at all levels in the procedures of program delivery, referral,

assessment, intervention, and institutional policies. These procedures can continually be reviewed and adjusted to provide better service for MHSUs such as establishing a mental health court. In relation to FMOH's (2019b) goals, the emphasis is on strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for healthcare delivery. It is unclear how these goals are interpreted and translated in other sectors, or whether the articulated collaboration extends to settings beyond the healthcare system.

The National HR policy is expected to facilitate the accreditation of eligible private health facilities and increase training opportunities through internships and post-basic training for all health professionals. The concurrent power of government as articulated in the Constitution of 1999 is further harnessed in the policy to promote inclusion through a coalition of the federal and state governments to provide direct access to care for people at the PHC level. Specifically, the Federal Ministry of Health provides leadership, formulates national policy, funds research and programs, supports services, and recruits mental health practitioners and other health workers to work at the grassroots level. It promotes professional visits to areas without experts (WHO, 2016; FMOH, 2019b). The FMOH is responsible for developing guidelines on both the capital and material resources required for health promotion by the three tiers of government. Part of its responsibilities is to promote the development of human resources for promoting mental healthcare at all levels of government. In recognition of the need for a behavioural change, the FMOH articulates collaboration as a means of reaching this goal by partnering with national and international agencies and NGOs such as the WHO and the UNICEF on inclusion and health related issues. The FMOH also documents and provides all healthcare service users with relevant information.

The FMOH (2019b) stipulated the expected roles of the state government such as participating in monitoring, evaluating services, writing progress reports, and supporting the

FMoH's initiatives. The state is also expected to facilitate relationship building between public and private investors to promote inclusion and diversity and provide technical support. It also works in collaboration with the federal agency to support activities at LGA, community, and ward levels. States' involvement should include creating a division at the State Ministry of Health that adapts and coordinates a platform to engage all stakeholders in health promotion.

LGAs create a health promotion unit for PHC department. This is to ensure the adaptation and coordination of health promotion with all stakeholders at this level. LGAs are also responsible for developing capacity for efficiency that is equivalent to the state level. LGAs' PHC units are expected to adapt existing coordination platforms to engage and manage relationships with all stakeholders in MH promotion. The strength and expansion of PHCs by LGAs should be similar or close to the state level. Section 4.2. of the FMoH's (2019) guidelines reflects on care and committee relationships at the ward (district) level as expressed in the National Health Act (2014) and the National Health Policy (2016). At this level, there should be a committee set up to govern ward activities. The district is also expected to implement health promotion and protect consumer rights.

The committee should identify and propose programs that can promote a healthcare plan and protect consumers' rights and needs in wards and villages. The committee's responsibilities also entail the development of action plans for intervention, fund mobilization, providing support service for monitoring, and health promotion assessment. It is expected to coordinate health promotion with diverse stakeholders Schools, NGOs, community outreach programs etc. at the ward level. The committee's roles also include advocacy, coordination, acting as a linkage with local stakeholders to increase their participation and liaising with other healthcare staff. LGAs should also mobilize resources from the local community. The committee is also expected to provide quarterly and annual reports on its activities at the grassroots level and forward them to the LGA Health Promotion Unit.

The FMOH (2019b) recognizes the healthcare domain as multi-dimensional and cross cutting, and that its efficiency and effectiveness depend on the supportive roles of all levels of government. The federal and state (forum) boards are expected to release operational plans annually, while the LGA is also expected to provide workplans for its roles. This is to strengthen public management capacity and policy implementation. The FMOH (2019b) articulates collaborative operational planning with diverse stakeholders as a means toward streamlining its diverse plans and thereby increasing efficiency.

The federal government recognizes its ownership of this system to enhance efficiency and reduce risk. Thus, the notion of collaboration essentializes the participation of the ministries of health (state and federal). States are expected to mobilize support at the PHC level from the community and undertake other supportive roles such as provision of space and local manpower. Other stakeholders – such as community members, family, service users and other non-governmental bodies – are expected to contribute to the set objectives. However, evaluation of these strategies tends to focus on the healthcare sector, and some challenges identified include lack of funds, understaffing and low community involvement (Obayi et al., 2017; Aregbesola & Khan, 2017; Ibrahim & Wan-Puteh, 2018). Adaptation of the National Strategic Plan on collaboration has also been linked to the involvement of the Australian Network of Service with a religious organization in Benue state, Nigeria, to promote mental health awareness (Ryan et al., 2020). However, to the researchers' knowledge, there is little or no empirical evidence of an extension of this collaborative strategy beyond the health care and religious sectors.

2.6.1. Key assumptions in the implementation of the mental health strategies

Cooperation and commitment of all stakeholders are the key to the success of the implementation of this National HRH Strategic Plan, both within and outside the healthcare sector. All stakeholders are expected to demonstrate practical commitment to the

implementation of the above strategies, and their commitment will be measurable in terms of their availability and action to prioritize, design, and estimate annual implementation plans based on the strategic plan. The practical commitment is also expressed in terms of prompt allocation, disbursement, and utilization of available funding and required resources. The approach is expected to (a) encourage government and stakeholders' support to strengthen strategic and operational HRH functions and systems at all levels; (b) encourage joint stakeholders' commitment towards integrated planning, collaboration, and actions for effective service delivery; (c) foster stakeholders' alignment of pre-service training programmes and production capacity with the priority needs of the health sector, and (d) make provision for adequate resources to provide special incentives to attract and retain health staff at deprived locations and promote public-private partnerships at federal, state, and local government levels.

The HRH guidance is expected to guide the delivery of healthcare services, neurological and mental health, beyond healthcare settings such as provision of health information guidance and mental health leadership training programs in the community. Thus, it is hypothesized that the adoption of these FMoH's guidelines in promoting mental health in public and private educational sectors will not differ significantly in terms of the structures of relationships and the types and quality of services provided to foster inclusion in workplaces.

Since these guidelines are expected to cut across diverse settings, therefore, policy instruments and the context of service delivery require a framework that best captures FMoH and HRH strategic plans to evaluate their effectiveness. Thus, integration theory (Tuckman, 1965) captures the theoretical and practical implications of collaborative strategies. It explains government representatives' and employers' alliance in policy delivery. This will be explored after the review of empirical research on bureaucratic roles.

2.6.2. Empirical studies on bureaucracies' roles in policy implementation

Government administrative units often act as regulatory bodies in implementing a policy. Synergy becomes a vital component of strategy to manage their affairs. Filgueiras et al. (2020) examined the concepts of state capacity, policy capacities, and programs in Brazil's federal civil service to analyze the role of bureaucratic actors in the implementation process. Roughly 59.4% of policy workers are university degree holders, their average age was 45 years, 34.5 percent had ten years of working experience in the same policy arena, and 57.2% had held some strategic position in the public sector. Using a factor analysis, the findings presented a theoretical framework with four components specifying the dynamics of policy work which accounted for 59.3% of the observed variance in performance measured.

These components are (a) relational type of work that involves representation, negotiation and coordination tasks with internal and external policy partners; (b) analytic oversight work that groups data production tasks with activities related to compliance and accountability agencies' recommendations, (c) the managerial role that involves technical tasks or resource mobilization regarding managing contracts, agreements and prospect funding, and (d) administrative work that deals with operational tasks. The findings suggested that the analytical capacity of the Brazilian federal civil service focused on accountability instead of prioritizing policy production or development. In other words, the analytic dynamics of the federal bureaucracy are guided by compliance and auditing actions. As related to relational capacity, the result suggests that the set of policy work constitutes complex coordination activities performed by the government to promote policy coherence. The bureaucracy performs policy work with a relational capacity approach. Its functions include negotiating, representing, participating, meeting interest groups, joint projects, and promoting equity and inclusive bills.

Similarly, Onyekwelu, et al.'s (2015) studied challenges in the administrative capacity to manage effective policy studied. The authors studied the functional roles of bureaucracy in rationally and efficiently tackling and accomplishing national and state goals. They established that bureaucracy in Nigeria is characterized by dismal performance that can be attributed to politicization, corruption, deviation from norms and guidelines, poor recruitment and structural defects, and political issues. Behavioural and attitudinal issues include problem magnification for selfish reasons, suppression of a problem to cover inadequacy, corruptive practice; economic problems related to poor organization, lack of funds, absence of planned sustainability for policy initiatives, political issues that are categorized as indiscipline, political demands, and favouritism within the ruling party. More so, it was reported that the bureaucracy in Nigeria has performed far below public expectations, especially in its role in public policy formulation and implementation.

A qualitative study by Luca (2016) was conducted in Turkey's central economic bureaucracy with 32 participants. The participants included 18 civil servants from the ministry and 14 others, including policy scholars, from an institution of higher learning in Turkey, experts from the EU, retired managers, and finance experts. The findings suggest that bureaucratic autonomy and accountability play relevant roles in determining policy effectiveness because having autonomous power to coordinate policy implementation can minimally reduce interference from politicians, as civil servants are knowledgeable in the area and provide data and experience to guide the decision-making process. Thus, when a capable, knowledgeable, and authoritative organization directs project cycles, it can positively contribute to the technical management of the projects. However, when an organization is sufficiently insulated from government, its ability to implement sound policies is contingent on the political context. The greater commitment needed for the policy's survival may be lacking as witnessed in the delivery of Nigerian national healthcare coverage. Khan &

Aregbesola (2017) explained that even though states embrace the initiatives, these initiatives suffer from low investment. Many states fail to implement them, and as a result, only a small percentage of Nigeria's workers are covered.

This study concluded that the institutional framework, the diverse local contexts in which policy is implemented, low investment, the motivation, the divergent views of those involved in the implementation process, and leadership style have implication on core administrative roles. They attributed policy failure to the absence of inputs from those the policy are meant to serve. Similarly, Luca (2016) attributes policy success to active social participation that enhances policy practice and improves conditions for accountability, and too much reliance on political officials for direction may reduce social participation and policy efficacy. Luca's study also revealed significant resistance of bureaucrats to measures that could increase bureaucratic efficiency and transparency. Hence, policy fails when self-interest overrides collective interests.

In addition, Mendes and Aguiar's (2017) case study analyzed the implementation of public policy on the regulation of beds in intensive care units in relation to the policy statement, institutional conditions, and the strategies adopted by the state and municipalities in Bahia, Brazil. They conducted interviews with 55 participants comprising 20 public administrators, 27 directors and hospital technicians, and 8 physicians and regulation technicians. The findings revealed discrepancies between policy statements and their delivery. Even with the availability of technical expertise, ethnic differences, government officials divergent view, self-interest, the use of relational forms of capacity building in policy implementation- such as diverse goals and motives of partners often lead to suppression of dissenting opinions, conflicting interest, dependency, power imbalance and drains resources. Also, differences in local contexts for policy implementation, and diverse informal professional experiences reduced the impact of policy outcomes. The reduction made policy implementation differ substantially from the

policy statement. Bureaucrats also influenced the implementation of public policies in health care.

Public administrators can resort to experiential knowledge and dialoguing during emergency when there is uncertainty or no clarity and when directives are unclear in explaining a given phenomenon. Given the complexity involved in policy delivery, one concern that is explored in this thesis is the conditions and strategies for an organization's involvement in implementing inclusive programs in workplaces. Even when programs are planned, it may result in differential outcomes in the two education sectors due to incompatibility in goals that each education sector prioritizes.

2.6.3. Summary of empirical findings on (state roles) in policy delivery

From the literature review, organizations and public responses to inclusion are undercut by challenges ranging from human to material-related problems. Essentially, organizations' values and missions have been shown to have effects on organizations' involvement in inclusive programs. However, recent findings from the healthcare sector in Nigeria have raised doubt about the readiness of the healthcare sector to promote social inclusion. In the Northcentral region of Nigeria, there is a discrepancy in the quality of service across PHC settings. Some factors contributing to this difference are poor coordination, lack of integration, lack of commitment, lack of staff retention, unqualified healthcare personnel, and lack of program continuity (Anyebe, 2012). Also, Abimbola et al. (2017) established that resource mobilization and awareness creation are part of the responsibilities of the PHC but are often neglected because of the lack of material and human resources. They also affirmed the lack of guidelines and poor coordination at this level hinder their performance.

A series of policy changes and program developments in Nigeria includes the National Mental Health Policy (2013) and the National Discriminatory (Prohibition) Act (2018), aimed at shaping the standard of practice, promoting equity, and reducing discrimination, which

affects other institutional instruments. Ample studies have linked the availability and quality of social capital to the success of policy in promoting the social integration of MHSUs. Such factors include structural embeddedness, respect for human dignity, freedom, national and international law protection and security, and motivation from the community, among others.

The United Nations Department of Economic and Social Affairs (DESA, 2009) examined enabling factors and conditions that facilitate inclusion. They include participation in civic roles, social, economic, and political activities, a strong civil society, universal access to public infrastructure and facilities, removal of barriers to public information, equity in the distribution of wealth and resources, tolerance for and appreciation of cultural diversity, education, effective leadership, and a need to create better narratives of the future of an inclusive society. In several of the studies reviewed, the concept of social capital is embedded in the components of a collaborative strategy to promote inclusive policy. At the onset of the collaborative strategy, a shared understanding is needed to facilitate the management of effective networking. The concept of social capital can be promoted through dedicated funding, understanding of program aims, joint planning, mutual respect, effective communication, incorporation of local knowledge, and population health planning, among other actions (Aysola et al., 2018; Adam et al., 2020; Ashikali et al., 2021). Nonetheless, Adam et al. (2020) asserted that access to data and the validity of information appear to be big issues affecting research of this nature in Nigeria.

The consensus that could be reached from these past studies is the importance of relationship building between government agencies and other stakeholders to facilitate inclusive policy. Nevertheless, it is problematic to ascertain the relationship among government agencies, between the federal government and the states, and their roles at the community level. Essentially, the Ministry of Health utilizes its HMO's strategy to promote inclusion among diverse sectors. Although the HRH's policy and guidelines (2008) articulate collaboration

between the federal and state governments, there appears to be an information gap about what constitutes state involvement, especially at the grassroots level where this partnership is expected to occur. Also, the degree of involvement and quality of support offered by the Federal Ministry of Health to support workplaces seems unexplored.

Therefore, the rationale for appraising the success of the collaborative measures at the grassroots level is to expand social work knowledge based on the nature of strategic relationships for promoting inclusion in Nigerian workplaces, and on conditions that enable their success or otherwise. Again, since the goal of inclusion is to create a friendly, open, and accommodating environment for MHSUs' employees. It is, therefore, imperative to examine the contextual issues relating to FMOHs' strategy in capacity building between the private and public education sectors to reduce stigma and promote acceptance of MHSUs in workplaces.

2.7.0. Evaluation of literature on Nigerian education sectors' integration of anti-stigma programs

Empirical evidence on schools' approach to MHSUs integration in the workplace and delivery of anti-stigma programs is scarce. A few related studies in this area have focused on awareness (Atilola, et al. 2022; Onyemachi, 2023). A cross-sectional study by Olanrewaju et al in the southwest established that schools' social intervention focused more on awareness creation to curb the high prevalence of drug and substance abuse among undergraduates. A cross-sectional study by Onyemachi (2023) in the Southeast Nigeria on teachers' readiness to educate learners on MH. It was established that knowledge of health promotion among teachers facilitates readiness to impact the pupils. Ryan et al. (2017) focused on community engagement which involved NGOs, religion, and PHCs. Only the WHO's (2019a) study affirmed leadership programs in schools and rural areas. Thus, based on the data accessed and reviewed in the current study, knowledge of a school's approach to integration of MHSUs' employees and adoption of relationship building as articulated in the FMOH (2013) is scarce. The paucity

forms the rationale for examining the concept of relationship building to foster inclusion in Lagos State's education sectors.

2.8.0. Contextualizing relevant concepts in the study

Figure 4: *Concepts of mental health strategic alliance/relationship building as contextualized in this study*

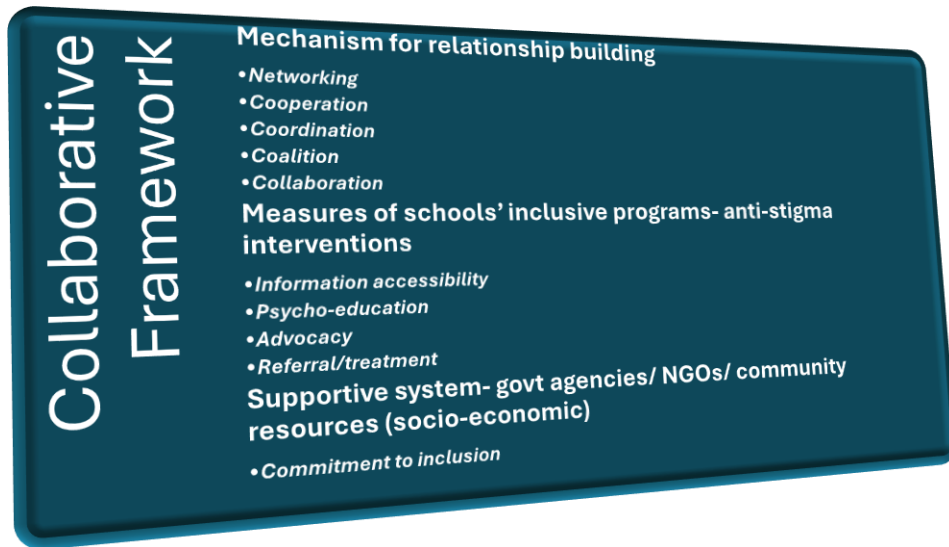


Figure 4 above indicates five phases of collaborative structures starting from the lowest phase- networking to the highest phase- collaboration and four constructs of anti-stigma strategies examined are information accessibility, psychoeducation, advocacy and referral/treatment. Government/ NGOs roles and community resources (presence of NGOs in the community and socioeconomic standard of an area) that can foster commitment to promote inclusion in workplaces.

CHAPTER THREE

RESEARCH METHODS

3.0. Introduction

This chapter discusses the purpose of the study, the research question, and the hypotheses. It explains the study's research design, population of the study (public and private schools in Lagos State), sampling technique and sample selection, research instruments, data collection and data analysis procedures.

3.1. The rationale for the hypothesis

Studies have justified that organizations rationalized motives for participating in prosocial behaviour which influences participation in inclusive programs (Halbesleben & Bellairs, 2016; Nelissen et al. 2017). That is, whether an adoption of a policy is likely to bring efficiency, foster innovation or beneficial -profitable or not). It has also been established that organizations' values influence decision making. The UN DESA (2009) linked the global goal of education to inclusion, to suggest why education systems are readily committed to inclusive policies. However, given the objective of the private education system to make profits, it is hypothesized that adoption of collaborative framework and inclusive programs in private and public education sectors may differ substantially. This study's goal is to examine the extent to which collaborative framework is adopted in private and public schools to facilitate inclusion for MHSUs' employees in Lagos state.

3.1.1. *Research Objectives*

1. Describing the structure of collaborative framework adopted in public and private schools in Lagos State.
2. Assessing private and public-school administrators' views on Lagos State's government support for MH inclusion in the education sectors.

3. Describing the available inclusive service system offered through collaborative strategies to reduce stigma in private and public schools
4. Determine the effectiveness of the inclusive services that are provided in private and public schools to reduce stigma in schools
5. Determining whether collaborative structures and anti-stigma measures adopted by both private and public schools in Lagos State differ.

3.1.2 Research questions

1. What are the collaborative structures adopted in private and public schools to promote MH inclusion in Lagos State?
2. What is the nature of governments' supports received by public and private schools to implement inclusive programs in schools in Lagos State?
3. Which of the mental health anti-stigma measures are adopted by private and public education sectors in Lagos State?
4. To what extent are these inclusive programs effective in reducing stigma in private and public education systems in Lagos State?

3.1.3. Hypotheses

Ho. There is no statistically significant difference in the structure of relationships and strategies adopted by private and public education sectors to promote mental health inclusion.

H1. There is a statistically significant difference in the structure relationships and strategies adopted by private and public education sectors to promote mental health inclusion.

3.2. Research design

The study is both descriptive and cross-sectional; it closely examined the Lagos State's educational context in the delivery of the inclusive agenda of the Federal Republic of Nigeria. It aims at describing issues affecting the delivery of inclusive policy at the grassroots level and proposed a survey design. Aday and Cornelius (2006) opined that health survey

designs are used in gathering information on a subset of a universe that the researcher is interested in studying in a naturalistic setting. They allow researcher(s) to generate information and relate, summarize, present, and interpret data in a systematic manner for the purpose of clarification or making informed decisions. In a cross-sectional study, variables are not manipulated or controlled; instead, information is collected from a representative sample of a population of interest with the aid of appropriate research instruments. In this study, information about the variables of interest was collected from the respondents without manipulating or controlling variables.

The descriptive part of the analysis employed descriptive statistics to perform counting and describe characteristics of the variables of interest. It deployed measures of central tendency and variation for the demographic variables and inferential statistics to compare private and public schools in Lagos State. Thus, inferential statistics as a statistical procedure allows data to be inferred from the sample, to make inferences to the population. In this study, inferential statistical tools- independent sample t-test, and multiple regression were adopted to analyze research questions (1) and (4) respectively. For the hypothesis testing, a multivariate analysis of covariance was adopted.

3.2.1 Research settings

The primary setting for this study was Lagos State. The choice of this location was based on previous NGO research findings which established that Lagos State is more receptive to policy adaptation compared to other states in Nigeria (WHO, 2006, 2015). Also, the sociocultural diversity and economic dominance of the state made it appropriate for this study. The large size of its population and the presence of active advocacy groups (non-governmental agencies) in the state also contributed to its selection as the research setting for this study. Advocacy groups' strategic relationship with the government in promoting the inclusive policy was

another factor. Advocacy groups contribute to decision making, fund programs, and play advisory roles in the state.

3.2.2. Research participants and eligibility criteria

The educators and other senior administrative staff with more than two years experience are research participants. To be eligible administrative staff members must be involved in coordinating schools' activities, and these activities are directly coordinated by the State Universal Basic Education Board (SUBEC) at the Local Government (LG) level. The education sector is considered a service-oriented sector with values and ethical guidelines. In each of the selected schools, two participants were sampled. Target personnel included school psychologists/counsellors/social workers, school owners/directors, supervisors, heads of department, principals, vice principals at the school level, and human resource managers. The requirement for participating in the study was a minimum of two years' active practice in a senior professional capacity.

3.2.3. Target Population

Lagos State consist of 20 LGAs that are grouped under six educational districts for efficient management. The public schools comprise pre-primary and primary (1016 schools), junior secondary school (322) and senior secondary schools (350), according to Lagos State Census Board (2019). No documented information exists on the exact number of private primary and secondary schools in Lagos state, Mrs. Adefisayo, Commissioner for Education, estimated that about 20,000 private schools operate in Lagos State (Times Agency Report, May 22, 2021). Nonetheless, the Lagos State School Board (2019) documented 5,105 registered private schools without breaking them down into levels.

3.3. Sample and Sampling Techniques

The study examined the implementation of collaborative structures for enhancement of MH inclusion in Lagos State's private and public schools. Thus, a multistage sampling technique was considered (i) for cost-efficiency (ii) and time factor.

3.3.1 *The multi-stage sampling strategy*

A multi-stage sampling procedure was selected to either partition large clusters of the population into smaller units (primary units) or randomly select from existing primary units. Thus, the educational districts represented the primary unit, and the LGAs represent the secondary unit (Wang et al., 2006; Valliant et al., 2018). The primary units were independently partitioned into secondary units (LGAs), then tertiary units (list of schools in selected LGAs) from which an appropriate and manageable sample size was randomly selected. As opined by Ardilly and Tillé (2002), the technique is not time-consuming and reduces research costs; as such, it was advantageous to this study.

3.3.2. *Choice of educational districts*

Primarily, the Lagos State education areas are grouped into six education districts for administrative purposes and has 20 Local Government Areas (LGAs), unevenly distributed across these six educational districts (See appendix D). The target population for the proposed study comprised all public and private pre-primary, primary, junior, and senior secondary schools in Ikorodu, Eti-Osa and Ikeja LGAs in Lagos State. Based on these selected three clusters, the estimated total population for public schools was 245 and private schools, 597.

As indicated above, the study utilized the primary arrangement (educational districts) and used simple random sampling to select three educational district headquarters: district II-

Maryland, district III- Ikoyi, and district VI- Oshodi, using an Excel sheet¹. Educational district II covers administrative services in Ikorodu, Kosofe, and Shomolu LGAs. Educational district III manages Epe, Eti-Osa, Ibeju-Lekki, and Lagos Island LGAs, while district VI managed Ikeja, Mushin, and Oshodi/Isolo LGAs. The random selection of three districts served as a representation of the entire population.

3.3.3. Rationale for cluster sampling

Research objectives and analytical frameworks are vital in determining appropriate sampling techniques. For a cross-sectional research study with two groups for comparison, the study's goal and assumptions often determine the sample size (Aday & Cornelius, 2006). Since this study is both descriptive and explanatory, a multi-stage cluster sampling approach for unequal clusters was applied to determine a sample size drawn from the three selected LGAs. Cluster sampling for unequal clusters refers to clusters with different cluster sizes and number of sub-units. Cochran (1953) and Mehrotra et al. (1987) reported that though an estimation without bias is possible with equal clusters, in practice, an equal cluster assumption is often unmet because subjects of interest vary in sample size and present unequal variances. Therefore, such a sample is not devoid of bias and may exhibit high sampling error. Nonetheless, Latpate et al. (2021) affirmed that if the variance of the two groups (public and private school) that is, the degree of variability of the two groups is $P < 1$, such bias is negligible. The result of the t-test supported that this assumption was not violated substantially, only in the subscale of collaborative scale "cooperation" that violate this assumption. Hence, the estimate of the variability between the two groups may not necessarily be calculated separately. Also, the rule of thumb suggested that variance of the two sample should not be more than four

¹ Procedure for conducting random sampling on Excel sheet; the cell containing the primary units is highlighted, then from the utilities group, randomize is clicked to select appropriate row and column randomly, and the desired sample size is specified by clicking the select button.

for the tenability of the result in this case, the score of the cooperation variable for the two sectors (Private- Mean= 14.4, SD 3.7; while Public- Mean =16.5, SD=3.7) is accepted as tenable. This assumption was upheld when calculating this study's population variance (see table 2). The study also increased the sample size since an increase in sample size can reduce sampling error and improve the sample's representativeness.

Table 1:

Number of schools for the selected Local Government Areas

Education Districts	LGA	Public Pre/Primary School	Public Junior Sec. School	Public Senior Sec. School	Private Nursery/Primary School	Private Secondary School.
II	Ikorodu	63	31	28	215	101
III	Eti-Osa	35	19	19	65	33
VI	Ikeja	32	13	12	124	59

(See appendix D. for full report of the public schools' population)².

3.3.4. Pilot study sampling

The sample size for the pilot test was selected using a three-stage sampling procedure. In the first phase, Oshodi/Isolo LGA was randomly selected out of four LGAs under education district II. The school population in the selected LGA was 56 public pre-primary and primary schools, 25 junior secondary schools and 22 senior secondary schools. Furthermore, 30 schools were randomly selected from 106 and 305 private secondary schools and pre-primary and primary schools respectively, using an Excel sheet.

² Lagos State Ministry of Education, (2019) school census board report of 2017-2018, pg. 11, did not offer a breakdown of the number of private schools in Lagos, but estimated that more than 11,000 private schools are registered. However, the commissioner for education, Mrs Olufisayo, estimated that more than 20,000 private schools are registered in Lagos state in her speech while addressing the Times Newspaper on 24th May 2021

In the second stage, the number of sampled private and public primary schools was estimated. Six public schools were calculated through a population mean formula and 24 private schools were drawn. Third, an Excel software application was used to randomly select the sampled schools. Since the study focuses on the inclusive policy implementation (federal government programs performed at the grassroots levels). The schools' administrators were targeted as part of policy implementers in schools. Also, their involvement was specified in the FMoH (2008), as vital to building inclusive workplaces for schools' community. Thirty survey questionnaires were administered but only 26 were returned and analyzed, (see appendix R, p., 494) for the full report on reliability).

3.3.5. Sampling procedure and justification of the choice

For this study, a three-stage sampling technique was adopted because of its practicality. It does not require listing all members of the population, but only those schools in the Primary Sampling Units (PSU), Secondary Sampling Units (SSU) and Tertiary Sampling Units (TSU) are necessary. At the first phase (PSU), the 20 Local Government Areas (LGAs) were unequally grouped under six educational districts in Lagos. A simple random sampling was performed on an Excel sheet to select three clusters (educational districts headquarters) district II, III and VI. District (II) comprised three LGAs, district (III) consisted of four LGAs and District (VI) comprised three LGAs. The second phase (SSU stage) involved drawing a simple random sample to select one LGA from each of the three selected clusters since the goal was a reduction in the number of districts from which schools were drawn.

The selected LGAs were Ikorodu, Eti-Osa, and Ikeja. Ikorodu has a total population of 122 public schools and 316 private schools. Eti-Osa has 73 public schools and 98 private schools, and Ikeja has 57 public schools and 183 private schools (See table 1 above for the distribution of the population). At the third phase (TSU), the population of primary schools, junior and senior secondary schools were merged as one component to further categorized into

two groups – public and private schools (See table 2 for the distribution of these two groups and their population proportions). Two important issues were considered in the estimation of the appropriate sample size for hypothesis testing with group comparison: the number of variables and their sub-components and cost efficiency.

Also, using a cluster sampling as a probability sampling technique as opined by Ahn et al. (2012) allowed the drawing of a sample from a pre-existing large population that is widely, geographically dispersed. In the absence of pre-existing groups, the researcher can also group the population into clusters from which a desirable sample can be randomly selected. Although, the method is prone to high error and bias because when clusters are comprised of populations with similar features, it can lead to overrepresentation or underrepresentation of samples in the clusters. Additionally, if heterogeneity between clusters and homogeneity between subjects within clusters are high, there is a likelihood that the estimator may be inaccurate. Therefore, an increased sample size, random sampling, and adequate knowledge of the target population, among other approaches, can help reduce these shortcomings. For unequal clusters, proportional allocation, estimation of mean (average) cluster variance of the two populations and randomization have been found efficient (Zhan et al., 2021) which was applied in the present study. This assumption was tested, the outcome of the independent sample t-test indicated that only cooperation variable violated this assumption. This was discussed fully under limitations of the study and the justification for the measure adopted for its inclusion was explained on pg 220.

3.3.6. Procedure for sample size allocation

At the first phase, a probability proportionate to size was used; a ratio estimator was employed to draw samples from the primary units (unequal clusters). This procedure offers a good estimate of the proportions or means in the samples (*mi*- mean per element in the tertiary

units) and reduces bias³. Hansen-Hurwitz (1946) asserted that the technique allows a researcher to set the sample size in each sub-unit proportional to the number of sampling units found in that stratum, provided the variation in size is not extremely high among sub-units. In this study, a binominal variable (1, 0) was used to denote the probability of being selected or not, from each cluster. This method gave equal selection opportunity to all elements within a cluster. Thus, the binominal variable (1) was represented by the subscripts (y_{ij}) and used in identifying each variable (see the footnote for this description). Furthermore, because clusters are unequal in size, the researcher calculated the population mean by using the mean and variance equation to calculate the mean per primary units and same for secondary units. Table 2 presents the sample size for private and secondary schools.

From the tertiary unit clusters⁴, a sample size of 142 was calculated for both sectors (41-public school) and 101- private school). This was drawn from 252 (total number of public schools in tertiary units of cluster) and 597 (total number of private schools in tertiary units of cluster) schools were selected using simple random sampling without replacement. These two samples were later adjusted to 53 and 125 for public and private schools respectively. The sampled size was justifiable to estimate minimum effect sizes for the study based on the previous similar study by Aarons et al., (2009).

The final selection was purposeful and focused on policy implementers. Therefore, two school administrators with a minimum of two years' work experience in senior administrative capacity were purposively selected because they meet the research objectives. They were

³ Public schools' data utilized to calculate sample size and effect size were retrieved from Lagos State Ministry of Education (2019) Census Board Report of 2017-2018; the state has 1,687 public schools. By grouping it to clusters, 252 were selected using simple random sampling technique. See the appendix D. For the private sector, the researcher opted for data blocking to identified registered schools, in designated research settings. The total number of registered private schools in research areas is 597. Both sample size and effect size were estimated based on the available information. A summary of how the sample were drawn is offered in appendix E.

⁴ For application of Cohen's d (1981) formula for calculating effect size, see appendix E. After calculating the sample size, the researcher combined the two tertiary clusters (private & public-school lists) to calculate the proportionate population mean for each sector, then, multiplied by the calculated total sample size, to get sample size for each sector.

considered qualified to provide information about the implementation of the inclusive programs in schools. However, where more than two personnel qualified, those with longer job experience were considered. Below is the Hansen-Hurwitz's (1946) formula adopted to estimate the sample size. Also see the footnote on the next page for full detail of its description.

For Hansen-Hurwitz' (1946) cluster sampling⁵:

$$\hat{p} = \frac{\sum y_i}{n}$$

$$\hat{U}_{r(i)} = \frac{1}{n(n-1)} \sum (\bar{y} - \hat{\mu})^2$$

$$\bar{y} = \frac{\sum_{i=1}^n \sum_{j=1}^m y_{ij}}{n_m}$$

The researcher harnessed Aarons et al.'s (2009) study with a sample size of 170 and $ds=0.27$ (effect size) which was described as moderate to adjust the sample size to 180 and $ds=.31$ for this present study. Thus, for validation purposes, this sample size was plugged into G*Power calculator (Franz et al. 2009), from which the sample size of 178 was estimated for this study. Thus, using a Cohen's d (1988) effect size formula to estimate the practical significance of the findings, $ds=0.31$ was calculated. Although Cohen's d effect size has been criticized as often biased in its effect size estimation when two sample sizes differed, or when standard deviations differ significantly for the two groups, researchers often suggested Hedges'

6. Where: U means Universe of PSU, U_i represents universe of elements in PSU $_i$ (i =subscript). M means Number of the PSU in the universe. N_i denotes number of elements in the population universe of PSU i . N equates Total number of elements in the populations; π_i = selection probability of PSU i ; π_{ij} = joint selection probability of PSUs i ; m_i denote numbers of samples PSU; n_i = number of sample elements in PSU i ; s = set of samples PSUs, while s_i represent set of sample elements in PSU i ; y_k indicates analysis variable for element k in PSU i (subscript i is implied); \bar{y}_U denotes mean per element in the population y ; \bar{y}_U denotes mean per element in the population in PSU. See appendix E. for a brief explanation of how the formula was applied.

Cohen's d. (1988) formula was first applied to determine 'ds'
$$\frac{\bar{x}_1 - \bar{x}_2}{\sqrt{\frac{(7^{1-x}S^2 + (n_2-1) \times S^2_2)}{n_1+n_2-2}}}$$
 Where: \bar{x}_1, \bar{x}_2 : the mean

sample1 & mean sample2. n_1, n_2 : sample size 1, & sample size 2; and S_1, S_2 denotes sample 1, sample2 variance. Hedge's g formula was later applied to determine unbiased effect size.

g formula, which is less biased in this area (Lakens, 2013). Hedges' g shows how much two sample groups differ from each other. For this study, when Hedges' g formula was applied, no significant difference was found in the effect size value. To apply Cohen's d formula, the calculated sample size value, the mean of the sample size for each group and the pooled standard deviations of the two samples were applied.

Table 2

Probability proportionate mean sample to size from the study population

LGA	Public	Population	Private	Population
		Proportion $\mu(\pi)$		Proportion $\mu(\pi)$
Ikorodu	122	0.49	316	0.53
Eti-Osa	73	0.30	98	0.16
Ikeja	57	0.21	183	0.31
Total	252	1.00	597	1.00
	($\mu=0.29$)		($\mu=0.70$)	

In table 2, the first column shows the names of the study locations. Column two indicates the public-school population for each LGA, while column three showed the value of the population proportion for public schools in each LGA. The fourth column indicated the proportion for private schools' population, while column five showed the population proportion.

For hypothesis testing, Ho1: The estimated sample size for the two groups was approximately 142 but adjusted to 180 to increase the test power. To calculate the sample size for groups 1 and 2 (public and private), the proportionate population mean was calculated based on 849 schools [data drawn from tertiary units of the cluster for both public (252) and private (597) sectors]. For the public sector, the proportionate population mean (μ_1) was 0.296 which was later multiplied by the adjusted sample size (180) and gave 50.32 sample size for the public

sector. The same was done for the private sector; the proportionate population mean (μ_2) 0.703, and 126.5 sample size was estimated. Aday and Cornelius' (2006) suggestion of adequacy of .80 power ($1 - \beta$ err prob) was adopted to detect the true effect size. (See appendix E for detail). Table 3 below shows the distribution representative sample size (schools) per LGA for each sub-group. ⁶

Table 3
Estimated sample size from the selected LGA

LGA	Public	Private	Cohen's d
			$\frac{\bar{x}_1 - \bar{x}_2}{\sqrt{\frac{(n_1 - 1) \times S_1^2 + (n_2 - 1) \times S_2^2}{(n_1 + n_2 - 2)}}}$
Ikorodu	0.49x53=25.9	0.53x125=66.13	0.31
Eti-Osa	0.30x53=15.9	0.16x125=20	
Ikeja	0.21x53=11.1	0.31x125=38.75	
Total	53.9 (54 appr.)	125 (126 appr.)	

Table 3⁸ indicates the distribution of public schools in each LGA: Ikorodu, 26; Eti-Osa, 16, and Ikeja, 11, and the last column indicated the effect size. For the private schools: Ikorodu, 66, Eti-Osa, 20, and Ikeja, 39. Schools were randomly selected using Excel sheets (application software) by performing a simple random sampling without replacement on the application to pick the selected schools. The final phase of selecting participants as earlier explained was purposeful to target the school administrators because they were policy implementers. However, due to financial constraints, the researcher sampled 346 participants.

⁶ To calculate sample size for each LGA in group 1 (public sector) and group 2 (private sector), the proportionate population means for each LGA was multiplied by its respective sample size for each of the LGA (study locations). Note. The calculated effect size 0.31 is based on adjusted sample size of 53 for the public-and 125 for private schools. Where $\bar{x}_1 = \text{sample mean}_1$, $\bar{x}_2 = \text{sample mean}_2$, $n_1 = \text{sample size for public}$, and $n_2 = \text{sample size for private school}$. See appendix E for details. ⁸ Hedge's g: $g = d \left(1 - \frac{3}{4(n_1 + n_2) - 9} \right)$. See appendix E for application of the formula.

3.4. Description of the instruments and reliability

The instruments were pilot tested using SPSS Version 21 and Stata Version 12. The researcher administered thirty questionnaires, only twenty-six participants returned the completed survey forms. The composite variable that consists of 35 items measuring the structure of relationships yields a Cronbach alpha of .892. Also, the composite variable of 27 items that measure the anti-stigma scale yields a Cronbach alpha of .933, and this scale has high internal consistency. Bland and Altman (1997) asserted that the research purpose and context matter in the application of Cronbach's Alpha value. They argue that values of .7 and .8 are acceptable for group comparison. Thus, the values Cronbach's Alpha value of .078 used in this paper is considered as satisfactory.

The results of the reliability coefficient of the instruments (subscales) are discussed below. The researcher adapted six items from Mental Health Literacy Scale by (O'Connor, 2015) to measure discrimination, for example: how willing would you be to employ MHSUs' employees was rated as 1=definitely not willing to 5=definitely most willing. Scale before was ($\alpha = .71$, now $\alpha = .82$)

The second was government support, a scale developed from Anyebe et al. (2019) in-depth-interview on stakeholders' roles in relationship building. Eight items were constructed, for example: the government provides office in the LGAs to receive MH information was rated as 1=strongly disagreed to 4=strongly agreed, scale $\alpha = .94$

Collaborative change in school's scale by Frey et al. (2004) was also employed. The researcher utilized five levels of MH strategic alliance: eight items on networking, seven items on cooperation, seven items on coordination, eight items on coalition, and six items on collaboration. For example, original scale items under coordination measured active involvement in community mental health and rated 0=no interaction to 5= high interaction. The

scales were reconstructed on 4-point Likert scale: (1-Strongly agreed to 4-Strongly agreed). The scale was α .81 to .93; it was reconfigured to α = .86 to .91.

For schools' anti-stigma interventions, two scales were adapted Tait et al's (2002) and Quality Assurance MH Scale by Agency for Healthcare Research and Quality (2017). Collaboration, a subscale of anti-stigma scale, was excluded because the item deviates from the measured services as described under inclusive strategy in FMOH (2019) HRH guidelines but it was replaced with advocacy from Quality Assurance Scale.

Three anti-stigma subscales adapted from Tait et al. (2002) were information accessibility, psychoeducation, and referral/treatment. For example: workplace provides information to access MH treatment rated 1=strongly disagreed to 4=strongly agreed) Scale before α = .61 to .86, now α = .78 to .88. Also, six added items measured advocacy (anti-stigma intervention) through the Agency for Healthcare Research and Quality (2017). The assessment was written as follows: ...school links staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in seeking treatment was rated 1=strongly disagreed, 4= strongly agreed before α =.85, now α = .94. Lastly, to measure performance in relation to their commitment toward inclusivity, thirteen items were adapted from **Organizational Social Responsibility Scale** measuring by Toliver et al. (2013). For example, my organisation works to make sure its employees feel supported was rated as 1=very poor to 6=excellent, scale before α = .86, and reconfigured as α = .94. See appendix R (p.506) for the full description of the reliability.

3.5. Validity of the instrument

Validity refers to the degree of confidence that could be placed in the outcomes of a study to predict similar outcomes in other settings with similar populations (Nelson, 1980). To maintain the validity of this study, existing measurement that adequately cover all aspects of

the collaborative relationship and programs targeting stigma reductions were included. It was pilot tested using Confirmatory analysis and the results of the measurement were also compared with the previous study. Data were randomly collected from two separate groups (private and public schools). Thus, response from private schools did not affect participants' response from the public schools.

3.5.1. CFA Model fit

A total of 336 respondents were involved in this survey study, and Stata version 12 was employed to conduct CFA. First, data were analyzed using descriptive statistics to test the non-violation of assumption of normality, and a test of reliability was conducted on the composite variables for strategic alliance (structure of relationships) and anti-stigma measures, and on each sub-components of these two variables. For example, the structures of relationship consist of five sub-components (networking, cooperation, coordination, coalition, and collaboration), while anti-stigma comprises information accessibility, psychoeducation, and advocacy of treatment/referral. The Cronbach alpha for the two composite variables are .89 and .93 respectively. For each sub-component, see the appendix for detail of the reliability. The results showed that each of the factors measuring strategic alliance (structure of relationships) demonstrated a good fit They align with Browne and Cudeck's (1993) criteria: a good model fit (RMSEA <0.05), adequate fit (RMSEA between 0.05 and 0.08), poor fit (RMSEA >0.1), P-value >0.05, CFI>0.95, and TLI >0.95. Also, the results of for the anti-stigma analysis showed that each of the factors measuring anti-stigma demonstrated a good fit in line with Browne and Cudeck's (1993) criteria. It is important to ascertain that our variables did not fit a multidimensional model as hypothesized; instead, it converged as a unidimensional model. Thus, the results of the CFA confirmed that the data collected fit a unidimensional model and is suitable to be adopted to study MH strategic alliance, that is structures of relationship for

mental health promotion and anti-stigma strategies in the context of education in Lagos State, Nigeria.

The issue of non-convergence of data as a multidimensional scale was first observed during the pilot study and was attributed to the smallness of the sample size. However, a similar outcome was observed using data from the main study, suggesting that the scale is best treated as a unidimensional model since each sub-item converged on the sub-component they measured. For example, all five items (indicator variables) measuring latent variable, advocacy, converge independently. The same was observed for psychoeducation, information, and referral/treatment. This pattern was observed among composite constructs measuring strategic alliance in the education sector (see appendix for detail., pg. 409- 506).

3.6. Procedure for data collection and ethics approval

The researcher received ethics approval from the University of Manitoba Research Ethics Board. The researcher presented a one-page introductory letter and a summary page of research objectives to the Lagos State Department of Public Affairs, Ikeja, a mandatory procedure to obtain an approval letter to gain access to the three research settings. Two experienced research team members were recruited and trained on proper field research conduct, and their roles were explicitly defined. The two research assistants were trained for one week before the commencement of data administration. Both paper and electronic formats (in pdf format) were provided, however, the participants expressed preference for paper copies. Based on experience, participants often misplace questionnaires, abandon, or fail to complete them. To minimize such loss, two qualified participants from each school were sampled. Where two are completed, the average response was calculated and included in the analysis. The data collection exercise took four weeks.

3.7. Method of data analysis

The researcher utilized Statistical Package for Social Science (SPSS) Software version 21 and Stata application version 12 to analyze the data. The procedure for data analysis involved coding, uploading, and data screening. A descriptive analysis was performed to inspect univariate descriptive statistics for errors in coding and to rectify them. Out-of-range values, plausible means and standard deviations and univariate outliers were inspected. Negative items were recorded. The missing values were less than 5% and assumption of normality skewness and kurtosis was checked.

An independent sample t-test was conducted to analyze research question one. See Table 5 for the description of the variables used in responding to research question one. Both descriptive statistics and independent sample t-test were conducted for research question one. The results are presented in tables. The means, standard deviations, and weighted mean were used to answer research questions 2 and 3 which were presented in tables 7a-7e. A multiple linear regression analysis was performed to analyse research question 4. Table 4 below itemizes the variables used in answering research question 4.

Table 4:

Variables description for research question 4

Variable Name	Designated items in the instrument	Description/ measurement level- ordinal variables (transformed)
DV	31-43 (single scale)	School's level of performance/ordinal
IV (Predictors)	27. a sub scale with eight items	Availability of information (sub-components of anti-stigma)/ordinal
	28. a sub-scale with six items	Psychoeducation (sub-components of anti-stigma)/ordinal
	29 a sub-scale with four items	Advocacy (sub-components of anti-stigma)/ ordinal
	30. a sub-scale with nine items	Treatment (sub-components of anti-stigma)/ ordinal

Items 31-43 were treated as DV and for IV, (Predictors) items 27-30 which had 27 items distributed across four sub-scales ‘information, psychoeducation, advocacy, and treatment’ were treated as stigma reduction programs. Using the “recode into same variable” function in SPSS menu, each sub-scale was checked for negative words and reversed like item 27 (a) which was negatively worded as ‘your school makes it difficult to arrange treatment’ with response rate as 1=Strongly Disagree, 2= Disagree, 3= Agree. 4= Strongly Agree was reversed 1= strongly Agree, 2= Agree, 3= Disagree and 4=Strongly Disagree before summing it up to form the aggregate score. Seven items on information accessibility were computed to obtain an aggregate score. Negatively worded item 29 (p) under advocacy was deleted to improve the scales before obtaining its aggregate score. DV had 13 items measuring effectiveness of schools’ performance in implementing anti-stigma measures. The negatively worded item 43 was reversed before calculating the aggregate score for each sub-scale. Aggregating scores for each scale and subscale allowed the scale to be treated as interval scale.

Items were dummy coded as (0) and (1) and a multiple regression analysis was conducted to determine the level of its significance. Multiple regression analysis enabled the researcher to assess how the variance in the DV variable was accounted for by the IV’s component to analyze the interrelationship between the variables. By applying this technique, the predictive ability of each of the composite score for the sub-scales that forms anti-stigma measures (IV) over the (DV) was evaluated.

Extreme correlation cases were checked by using SPSS default program and index condition for variance inflation and linearity assumption (see the footnote for detail)⁷. Also, residual plots and standardized residuals (ri) boxes were checked to determine model fitness –

⁷ The quantity $\frac{1}{(1-R_j^2)}$ refers to as the jth variance inflation factor, where R_j^2 denotes the squared multiple correlation for predicting the jth predictor from all other predictors.

scores that differ from their actual y scores [check the footnotes for Stevens' (2002) rule of thumb for measuring outliers on the IVs⁸]. Cook's distance was used to examine cases or influential data points. Mahalanobis distance (Ds) values was checked for outliers⁹ Homoscedasticity and independence of residuals were checked to determine the tenability of the assumptions of the linear regression model. The results of the model were presented in the model summary (R^2), ANOVA and Coefficient table to show overall predictive ability of the set of predictors. The results of the t-test coefficients for each slope were used to determine the relative contribution of individual predictors (IV) to predict the outcomes, while controlling all other predictors. The regression equation and the slope are as follow:

Given regression equations of:

$$y = a + b_1x_1 + b_2x_2 + b_3x_3 + b_4x_4 + b_5(x_{_1}) + b_6(x_{_2}) + b_7(x_{_3}) + b_8(x_{_4}) + \varepsilon$$

y = Outcome (level of commitment)

a = Intercept on the Y axis (value of x when $y=0$)

$b_1 - b_4$ = Regression slope for the four main predictors

$b_5 - b_8$ = Regression slope for interactions of sector (institutional type) and the four main predictors

Predictors= Inf (information), psy. (psychoeducation), adv.(advocacy), tre (treatment)

ε = the residual error between x and y.

Finally, a multivariate analysis of covariance was performed to test a single hypothesis raised in this study: Ho1 (There will be no statistically significant difference in the anti-stigma

⁸Hat elements (hii), the average hat elements are p/n , where $p = k + 1$. Thus, Stevens stated that $3p/n$ formula should be used. Any leverage greater than $3p/n$ should be examined (i.e. any point that is more than 3times the mean of all the distances).

⁹ "The Chi-Square critical values table was used to determine variable with a multivariate outlier. A criterion of $\alpha = .001$ with df equal to the number of independent variables" was used to identify the critical value for which the Mahalanobis distance must exceed (Tabachnick & Fidell, 2007, p. 93).

measures and strategic conditions adopted by both private and public schools to promote MHSUs' employees' mental wellbeing).

Table 5: Variables that measure the null hypothesis

Variable Name	Items/ measurement level	Variable Descriptions: summed up to become interval scale
IV	Item 7 (categorical var.)	School (with 2 levels- public & private schools)
DV1	Items21 (ordinal variable)	Networking (sub-scale of Strategic alliance)
	Item 22 (ordinal variable)	Cooperation (sub-scale of Strategic alliance)
	Item 23(ordinal variable)	Coordination (sub-scale of Strategic alliance)
	Item 24 (ordinal variable)	Coalition (sub-scale of Strategic alliance)
	Item 25 (ordinal variable)	Collaboration (sub-scale of Strategic alliance)
DV2	Item 27 (ordinal variable)	Information (anti-stigma sub-scale)
	Item 28 (ordinal variable)	Psychoéducation (anti-stigma sub-scale)
	Item 29 (ordinal variable)	Advocacy (anti stigma sub-scale)
	Item 30 (ordinal variable)	Treatment (anti stigma sub-scale)
Co-variate	Item 3 (ordinal variable)	Socio-economic condition of the school location

Table 5 shows the variables of interest in analysing the hypothesis stated below: The IV variable is a type of school with two groups (public and private) and as a nominal variable will be coded as 1 and 2. There are two DV with sub-scales: DV1 is strategic alliance and has five sub-scales, and DV2 refers to anti-stigma programs with four sub-scales as illustrated in the table 5. The responses to items in each sub-scale were cumulated to compose interval scale. Only one covariate (socioeconomic condition) was involved.

For Hypothesis testing, the study evaluated the statistically significant mean differences of independent (group) variables on multiple continuous dependent variables (DV) while controlling for extraneous variable (covariate-socioeconomic condition). The researcher opined that the application of MANCOVA could help in controlling the co-variate effect on

the differences between the two groups, hence reduce error and increase the power of the test. Studies on organizational OCB studies (Nelissen et al. 2017; WHO 2013c) have shown that socioeconomic condition of an environment can predict success or otherwise of a program.

The relatedness of the two groups of independent variables (private and public schools) that the study is comparing necessitates the choice of this analytical method for three reasons. First is for direct comparison of the private and public schools. MANCOVA does not only allow the researcher to run an analysis of co-variance, but also allows a separate univariate analysis for each DV while controlling for all other variables. Secondly, by running MANCOVA, it will reduce the risk of committing a type I error because it adjusts for the chances of committing this type of error by controlling for effects on the dependent variables other than those related to the independent variable. Third, it avoids running multiple separate Analysis of Covariance (ANCOVA) which would accumulate the probability of type 1 error far beyond the alpha level of any of the individual tests.

A test of multivariate normality was conducted before performing MANCOVA analysis, and the researcher tested for normality (normal distribution) by running a descriptive statistic to check the cases and determine whether the assumption of normality was not violated. Due to the sensitivity of this method to outliers, assumptions about univariate and multivariate outliers were checked. Also, a bivariate scatter plot was plotted to further test the assumption of linearity, aiming at detecting a linear relationship between the pair of the DVs.

In addition, multicollinearity and singularity of the predictors (IV) were tested to determine whether the two pairs of IVs are moderately or highly correlated. A test of correlation (Pearson-Moment Correlation) was carried out to assess the strength of the relationship (See table 10b). A box test of equality of variance and covariance matrices and Levene's test of equality of error variance was also conducted to determine whether the assumptions of homogeneity of variance-covariance matrices and equality of error variance have not been

violated. This analysis was performed as part of the main analysis since MANCOVA generates this result in the box's M test. If it obtained a sig. value larger than .001, for a test of equality of variance for unequal sample, then this assumption, according to Tabachnik and Fidell (2018), has not been violated. The researcher equally searched for the value of a test of equality of error variance, to determine whether this assumption was violated or otherwise. Any values lesser than .05 indicates a violation of this assumption. Homogeneity of regression was tested to assess means on DV across groups (IV) while controlling the covariate variables.

A one-way MANCOVA was performed to test the significant mean difference between the two groups on the linear composite of the two DVs with effects of the covariates. The presence of NGOs was dropped as a covariate, only socioeconomic was retained and controlled. Also, the assumption of equality of regression of covariate on each DV (public and private school) was checked. The overall multivariate test was performed to assess the significance or otherwise of the DV. A test of overall homogeneity of regression was performed to assess if there is a mean difference of the anti-stigma and structure of strategic alliance across the two groups (IV) while controlling the covariate variable.

Due to the unequal nature of the sample size, a Pillai's Trace statistic was employed for its robustness. Since the result was significant, further analysis to test for between-group effects was performed. A conservative alpha level was adopted by performing a Bonferroni adjustment to avoid a family-wise "type I error." Thus, the number of DV were divided by the original alpha level 0.05. Thus, the new sig. value was compared with the result of the observed mean difference between each of the DVs and the IVs and to the significant statistically difference between them. Lastly, effect size was calculated using the results of the Partial Eta Squared to determine the variance in the DV; Cohen (1988) was applied to describe the smallness of the effect size. The results were presented in the appropriate table.

MANCOVA Model¹⁰:

The Sum of Square Cross-Product Partitioned (SSCP) Matrices For hypothesis testing:

$$T = \sum_{j=1}^m \sum_{i=1}^{n_j} (x_{ij} - \bar{x}_T) (x_{ij} - \bar{x}_T)^T$$

Hypothesis Matrices

$$H = \sum_{j=1}^m n_j (\bar{x}_j - \bar{x}_T) (\bar{x}_j - \bar{x}_T)^T$$

Error Matrices

$$E = \sum_{j=1}^m \sum_{i=1}^{n_j} (x_{ij} - \bar{x}_T) (x_{ij} - \bar{x}_T)^T$$

Regression slope: $y_i = \beta_0 + \beta_1 x_i + \epsilon$

Where: β_0 represent the line that crosses the Y axis, and β_1 (intercept) denotes the slope and ϵ means unexplained residual error between the linear relationship of the two variables in comparison.

For categorical data: it is assumed that $E(\epsilon_j) = 0$, and $cov(\epsilon_j) = 1$

Where: x_{ij} Number of individual score

Covariate $E(\epsilon_j) = 0$, and $cov(\epsilon_j) = 1$

¹⁰ One-way MANCOVA is often expressed as MANOVA equation with co-variance, estimated as S or (SSCP matrices) which denotes a squared deviations reflecting a correlation among DVs. It represents the sum of

squares cross-product partitioned (SSCP) $S_T = S_D + S_{Tr} + S_{D \times Tr} + \dots + S_s(DTr)$ ¹⁰

Therefore, Total SSCP (matrix) = Between SSCP (matrix) + Within SSCP (matrix). Note: The hypothesis matrix seeks the differences between the group mean and the grand mean (GM) for each DV, square it, the square value is multiplied by its matrix, finally the value will be multiplied by the group size, then sum up all. Error variance is estimated by taking each individual score and compare it to the GM for each DV.

$$\bar{x}T = \text{Grand Mean (GM)}^{11}$$

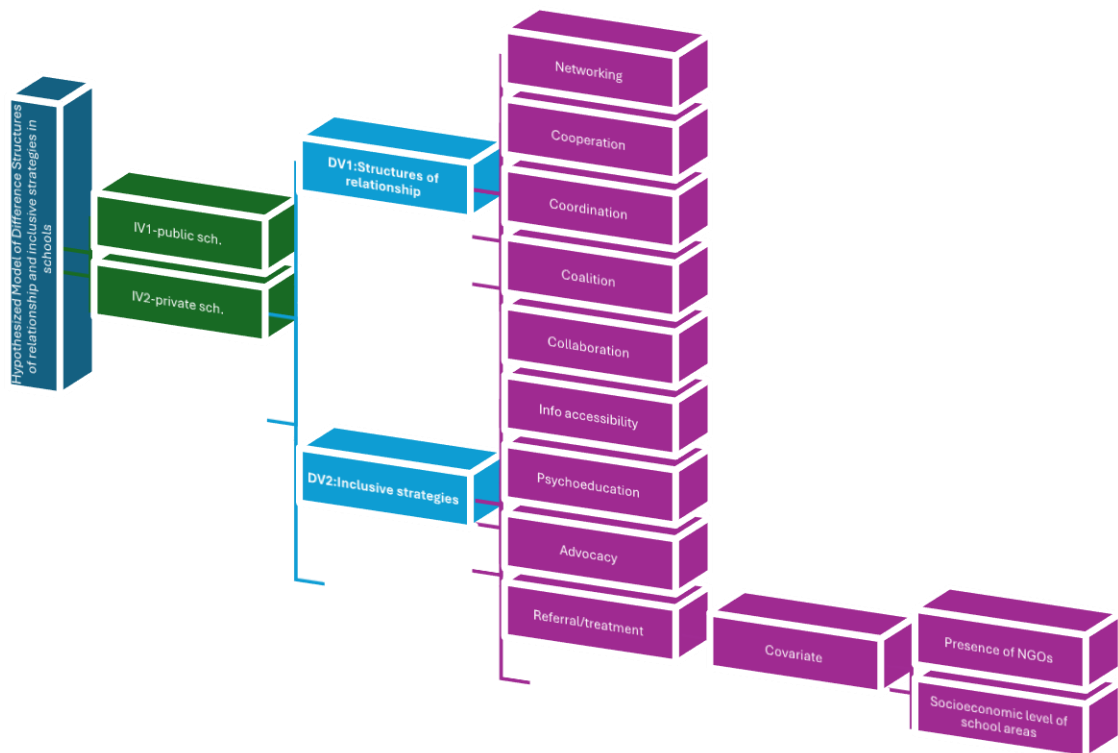
H= Hypothesis

n_j denotes the number of group size in the observation.

E= denotes error variance.

3.8.

Fig. 5. Hypothesized structures of schools' relationship model and anti-stigma strategies.



Analysis of the section C of the survey instrument was coded to gain a broader perspective by deploying a qualitative method to analyze and support interpretation of the four research questions.

3.9. Ethical Issues from the field

¹¹ Total score is estimated by summing the individual score, then deduct the score from the Grand Mean and squared it by multiplying the score by its transposed, and finally add it up to get the total score. Note this is estimated for each DV.

The University of Manitoba Ethics Board approval and Lagos State Public Affairs' approval were received before the data collection began. The research team visited each three education district headquarters to present the state's approval and permission was granted before visiting the designed LGAs for the data collection. Throughout the study, all research protocols were observed as clearly indicated in the consent form that participation is voluntary. Research team explicitly stated that participants could keep the \$5 honoraria even when participants chose to withdraw after giving their consent. PI ensured the research team received a week's training before going to the field. Also, an open line of communication was maintained, and debriefing was an ongoing issue throughout the data collection phase. All collected data were sealed and returned in the original large envelope to maintain confidentiality and participants' privacy. Data were analysed and a summary of the findings was emailed to participants who supplied correct email addresses. A three-page summary was printed and delivered to each education district for those who did not indicate their email addresses or those with incorrect ones. No participants' personal information was stated in the final analysis or the feedback. A few participants refused to participate due to the low incentives and requested more than the specified amount in the consent forms. The research team did not coerce them but chose other schools.

The research team experienced several challenges during the data collection. Both electronic and physical questionnaires were proposed; however, more than 95% of participants declined the electronic format. Some claimed that they had forgotten their email addresses or passwords. Those who accepted the electronic survey did not return the completed forms despite the reminders and school visit. Sending feedback to the study areas was also problematic because many emails bounced back. Thus, sending printed copies to district headquarters became the practical choice. This aligns with the ethical procedure discussed in the study proposal,

requiring a three-page study summary to be forwarded to participants via email, and physical copies to be submitted at the district offices.

The demand for higher incentives by some private school administrators slowed down the research pace in Ikorodu LGA. Despite explaining the study's purpose and incentive limitations, these individuals remained uncooperative, leading the PI to choose other proximate private schools. In Ikeja, a public-school administrator refused to take part due to perceived power relations. A level 16 officer signed the study's approval letter from the Tutor-General's Office; consequently, the administrator insisted that no junior officer could authorize his compliance. Despite intervention from the Tutor-General's Office, the issue was unresolved, and alternative schools were selected from a list provided by the Tutor-General's office to replace those that declined participation.

CHAPTER FOUR

FINDINGS

4.0. Introduction

This chapter presents the results of the analyses of the data collected from the participants as well as the summary of the major findings. In the study, out of the 346 copies of questionnaires administered to the school administrators across the selected educational districts in Lagos State, 336 copies were returned. This represents a 97.1 percent return rate. Therefore, the demographic data, as presented in Table 6, reflects the responses of 336 participants.

Table 6

4.1. Demographic Characteristics of the Study Participants

Demographic Characteristics	Private Schools		Public Schools		Full Sample	
	n	%	n	%	n	%
Education District						
Ikeja/Maryland	76	33.0	22	20.8	98	29.2
Eti-Osa	40	17.4	32	30.2	72	21.4
Oshodi/Isolo	114	49.6	52	49.1	166	49.4
LGA						
Eti-Osa	40	17.4	32	30.2	72	21.4
Ikeja	76	33.0	22	20.8	98	29.2
Ikorodu	114	49.6	52	49.1	166	49.4

Social Economic Status of the						
School's Area						
< N 2.5 million	132	57.4	52	49.1	184	54.8
N 2.5million – 5,599,999	30	13.0	28	26.4	58	17.3
N 6 million - 8,999,999	14	6.1	5	4.7	19	5.7
N 9 million- 11,999,999	9	3.9	5	4.7	14	4.2
N 12 million- 14,999,999	2	.9	2	1.9	4	1.2
N15,000, 0000 and above	21	9.1	5	4.7	26	7.7
No Response (NR)	22	9.6	9	8.5	31	9.2
Availability of NGOs promoting						
MH in the school area/LA						
Strongly Disagree	21	9.1	11	10.4	32	9.5
Disagree	58	25.2	17	16.0	75	22.3
Agree	108	47.0	53	50.0	161	47.9
Strongly Agree	29	12.6	19	17.9	48	14.3
No Response (NR)	14	6.1	6	5.7	20	6.0
Years of Experience as an						
Administrator						
<5years	116	50.4	50	47.2	166	49.4
5years to 10 years	49	21.3	28	26.4	77	22.9
10+years	63	27.4	24	22.6	87	25.9
No Response (NR)	2	.9	4	3.8	6	1.8
Place of Work						
Nursery and Primary school	51	22.2	25	23.6	76	22.6
Junior Secondary school	54	23.5	38	35.8	92	27.4
Senior Secondary school	125	54.3	43	40.6	168	50.0
Size of your School's Workforce						
1-20	77	33.5	37	34.9	114	33.9
21-40	87	37.8	41	38.7	128	38.1
41-60	39	17.0	27	25.5	66	19.6
61-80	13	5.7	-	-	13	3.9
81+	10	4.3	1	.9	11	3.3
No Response (NR)	4	1.7	-	-	4	1.2

Gender						
Female	125	54.3	61	57.5	186	55.4
Male	103	44.8	43	40.6	146	43.5
Non-binary	-	-	1	.9	1	.3
Not Willing to Share	-	-	1	.9	1	.3
No Response (NR)	2	.9	-	-	2	.6
Educational Qualification						
Diploma/Certificate/ NCE	31	13.5	3	2.8	34	10.1
Graduate (HND, BSC, B.Ed.)	145	63.0	70	66.0	215	64.0
Postgraduate (MSC, M. ED, MSW, MPhil, PhD)	43	18.7	31	29.2	74	22.2
Others	9	3.9	2	1.9	11	3.3
No Response (NR)	2	.9	-	-	2	0.6
Age						
≤ 25	3	1.3	-	-	3	.9
26-35	53	23.0	3	2.8	56	16.7
36-45	74	32.2	12	11.3	86	25.6
46 & above	100	43.5	86	81.1	186	55.4
No Response (NR)	-	-	5	4.7	5	1.5
Position at Workplace						
Human Resources Manager (HR.)	17	7.4	1	.9	18	5.4
Principal/ V. Principal/ School director/ Head teacher/Proprietor	109	47.4	51	48.1	160	47.6
Head of the Department (HOD.)	84	36.5	46	43.4	130	38.7
Others (Counsellor/Psychologists)	20	8.7	8	7.5	28	8.3

The results in Table 6 show the distribution of the demographic characteristics of the study participants. As shown in Table 6, 49.4% of the total participants were sampled from Oshodi/Isolo Education District, while 29.2% and 21.4% respectively were sampled from Ikeja/Maryland and Eti-Osa Education Districts. In terms of participants selected from each LGA, Ikorodu LGA had the highest representatives (49.4%), while Eti-Osa had the least with

21.4%. More than half (54.8%) of the participants indicated that the socio-economic status of their schools' areas was less than N 2.5 million, while 17.3% indicated between N 2.5 million and 5,599,999. However, 9.2% of the participants declined response to this item, and it was designated as 'No Response'. In relation to the availability of NGOs for MH promotion in the participants' school areas, while 14.3% and 47.9% strongly agree and agree respectively, 22.3% and 9.5% disagreed and strongly disagreed, whereas 6.0% declined. Among the sampled participants, 49.4% had less than 5 years of administrative experience, 22.9% had between 5 to 10 years of experience, and 25.9% had experience of 10 years and above. The majority (50.0%) of the sampled participants were working in senior secondary schools, 27.4% were working in junior secondary schools, while 22.6% were working in nursery and primary schools.

In terms of the size of the schools' workforce, 38.1% of the participants indicated having between 21 and 40 staff members, 33.9% indicated between 1 and 20 staff members while only 3.3% indicated 81+ staff members. However, 1.2% of the participants declined response to this item. Gender distribution of the participants showed that male school administrators had the highest percentage (64.0%), females were 10.1% and non-binary had 0.3% of the total sample. Nevertheless, 22.0% of the participants indicated 'other' gender, 3.3% were not willing to disclose their gender status, and 0.6% declined outright. The educational qualifications of the participants showed that 25.3% had postgraduate degrees, 16.7% had graduate degrees, 0.9% had diploma/certificate/NCE, while 55.7% indicated other certificates. The age distribution showed that 55.7% of the participants were 46 years and above, 25.3% were between the ages of 36 and 45 years, 16.7% were between 26 and 35 years, 0.9% were less than 25 years, while 1.5% declined their age status. The results further showed that 47.6% of the participants were principals, vice principals, school directors, head teachers or

proprietors. 38.7% were heads of department, 8.3% were school counselors/psychologists, and 5.4% were human resources managers.

4.2. Analysis of the Research Questions

To answer the stated research questions in this study, the data collected from the respondents were slightly modified. In each LGA, for schools where two participants completed and returned their questionnaires, their responses to the key variables of interest were scored and averaged to obtain a single score. However, where only one participant completed and returned their questionnaire form, the score was used as it was. With this modification, 180 participants were envisaged; however, two participants failed to respond to about 52% of the total items in the survey and as a result, they were eliminated from the final analysis. Therefore, the result of the analysis was based on the responses of 178 participants who complied substantially.

Research Question 1. What types of *collaborative structures are adopted in public and private schools in Lagos State.*?

In order to answer this research question, school administrators' responses to composite items 21, 22, 23, 24, and 25 representing the five collaborative structures (networking, cooperation, coordination, coalition, and collaboration) interventions were subjected to an independent t-test of difference. The school type represents the IV (categorical variable), and the composite scores of each collaborative sub-components represent the DV. The results are presented in Tables 7 for robust explanations on the observed difference see (appendix S details). The results of the difference in structures of relationships designed for anti-stigma interventions in the public and private schools in Lagos State is presented in Table 7.

Table 7

Differences in Collaborative Structure for MH Inclusion in Public and Private School Administrative Systems in Lagos State

S/N	Collaborative levels	PRIVATE		PUBLIC		<i>t</i> (174)	<i>P</i>
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
A	Networking	20.04	4.85	20.35	6.51	-.356	.722
B	Cooperation	14.98	3.70	16.58	3.74	-2.656	.009*
C	Coordination	12.43	3.83	13.45	3.87	-1.655	.100
D	Coalition	11.68	3.03	11.88	3.02	-.432	.673
E	Collaboration	14.08	3.87	15.46	4.13	-2.183	.030

$p < .05$, * $p < .01$ (Bonferroni adjustment) see the footnote.¹²

The results in Table 7 show the differences in structures of relationships designed for promoting anti-stigma interventions by the public and private school in Lagos State.

An independent samples t-test was conducted to compare the mean score of structures of relationships in private and public schools in the three study areas- Ikorodu, Ikeja and Eti-Osa. As shown in the result, networking¹³ mean score for the private sector is (($M=20.042$, $SD=4.85$) and for public sector is ($M= 20.35$, $SD6.51$); $t(174) = -.356$, $p > .01$ (two-tailed) which was not significant. The magnitude of the mean difference = $-.31$, 95% CI: -2.03 to 1.41). Eta squared = 0.002 , shows a small effect size. However, significant differences is observed in cooperation: private ($M=14.98$, $SD= 3.70$), public ($M=16.58$, $SD=3.74$), $t(109)$ ¹⁴ = -2.656 , $p < .01$ (two-tailed). The magnitude of mean difference = -1.59 . 95% CI: $.22$ to $-.40$. Eta squared = 0.15 , signifies a large effect size (Cohen, 1988, p. 284-287).

Coordination mean score for private sector ($M=12.43$, $SD. 3.83$), public ($M=13.44$, $SD= 3.87$); $t(176)= -1.66$, $p > .01$ (two-tailed). The magnitude of mean difference= -1.0 (CI: -2.39 to $.20$). Eta Squared = 0.009 and suggests a small effect size. Coalition mean score for private schools ($M=11.67$, $SD=3.03$) public schools ($M=11.88$, $Sd= 3.02$); $t(176)= -.42$, $p > .01$. The magnitude of mean difference = $-.20$, 95% CI: -1.15 to $.75$. Eta Squared -0.002 , a small effect size.

¹² Calculated new p-value = $.05/5 = 0.01$.

¹³ For networking, the result of F statistic was significant $F(174) = 7.180$.

¹⁴ Equal variance not assumed is reported for cooperation.

Collaboration mean score for private ($M=14.08$, $SD= 3.87$), public ($M=15.46$, $SD= 4.46$), $t= -2.183$, $p>.01$ (*two-tailed*). The magnitude of mean difference= -1.38 , 95% CI: -2.63 to $-.13$. Eta Squared = 0.01 , also signifies a small effect size= -1.38 (CI: -2.36 to $-.13$). As revealed in this result, in relation to cooperation where a significant difference was observed, the result suggests that public schools experienced a higher and significant relationship when compared with their private school counterparts.

Research Question 2

What is the level of supports that the school receives in the implementation of preventive care and intervention (anti-stigma programs) targeting accommodation for MHSUs' employees in private and public schools?

To answer this research question, item 26 that measured the level of the state's support received by the private and public schools in promoting preventive care and intervention program(s) targeting accommodation for MHSUs' employees were summed up to form a composite variable. The research objective is the main factor that was considered in calculating the weighted mean. The intended objective is to determine the average level of government's support to schools on the range of very poor to excellent. Thus, all the mean of the sub-constructs were summed up and divided by all the number of items, see the categorization under the table 8. It was subjected to a descriptive analysis of mean, SD, and weighted mean. The result is presented in Table 8.

Table 8***Level of Support Received by Schools in the Implementation of Anti-Stigma Program(s) Targeting Accommodation for MHSUs Employees in Private and Public Schools***

S/N	Government Support	PRIVATE			PUBLIC		
		Mean	SD	RMK	Mean	SD	RMK
a	The State provides office(s) at LGAs level in supporting mental health programs in the school and/or its surrounding community	2.14	1.20	<i>P</i>	2.80	1.24	<i>F</i>
b	The State provides periodic information about mental health initiatives	2.57	1.12	<i>F</i>	3.08	1.17	<i>F</i>
c	The State includes in its annual budget funds for MH promotion in the school and / or its surrounding community	2.34	1.17	<i>P</i>	2.94	1.26	<i>F</i>
d	The State links the school to local resources that promote mental health	2.13	1.15	<i>P</i>	2.82	1.27	<i>F</i>
e	The State exhibits dedication to championing well-being and mindfulness programs	2.56	1.32	<i>F</i>	3.49	1.37	<i>F</i>
f	The State recruits support workers to promote mental health at the local government area and State levels	2.47	1.19	<i>P</i>	3.23	1.32	<i>F</i>
g	The State provides periodic training to support groups to promote mental health in the workplace	2.48	1.16	<i>P</i>	3.01	1.44	<i>F</i>
h	The State provides information that links the school as a workplace to advocacy groups	2.25	1.15	<i>P</i>	3.04	1.39	<i>F</i>
	Weighted Mean	2.37		<i>P</i>	3.05	F	<i>F</i>

Key: Mean [1.00-1.49 = Very Poor (VP); 1.50- 2.49= Poor (P), 2.50-3.49=Fair (F), 3.50-4.49= Good (G), 4.50-5.49= Very Good (VG), 5.50-6.00= Excellent (E)]

The results in Table 8 show the descriptive analysis of the level of support that the school receives for the implementation of anti-stigma program(s) in private and public schools in Lagos State. As shown in Table 8, the school administrators in private schools rated the level of support in terms of the state's provision of desk office(s) at LGA level in supporting mental health programs in the school and/or its surrounding community as poor: ($M=2.14$, $SD= 1.20$), while their counterparts in public schools rated it as fair ($M=2.80$, $SD= 1.24$).

There seems to be an agreement in rating government support in terms of State provision of periodic information about mental health initiatives. This statutory responsibility was rated fair by both private ($M=2.57$, $SD= 1.12$) and public ($M=3.08$, $SD= 1.17$) school administrators. On the inclusion of funds for MH promotion in schools and/or its surrounding community in Lagos State's annual budget, the school administrators in private schools rated this responsibility as poor ($M=2.34$, $SD=1.15$), while those in public schools rated it fair ($M=2.94$, $SD= 1.26$). Also, while the school administrators in private schools rated government support in terms of linking the school to local resources that promote MH as poor ($M=2.13$, $SD= 1.15$); those in public schools rated it as fair: ($M=2.82$, $SD= 1.27$). Both the school administrators in private ($M=2.56$, $SD= 1.32$) and public ($M=3.49$, $SD= 1.37$) schools rated government's support in terms of dedication to championing well-being and mindfulness programs as fair. While the school administrators in private schools rated Lagos State's support in terms of recruiting workers to promote MH at the LGA and state levels as poor ($M=2.47$, $SD= 1.19$), the public school rated it as fair ($M=3.23$, $SD=1.32$). Similarly, the private schools' administrators rated government support of provision of periodic training to support groups to promote MH in the workplace and provision of information that links the school as a workplace to advocacy groups as poor with respective mean values of 2.48 and 2.25, with SD values of 1.16 and 1.15. Whereas those in public schools rated it as fair with respective mean values of 3.401 and 3.04, with SD values of 1.44 and 1.39. Therefore, given the administrators'

government support assessment weighted mean values of 2.37 and 3.05 for private and public schools respectively, it is implied that the school administrators in private schools rated the level of support that the school receives in the implementation of anti-stigma program(s) as poor, while their counterparts in public schools rated it as fair. This outcome therefore suggests a lack of uniformity in the support that the school receives in the implementation of anti-stigma program(s) targeting accommodation for MHSUs employees in private and public schools in Lagos State.

Research Question 3 *What are the available service systems for anti-stigma that school provides through collaborative strategies in the private and public education sectors?*

To answer this research question, two approaches were adopted. In the first instance, responses to each sub-component items 27, 28, 29, and 30 which represent the four aspects of the preventive care (information, psychoeducation, and advocacy), and interventions for anti-stigma (referral/ treatment) in the schools were summed up to form composite variables. They were later subjected to a descriptive analysis of mean, SD, and weighted mean. To obtain the weighted mean for each component, the mean obtained for each item that form component were added together and divided by the number of items constituting that component. The results were presented in Tables 9a to 9d separately. Also, the summary of results for all the available preventive and intervention services for anti-stigma is presented in Table 9e.

Table 9a

Descriptive Analysis of Participants' Responses to Items Measuring Anti-Stigma (Information Aspect of Preventive Care) by the Public and Private School Administrative Systems in Lagos State

S/N	Information	PRIVATE			PUBLIC		
		M	SD	RMK	M	SD	RMK
a	It is difficult to arrange treatment appointments at my school	2.51	1.02	A	2.59	1.02	A
b	My school provides the opportunity to access information on mental health treatment.	2.39	0.93	D	2.24	0.85	D
c	My school encourages sharing personal experiences of mental health treatment with others	2.31	0.89	D	2.36	0.85	D
d	My school helps by providing information that reduces mental health stigma, when appropriate.	2.60	0.88	A	2.60	0.75	A
e	My school encourages employees to be open-minded about the mental health experiences and feelings of colleagues.	2.73	0.96	A	2.78	0.82	A
f	My school responds to employees with mental health problems with empathy.	2.90	0.91	A	2.74	0.84	A
g	My school encourages peer support for people with mental health problems.	2.71	0.85	A	2.70	0.85	A
h	My school encourages employees with mental health problems to seek help from hospital/s community health programs & support groups.	2.90	0.96	A	2.90	1.00	A
	Weighted Mean	2.63		A	2.61		A

Key: Mean [1.00-1.49 = Strongly Disagree (SD); 1.50- 2.49= Disagree (D), 2.50-3.49=Agree (A), 3.50-4.00= Strongly Agree (SA)]

The results in Table 9a show that the school administrators in both private and public schools in Lagos State agreed that it was difficult to arrange treatment appointment in their respective schools: private ($M=2.51, SD = 1.02$), public ($M=2.59, SD = 1.02$). They provided information that reduces MH stigma when appropriate: private ($M=2.60, SD = 0.88$), public ($M=2.60, SD = 0.75$); encouraged employees to be open-minded about the MH experiences and feelings of colleagues: private ($M=2.73, SD = 0.96$), public ($M=2.78, SD = 0.82$); they responded to employees with MH problems with empathy: private ($M=2.90, SD = 0.91$), public ($M=2.74, SD = 0.84$); encouraged peer support for people with MH problems: private ($M=2.71, SD = 0.85$), public ($M=2.70, SD = 0.85$); and encouraged employees with MH problems to seek help from hospitals/community health programs and support groups: private ($M=2.90, SD = 0.96$), public ($M=2.90, SD = 1.00$). However, the school administrators in both private and public schools in Lagos State disagreed on provision of access to information on MH treatment: private ($M=2.39, SD = 0.93$), public ($M=2.24, SD = 0.85$); and did not encourage sharing personal experiences of MH treatment with others: private ($M=2.31, SD = 0.89$), public ($M=2.36, SD = 0.85$). Therefore, given the administrators' assessment weighted mean values of 2.63 and 2.61 for private and public schools respectively, it is implied that school administrators in Lagos State agreed with the existence of information as part of preventive care in their various schools.

Table 9b

Descriptive Analysis of Participants' Responses to Items Measuring Anti-Stigma (Provision of Psychoeducation an Aspect of Preventive Care) in the Public and Private School in Lagos State

S/N	Psychoeducation	PRIVATE			PUBLIC		
		<i>M</i>	<i>SD</i>	<i>RMK</i>	<i>M</i>	<i>SD</i>	<i>RMK</i>
i	My school offers educational materials on mental health, treatment, and guidelines (e.g., documents, videos, websites)	2.17	0.91	<i>D</i>	2.00	0.83	<i>D</i>
j	My school offers information to staff on hospitals managing mental health symptoms.	2.45	0.92	<i>D</i>	2.33	0.92	<i>D</i>
k	My school offers information on stress, mental health and/or available programs.	2.54	0.96	<i>A</i>	2.50	0.95	<i>A</i>
l	My school educates staff on treatment plans and return to work arrangements.	2.54	0.95	<i>A</i>	2.50	0.95	<i>A</i>
m	My school educates families of employees with mental health problems on support services to manage stress and enhance mental wellbeing.	2.39	0.98	<i>D</i>	2.27	0.92	<i>D</i>
n	My school provides access to hotlines to learn support that works.	2.27	0.85	<i>D</i>	2.27	0.86	<i>D</i>
	Weighted Mean	2.39		<i>D</i>	2.31		<i>D</i>

Key: Mean [1.00-1.49 = Strongly Disagree (*SD*); 1.50- 2.49= Disagree (*D*), 2.50-3.49=Agree (*A*), 3.50-4.00= Strongly Agree (*SA*)]

The results in Table 9b showed that the school administrators from both private and public schools in Lagos State agreed that they offer information on stress, mental health, and/or available programs: private ($M=2.54$, $SD = 0.96$), public ($M=2.50$, $SD = 0.95$) and educate their staff on treatment plans and return to work arrangements: private ($M=2.54$, $SD = 0.95$), public ($M=2.50$, $SD = 0.95$). They, however, disagreed that they

offer educational materials on mental health, treatment, and guidelines: private ($M=2.17$, $SD = 0.91$), public ($M=2.00$, $SD = 0.83$); offer information to staff on hospitals managing mental health symptoms: private ($M=2.45$, $SD = 0.92$), public ($M=2.33$, $SD = 0.92$); educate families of employees with MH problems on support services to manage stress and enhance mental wellbeing: private ($M=2.39$, $SD = 0.98$), public ($M=2.27$, $SD = 0.92$), and provide access to hotlines to learn support that works: private ($M=2.27$, $SD = 0.85$), public ($M=2.27$, $SD = 0.86$). Therefore, given the administrators' assessment weighted mean values of 2.39 and 2.31 for private and public schools respectively, it is implied that the school administrators in Lagos State disagree on the existence of psychoeducation as part of preventive care in their various schools.

Table 9c**Descriptive Analysis of Participants' Responses to Items Measuring Anti-Stigma (Advocacy Aspect of Preventive Care) by the Public and Private School Administrative Systems in Lagos State**

S/N	Advocacy	PRIVATE			PUBLIC		
		<i>M</i>	<i>SD</i>	<i>RMK</i>	<i>M</i>	<i>SD</i>	<i>RMK</i>
o	My school makes it easy to seek help for mental health problems when needed.	2.65	0.88	A	2.70	0.84	A
p	My school encourages building and nurturing real-life, face-to-face social connections between employees with mental health problems and other employees.	2.60	0.81	A	2.55	0.82	A
q	My school sets and works towards personal, wellness, and work-related goals.	2.87	0.85	A	2.94	0.80	A
r	My school links staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in seeking treatment.	2.41	0.88	D	2.48	0.89	D
	Weighted Mean	2.63			2.67		

Key: Mean [1.00-1.49 = Strongly Disagree (SD); 1.50- 2.49= Disagree (D), 2.50-3.49=Agree (A), 3.50-4.00= Strongly Agree (SA)]

The results in Table 9c show that the school administrators in both private and public schools in Lagos State agreed that their schools made it easy to seek help for mental health problems when needed: private ($M=2.65$, $SD = 0.88$), public ($M=2.70$, $SD = 0.84$); encouraged the building and nurturing of real-life, face-to-face social connections between employees with mental health problems and other employees: private ($M=2.60$, $SD = 0.81$), public ($M=2.55$, $SD = 0.82$), and set and worked towards personal, wellness, and work-related goals: private ($M=2.87$, $SD = 0.85$), public ($M=2.94$, $SD = 0.80$). However, they disagreed that their schools linked staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in

seeking treatment: private ($M=2.41$, $SD = 0.88$), public ($M=2.48$, $SD = 0.89$). Therefore, given the administrators' assessment weighted mean values of 2.63 and 2.67 for private and public schools respectively, it is implied that the school administrators in Lagos State agree with the existence of advocacy as part of preventive care in their various schools.

Table 9d

Descriptive Analysis of Participants' Responses to Items Measuring Anti-Stigma (Referral/Treatment Aspect of Interventions) Run by the Public and Private School Administrative Systems in Lagos State

S/N	Treatment	PRIVATE			PUBLIC		
		M	SD	RMK	M	SD	RMK
s	My school plans intervention(s) that allow workers to understand the need for treatments, including medication.	2.42	0.90	D	2.56	0.89	A
t	My school promotes outreach programs (assertiveness, learning, social planning, mental health support training), to workers.	2.36	0.83	D	2.36	0.82	D
u	My school overlooks the importance of mental health support groups for staff.	2.11	0.73	D	2.08	0.79	D
v	My school encourages employees to seek mental health treatment.	2.79	0.74	A	2.86	0.79	A
w	My school refers staff to treatment and support.	2.63	0.81	A	2.69	0.91	A
x	My school conducts home visits to monitor staff's progress on their journey to recovery from mental illness.	2.32	0.82	D	2.37	0.79	D
y	My school seeks mental health professional support on behalf of staff	2.18	0.79	D	2.27	0.85	D
z	My school offers support services to link staff to mental health resources, including local support groups.	2.21	0.83	D	2.39	0.87	D
aa	My school provides continuous support during and after recovery from mental illness.	2.43	0.86	D	2.59	0.90	A
	Weighted Mean	2.38		D	2.46		D

Key: Mean [1.00-1.49 = Strongly Disagree (SD); 1.50- 2.49= Disagree (D), 2.50-3.49=Agree (A), 3.50-4.00= Strongly Agree (SA)

The results in Table 9d show that the school administrators in both private and public schools in Lagos State agreed that their schools encouraged employees to seek mental health treatment: private ($M=2.79$, $SD = 0.74$), public ($M=2.86$, $SD = 0.79$) and referred staff to receive treatment and support: private ($M=2.63$, $SD = 0.81$), public ($M=2.69$, $SD = 0.91$). They however disagreed that their schools promoted outreach programs (assertiveness, learning, social planning, MH support training) to workers: private ($M=2.36$, $SD = 0.83$), public ($M=2.36$, $SD = 0.82$); overlooked the importance of MH support groups for staff: private ($M=2.11$, $SD = 0.73$), public ($M=2.08$, $SD = 0.79$); conducted home visits to monitor staff's progress on their journey to recovery from mental illness: private ($M=2.32$, $SD = 0.82$), public ($M=2.37$, $SD = 0.79$); sought MH professional support on behalf of staff: private ($M=2.18$, $SD = 0.79$), public ($M=2.27$, $SD = 0.85$) and offered support services to link staff to MH resources, including local support groups: private ($M=2.21$, $SD = 0.83$), public ($M=2.39$, $SD = 0.87$). Interestingly, while the school administrators in private schools disagreed that their schools planned intervention(s) that allow workers to understand the need for treatments, including medication ($M=2.42$, $SD = 0.90$), and provided continuous support during and after recovery from mental illness ($M=2.43$, $SD = 0.86$), their public school counterparts agreed their schools planned intervention(s) that allow workers to understand the need for treatments, including medication ($M=2.56$, $SD = 0.89$), and provided continuous support during and after recovery from mental illness ($M=2.59$, $SD = 0.90$). Therefore, given the administrators' assessment weighted mean values of 2.39 and 2.46 for private and public schools respectively, it is implied that the school administrators in Lagos State agreed with the existence of referral/treatment as part of MH interventions in their various schools.

The summary of results for the available service systems for anti-stigma that school provides through collaborative strategies in the private and public education sectors in Lagos State is presented in Table 9e.

Table 9e

Available Service Systems for Preventive Care and Interventions (Anti-Stigma Measures) that Schools Provide through Collaborative Strategies in the Private and Public Education Sectors in Lagos State

S/ N	Anti-Stigma Interventions	PRIVATE		PUBLIC	
		Weighted Mean	RMK	Weighted Mean	RMK
A	Information	2.63	A	2.61	A
B	Psychoeducation	2.39	D	2.31	D
C	Advocacy	2.63	A	2.67	A
D	Treatment	2.38	D	2.46	D

The results in Table 9e show that the school administrators in the public and private schools in Lagos State unanimously agreed on the availability of information and advocacy as anti-stigma interventions in their various schools but disagreed on the availability of psychoeducation and treatment as anti-stigma interventions. This result therefore implied that schools in Lagos State placed more value on information and advocacy as service systems for anti-stigma strategies. For better understanding of this analysis, FMOH (2019b) categorized information accessibility, psychoeducation and advocacy as preventive care while categorizing treatment (counselling) and referral as interventions. Thus, not all variables described as preventive care as observed are actively pursued in both education sectors in Lagos State.

Research Question 4. *To what extent do the workplace supportive measures enable the promotion of an accommodating environment for the employees of mental health service users?*

A multiple regression analysis was performed to answer research question 4 using the school administrators' cumulated scores of four sub-scales representing the predictors (IVs). For clarity, (subscale 27- denotes information and has eight items), subscale 28 denotes psychoeducation with six items), (subscale 29- advocacy with four items), 30 (subscale 30-

represent referral/treatment). Item 31 to 44 measuring commitment is a composite variable and represents the outcome variables (DV). The main effect of institutional type (school sector) was also determined. The school sector variable was dummy coded as 0 and 1 where public was coded [0], and private was coded [1]. The interaction terms were calculated for institutional type with each of information, psychoeducation, advocacy and referral/treatment scales, and were included as independent variables. The four predictors were first mean centred before the computation of the product terms that represent the interaction. Mean centring helps simplify interaction terms and interpretation of the main effects and makes the regression model's intercept more meaningful. The mean centring entailed subtracting the mean of each predictor from each case. The mean centring in multiple regression reduces the possibility of multicollinearity between the product and the constituting terms of interaction (Hayes, 2020). The result of the multiple regression analysis is presented in Table 11.

Before the regression analysis, preliminary data analyses were conducted to check missing values and outliers. Also, the test of normality, along with multicollinearity, was conducted. To check missing values on the dataset, descriptive analysis of frequency and percentage was carried out. The normality was tested via skewness and kurtosis, while the multicollinearity test was performed by running intercorrelations among the variables. The results of normality and multicollinearity tests are presented in Tables 10a and 10b.

Table 10a:

Indices of Normality for the Variables in the Regression Analysis

Variables	Skewness	Kurtosis
Commitment	-.54	-.14
Information	-.51	-.12
Psycho-Education	.02	.07
Advocacy	.12	.87
Treatment	.29	.64

As shown in Table 10a, all the variables manifested a normal distribution as none of the values for skewness and kurtosis is higher than ± 3 as recommended by Stevens (2002).

Table 10b

Intercorrelations among Variables in the Regression Analysis

	Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5
1	Commitment	47.10	12.21	-				
2	Information	19.63	4.94	.080	-			
3	Psychoeducation	13.35	3.95	.148*	-.037	-		
4	Advocacy	10.58	2.06	.212**	.177*	.106	-	
5	Treatment	22.46	4.48	.160*	.154*	.120	.744**	-

* $p < .05$, ** $p < .01$

The results in Table 10b show that none of the predictor variables is highly correlated to suggest any evidence of multicollinearity. When any of the independent or predictor variables are highly correlated, that is. $r = 0.9$ and above, it suggests the existence of multicollinearity (Pallant, 2011; Tabachnick & Fidell, 2018). This result suggests that none of the variables exceeds 0.74. The minimum and maximum correlation coefficients respectively are - 0.04 and 0.74. In other words, all the predictors' variables are moderately correlated, and this suggests the absence of multicollinearity among the variables (See Appendix N for more on assumption testing).

Table 11

Summary of Regression Analyses of Schools' Performance in Committing to Preventive and Intervention Services (Anti-Stigma) in Private and Public Schools in Lagos State (N = 178)

Variable	<i>B</i>	<i>SEB</i>	β	<i>t</i>	<i>p</i>
(Constant)	49.431	1.586		31.164	.000
Sector_Dummy	-4.261	1.925	-.163	-2.213	.028
Information	.406	.351	.161	1.157	.249
Psychoeducation	.083	.416	.027	.199	.842

Advocacy	.736	1.043	.124	.705	.482
Treatment	.600	.479	.221	1.251	.213
Sector*Information	-.367	.416	-.123	-.881	.379
Sector*Psychoeducation	.468	.499	.125	.937	.350
Sector*Advocacy	1.346	1.340	.184	1.004	.317
Sector*Treatment	-1.271	.614	-.380	-2.071	.040
<i>R</i>		.372			
<i>R</i> ²		.138			
<i>AdjR</i> ²		.091			
<i>F</i>		2.893*			

* $p < .05$ ($p = .003$) Dependent Variable: Performance; Sector (Institutional Type)

The results in Table 11 show the result of the four workplace supportive measure variables and explains 13.8% of variance in the schools' commitment, ($R^2 = .138$, $F_{(6,162)} = 2.893$, $p < .05$). It was also discovered that none of the main predictor variables significantly predicted commitment: information ($\beta = .16$, $p > .05$); psychoeducation ($\beta = .02$, $p > .05$); advocacy ($\beta = .12$, $p > .05$), and treatment ($\beta = .221$, $p > .05$). Also, the mean of DV (schools' commitment) after controlling for the other independent variables is ($M = 45.63$, $SD = 12.81$). It was observed that school type (sector dummy) influences schools' delivery of preventive and interventions (anti-stigma programs) more positively in public schools. However, school-type significantly predicted the outcome variable, and a significant interaction effect of sector and treatment was observed ($\beta = -.380$, $p < .05$). Given the value of β $-.380$ this shows an inverse relationship. It implies that the commitment to treatment reduces stigma and differs depending on the school sector. Public schools has the higher treatment mean score ($M = 22.46$, $SD = 4.48$) than private schools ($M = 22.24$, $SD = 4.43$). suggests that treatment explains commitment significantly more in public schools than private schools in public schools than in private schools. Note that, in the regression equation, these means are adjusted for the independent variables.

Given regression equations of:

$$y = a + b_1x_1 + b_2x_2 + b_3x_3 + b_4x_4 + b_5(x_{_1}) + b_6(x_{_2}) + b_7(x_{_3}) + b_8(x_{_4}) + \varepsilon$$

y = Outcome (level of commitment)

a = Intercept on the Y axis (value of x when $y=0$)

$b_1 - b_4$ = Regression slope for the four main predictors

$b_5 - b_8$ = Regression slope for interactions of sector (institutional type) and the four main predictors

Predictors= Inf (information), psy. (psychoeducation), adv.(advocacy), tre (treatment)

ε = the residual error between x and y .

Therefore,

$$y = 49.4 + .41x_1 + .08x_2 + .74x_3 + .60x_4 - .37x_{_1} + .47x_{_2} + 1.35x_{_3} - 1.27x_{_4}$$

The multiple linear regression model shows that only treatment among the four predictors contribute to the model. As revealed, the base level of schools' levels of commitment is 49.4, when information (x_1) increases by one-unit, it is associated with an observed (0.41) in the level of commitment to anti-stigma services. The interaction terms effect of each predictor on DV (commitment to treatment) is linear. Thus, the negative coefficient values for interaction terms (x_1^2 and x_4^2) indicates that the treatment has a stronger or more positive effect in Public school (School type = 0) compared to Private school (school type = 1).

4.3. Testing of Research hypothesis

Ho. There is no statistically significant difference in the structure of relationships and strategies adopted by private and public education sectors to promote mental health inclusion.

H1. There is a statistically significant difference in the structures and strategies adopted by private and public education sectors to promote mental health inclusion.

Before executing the Multivariate Analysis of Covariance (MANCOVA), data were screened, and descriptive analyses were conducted. Scatter plots and boxplots provided a visual representation of the variables; multivariate (structure of strategic alliance variable) has three

outliers, four outliers were noted in anti-stigma programs that serve as strategies variables. When items were further crosschecked, individually, this pattern was similar across responses from private sectors. Also, the values still fell within the expected score range for the two subscales. Hoaglin and Iglewicz's (1987) rules of observation of the lower and upper quartile of a sample which suggested 1.5 value as a threshold to consider cases as outliers were adhered to. Five subscales formed the structure of relationships; collaboration had nine items scored on a 4-point Likert Scale. The possible scores were aggregated; the lowest and the highest possible scores were between 9 and 36. Thus, the 15.5 score as an outlier fell within the possible score range. A similar pattern was observed in treatment with nine items. The possible scores for the subscale were between 9 and 28, and the case of outliers had a value of 20.5. Advocacy has four items with possible range scores of 4 and 16 and outliers of between 4.5 and 16.

For this analysis, these values were omitted, reducing the sample size to 175 (Public schools were 57, while private schools 118). Though it reduced the sample, it did not adversely impact the power of the test. The descriptive statistics results for the structure variable were M, 74.4; SD, 10.55; Kurtosis, 1.2, and skewness, -.167. Strategy was M, 66.18; SD, 9.6; Kurtosis, .76, and Skewness, .26. Also, Steven (2002) suggested a Kurtosis value +/-3 for a normality assumption of a large sample size. Hence, it is considered that the assumption was not violated. Based on Levene's test, the intercorrelation was considered satisfactory. The Box's test was checked: the p-value was .794 at $\alpha = 0.05$; the value implies that the assumption of equality of covariance was met (see appendix O for assumptions testing for univariates and multivariate).

A One-Way Multivariate Analysis of Covariance (MANCOVA) was conducted to investigate the difference in the structure of relationships and methods of anti-stigma measures adopted in public and private schools. The composite variables form the two dependent variables in the analysis. The first DV is structures of relationships (with five sub-components: networking, cooperation, coordination, coalition, and collaboration), and the second DV is anti-

stigma strategies (with four sub-components: information, psychoeducation, advocacy, and treatment/referral). The independent variable is school types (public and private schools), and the socioeconomic indicator of the school areas represents the covariate. At the outset of the study, two covariates were included in the proposal (socioeconomic and presence of NGOs in the school areas). However, during the analysis, presence of NGOs was excluded because they have no significant contribution to the findings, and the outcome was the same across the three study areas.

Table 12a

Multivariate Tests of Difference in the Structures and Strategies Adopted by Private and Public Schools to Promote Mental Health Inclusion

Effect	Value	F	Hypothesis df	Error df	p	η	
Intercept	Pillai's Trace	.898	731.987	2.000	166.000	.000	.898
	Wilks' Lambda	.102	731.987	2.000	166.000	.000	.898
	Hotelling's Trace	8.819	731.987	2.000	166.000	.000	.898
	Roy's Largest Root	8.819	731.987	2.000	166.000	.000	.898
Socio_Ec onomic	Pillai's Trace	.013	1.086	2.000	166.000	.340	.013
	Wilks' Lambda	.987	1.086	2.000	166.000	.340	.013
	Hotelling's Trace	.013	1.086	2.000	166.000	.340	.013
	Roy's Largest Root	.013	1.086	2.000	166.000	.340	.013
Sector	Pillai's Trace	.048	4.161	2.000	166.000	.017	.048
	Wilks' Lambda	.952	4.161	2.000	166.000	.017	.048
	Hotelling's Trace	.050	4.161	2.000	166.000	.017	.048
	Roy's Largest Root	.050	4.161	2.000	166.000	.017	.048

η = Eta Squared (Effect Size)

The results in Table 12a show a one-way between-group multivariate analysis of covariance conducted to determine the difference in the structures and strategies of the networks adopted by private and public schools to promote mental health inclusion in Lagos State. The dependent variables in this analysis were structures and strategies of the networks adopted. The independent variable was the sector the schools belong to (private and public), while the socio-economic variable measure was used as covariate. The result showed that there is a statistically significant main effect of a sector on the combined dependent variables after controlling for covariate, $F(2, 166) = 4.16, p < .05$; Pillai's Trace = .05; partial $\eta^2 = .05$. that is, models implementation (structures and strategies) statistically significant different between private and public sectors. The school sector was able to account for 5% of the observed variance noticed in the dependent variable. This is a small effect size, according to Cohen (1988). Since p value is less than .05, the stated null hypothesis is rejected. Therefore, this result implies that there is a significant difference in the MH structures and strategies adopted by private and public schools in connecting with MH agencies. The effect of the intercept is statistically significant, with a strong effect size (Roy's Largest Root = 8.819), as confirmed by the significant F-statistic (731.987) and the p-value (0.000), which is less than the alpha level of 0.05; indicating that the IV's effect (school type) is strong to impact on the outcome. This implies that the model explains a large portion of the variation in the data. The intercept explains the variation in the dependent variables as significant therefore a univariate analysis is required to determined which of our dependent variables makes a higher significant contribution. The results of the Univariate analysis of each dependent variable are presented in Table 12b.

Table 12b***Univariate Tests of Between-Subjects Difference in the Structures and Strategies of the Networks Adopted by Private and Public Schools to Promote Mental Health Inclusion***

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	<i>p</i>	η^2
Corrected Model	Structures	1128.37	2	564.18	5.29	.01	.060
	Strategies	123.08	2	61.54	.67	.52	.008
Intercept	Structures	103381.89	1	103381.89	969.18	.00	.853
	Strategies	74025.24	1	74025.24	802.30	.00	.828
Socio-Economic Sector	Structures	230.88	1	230.88	2.16	.14	.013
	Strategies	2.37	1	2.37	.03	.88	.000
	Structures	858.56	1	858.56	8.05	.01	.046
	Strategies	119.11	1	119.11	1.29	.26	.008
Error	Structures	17813.89	167	106.67			
	Strategies	15408.41	167	92.27			
Total	Structures	960638.06	170				
	Strategies	755919.50	170				
Corrected Total	Structures	18942.26	169				
	Strategies	15531.49	169				

The results in Table 12b show that the dependent variables were considered separately. To reduce the chance of committing a Type 1 error, most especially, when a series of separate analyses were performed, the Bonferroni adjustment was adopted. This was done by dividing the original alpha level of .05 by 2 (number of dependent variables: structures and strategies) which gave a new alpha level of 0.03 (Tabachnick & Fidell, 2007, p.270, Pallant, 2011, p.295). The new statistical significance, using a Bonferroni adjustment alpha of 0.03 was structures, $F(1, 167) = 8.05, p = .01; \eta^2 = .05$ with respective mean: private ($M = 72.85, SD = 10.74$), public ($M = 77.64, SD = 9.53$). This outcome suggests that school administrators in public schools rated the level of existing structures of the networks adopted to promote mental health inclusion significantly higher than their counterparts in private schools. Furthermore, a Univariate

analysis was performed to detect the specific aspect of the structures where the significant difference existed among the five structures of networking, cooperation, coordination, coalition, and collaboration. The result is presented in Table 12c.

Table 12c

Univariate Tests of Between-Subjects Difference in the Structures of the Networks Adopted by Private and Public Schools to Promote Mental Health Inclusion

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	<i>p</i>	η
Corrected Model	Networking	293.72	2	146.86	5.18	.007	.057
	Cooperation	141.30	2	70.65	5.47	.005	.060
	Coordination	69.37	2	34.68	2.42	.092	.027
	Coalition	6.29	2	3.15	.37	.692	.004
	Collaboration	91.19	2	45.59	2.89	.058	.033
Intercept	Networking	9988.48	1	9988.48	352.36	.000	.672
	Cooperation	3665.67	1	3665.64	283.81	.000	.623
	Coordination	3286.94	1	3286.94	229.23	.000	.571
	Coalition	2493.42	1	2493.42	291.96	.000	.629
	Collaboration	3326.39	1	3326.39	211.31	.000	.551
Socio_Economic	Networking	288.95	1	288.95	10.19	.002	.056
	Cooperation	24.38	1	24.38	1.89	.171	.011
	Coordination	16.58	1	16.58	1.17	.284	.007
	Coalition	1.99	1	1.99	.23	.630	.001
	Collaboration	15.19	1	15.19	.97	.327	.006
Sector	Networking	1.84	1	1.84	.07	.799	.000
	Cooperation	121.88	1	121.88	9.44	.002	.052
	Coordination	49.84	1	49.84	3.48	.064	.020
	Coalition	4.02	1	4.02	.47	.494	.003
	Collaboration	79.15	1	79.15	5.03	.026	.028
Error	Networking	4875.71	172	28.35			
	Cooperation	2221.55	172	12.92			
	Coordination	2466.35	172	14.34			
	Coalition	1468.94	172	8.54			

	Collaboration	2707.61	172	15.742
	Networking	76273.75	175	
	Cooperation	43881.25	175	
Total	Coordination	30687.86	175	
	Coalition	25232.50	175	
	Collaboration	39766.75	175	
	Networking	5169.43	174	
Corrected	Cooperation	2362.85	174	
Total	Coordination	2535.72	174	
	Coalition	1475.24	174	
	Collaboration	2798.79	174	

The results in Table 12c showed that the dependent variable of structures with five (5) sub-scales were considered separately. To reduce the chances of committing a Type 1 error, most especially, when a number of separate analyses are performed, the Bonferroni adjustment was adopted. This was done by dividing the original alpha level of .05 by 5 (number of sub-scales) which gives a new alpha level of 0.01 (Tabachnick and Fidell, 2007, p. 270, Pallant, 2011, p.295). The difference that reached statistical significance, using a Bonferroni adjustment alpha of 0.01, was cooperation, $F(1, 172) = 9.44, p = .002; \eta = .05$, with respective mean: private ($M = 14.84, SD = 3.54$) and public ($M = 16.58, SD = 3.74$). This outcome suggests that school administrators in public schools rate the level of existing cooperation with other agencies to promote mental health inclusion for employees significantly higher than their counterparts in private schools.

4.4. Summary of the Findings

Research Question 1. *What are the structures of relationships designed for anti-stigma interventions by the public and private school administrative systems in Lagos State?*

Research question one sought to find out the structures of relationships for MH inclusion in the public and private schools in Lagos State. The study revealed that this structure of relationships is not fully promoted in public and private schools in Lagos State. At the

networking, coordination, and coalitions levels, the observed activities in each phase are the same in the two sectors. Although differences are observed in the degree of public schools' involvement at the levels of cooperation and collaboration, such observed differences do not account for meaningful interaction between the schools and the NGOs. Public school administrators rarely interact with the NGOs and the absence of community MH workers relationship with schools are noted. There is a complete absence of relationships between the state agencies (the Ministry of Health, and the School Education Board), and private schools on MH issues. The lack of guidance, directives and training were reported in the private schools. Although school administrators in the public schools received occasional guidance, NGOs' roles in MH inclusion in schools are observed but not sufficient to lead to a greater commitment and lasting bonds capable enough to foster mutually beneficial relationships in promoting MH inclusion.

Schools' administrators responses in both private and public sectors about each structure were noted. In the aspect of networking, school administrators lack capacity to integrate MH frameworks into the school's community; MH support workers are lacking in schools. In private schools, MH social workers and other support workers are employed. Understandably, both material and financial support for MH promotion and inclusion are lacking in both sectors. Private schools never received timely material/financial support from any agencies, their public schools' counterparts often received timely material/financial support from agencies that promote MH. The notion of relationship building in MH appears lost in private schools as revealed in their comments to the qualitative research questions.

Also, the expected structure of cooperative relationship appears less active, the private school administrators do not receive timely guidance from the Ministry of Health, while their public-school counterparts agreed that their schools occasionally received timely guidance from the Ministry of Health. The highest phase of the collaborative structure is missing in the

private sectors. The findings therefore suggest a lack of expected structures of relationships designed for anti-stigma interventions by the public and private schools' administrative systems in Lagos State.

Research Question 2. *What is the level of support that the school receives in the implementation of anti-stigma program(s) for MHSUs' employees in private and public schools?*

Research question 2 was raised to determine the level of support that the school receives in the implementation of anti-stigma program(s) targeting accommodation for MHSUs' employees in private and public schools. Findings revealed that the school administrators in private schools rated the level of support received by the school in this regard as poor, while their counterparts in public school rated it as fair. Specifically, in terms of Lagos State's provision of periodic MH information and dedication to championing well-being and mindfulness programs, both the private and public-school administrators were unanimous in their assessment and these two responsibilities were rated as fair. Overall, the outcome suggests a lack of uniformity in the support that private and public schools received towards the implementation of anti-stigma program(s) targeting accommodation for MHSUs' employees in Lagos State. Findings suggest that public schools in Lagos State received more attention than their private counterparts in terms of the support received for the implementation of anti-stigma program(s) targeting accommodation for MHSUs' employees.

Research Question 3. *What are the available service systems for anti-stigma that schools provide through collaborative strategies in the private and public education sectors?*

Research question 3 was raised to find out the available service systems for anti-stigma that schools provide through collaborative strategies in the private and public education sectors in Lagos State. The findings revealed that the public and private school administrators in Lagos State unanimously agreed on the availability of information and advocacy as anti-stigma

interventions in their various schools but disagreed on the availability of psychoeducation and treatment aspects.

Specifically, while the assessment scores of both private and public-school administrators suggest availability of information and advocacy services as part of anti-stigma interventions on the one hand, and non-availability of psychoeducation and treatment on the other, some discrepancies were observed in the treatment service tasks. Equally, private schools disagreed that they plan intervention(s) that allow workers to understand the need for treatments, including medication, and that they provide continuous support during and after recovery from mental illness. Whereas they agreed that they have been complying with these two treatment tasks mentioned. The findings therefore suggest that schools in Lagos State place more value on information and advocacy as service systems for anti-stigma strategies.

Research Question 4. *To what extent do the schools' inclusive strategies enable inclusion of MHSUs' employees?*

Research question 4 was raised to determine the extent to which workplace supportive measures enable inclusion in the private and public schools in Lagos State for MHSUs. The findings revealed variance in the effectiveness of inclusive strategies for MHSUs in private schools, ($R^2 = .138$, $F(6,162) = 2.893$, $p < .05$) combinedly. As indicated, single handedly, none of the main predictor variables significantly predicted MH inclusion: information ($\beta = .16$, $p > .05$); psycho-education ($\beta = .02$, $p > .05$); advocacy ($\beta = .12$, $p > .05$), and treatment ($\beta = .221$, $p > .05$). However, school sector significantly predicted the outcome variable and also a significant interaction effect of sector and treatment was observed ($\beta = -.380$, $p < .05$). It implies that the influence of treatment differs depending on the school, more so, treatment tends to be beneficial to the public school compared to the private schools. In short, combinedly, the four predictors could only account for 13% observed variation in stigma reduction in schools but independently none of the predictors significantly influenced the outcome variable. The

conclusion that can be drawn from these results is that there is possibility of other variables outside the measured variables influencing the outcome variable, hence, suggesting the need for further study.

Hypothesis

Ho. There is no statistically significant difference in the structures and strategies adopted by private and public sectors to promote mental health inclusion.

H1. There is a statistically significant difference in the structures and strategies adopted by private and public sectors to promote mental health inclusion.

The research hypotheses in this study aimed at examining the possibility of a significant difference or otherwise in the structures and strategies adopted to promote inclusion for MHSUs' employees by private and public schools in Lagos State. The findings revealed a significant difference in the structures of the networks adopted by private and public schools in connecting with other agencies to promote MH inclusion, $F(5, 168) = 3.73, p < .05$; Pillai's Trace = .10; partial $\eta^2 = .10$. The school sector accounted for 10% of the observed variance noticed in the structure of the relationship adopted for connecting with other agencies to promote inclusion for MHSUs' employees. However, after adopting a Bonferroni adjustment, a significant difference was only observed at cooperation level $F(1, 172) = 9.44, p = .00; \eta = .05$. The level of existing cooperation with other agencies in promoting inclusion for MHSUs' employees was found significantly higher among the public schools than their private counterparts in Lagos State. Therefore, the null hypothesis which states that there is no statistically significant difference in the structures and strategies adopted by private and public schools to promote inclusion MHSUs' employees was rejected.

On the other hand, the findings revealed that there was no significant difference in the anti-stigma strategies adopted by private and public schools to promote inclusion for MHSUs employees in Lagos State, $F(4, 166) = 0.43, p > .05$; Pillai's Trace = .01; partial $\eta^2 = .01$. The

school sector accounted for only 1% of the observed variance noticed in the anti-stigma strategies adopted to promote inclusion. The stated null hypothesis is therefore upheld. The findings imply that the anti-stigma strategies adopted by private and public schools to promote inclusion for MHSUs' employees in Lagos State were at the same level.

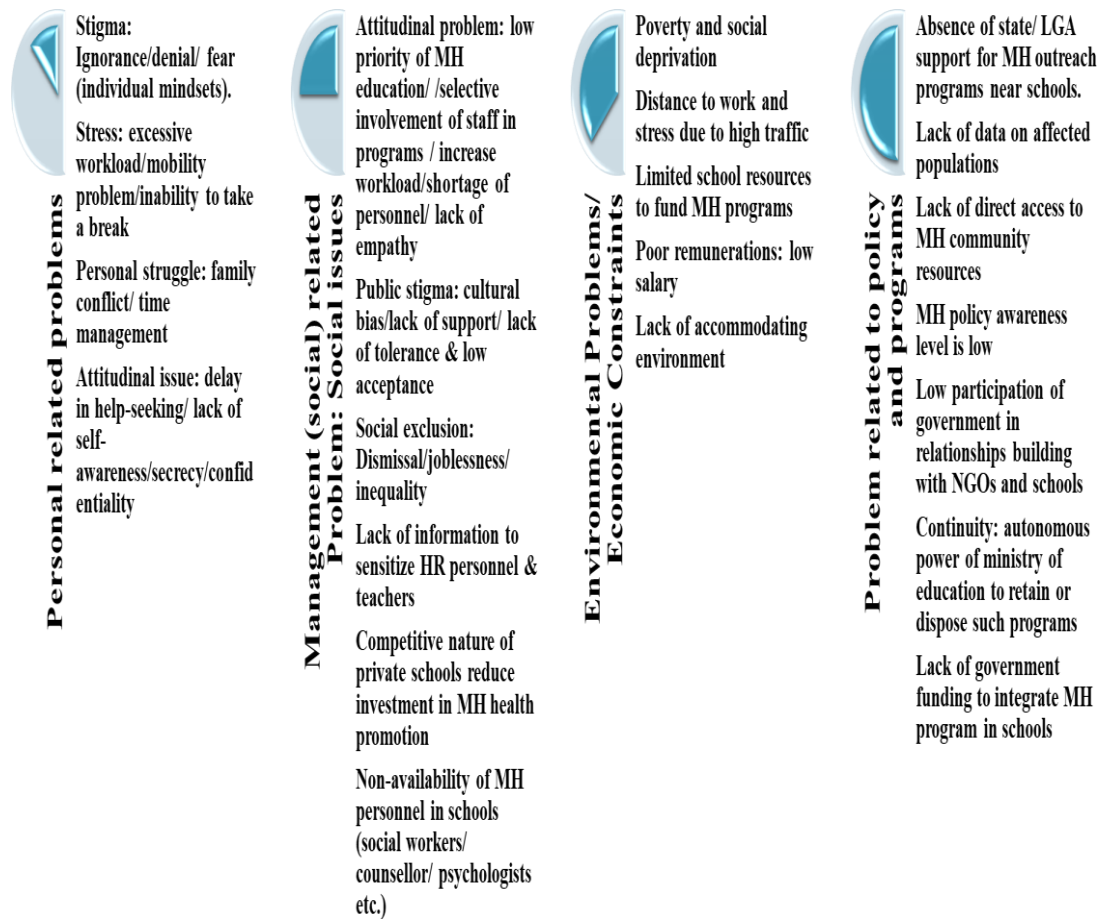
For better comprehension of participants' responses to hypothesis testing of strategies and structures of promoting MH programs in Lagos State, an additional qualitative question was included in the survey questionnaire. A question on each participant's view of a greater challenge to mental health promotion was raised. The result of the analysis is presented below to corroborate the quantitative results.

4.5. Analysis of the qualitative data

A thematic analysis was applied to analyse the qualitative data raised in the survey forms. At the initial phase, an open coding was used to identify participants' divergent and convergent views. Participants' thoughts were separated based on their LGAs and the education sector. A numeric value was introduced to signify the number of participants who shared similar views in the same LGA/and school sector in a tabular format. The essence of meaning is paramount in a qualitative study; thus, experience and observation during data collection also shaped this interpretation to corroborate the quantitative aspects of this study. The results were integrated into the discussion chapter to illustrate participants' responses which further help in clarifying participants' responses and the findings (Creswell et al., 2003; Naeem, 2023). Analysis of the additional qualitative questions are reported below.

- a. What would you consider as greatest challenges to mental health promotion in workplaces?**

Fig. 6: Challenges to mental health promotions in schools.



Four divergent views emerged during the analysis. These are: personal related problems, school (social) related problems, environmental and economic constraints, and policy and programs related issues.

- 1. Personal related problems:** Self-stigma (mental illness is a hidden identity) and attitudinal problems were identified as major setbacks to MH promotion and service utilization. These manifest in the form of ignorance, denial, fears, and secrecy which often influence health-seeking behaviour of the employees (teachers) in seeking timely support and treatment. As observed in the comment below:

“The greatest challenge is the stigma attached to admitting to having mental health issues. People living with mental health issue always keep problems within themselves without seeking for assistance. Staff suffering from mental health issues are not ready to discuss it with other people therefore, mental health cases among staff are hidden from others.”

The fear of dismissal once an employee declares his/her MH state seems more critical to administrators in private schools than their counterparts in public schools. As noted in a participant’s response.

Private: *“Failure of employees to discuss or disclose their mental health status is because of the fear of being dismissed.”*

In addition, excessive workload was identified as part of the stressor that can exacerbate MH problems among teachers. Some factors attributed to this issue as noted in the scripts are understaffing which increases staff work and poor transportation system to the workplace.

“Workloads and stress levels in some workplaces can exacerbate mental health issues, balancing productivity with mental health support is a challenge.”

Also, family conflicts and lack of time management were categorized under personal struggles and described as disabling factors for the MH of teachers. Both administrators in private and public schools seemingly agreed that excessive workload greatly impacts their mental health. However, participants from private schools essentially admitted that poor remuneration is also a major issue to maintain a good balanced diet and live a comfortable life.

2. **School management** (social) related problems include attitudinal problems, public stigma, social exclusion, lack of information, private school unhealthy competition, and lack of MH personnel in school/MH resources near the school.

Attitudinal problems: This was coded broadly to encapsulate both personal and organizations’ focus which often influences employers’ direction on what to invest on. The researcher merged

these two divergent thoughts because personal experience or close proximity as revealed in Owadara's (2021) study can influence an individual's concern for promoting MH. Participants noted that employers (in private schools) are generally profit-oriented and may not entirely prioritize programs that run contrary to such goals.

".... employees do not feel like they can open up about their feelings, employers focus on business and profits than employees' welfare and office politics."

Another participant in the private sector commented as follows. *"My workplace will never allow anyone with mental health problems to work as an employee."*

Public stigma emerged as a problem influencing management response to MH promotion. Essentially, linguistic, cultural stigma, and bias are suggested as affecting support for MH promotion.

".... The greatest challenges to mental health [is] cultural and linguistic barriers and can be difficult to overcome; the larger populations of the society, even my schools are passive about it."

Lagos state is a cosmopolitan state with more than 22 million people, according to a World Bank report (2020). Diverse ethnic groups hold divergent views on how MH is viewed and discussed (Jegede, 2005). This may have significant impact on attitude, beliefs, and perception about the notion of acceptance and inclusion. As noted in participants' comments, lack of support from schools and colleagues influences MH promotion in schools as commented below.

"Our workplace...A toxic workplace that factors bullying, harassment or abuse, lack of training or guidance for the role you are expected to fulfill. Unclear or limited communication from management or lack of it."

In addition to the statement, the researcher's observation while commuting to the study areas revealed the state of MH among the public. She perceived the absence of empathy, especially

for persons living with such experience. She witnessed passengers' disdainful comments when discussing a man who was reportedly dumped by the roadside by his family. There seems to be a consensus among the passengers on the bus that most cases of mental illness arise from 'one's own wrongdoing'; they suggested that mental illness is a self-inflicted problem. Such a dangerous perception may impact the acceptance/rejection of MHSUs and the level of support for such individuals.

3. Environmental and economic constraints

Participants expressed their views on problems inherent in the environment and economic constraints as challenges to MH promotion.

Social exclusion and public notion on MH can foster exclusion and shift employers' focus. Hence, a reduction in economic and social participation as commented by a participant can exacerbate mental illness.

"Poverty and social deprivation affect mental health."

Importantly, mobility problem due to high traffic in Lagos State and low remuneration make commuting between home and work extremely difficult for teachers. Participants also noted poor diet among teachers as a problem.

"I consider hectic traffic 'to and fro' from work,' 'poor salaries/wages and poor diet as a serious challenge to mental health."

These views are similarly expressed by both public and private school administrators. Importantly, administrators in private schools are more concerned about the low wages than their public counterparts.

Lack of an accommodating environment can also be termed social exclusion. The absence of a supportive environment may not be entirely due to a deliberate attempt or oversight by policy makers and implementers but rather resistance to change on the part of the public, which is another issue that is worth exploring in future studies.

4. Problem related to policy and programs

Lastly, participants in both private and public schools identified policy and program-related issues as inimical to MH health promotion in Lagos State. Some of the problems identified are absence of state/LGA support to promote MH outreach programs near schools, lack of data on the affected population to influence quality of support services and care, lack of direct access to community MH resources, low participation of government in strategic relationship building with NGOs, lack of continuity, use of discretion, and lack of government funding to integrate MH programs in schools. These are further explained below. Participants in both private and public sectors highlight the absence of state/LGA support to promote MH outreach programs close to schools.

“Non-availability of mental healthcare centres near school or in the community.”

In particular private and public-school administrators indicated less communication between the government and the private sector, as indicated by a participant below.

“No relationship between government and school owners.”

Participants mentioned lack of information and absence of data about MHSUs in influencing the quality of support and care they receive.

“There is little awareness about mental health and insufficient data to guide mental health programs.”

Participants in public schools indicated lack of direct access to community MH resources as a challenge to MH promotion in the school areas. They however agreed that to some extent schools with similar cases often networked with one another to support their staff.

“... the state government do not have much or adequate concern toward the welfare of staff to provide mental health care programs. Schools with similar cases take care of their victims.”

However, a participant expressed concern about the lack of support and continuity of such services where available; it is usually based on the management's discretion. The participant cited a particular sordid experience managed by her previous school. When the individual was transferred to another school, the new school lacked the background knowledge about the history and nature of support available to the individual. Consequently, the ailment could not be managed, and it led to a major crisis.

“...to simply put it, we have not come to that stage.... Something of this nature happened to a close colleague in my previous school and was promptly addressed by the school director and other colleagues rallied around her because we know the on-set of the disease. However, when the ministry transferred her to another school, the support was no longer available. ... she was not managed well, and the problem escalated.”

In addition, low participation of government in strategic relationship building with schools and NGOs are identified. Two emergent views were noted in response to questions on challenges to MH promotion in the education sector. While participants in the private sector articulate the lack of relationships between the state and the private schools, public administrators' focus is on government relations with NGOs in promoting MH in schools.

Private: “No relationship between the government and school owners.”

Public: “No existence of relationship building among NGOs, State, and federal agencies to stop discrimination.”

More so, lack of continuity, uniformity, and use of discretion are stated as some of the major challenges confronting MH promotion in public schools.

Public: “...mental health awareness, evaluation, and continuity is lacking. Inflexibility in work arrangements.”

Private: “The greatest challenge is the lack of communication from the government to schools and other bodies.”

As noted, it was clear that communication between the government, private schools, and NGOs is non-existent. Participants' comments crystalized the result of the hypothesis; it revealed why the absence of structure of strategic alliance is lacking. The supportive system to guide its implementation is not always there. A few public schools who affirmed receiving seminars or workshops from NGOs also affirmed that their schools' goals and that of the NGOs do not align. Hence the notion of 'shared value' and integration is lost in such arrangements.

Lastly, the lack of government funding to integrate MH program in schools is another factor. Although, private school administrators expressed concerns about the lack of MH awareness and overwhelming workload, none mentioned programs continuity.

Public: "Fund/ Individual and government's laissez-faire attitudes affect programs delivery...government and non-governmental agencies should fund every move to ameliorate the suffering or challenges of MHSUs from mental health related issues."

Private: "Government is not doing much to promote mental health programs. Secondly, not so many schools have been informed or are aware of MH programs."

From the foregoing, participants suggested that issues affecting MH inclusion are cumbersome and should not be narrowed down to a single factor. These identified factors are intertwined as evidently demonstrated in the findings. When school administrators recognized the non-existence of certain strategies and structures in promoting MH in schools, this does not necessarily mean that the factors responsible for such absence are solely management/employers' shortcoming or misalignment with their organizations' goals. However, workers' relationships and resources can hinder acceptance and investment in such inclusive programs as indicated by a participant *'lack of support and encouragement from co-workers, lack of financial assistance. Sometimes moral support is not readily available.'*

Another crucial issue in this analysis is that most causes of stigma and indecision in promoting MH programs are interwoven and interrelated. These issues are both 'personal

public' related issues because 'ignorance' stems from inadequacy or 'lack of information' which increases secrecy and fear of discrimination. Ignorance is not just a personal issue for MHSUs; school management may also lack in-depth knowledge of MH problems, their causes, and preventions. This can increase disinterestedness in embracing and promoting such programs. As evident in this report "*some employers may not welcome such discussions at all.*" because "*many organizations may have limited resources dedicated to mental health. Modern workplaces often come with high demands and long hours which are stressful.*" Hence, employees working in such environments may receive little or no support from the managements or schools. The prolonged hours at work coupled with incessant traffic jam as revealed in some participants' comments can undermine the success of such programs across schools in Lagos State.

If school managements are sceptical about investing time and resources in MH promotion programs and such are eventually implemented, discontinuity is inevitable. Many participants also indicated inadequate information and support from the state to link schools to local resources. "*What I will consider as a great challenge(s) is lack of funds to engage in mental health programs with government and other bodies*" This narrative also indicates that the absence of, or inadequate, information hinders support for MH inclusion. Schools lack necessary resources to singlehandedly initiate such programs. This perhaps explains why participants' responses to the hypothesis revealed that strategic alliance works at the cooperation level among public schools, but it is absent in private schools. Hence, the concept of strategic alliance (relationship building) as indicated in Federal Health Policy Promotion (FMoH, 2019c) and FMoH (2013) National Mental Health Policy is minimally implemented among the three study areas.

4.7. Other Emerged Themes on Students' Mental Health in Lagos State

Although, students' mental health was never the focus of this study, emerged themes from the qualitative data revealed its importance to the schools' administrators. There is a consensus among participants in both private and public sectors that adolescents face a multifaced challenges in the academic and social and economic contexts which impact their mental health. However, public school administrators specifically identified that the changes in family patterns such as being raised in a single-parent home, divorce, and parents' deaths influence the MH outcome of students. Additionally, poverty, stress due to poor living conditions, and commuting problems exposed students to increasing pressures as revealed in this comment.

I think stress is a major issue for both the teachers and our students. It recently came to my notice that one of my students here, a girl of fourteen years is the sole breadwinner for her family. The girl is an orphan and lives with her grandmother who is visually impaired. Before the girl comes to school she has to hawk and send her grandmother to under bridge 'Ikeja bridge' where the old woman would station to beg for alms and once the school closes, she too resume there- joins the old woman. In my latest conversation with the girl, I learned the old woman is sick, the burden has become too much for her to shoulder alone. Look around you there is no support for such situations here, I just told my colleagues to overlook her truancy, and I make a case among the staff to lend helping hands whenever possible. You have to admit, we can only do a little as each of us too are struggling to cope financially with the meagre salary... NGOs work does not address deep rooted poverty- a result of the poor socioeconomic background of our students in their often-one-time intervention.

In private settings, school administrators are mostly concerned about academic pressure, drug abuse, peer pressure, and family disintegration pressure, and attribute these factors to anxiety, depression, and burnout among students.

Our school provide MH education, well... for students, --- academic and peer pressure are common stressors among students and recently we launch anti-bully programs as part of our extra-curricular activities.

It is apparent that administrators in both private and public schools are concerned about MH in schools; however, their focus differs. While public schools attached sociocultural knowledge of mental illness to stigma which affects attitude to seeking help and the quality of support available to the school community (student and school workforce), private schools narrowly defined their intervention as focusing on students alone. The need to protect the school's image remains a recurring theme in the data.

Parents pay exorbitant fee to register their children here and who in his or her right mind will advocate for the teachers' mental health program, unless you want to go out of business. No. Our school management will never promote teachers' MH for fear of parents or guardians reacting negatively to it, no parent will pay to have a person suffering from mental illness instruct their children.

4.8. Similarities and differences in mental health integration in the public and private sectors

There is a consensus among administrators in both school settings that MH services are inadequately provided. Both sectors agreed that schools lack adequate mental health resources or professionals to support students and staff. There is a difference in schools' priority. Where professional MH service staff such as social workers and counsellors are employed, they are often stressed and ill-equipped to handle such crises. This lack of resources often reduces the level of support and exacerbates students' and staff's struggles.

Stigma is another recurring theme in the analysis in both sectors. The stigma surrounding mental health hinders disclosure and help seeking behaviours among the school communities. There is a widespread misconception that mental health problems are a sign of weakness, or worse, are associated with witchcraft or supernatural forces. This misconception hinders openness about mental health, constitutes a hindrance to students and teachers access to proper MH care. However, private schools attached so much importance to the school's image when emphasizing their position on MH promotion while in public schools, stigma is only connected to help-seeking behaviours.

Public schools believed that preventive care such as psychoeducation, advocacy, and awareness creation through the provision of MH information is not well defined by the service providers (NGOs) to meet schools' need. They are dissatisfied with how NGOs run the program 'like a show event' with no input from the schools. The lack of trust is also evident as illustrated in a participant's narrative, "I believe the NGOs come here to mark a register. Their program is a one-day event, occupies the whole school activity for that day, by the time it ends at six pm students and teachers are too tired to retain anything useful from it."

In private schools, it was evident in their comment that there is no extant relationship between the school and NGOs: "We rarely have NGOs programs in our schools." Although, the participants affirmed that they promote MH, such interventions are limited to students and often centre on 'drug abuse, anti-bully, examination stress' as evident in their comments. Also, some private schools are run by religious organizations, but this aspect was not anticipated in the study. Their motive for establishing private schools is not clear whether it is to deliver civic responsibility or it is money driven as most of these schools are far too expensive for students from low-income families. This perhaps impacts how MH interventions are construed in private schools. It draws attention to the concept of values in the education sector.

Education's overall goal is to promote diversity and provide inclusive education that is free of prejudice and stigma as prioritised in public schools. However, the profit motive of private schools has eroded this broad national goal of education in Lagos State. Though some private schools claimed they had resources for MH promotion, such as 'counselling centres, employ school psychologist, social worker', school image and the fear of losing potential business often influence the extent of private schools' involvement in MH programs. This also raises a concern about whether MH professionals are employed to teach or provide MH services to the school's populace. In addition, private schools have less contact with the state education board on MH issues; this may be responsible for the poor delivery of MH programs in these private schools.

CHAPTER FIVE

FINDINGS AND RECOMMENDATIONS

5.0. DISCUSSION OF FINDINGS AND RECOMMENDATIONS

This study examined the concept of strategic alliance (relationship building) in the pursuit of the Federal Government of Nigeria's agenda of inclusivity among the Nigerian populace. Specifically, it surveyed the implementation of participation strategies to enhance inclusive workplaces in the public and private schools in Lagos State. In the updated National Mental Health Policy, FMOH (2013), MH promotion as indicated in the Federal Health Policy Promotion (2019a) is expected to be implemented at all three levels of government – the federal, state, and local governments. Local communities are expected to be integrated to create awareness, monitor, mobilize and actively participate in policy and program implementation. Some shortcomings of the previous approach are highlighted in the National Health Policy (2016) and FMOH (2008). They include its inadequacy to promote relationship building among relevant sectors and the lack of accountability. Suggestions for intersectoral collaboration among the necessary agencies and communities were highlighted. State representatives and NGOs' roles were stressed to promote inclusion in the labour market.

This present study therefore examined the delivery of this collaborative framework to evaluate its adequacy in facilitating stigma reduction and inclusion for MHSUs as staff in the education sector. Based on this study's goals, four research questions and a single hypothesis were raised. The questionnaire was structured into three sections: A, B, and C. Item A covers demographic details. Item B entails five collaborative structures, government supports, four anti-stigma constructs, and schools' performance, while C covers two qualitative questions: (i) challenges in implementing the initiative and (ii) suggestions for improvement. These

questions helped in developing a better understanding of the participants' responses to the items in the scales.

After open coding, the researcher developed themes using reflexive thematic analysis to incorporate qualitative data into the quantitative results. Naeem et al. (2023) asserted that reflexive thematic analysis emphasized subjectivity, deep interaction, and recursive engagement with the data. Thus, the researcher identified patterns of similarities and dissimilarities in participants' responses for categorization and developed the themes. These steps helped the researcher to generate new ideas and gain more understanding about the underlying meaning of participants' responses to some quantitative items to further clarify the outcome of the findings. Below are the research questions and hypothesis raised.

1. What are the collaborative structures adopted in private and public schools to promote MH inclusion in Lagos State?
2. What is the nature of government supports received by the schools to implement inclusive programs in schools in Lagos State?
3. Which of the mental health inclusive programs- information, psychoeducation, advocacy, and treatment are implemented by private and public education sectors in Lagos State?
4. To what extent are these inclusive programs reducing stigma in private and public education systems in Lagos State?

Ho1. There is no statistically significant difference in the collaborative structures and strategies adopted by both private and public education system to promote MHSUs' inclusion in Lagos.

The results of the key findings are discussed below.

5.1. Key findings and observed conceptual model

This finding revealed the existing structure of strategic (collaborative) relationships and the method adopted in promoting MH (anti-stigma) in the private and public education sector.

It also assessed the level of Lagos State's support in facilitating such strategic relationships and school administrators' perceptions of schools' commitment toward implementing such programs.

5.1.2 The structures of MH relationship in Private and Public Schools

The outcome of the first research question revealed the structures of MH relationships in private and public schools. It showed that both private and public schools' involvement in collaborative relationships designed for MH inclusion is at the lowest end of the collaborative spectrum. As revealed in the results, a significant difference was observed in the cooperation level in public schools which implies that public schools have slightly outperformed private schools at this level. From the results, neither public nor private schools' scores significantly differed at the level of networking, coordination, coalition, and collaboration. The results suggest that public schools experienced a higher and significant relationship only at the cooperation level when compared with their private counterparts.

In corroborating past studies, the adoption of strategic alliances (collaborative relationships) hinges on forming a strategic relationship with diverse organizations that promote MH programs and focuses on leadership building. Thus, stakeholders' participation is the key to MH programs' success. At all levels of governments, government agencies (Ministry of Health and Ministry of Education, social security, and welfare system), labour leaders, international MH advocacy support groups such as the WHO, Clinton Foundation, employers/organizations, community leaders, community healthcare workers/ extension officers, other local support groups, family and MHSUs are involved (WHO, 2003b; 2004a; 2019d; Anyebe et al. 2019). They are expected to structure MH promotion, identify needs, and pursue specific MH services that target well-being as well as social and economic integration such as health training, advocacy skills, mental health leadership, and service development (WHO, 2013; Abdulmalik et al., 2016; Ryan et al., 2020; Onyemachi, 2023). Workplaces are

expected to utilise the available resources through these platforms to support employees and direct MHSUs to the needed services with up-to-date information.

Importantly, the qualitative results showed that even though public school operates at the cooperative level, their activities are minimally conducted but are in contrast to FMOH's (2019a) policy guidelines. For example, the presence of MH NGOs in schools appears to be the only structure of relationships observed in the education sector. Even with that, across the three education districts and their respective LGAs, the roles of NGOs in private and public schools are either minimal or non-existent. These roles do not suggest that strategic alliances (collaborative structures) are not in existence. However, they are ineffective, and not properly executed to change behaviour and facilitate MH inclusion for service users' employees. As commented by a participant in the public school: *“NGO services (seminar) is a “fire brigade approach, time consuming and tiring for staff and students (from 9am-6pm), awareness program is one time approach, a complete waste of time, like a show event, the NGOs take photo, and no follow-up.”*

Findings by Ryan et al (2020) in Sierra Leone shared similar conclusions that a major setback to MH inclusion at the community level is poor planning at the decision level, lack of resources, and low awareness. Specifically, Abdumalik et al (2016) affirmed that investment in MH programs is still lagging in Nigeria and attributed it to the lack of political will as well as behavioural and social factors. Abdumalik et al emphasised that application of the concept rarely involves labour leaders or addresses personal, sociocultural, and environmental issues affecting MH inclusion. Promoting collaborative relationships is expected to facilitate awareness and bridge information gaps among various government agencies (welfare, prison, education, healthcare system) and other stakeholders (FMOH, 2019a; 2019c), but it is often lacking.

Ryan et al. (2017b) established that such multisectoral coalitions are key in promoting MH inclusion. However, such a relationship requires massive funding and a high level of commitment which are absent. This is also observed in this study; essentially, in the aspect of cooperation, private schools' administrators deny having an alliance with the State Ministry of Health and the Education Board for MH guidance. Conversely, public school administrators affirmed maintaining such a relationship with the government agencies. Presently it is indeterminate how strong such alliances are to sustain program continuity.

5.1.3. Measures of Governments' Support for MH Inclusion in Educational Systems

The study assessed the level of support that schools receive from the State to implement anti-stigma program(s) in private and public education sectors; findings suggest that the State support services among staff members are low. Findings revealed that the school administrators in private schools rated the level of support received in implementing anti-stigma program(s) as poor, while their counterparts in public schools rated it as fair. Specifically, in terms of Lagos State's provision of periodic information about MH initiatives and dedication to championing well-being and mindfulness programs, the private and public-school administrators were unanimous in their assessment, and these two responsibilities were rated as fair.

The outcome suggests a lack of uniformity in the level of support that private and public schools received in anti-stigma programme implementation in Lagos State. Public schools in Lagos State received more implementation support of anti-stigma than their private counterparts. More importantly, the results of the qualitative analysis revealed that actual schools' MH support to staff is rare, and where it is provided, it is based on school directors' discretion, and often ineffective due to lack of continuity when teachers are transferred. As indicated in the present study, participants in the private sector are concerned about communication gaps between schools and the state government and attribute the unavailability of this framework in schools to the absence of guidance from the State agencies, the school

board, and community healthcare system in terms of ‘finance’ and ‘information resources.’ A participant commented that, “*government is yet to reach out to private organizations on mental health.*” There is a shared concern among administrators in the private education sector that the Ministry of Education rarely interacts with private organizations; therefore, many of them are unaware of such a supportive structure.

In addition, Waqas et al. (2020) pointed to the lack of program continuity in schools which supports the present findings and establishes that attitudinal change is needed to achieve desirable outcomes. Similarly, Mascayano et al. (2020) furthered that any inclusive programmes or measures should involve organizations and HR personnel in their design, remove culturally sensitive expressions, and encourage the programmes’ acceptance. These are also evident in the present study, as participants advocate the re-orientation of HR personnel for the removal of culturally sensitive words in recruitment exercises to enhance the social integration of MHSUs.

More so, a few discrepancies in the school administrators’ responses from private and public schools show that expectations in alliance formation are consistently neglected. Thus, the concept of shared value is lost in this arrangement. NGOs’ participation in inclusive promotion and training is never shaped through mutual agreement, and it appears private schools lack the understanding of what inclusivity connotes. Employees and MHSUs are excluded from the concept of active participation in MH promotion and motivating goals. This perhaps signifies a major flaw in executing inclusive programs in schools. When schools are not carried along in defining expectations, relationships are diffused and programs provided through such platforms are bound to be ineffective to remove stigma and facilitate inclusion.

There is also a complete detachment or lack of relationship between the Lagos State Government and private schools as well as between NGOs and private schools in establishing collaborative structures that promote MH. Understandably, public schools agreed that they

received minimal support from the State government and NGOs; essentially, the results of the qualitative analysis revealed that such support is a one-time approach. Consequently, financing and the needed personnel are often unavailable for programme continuity. Similar to this finding is Castillo et al.'s (2019) study which established that stakeholders' participation in building strategic alliances is fundamental to the sustainability of MH programs. The study highlighted that the existing structure could serve as a springboard for program development. Also, improvement in social relations between the schools and the communities and between family and MHSUs' involvements are key to programs' sustainability and continuity. It is evident from this report that such participation is lacking in the study areas. NGOs' low activities in private schools or why they prefer to operate in the public schools could be an area of interest for future studies. Focus should be on the motives behind such preference.

In addition, Castillo et al. linked the success of psychoeducation, advocacy, therapeutic relationships, and follow-up to active participation and computer literacy, as many interactions are carried out online and individuals can log in to seek support. Although the physical therapeutic effect (physically present) might be lost if clients (workers) lived in a remote area, nevertheless, the outcome has proven useful where there is a greater commitment by the individuals involved. This is an additional area of concern in this study, as it became apparent during data collection that many participants would have declined to participate if the survey was online. Some affirmed not remembering their email address and password. Such a reality perhaps has implications for research and MH awareness creation in this global age.

5.1.4. Available Preventive care and interventions (anti-stigma) programs in schools

The outcome of research question three on the available anti-stigma programs that private and public schools provide in Lagos State revealed that private and public-school administrators in Lagos State unanimously agreed on the availability of information and advocacy in their various schools but differed on the availability of psychoeducation and

treatment. This suggests that inclusive strategies exist in schools in Lagos State but might not be fully practised or integrated as stipulated in the FMoH (2019a) HRH guidelines.

Essentially, this guideline articulates advocacy and community participation in linking individuals to the available MH resources; hence, the role of government agencies such as Ministry of Health at LGA is articulated (FMoH, 2019a). Private school administrators indicated the absence of such support. While those in public schools admitted that some aspects of the program are missing or not addressed. As revealed in some participants' comments from the qualitative questions, the absence of 'information/data,' 'lack of empathy' (negative attitude of the HR/ use of non-inclusive terms), and non-availability of MH resources are suggested as hindrances to the implementation of anti-stigma in schools. The outcome of this study revealed that school administrators are aware that joint participation is the key to the success of anti-stigma programs in schools despite not actively pursuing it.

Importantly, studies by the WHO (2017), Castillo et al. (2019), and Ryan et al. (2020) highlighted the roles of community entities in enhancing multi-sectoral coalitions to fund research and implement programs in the communities. Such understanding was also reflected in the present study. Nevertheless, the absence of it was stressed as a major setback to anti-stigma program and support service participation in schools. A participant in the public education sector observed that, *“support is not available, where available it is not provided by the school but based on the established relationship between staff and the school director. Individualized services are not available but support from the school director is based on personal experience and empathy.”*

The above comment raised another crucial issue which is also relevant to research question one. It is about whether it is safe to solely attribute the absence of programs or lack of uniformity in programs and service execution across schools to the absence of the State's support or extend the problem to individuals' disposition (school administrators' or

proprietors' personal experience and perception). It is evident that despite the observed low government support even in public schools, a few school directors still embrace and provide social support, referral, and follow-up services for their MHSU staff.

Adam et al's (2020) findings shared similar views and linked policymakers, NGOs, community, families, workplace, and MHSUs' active participation to MH programs' successful implementation and utilization in Sierra Leone. However, the WHO (2017) cautioned that the availability of information may not entirely cause a desirable change as the cultural milieu of each state often impacts MH programs' success. Evidently, in this thesis, the answers to the qualitative questions indicated that linguistic and cultural barriers impact the acceptance of an MH program as affirmed by a participant. *“Yes. Cultural and linguistic barriers can be difficult to overcome.”*

Again, while the assessment scores of administrators in private and public schools suggest the availability of information and advocacy services as part of anti-stigma interventions on the one hand and the unavailability of psychoeducation and treatment on the other, some discrepancies were observed in the response to the treatment service. Private schools disagreed that they plan interventions that allow workers to understand the need for treatments, including medication, and that they provide continuous support during and after recovery from mental illness. Whereas public school administrators agreed that they comply with these two treatment tasks. The findings therefore suggest that schools in Lagos State placed more value on information and advocacy as service systems for anti-stigma strategies.

5.1.5. Commitment to Schools' Preventive and interventions (Anti-Stigma) Programs

Based on research question four which examines the extent to which the schools' inclusive programs successfully reduce stigma and enable inclusion of MHSUs in private and public sectors in Lagos State, findings revealed that none of the four preventive care and interventions constructs individually, significantly contribute to schools' commitment to MH

inclusion in the two sectors. However, when these four constructs were combined: information, psychoeducation, advocacy, and treatment/ referral, they jointly significantly impacted schools' level of commitment. Importantly, school type did not differently impact the use of information, psychoeducation and advocacy as anti-stigma measures. School type, however, impacts the use of treatment as anti-stigma measure.

More so, extracts from participants in private schools indicate that *“None of our staff is suffering from mental illness, so we have little awareness or guide about mental health for staff.”*

On the other hand, comments from public schools revealed that *“support is not available, where available it is not provided by the school but based on the established relationship between staff and the school director. Individualized services are not available but support from the school director is based on personal experience and empathy.”*

Based on these responses, the researcher extrapolates that knowledge of private schools' administrators about MH support service is limited. These patterns of responses appeared the same across the three districts (research settings). Private school administrators affirmed employing social workers/school counselors or psychologists; however, it is unclear whether they are employed to teach or provide psychosocial support to the school's community. Administrators' attitudes play a role in MH inclusion for their workforces. Contrarily, the promotion of MH as revealed by Atilola et al. (2024), Margaretha et al. (2023) and Onyemachi's (2023) studies showed that MH interventions helped develop coping and resilience skills in schools. This is not the same in the present study, perhaps the concentration of most studies reviewed on students might account for this difference.

Specifically, Ashakali et al. (2021) attributed active leadership roles to MH program provisions. They affirmed that even when the organization climate is attuned to inclusive relationship promotion, team leaders who are inclusion-oriented are more likely to succeed in

implementing inclusive structures than those without inclusive orientation. Similarly, Nelissen et al. (2017) revealed that core values and organisational mission impact policy and programme outcomes. If inclusive programs (such as an anti-stigma program) is in line with workplace values, organizations are likely to accept and respond better than when such programs are forced on them.

5.1.6. Association between students and workers' mental health experience in schools

Although stress, discrimination, pressure, and personal crisis are parallels between students' mental health and workplace mental health, there appears to be notable differences in their manifestation and the level of support they receive.

i. Nature of factors responsible for MH crises and stress

Among students, mental health issues often arise due to externally motivated academic pressures and social stressors such as peer pressures, family issues, and rural-urban migration which reduces support from the familiar networks and poses future uncertainties. For employees, personal factors such as interpersonal conflicts at home, economic constraints, and job-related stress like job insecurity, too much workload, poor relationships among colleagues or senior colleagues, and poor time management cause mental health challenges. Specifically, the academic pressure in schools, including exams and the desire for academic success, is quite different from the pressures faced in the workplace, such as deadlines, performance reviews, and meeting organizational goals.

ii. Support Systems:

In the three research settings, Eti-Osa, Ikorodu, and Ikeja, there is a lack of formalised MH programs. Although the FMoH (2019) articulates the need for Employee Assistance Programs (EAPs), counselling support services, and comprehensive mental health insurance in workplaces, evidence of a comprehensive MH program is rare in schools except for coverage insurance available to public servants. Even with that, it is unclear whether MH provision is

included in the healthcare coverage in private schools due to management's profit priority. Additionally, participants emphasised that the high level of unemployment technically may be responsible for management's lackadaisical attitude towards employees' MH promotion since employees can easily be replaced. More empirical studies may be needed in this area to have an in-depth understanding of how these factors unfold and impact employees' well-being promotion, schools' understanding and interpretation of mental health policies, and the decision to provide time off for mental health-related issues.

As earlier observed, schools in Lagos State affirmed having MH personnel while admitting that they typically lack formal MH structures. Specifically, private schools' role is often limited to academic and behavioural issues among students without examining their deeper psychological concerns. It is also not clear whether MH professionals in schools are well-supported to manage the diverse complex and volume of students' MH needs.

iii. *Institutional Response*

The study revealed the important role of HR and MH professional personnel in providing MH in the workplace. Although MH provisions are guided by the HR policies as part of the established comprehensive approach to creating inclusive workplace, educators are expected to be trained by qualified MH professionals from healthcare settings in schools. The provision of MH interventions is less formalised for teachers and administrators. There is a complete absence of relationships between the schools and the healthcare sector which is expected to train the educators. Thus, schools often lack adequate training to recognise a crisis and make appropriate referrals. Furthermore, support services for students in both private and public schools are limited. Supports come from immediate family and external sources of support such as NGOs. Another crucial issue is the cultural hesitation to seek help among employees which is linked to fear of rejection.

5.1.7. Key findings on the hypothesis: Differences in structures and strategies for mental health promotion in school's settings (public and private schools)

Lastly, the result of the single hypothesis generated in this study which states that there is no statistically significant difference in the structures and strategies adopted by private and public schools to promote mental health inclusion revealed a significant difference in the structures of the relationship (strategic alliance structures) adopted by the two sectors.

The present findings revealed that there was a significant difference in the structures of relationships adopted by private and public schools in connecting with other agencies to promote MH inclusion. The school sector was able to account for 10% of the observed variance noticed in the collaborative structures adopted in connecting with other agencies to promote MH. This 10% observed difference was only significant in public schools, suggesting that public schools have higher treatment rate than private schools in the three study areas. However, after adopting a Bonferroni adjustment, a significant difference was only observed at the cooperation level. The level of existing cooperation was found significantly higher among the public schools than their private counterparts in Lagos State.

Therefore, the null hypothesis was rejected to uphold an alternative hypothesis which states that a significant statistical difference exists in the level of cooperation with other MH agencies between the private and public education sectors in Lagos State. Participants' responses to additional qualitative question in the survey helped to clarify and offer better insights on the observed differences between the two groups.

Administrators in the private education sector admitted that '*low investment in MH promotion*' and lack of State's support reduces such participation. Also, organizational core values and missions and limited resources influenced management decisions in the private sector. Successful MH promotion means "*to work in collaboration with recognized health professionals (management), organization (local or international) their counterparts in public schools*"

Findings by Taghva et al (2017) and Ashakali et al. (2021) supported this outcome and affirmed that inclusivity is the key to the successful building of collaborative relationships in the community. Ashakali et al. highlighted the need for the integration of structures and policy to enhance performance and concluded that evidence-based research is required to monitor and evaluate progress. However, where full involvement is lacking, or a few selective members of the public are involved, when only the NGOs have autonomy over programme design and execution and while schools remains as passive collaborators as observed in the research settings, it may be difficult to evaluate the success of MH programs.

Furthermore, this present study revealed that there was no significant difference in the anti-stigma strategies adopted by private and public schools in connecting with other agencies to promote MH in Lagos State. The school sector was able to account for only 1% of the observed variance noticed in the anti-stigma strategies adopted to promote MHSUs inclusion. The stated null hypothesis was therefore upheld. It implied that anti-stigma strategies adopted by private and public schools in Lagos State were at the same level.

Although the quantitative part of this study ascertains no significant difference in the knowledge of anti-stigma programs in the school sectors for information, psychoeducation, and advocacy, the qualitative study provides a number of reasons. Both private and public-school administrators agreed that the impact of the Federal, State, and LGAs in Nigeria, the NGOs and community mental healthcare at the grassroots in fostering strategic relationships, is not felt. Emphasis is placed on governments' expected roles as extracted from participants' comment. *"The government should communicate to both private and government establishments, persuading policies and programs that are based on mental health problems."*

Other findings like the WHO (2013; 2017) highlighted that core values of healthcare policy (accessibility, comprehensiveness, and efficiency) are fundamental to the integration of MH programs in a community. Gagne (2005) description of centeredness and richness of

collaborative structures also addressed these core values to emphasize the importance of stakeholders' full participation to MH inclusion. Failure to take cognisance of these associations may impact MH program outcome. Happell et al.'s (2020) findings corroborated the WHO's findings and complement the involvement of PHCs in the collaborative relationship to provide competent and resourceful MH personnel (psychiatric social workers, psychologist, psychiatric nurses, medical assistants, and counselors, etc.); these MH officials are crucial to the success of the initiative. However, in Nigeria, the shortage of funds hinders the effectiveness of the program as the FMoH (2019b) reports that the MH budget has not significantly improved despite the 15% increase in National healthcare budgets. Perhaps this may partly account for the poor state of the programme.

Similar to the present findings, Vyshka et al.'s (2018) study linked the polarisation of MH relationships to the absence of state's coordination and support in raising awareness and sharing information and resources in Albania. The study concluded that poor implementation of policy reduces public trust in the State and its agencies, hence affecting relationship building. Thus, the Vyshka et al. explained how the absence of state support can jeopardize collaborative structures just as the WHO (2017) and FMoH (2019b) affirmed that collaboration requires massive investment and continuity. Where government support is lacking, the least structure of collaboration may be difficult to implement as shown in the present findings that neither of the sector's performance in the implementation of collaborative structure differed.

Nonetheless, Frey et al. (2004) cautioned that not all the structures are expected to take place in the organization, but, when one or two of these structures are available, assessment of their functionality should be the focus. Thus, based on the present findings, only networking and cooperation seemed to be minimally operated in the study areas because not all activities in these phases are carried out in the two education sectors. There are challenges to implementing these phases of collaborative structures to promote MH programs in schools.

While some challenges are similar across the two education sectors such as the government's inadequate support/or attention, lack of funds, lack of professional guidance for practice, deliberate silence in the community/LGA, lack of empathy from HR/management, and hostile work environments, others are unique to each aspect of the education sector. Public schools and their education districts identified peculiar problems such as leadership personality and misalignment in the objectives of NGOs and public schools (where schools want on-site resource centers near the schools for referral, NGOs only deliver one-time seminars or workshops). In private schools, employers' profit orientations, preserving and maintaining schools' good image, information gaps (poor relationships between schools and the Ministry of Education to provide periodic reports and information), poor relationships between NGOs and schools are noted. All these factors have implications for policy implementers, social work education, practice, and interventions.

The four research questions and hypothesis provide insights into the structure of relationships and anti-stigma programs available in the education sectors in Lagos State. Based on the findings, the operation of the collaborative structures that exist in the three study areas (Ikorodu, Ikeja. and Eti-Osa) functions at the lowest level. Figure 7 represents the structure of collaborative relationships that exist in the three study areas.

The five model structures of collaborative relationships presented by Hogue (1993) range from the lowest to the highest level: choice and decision/Networking is the first level, next is the cooperative level. Coordination is the mid-level, coalition is the fourth level, and collaboration represents the fifth and the higher level on the spectrum. The interventions at the first (lowest) level on the spectrum involve searching for information at the outset of the program. At the networking level, project planning and objectives may not be explicitly defined. This level maintains the autonomy of each participant. The second phase is the cooperative level. Activities at this level include information sharing among members, finding

common purposes, defining the goals or objectives, MH awareness creation to MH personnel guidance, and organising occasional professional visits to schools.

The middle-level structure is coordination. It is a little higher than the cooperation phase. Here, the objectives have been clearly defined and planned, and activities have been well developed. This level focuses on strategic planning, mapping out activities, and sharing tasks based on members' preferences for further coordination. The WHO (2013) added that consultation with communities, local government/state on MH programs, direct involvement with the Ministries of Health and Education on MH programs and receiving updates on MH are essential. The coalition level is considered a higher-level including organizations having a representative to participate in MH policy/and program development, advocacy, and providing materials and financial support to run MH programs.

The last and highest level is collaboration. However, Barne and Billey (2000) added coadunation, which implies continuity. In this study, Hogue's model was adopted for two reasons: for measurement and analysis and the anticipated likelihood that Nigeria is yet to reach the coadunation phase. However, it is important to stress that constitutionally, the cooperative relationship of the three tiers of government is articulated in MH health promotion at the networking phase. This was not evidently seen in these results; hence additional research is required in this area for more clarity.

It is safe to assert that collaborative structure aids the distribution and redistribution of MH services where they are lacking and needed, or when poorly initiated. They can affect the level of trust in such relationships and result in poor outcomes of the services provided through such mediums. As evident in the present study, schools appear rather passive in this relationship; MH NGOs dictate what program to run and how it is presented. This negates the concept and guidelines for building a mutual relationship and implies a misalignment in the practice of strategic alliance in the study areas.

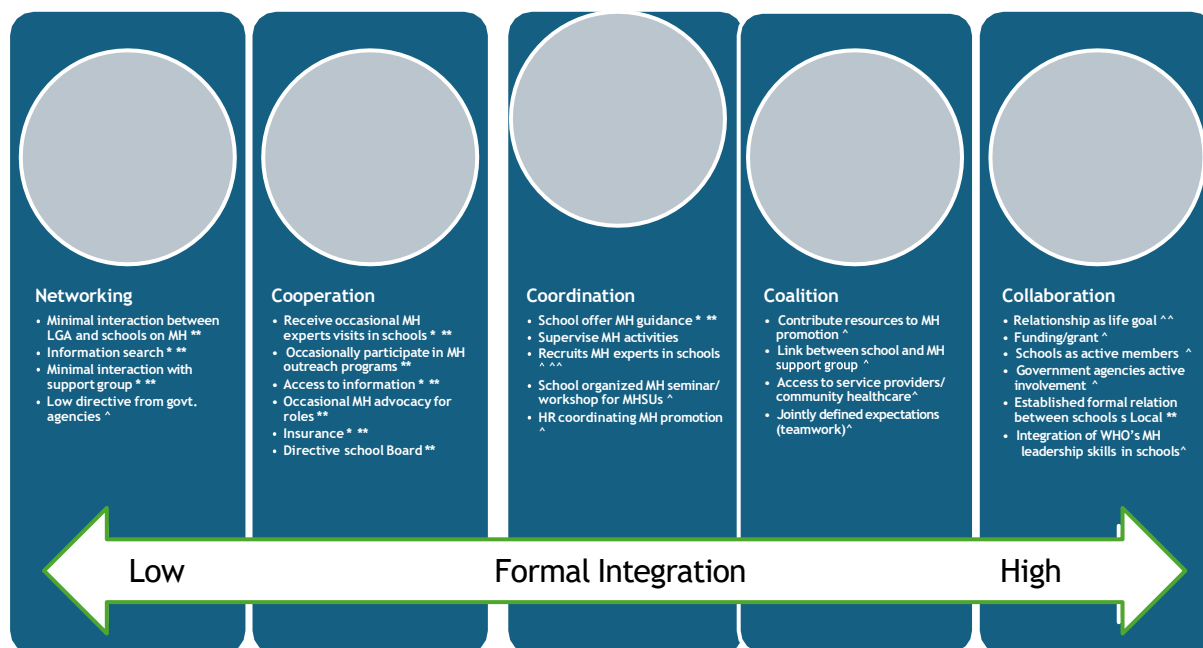
Past studies emphasised that the relational forms of capacity building in policy implementation enhance the internal and external social relations among partners in building trust, increasing efficiency, and minimizing loss in programs delivery (Ryan et al. 2020). The authors asserted that it builds trust and facilitates the development and continuity of networks. However, the present thesis has shown that this relational form of capacity building can negatively influence trust which is necessary for facilitating inclusion when such alliance is not well defined or where there is power imbalance. For example, the outcome of this study revealed that schools are rather passive consumers of MH programs, while MH NGOs (private MH agencies, community mental healthcare providers, and religious organizations) are actively involved as MH providers despite being described as parts of the chains of service providers in the FMoH's policy guidelines. Schools lack the autonomy to define the kind of services they want, how and when they want to be served. There evinces the poor communication between the schools and MH agencies. The relational status between MH agencies and schools is unequal and impacts the effective delivery of the inclusive program.

Activities at the collaboration phase which is the highest integration side of this spectrum include being part of the MH leadership structure, pooling resources for collective purposes, and assessing the progress and outcome of the shared activities. Based on the WHO's (2013) findings, activities at this phase also include being part of the leadership structure, financing community MH resources, participating in research, program evaluation, and employing MH personnel for program continuity. Frey et al (2004) theorized that the strategic alliance levels are not expected to operate simultaneously with each other because the resources that are needed for each phase are different and huge.

This perception was evident in Frey et al's study. Even though the goal is the same, that is, schools' protection, schools operate at different levels of the relationships. Therefore, the model of the structure of MH relationships presented below is based on the study outcomes. It

is evident that both private and public schools in Lagos state operate at the lowest end of the spectrum “networking and cooperation”. However, public schools are more involved in the activities at the cooperative level compared to their counterparts in private schools.

Figure 7: The observed conceptual model of structure of relationships (strategic alliance) in private and public schools in Lagos State



Note: (*) signifies the structure of services available in private school; (**) signifies its availability in public schools, (^) non-availability of service/structure.

5.2. Contributions to the knowledge

The present study revealed the collaboration structure for MH promotions existing in the Lagos State education system. It advances our understanding of MH promotion to comprehend the adoption of the concept of inclusion and the challenges to its implementation in Lagos State. Based on the research questions and the results of the hypothesis testing, this study's contributions are highlighted as follows:

1. The findings revealed the state of MH structures in Lagos State. The existence of the expected structures of relationships designed for MH inclusion in Lagos State was in place, while activities at the networking level remain the same in both sectors.

Difference occurs at the level of cooperation. However, coordination, coalition, and collaboration were not in operation or not actively pursued in both sectors. The result of the t-test showed differences in the operating structures of relationships in both sectors. A statistically significant difference exists at the cooperation level between private and public schools. Whereas at networking, coordination and coalition levels no significant difference was observed. However, caution should be exercised in the interpretation of this outcome. Based on the outcome of the qualitative data and the descriptive results, both participants in private and public schools unanimously affirmed the absence of teamwork. It does suggest that schools are more of consumers in this arrangement. Hence, there are some discrepancies in private and public-school administrators' views about the availability of MH resources. The private sector affirmed that they never received timely material/financial support from any agencies, while their public sector counterparts affirmed receiving a one-time '*fire brigade approach*' materials/workshops from local NGOs.

On the aspect of cooperation, there is a consensus between the two sectors that though this is in place, it is minimally in operation. If any guidance is received from the Ministry of Education, it is not on MH information or support. Nevertheless, there is an indication that to some extent, collaboration exists in Lagos State but at the extreme lowest end of the spectrum of collaborative structure. In private schools, it is important to stress that inclusion may not entirely represent support for workers but strictly the promotion of MH among students. Thus, collaboration for inclusion represents different meanings among participants in private schools across three education districts in Lagos State.

2. Findings also revealed a discrepancy in the supportive roles of the Ministry of Health and Education in promoting MH inclusion in schools. School administrators in the

private schools rated the level of state support their schools received in implementing anti-stigma programs as poor, while their counterparts in public schools rated it as fair. Specifically, in terms of Lagos State's provision of periodic information about MH initiatives and dedication to championing well-being and mindfulness programs, the school administrators in both private and public schools were unanimous in their assessment and these two responsibilities were rated as fair. On the whole, the outcome suggests a lack of uniformity in the support that private and public schools received in the implementation of anti-stigma program(s) targeting accommodation for MHSU employees in Lagos State. Findings suggest that public schools in Lagos State received more attention than their private counterparts in terms of the support that they received in implementing anti-stigma program(s).

3. The findings also revealed that administrators in the public and private schools in Lagos State agreed on the availability of information and advocacy as anti-stigma interventions in their various schools but disagreed on the availability of psychoeducation and treatment aspects. Specifically, assessment scores of administrators in both private and public schools suggest the availability of information and advocacy services as part of anti-stigma interventions on the one hand, and the unavailability of psychoeducation and treatment on the other hand. Some discrepancies were observed in the service tasks on treatment, while the private schools affirmed that they do not plan intervention(s) to educate staff on MH treatments and medication or provide continuous support during MH crises and after recovery. Conversely, public school administrators agreed that they complied with these two treatment tasks. The findings, therefore, suggest that Lagos State schools prioritise information and advocacy as service systems for anti-stigma strategies.

4. Findings on the extent to which workplace supportive measures enable inclusion for MHSUs in private and public schools in Lagos State revealed that individually, each anti-stigma component did not single-handedly contribute significantly to schools' level of commitment to MH inclusion. But in combination, the four anti-stigma measures; information, psychoeducation, advocacy, and treatment/referral jointly make 13% significant contributions to schools' level of commitment. More so, the values of the interaction based on the school sectors for information, psychoeducation, and advocacy do not impact differently. However, it was significant for the treatment/referral measure based on the school sectors. suggesting that the level of activity at the treatment domain differed in both public and private schools. Public schools are more committed to inclusion than their private school counterparts. From participants' responses to the qualitative questions, it was evident that MH promotion stakeholders exclude staff inclusion but promote mental health education (drug and substance abuse) for students. In public schools, school administrators' personal experience and empathy are the key motivators for promoting inclusion.
5. Furthermore, findings from this study revealed a significant difference in the strategic alliance structures adopted by private and public schools in connecting with other agencies to promote inclusion. The school sector accounted for 10% of the observed variance in the collaborative structures adopted for promoting inclusion. However, after adopting a Bonferroni adjustment, this significant difference (10%) was only observed at the cooperation level. Equally, this level of existing cooperation with other agencies toward promoting inclusion was significantly high only in the public schools in Lagos State. Therefore, the null hypothesis of no statistically significant difference in the structures and strategies of the networks adopted by private and public schools in

connecting with other agencies to promote MH inclusion was rejected to uphold the alternative hypothesis.

On the other hand, the findings revealed no significant difference in the anti-stigma strategies adopted by private and public schools in connecting with other agencies to promote inclusion in Lagos State. The school sector accounted for only 1% of the observed variance in the anti-stigma strategies adopted in connecting with other agencies to promote MHSUs' employees' mental well-being. The stated null hypothesis was therefore upheld. The findings imply that the anti-stigma strategies adopted by private and public schools for connecting with other agencies to promote inclusion in Lagos State were at the same level.

The qualitative aspect of this study crystallises the results of the hypothesis. Though the quantitative study explained minimal use of anti-stigma intervention, it was unable to explain the 'why' of the observed outcomes. From the participants' explanations, participation did not entirely mean that they were aware of government's supportive measures or have access to them. Programs termed anti-stigma might not entirely focus on inclusion or be directed at staff as supported by some private school-administrators' comments that private entities are about preserving their good image and are profit-driven. Hence, interventions are mostly directed towards the students and often focused on drug abuse and MH awareness.

The study evinces school administrators' understanding of MH inclusion. It revealed schools' knowledge of MH, support systems and level of commitment to MH promotion. It also highlighted factors that hinder or promote MH to suggest that sociocultural milieu in which policies are implemented have strong association to how mental illness is viewed and responded to. As evident in their comments, knowledge of MH policy and inclusive programs is minimally understood by school administrators

and pursued differently in private and public schools. Thus, there is a difference between expectations, awareness, and acceptance. As revealed in the study, MH awareness, though is being practised, does not meet the needs and expectations of the schools. The unrealistic approach through which anti-stigma program is being delivered poses a challenge to its sustainability and ability to make the needed change in a highly stigmatized work environment. Thus, building a specific relationship for inclusion between the two education sectors, though desirable, might be too difficult to attain given their differences in goals and objectives.

5.3. Findings’ Implications and Recommendations

The outcomes of this study have implications for policy implementers (Lagos State, its agencies, and NGOs), social work professionals, and school administrators.

Table 13. *Summary of the Findings, Contributions, Implications for Policy Implementation/ MH Social Work Practice and Future Study*

Findings	Contribution	Implication for Policy Delivery/ Social Work Service	Recommendation for Future Research
1. Existing structures of relationship minimally operate in private and public education systems. No significant difference was observed in the operation of networking structure in both sectors. But a significant difference	The awareness level of collaboration (strategic alliance) in the education system is still at its lowest. Improvement in MH awareness/ access to information can break cultural and linguistic barriers to inclusion.	The present study corroborates past findings emphasizing that the support for MH programs remains low in Nigeria. There exists minimal information on MH, access to treatment /and support service	What factors motivate NGOs’ presence in public schools? Are there any incentives/funds from the government attached to NGOs’ activities in public schools? Or does ease

<p>was noted at the level of cooperation.</p>		<p>remains a major issue due to stigma, and low investment in MH impact programs continuity (Aregbesola & Khan 2018a, 2018b)</p>	<p>of access influence NGOs' preference for public schools? To what extent does personal experience/or immediacy affect an attitudinal change in MH promotion? Should the focus be more on intentionality (leadership views), or organizational values to implement sustainable anti-stigma intervention? How well incompatible organizations' values account for variability in the implementation of inclusive policy/ programs?</p>
<p>2. Findings revealed that administrators in</p>	<p>The State support for MH promotion/inclusion</p>	<p>This study supports Abimbola et al's. (2020)</p>	<p>To what extent can the current approach</p>

<p>private schools rated the State level of support for the implementation of anti-stigma programs in schools as poor, while their counterparts in the public schools rated it as fair.</p>	<p>needs to incorporate material and human resources to ensure its sustainability.</p> <p>Create on-site/ or increase access to MH resources near schools.</p> <p>Promote wellness and reduce stress-related problems</p>	<p>finding that there is low investment in MH interventions. The authors showed that treatment gaps are between 76% and 85% in African countries; suggesting that MH support at the government level is minimal. Anyebe et al. (2019) affirmed that MH leadership is missing at the PHC level which is the key to its success in partnering with other stakeholders (such as schools). Peterson (1991) reiterated that collaboration is resourced-based, (looking inward to see where an organization's strength lies to utilize it to improve its</p>	<p>facilitate better relationships between the State and Federal orders of government to sustain MH interventions at the local level without fearing the federal government's interference in the state affairs?</p> <p>How can the state facilitate sustainable strategic alliances and compliance with MH guidelines between the private and public education sector without resulting to veto?</p> <p>Are there any existing forums for the involvement of HR personnel and the social workers to</p>
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		<p>performance. Thus, relationship building can enable such MH alliance to thrive where members use a comparative cost advantage to promote inclusion. This notion calls for a proper review of its applicability given socioeconomic context of Nigeria where two sectors are guided with opposing mission, vision, and goal. As revealed in the present study, public school sector is not profit-driven like its private counterpart. Also designing a new approach to measure direct and indirect performance of the state at the local level is crucial for a better</p>	<p>review insensitive languages that increases barriers to disclosure in workplace.</p>
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		conceptualization of strength and weakness of executing MH inclusive programs in Nigerian workplaces.	
3. Schools administrators established that there is availability of information and advocacy as anti-stigma interventions in their various schools. However, there are variations in the means of executing these practices. Also, the two sectors disagreed on the availability of psychoeducation and treatment. Additionally, respondents seem to attach MH illness to drug abuse, suggesting the need for more awareness and provision of MH health information.	This study revealed the state of social intervention in Lagos State and proposed the needs for periodic updates and monitoring of existing intervention. It also emphasizes that government should work with other MH support groups to build synergy that can influence meaningful contribution beyond NGOs one time approach to MH intervention.	There is a strong support for incorporation of services that are client/staff oriented to ensure their utilization and continuity. Human resources personnel should collaborate with MH stakeholders for the removal of insensitive language that acts as barriers to disclosure and service utilization.	To what degree can active involvement of HR in MH awareness creation enhance behavioural change in seeking MH support in schools? Is the interpretation of inclusion substantially unique in the education sector and does this impact on mode of delivery of MH programs? Can improvement of the existing MH platform for schools facilitate better relationships among recognized MH

			<p>professional bodies and support groups to remove barriers to utilizing MH service?</p> <p>Can situating MH personnel in community sites near schools improve service, utilization, continuity and reduce stigma than situating it in schools?</p>
<p>4. The four anti-stigma constructs measuring preventive care and interventions jointly contributed significantly to schools' level of commitment to MH inclusion. However, independently, each anti-stigma measure did not impact schools' level of commitment to MH inclusion. Nevertheless,</p>	<p>As revealed, none of the anti-stigma strategies measuring preventive care and interventions individually predicted schools' commitment to MH inclusion. However, when combined, they jointly impacted schools' level of commitment. This perhaps suggests a need to revisit how these strategies are</p>	<p>Policy Implementers can create a forum that promotes inclusion not just for school management but service users. This could involve enhancement of collaborative structures that are MHSUs' employees oriented. Such structures should also promote access to continuous social care-</p>	<p>Future research may examine why each anti-stigma measure fails to single handedly impact schools' commitment to MH inclusion. Also, an examination of the peculiarity of NGOs' roles in private and public schools is suggested.</p>

<p>school sector impacts the use of treatment/referral as an anti-stigma component.</p>	<p>implemented in schools. Such focus should be on NGOs activities, and how schools' expectations are defined by the NGOs. The idea that school sectors impact on treatment domain (anti-stigma strategy) raises additional concern for more research on why school-type impact treatment but does not impact information, psychoeducation, and advocacy. Or can it be attributed to oversights on the part of policy implementers or to problems inherent in the policy itself? (Perhaps the incompatibility of the program with social reality and cultural values). The concept of values appears to play a</p>	<p>treatment, and follow-up especially when staff is transferred.</p>	<p>Determining the extent to which individual perception and organization values influence management decision on continuity of MH interventions.</p> <p>An exploration of sociocultural milieu in which MH interventions occur to determine factors that contribute to MH inclusion and service utilization.</p> <p>To what extent does misalignment in Christian values and market values impact commitment to MH promotion in schools run by the religious organizations</p>
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	<p>role in schools' commitment to MH promotion. The rate of unemployment might have implication on why private school's owners might be less supportive of MH promotion since they can always find a replacement. There is a concern about how to describe what constitutes school's civic roles when religious organizations runs schools as a business enterprise.</p>		
<p>5 There is no significant difference in structure and strategies available in private and public schools to promote MH inclusion</p>	<p>The study identified no significant difference in the existing collaborative structure in the private and public education sector in Lagos State. Two explanations may be provided as observed in participants' responses:</p>	<p>The present study called for the proper implementation of MH policy, including creating awareness of existing platforms to promote its utilization. Education of HRM, school management,</p>	<p>Do motive and expectation influence established MH structures to result in differential outcomes in NGOs' activities provided to private and public schools?</p>

	<p>(a). There seemed to be little or no structure for MH integration between the public and private sectors to mobilize and solicit support.</p> <p>(b). The State's focus appears to be on the public sector, even with that, investment in MH is currently low.</p>	<p>improvement in the relationship between the Ministries of Health and Education, among schools, establishment of on-site resources near schools and recruitment of social workers to work with schools and MHSUs to remove barriers to service utilization and sensitize management.</p>	<p>Does having a federal representative at the LGAs change the modality of executing MH programs at the grassroots level to encourage accountability and continuity?</p>
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5.4. Study's Implications

The study's implications are further categorized into five areas as discussed below:

Implication for social work education: This study describes the existing structure of relationships (collaborative structures) in private and public schools in Lagos State. The thesis incorporates Hogue (1993). Frey et al, (2004) and Gagne's (2005) models of collaborative structures and examines it in relation to the existing structures in the study areas. It reflects the stage at which MH inclusion is and the level at which MH policy is embraced and understood in the education systems. The low level at which MH programs are being run in the study areas can partly be understood based on the study by Aregbesola and Khan (2018a, 2018b) and Ryan et al. (2020). These studies identified that low investment and lack of social support services hinder development in this area. Particularly, the absence of insurance coverage for Nigerian

populace reduces timely access to treatment and support services. Though the present thesis also confirmed participants' views on the low investment in MH programs, it does not see it as the main problem. Contrarily, attention is drawn to the disconnectedness between the state and the public in information sharing, there seems to be a low awareness about the availability of MH services. Or the information appears not well circulated to reach the target population. For examples, Lagos State has two models of insurance coverages - Lagos State Health Scheme (LSHS) covers a range of mental health conditions from mild to severe mental illness. Eko Social Health Alliance (EkoSHA) which performs free health insurance coverage to those with mental health conditions and other vulnerable groups (Lagos State Science and Technology, 2024) represents the second model.

As revealed, schools' administrators are not well-informed in this area, which also raised a concern about the gap between the government and the people in programs delivery. Consumers' engagement is vital to program execution and evaluation, which is lacking as observed in the present findings. Other empirical findings such as Szeto et al. (2019) and Shahwan et al. (2022) draw attention to sociocultural milieu in which programs are executed; hostile work environments and linguistic barriers are connected to issues affecting MH promotion; this also evident in the present study. The present study suggests that implementation problems are complex as depicted in the conceptual model (problems associated with building collaborative structures in schools). Future research may be helpful in exploring interrelated social issues that impact MH policy and program execution to further knowledge in social work education.

Implication for social work interventions: Knowledge of diverse sectors that promote mental health services is crucial to the helping profession. Such understanding begins with who is responsible for which roles and responsibilities to direct MHSUs to appropriate resources, be it on-site or in the local communities. As evident in this study, social work interventions in

schools are either absent or not acknowledged. In addition, inadequate resources and cultural sensitivities to mental health-related issues affect judgment and acceptance. This also raises a concern about the appropriateness of situating physical spaces for MH promotions within school premises. If executed, it is unclear whether such services will be utilized due to discrimination.

This study also indicates that though the private sector affirmed employing social workers in schools, it remains unclear whether such recruitment translates into providing social care services to the staff or whether they are mainly employed as teachers. More clarity is needed in this area. There is a need for both public and government sensitizations on social work interventions and the creation of supportive environments that can aid social care services. Therefore, participatory approach as a measure toward inclusion should emphasize stimulating cooperative relationships among all stakeholders and emphasize negotiated and acceptable objectives that are feasible and realistic.

Implications for schools/education management: This study's findings denote a complete lack of understanding of management roles in promoting inclusive policy in workplaces. Many school administrators assume that an organization plays minimal roles in promoting MH programs and suggest that government should enforce all education systems to get on board. Putting pressure on employees, excessive workload, transportation problems, and hostile work relationships are the norms across the two sectors. These factors seem to be overlooked when attributing the lack of commitment to MH programs in schools solely to government inadequacy. However, past findings have shown that enforcement of policies does not equate acceptance, that there is a difference between compliance and complaisant. Lindsay et al. (2019) established that workplace practices and values play a significant role in executing inclusive policies and programs. Future research should prioritize exploring workplace

practices and administrative dispositions of MH programs in schools, given the importance of empathy in their implementation, as it is supported in this study.

Implications for NGOs and Policy Implementers: The role of NGOs in policy and program implementation is crucial to the successful implementing of MH programs (Abdulmalik et al., 2016; WHO, 2019b). Religious organizations and local and international NGOs have a major role in supporting program implementation and continuity. However, as shown in the current study, NGOs' efforts in schools are minimal. Essentially, the 'one-time approach' of service delivery has been criticized as ineffective in supporting the complex social milieu that school management found themselves. On-site help services or resources that are at least close to schools are recommended to facilitate relationship building and continuous utilization of MH services. It raises a concern about whether limiting MH programs to one-time awareness creation as reflected in the current study can effect a substantial change among service users and colleagues at work and among school administrators. Motives for why NGOs' focus more on public schools than private schools remains unclear in this study. There is a need for revisiting NGOs' current approach to MH programs and where possible, a re-orientation about what works. Hence, service improvement is necessary to ensure the quality of service rendered to the schools.

In addition, there is a need to evaluate MH policy execution in Lagos. This is amplified by the findings of the present study that MH policy and program delivery are not well addressed outside the healthcare setting. Contrarily, section 7 of National Mental Health Policy (2013) articulates promoting collaborative relationships in the labour market. Timothy et al. (2018) and the WHO (2019b) agreed that the path to such relationships in Nigeria seems blurred because most program evaluations are confined to healthcare settings and prioritize access to healthcare and community relationships. MH health delivery in schools is not only complex but also complicated due to diverse cause and need of students, teachers, and other workforces

in the schools, resolving such challenges should begin at understanding the nature and dynamics of interactions within the school, and between the schools' community and associated service providers (NGOs and PHC/ CHS). It is important to take cognizant of market-driven motive of some religious bodies and its impact on inclusive goals. Hence, future research should pay attention to interrelated factors that hinder MH policy and program delivery as presented in the conceptual model offered in this study.

Implications for Theory: This study supported both theoretical and empirical findings about the concept of social capital in building strategic alliances; it showed that organizations' values often influence commitment (the quality of support and the extent of involvement). This study also revealed that public and private schools prioritize and pursue different values and goals. The absence of social support, 'networking-the search for information and resources', is noted among private education schools compared to their public counterparts that offer information and guidance. Even when public schools function at this level, resources are often limited. Derogatory language, shortage of personnel, poverty, tools, personal struggle, and subtle eroding of familial networks in a large city like Lagos impact how social inclusion is perceived and promoted. The mode of disseminating information also may affect how the concepts are used and their effectiveness. As revealed in this study only a few administrators showed interest in technology. Where information is online, many of these individuals are not tech savvy to guide their workers on searching and locating MH information. Essentially, private schools established by faith-based organizations indicated that they have MH supportive systems. Perhaps, the mission and vision of their organizations might have influenced their commitment to MH inclusion.

Also, the Yoruba sociocultural cosmology (in Lagos State, where people believed and valued familial network of support) and the sensitive nature of mental illness likely impact how social capital manifest in each phase of collaborative strategies (strategic alliance levels). From

this study, it was observed that being educated about the cause and treatment of mental health-related problems might be inadequate to facilitate support and promote inclusion. Schools' administrators are more likely to respond better, and support colleagues based on the existing relationship. Thus, being a witness to the onset of mental illness in persons appears to arouse empathy and schools' administrators are likely to support such individual on the recovery journey than when the individual has gained the 'sick identity' before being introduced to them. Based on the outcome of the findings, theory of strategic alliance will benefit more from the concept of social capital outcomes in understanding why organizations perform differently when promoting inclusion. Discussion of social capital outcomes should go beyond organizational values in policy related issue to include personal experience for better understanding of 'why' organizations often respond differently to inclusive programs.

In addition to Peterson's (1991) view on how an organization can exploit its most advantageous position (resourced-based) to improve its performance; such explanation appeared to have focused more on cost-efficiency of the program with little attention paid to socio-cultural milieu in which an organization operates. This is essential for proper adaptation of this model to study the concept of collaboration in promoting mental health inclusion within a cosmopolitan state like Lagos State with diverse ethnic groups which influences both behaviour and attitude toward MH policy and programs. As evident in this study, collaboration does not evolve as a shared value; instead, schools are more of a passive partner.

5.5. Suggestions for Future Research

The present study is descriptive and correlational. It offers insights into the complexity surrounding the implementation of MH policy and programs and helps in testing existing collaborative theory about education settings. The use of two additional qualitative research questions helped to explain the results of the findings. These responses from the field research also strengthen the need for qualitative research to elucidate some crucial issues that emerged

in this present study. Further research, particularly, qualitative method can be helpful to answer some of the research questions raised in Table 13 and provide more insights into problems and strengths of collaborative structures and MH strategies in Lagos State or elsewhere. Importantly, some areas are worth exploring in future research; individual perceptions about MH service utilization and organizational leadership behaviours (attitudinal issues). Also, evaluation of other stakeholders' commitment which entails the assessment of local support groups' strengths, the limitations in sustaining awareness and maintaining long-term relationships with organizations, organizational measures for reaching out to support systems, and policy implementers' roles in establishing and sustaining collaborative strategies across diverse sectors will be useful. On the methodological issue, future study may need to consider focus group to explore the effectiveness of inclusive programs and structure what is obtainable in the local settings. Also, an increase in sample size, involving multiple MH stakeholders and use of mixed design may offer more insight into this area of research.

5.6. Strengths of the Study

This study has several strengths. The study has taken a broader look into MH policy implementation in the education sector to advocate a structural change in program delivery which takes into cognizance the complex interactions in school environments and their influence on individuals and management relationships. Thus, this study offers an insight into reasons why MH interventions are either non-existent or poorly implemented.

An important aspect of the rationale for this study is to examine the availability of the collaborative structures as stipulated in the National Mental Health Policy (2013) and the FMOH (2019a) HRH guidelines. This study revealed the present state of collaborative structure in operation in Lagos State, networking and cooperation. They are on the lowest phase on the left side of the spectrum of collaborative structure. Although gathering information on the challenges facing inclusive programs in schools was never a direct goal of the present study, it

significantly helped to clarify why the observed structure currently remains the only practicable option. This helps in suggesting future research direction and methods of research that can best capture the issue.

Another significant issue is that the items that informed this study's instrument were taken from the FMoH (2019b) policy guidelines that specify objectives and goals of the policy and how it should be carried out to achieve the desired results. These items were structured to measure the extent to which the government delivers its promises of promoting relationship building in the labour market as stipulated in the National MH policy (2013) statement. This instrument was pilot tested before its usage to determine its reliability and validity. The reliability and validity indexes obtained in the instrument demonstrated an acceptable level that made it adequate for this study. The use of additional qualitative questions in the survey also offers an in-depth understanding of the subject and more clarity about participants' responses to some of the quantitative items, thereby providing a robust analysis and interpretation of the findings.

In addition, participants recruited for this study were school administrators, school counselors, and psychologists/social workers who are regarded as part of the school management. It is believed that they have a better understanding of policy implementation, and, as a result, they are considered to be well-informed and qualified to provide reliable information regarding the subject of interest within the educational setting. An in-depth study of the literature, the researcher's knowledge of the Yoruba sociocultural worldview, and her knowledge of mental health policy and programs also aided the conceptualization and analysis in this study.

Recruiting experienced field researchers for data collection in this study also contributed to the dependability of the outcome of this survey. A medical student and a PhD degree holder were recruited for the data administration. Again, a two-day training workshop

was carried out before data collection to address expectations, appropriate conduct, and schedule for completing data collection. Open communication and timely responses to issues arising from the field aid the data collection process. On the first day of the pilot-testing, the research team visited schools together, the PI used the opportunity to assess how the RAs conducted the introduction and data administration. This process improved the validity of the study outcomes.

Furthermore, the use of probability samples and adequate sample size reduced sample bias. Also, the application of robust statistical tools (multivariate analysis) and the introduction of a co-variate helped to control the confounding variable. This is another significance of this study. Transparency matters in establishing a study's validity; this study demonstrated this clarity in reporting all the data procedure and analytical processes. Consequently, the findings of this study could be adjudged as valid and reliable for further decision-making.

5.7. Limitations of the Study

Although there are benefits of administering questionnaires to school administrators because they are part of the policy implementers at the grassroots, the current study focused on various school managements' perspectives. Significantly, the concept of collaborative theory is wide and broad and involves diverse agencies and groups (federal, state, LGAs, employers, NGOs, community, and individuals). Thus, focusing only on school administrators may be a limitation to this current study. Nevertheless, the observed limitations did not adversely affect the outcome of this study because the school administrators were knowledgeable about their school affairs. They were the link that connected the school to the communities and the state agency (Ministry of Education).

Thirty questionnaires were administered during pilot-testing, only 26 were returned, and all four unreturned forms were from the private sector. Also, when validation of the latent constructs that measured anti-stigma and the level of collaboration were analyzed

diagrammatically, the variables did not converge. Two possible explanations were identified. The first is the smallness of the sample size (26 respondents) and the five latent variables where each sub-item that formed the observed variables range between six and nine. The second observed issue is the distinctive nature of the construct themselves where each measured different phases of the collaboration strategies. These might affect the outcome. Frey et al. (2004) reported that activities performed at each level are distinct. Therefore, it might impact the outcome of this analysis. It is worth noting that when measured separately, each of these items that formed the latent variable converged and had high reliability. When the main data were run, the variable still did not converge, however, when these variables were run as single variable (composite variable), they converged. Possible explanation might be in the complexity of variables or the sample size since the model met multicollinearity assumption.

In addition, at the initial phase of this study, the researcher proposed to sample two representatives per school. Approximately in eight schools, the school management only allowed one participant in the study. In six schools, only one returned the survey form out of two participants sampled, while two survey forms were not included because 50% of the items were not completed. These might impact the robustness of the possible perspectives because one opinion is provided instead of two. Similarly, in the proposal, oversampling was proposed to avoid loss of data. Due to financial constraints (high cost of fares, time, and fatigue from moving from one study area to the other), the researcher made some adjustments to the initial 360 representative samples. Only 346 were eventually sampled, out of which 336 were completed. Also, data were collected from both primary and secondary schools across two sectors, but in the analysis, they were categorized as private and public schools. Perhaps if this characteristic was evinced, this might have provided a more robust analysis. Nonetheless, it does not in any way affect the outcome of this study; besides, it was beyond the scope of this present study. Future research might want to take this into account.

Administrators from different schools, especially within a local government district, may have had contact with each other and influenced each other's perceptions on the study topics. Therefore, observations may not be completely independent. This study also tested the assumption of equality of variance. The rule of thumb for estimating unequal variance, it is assumed that when comparing the ratio of the larger variance to the smaller variance, it should not be less than four to assume equal variances. If using this criterion, the assumption was not violated. However, Laptale et al. (2021) posited that if the variance of the two samples is $P < 1$, such differences is negligible. The researcher tested this assumption and found that 'cooperation' variable violated the assumption with Private (Mean= 14.9, SD=3.7) Public (Mean 16.5, SD=3.7) the researcher followed the rule of thumb in the inclusion of the variable. An increase in sample size or collection of additional data is suggested for future study to meet Laptale et al's criteria (see appendix S).

Similarly, is the case of multivariate outliers reported in this study; this pattern of similarity in which the outlier occurs raises a theoretical issue about the framing of future research questions and questionnaires in such a way that allows re-grouping of items into subsections that measure distinct variables (students and staff) separately with adequately sampled size. As evident from the current study, private schools across the three study settings limit the concept of MH inclusion to MH promotion among students.

Furthermore, at the onset of this study, the researcher proposed the use of both paper and electronic survey formats. However, during the pilot-testing, the researcher realized the predominance of computers, school administrators still expressed a preference for paper survey. Some even asserted that they would have declined to participate if the survey was strictly conducted online. Returning to the field to retrieve the completed survey forms also added to the research cost.

Also, at the research planning stage, two covariates were introduced; however, during the analytical phase, only one co-variate was used because the result of the presence of NGOs in school areas was not different for the three study areas. Therefore, the presence of NGOs as a covariate was exempted. Only the income level (socioeconomic status of the school areas) as a covariate was used. Again, two participants did not complete at least 50% of the survey, and to avoid bias, these two participants' survey forms were not used. Thus, only 178 responses were used instead of the proposed 180 after averaging the completed sample (336) sample representatives. It should be noted that a single survey form was sampled in 14 schools, eight questionnaires were not returned, while two participants did not complete half of the survey forms. Nonetheless, this does not impact the .031 minimum effect size anticipated for this study. Also, the observed outliers when further explored were not outliers but due to the extreme scores from respondents. In addition, Hoaglin and Iglewicz's (1987) standard rule for exploratory factor analysis stated that for an observation to be considered an outlier, it had to fall below or above the interval between the cutoffs. Thus, customarily, the value of k is 1.5; the formula for the lower cutoff is $FL - k(Fu - FL)$, and for upper cutoff, it is $Fu + k(Fu - FL)$. Thus, these values (see appendix O) are within the possible expected scores.

Regarding the instrument used in this study, 'advocacy' has $\alpha=.78$. Multivariate analysis requires a high-reliability coefficient of $\alpha=.80$ and above to limit bias in the results (Tabachnick & Fidell 2018). Advocacy, a subscale of anti-stigma, was estimated as .64. The removal of item [b] under subscale was noted to have increased it to .78 which was approximately .80. No further deletion of item impacted the result. All other constructs have high reliability above .80. Thus, there is a need to exercise caution when interpreting the results; this subscale might need improvement in future studies. Also, the results of the pilot-test (CFA) converge as a simple model fit, not as a multidirectional model fit. This might indicate that the model is best fit for a unidirectional model fit or a need for further study.

Similarly, Lagos State is considered more adaptive and receptive to policy change because of the state government's support for development and economic advancement. The diversity of the city and the convergence of the public schools in one area 'mega-school system' in strategic locations to an extent might influence participants' response. In addition, the data collection was still ongoing during World Mental Health Day (October 10), thus this circumstance might have influenced certain responses as evident in Oshodi/ Isolo Districts where Mental Health Awareness banners were in full display. Also, one of the school administrators from Ikeja districts asserted being the school representative on wellness and awareness program at the LGA. This individual might be more knowledgeable than others.

Though MH awareness is high among public schools at Ikeja education district, this is not the same for private schools, where MH awareness level is low. This might have effect on internal validity because of the level of interaction between the State Education Board and public schools, unlike their private counterparts. Though the outcome of this study maybe generalizable to other states in Nigeria, researchers should be careful in its interpretation because different states allocate financial and human capitals differently and are receptive to MH support service differently. Cultural environments may also impact policy outcome and investment in MH; hence, they may significantly affect workplaces attitude.

Importantly, the issue of power relations emerged differently during the data collection exercise which impacts on time, cost and adds to stress in the field. A school director declined participating in the study because of rank; the individual claimed that a level 16 officer cannot sign an approval letter on behalf of Tutor-General which would mandate him to participate in a research study. Some insisted on a duly stamped official letter from the district headquarters to participate despite the approval letter being duly signed. This slowed down the data collection process. Nevertheless, the observed limitations as stated above did not adversely impact the outcome of the findings.

5.8. Conclusion

This study assessed workplaces' level of involvement in participatory approach to promote MH inclusion for MHSUs' employees in Lagos state, south-west Nigeria in accordance with the National HRH Strategic Plan (FMoH, 2019a). Specifically, it aimed at examining the extent to which private and public-school administrative systems have operationalized structures and strategies for reducing MH stigma in schools.

Based on the outcome of this study, the delivery of inclusive programs in both private and public schools in Lagos State is far from meeting the goals and expectations stipulated in the National MH Policy (2013). It was discovered that the guidelines and specifications for implementation are not adequately adhered to in both sectors, and disparity is observed in the structures and quality of services promoted in the private and public education sectors. Public schools being controlled and financed by the government seem to receive more attention than their private counterparts. The observed disparity could be attributed to some factors which are beyond the scope of this current study. In another view, responses of the participants to the additional qualitative questions provided in the questionnaire offered significant insights worthy of note in this study, and are listed as follows:

- Support is not always available, and where available, it is not provided by the school but based on the established relationship between staff and the school directors. Individualized services are not available but support from the school director is based on personal experience and empathy. Staff transfer often disrupts MH support and exacerbates the problem because there is no established relationship to facilitate continued support among schools.
- Lack of program continuity: NGO services (seminar) is a “*fire brigade approach*,” that is one time, time consuming, and tiring for staff and students. The organizers start from 9 AM and end by 6 PM. There is a general consensus among respondents that MH

programs are a one-time approach, a complete waste of time, and a showy event. The NGOs take photographs and do not follow-up.

- There is a general silence in the community and LGAs about mental illness and the stigma associated with it. In private schools, having a mental illness disqualifies a member of staff; no parent will want a teacher with MH challenges to teach their child(ren). Also, private schools are profit-oriented and may not want to invest in anything outside what can provide immediate results, their employees (staff) may be reluctant to work with colleagues with such challenges. Therefore, openness or disclosure is not embraced. It is very unlikely that employees will utilize the service even if such programs are available, due to fear.
- In integration and social capital theory, strategic alliances ‘relationships building’ is depicted as shared representations or collective interpretations of meaning which influence collective action. As evident in this present study, schools remain a passive partner; they rarely have an opportunity to define the type of service they want and how often they want it or when to deliver it.

5.8.1 Generalizability of the findings

The findings is relevant to other education sectors as it revealed the state of mental health in terms of prejudice and discrimination in the workplace. It also revealed factors affecting program delivery in schools which can be summed under the following: attitudinal, finance, problem of trust, and program discontinuity in the public schools. However, in private schools, commitment is a major setback to MH promotion; other factors include organizational values and communication gaps between the government agencies and the private schools. For generalization, researchers and policymakers should exercise caution when applying this study in other educational settings for the following reasons. Lagos State is a cosmopolitan state with more than 22 million inhabitants, according to World Bank (2020). Lagos is home to diverse

ethnic groups which put more pressure on citizens' social and economic adjustment. This necessitates the need for the government to step in to meet the physical and mental health needs of the populace. Another reason that encourages continuity of service in Lagos State is the political stability in terms of the party that rules the state (since the inception of the Fourth Republic in 1999 till date, only one ruling party has been in power). This has facilitated policy and program continuity and sustainability. Additionally, Lagos State is economically viable compared to other States in Nigeria which allows the State to invest in MH care.

5.9. Recommendations

The outcome of this study showed that both private and public schools operate at the lowest level of collaborative structures, networking and cooperation, in Lagos State. However, when operating at these two levels, its performance still failed to meet the standard recommended in the policy documents. For this purpose, the researcher proposes some recommendations that can improve the current level of collaborative structures in the education systems in Lagos State.

1. Currently, there is a consensus among school administrators that inclusive programs such as anti-stigma interventions are offered in both private and public schools. It is affirmed that such interventions are not adequately carried out in a way that can promote MH inclusion for the entire school community. Therefore, the government has a role to play in simplifying the policy objectives and providing accessible platforms for schools and other stakeholders to keep them informed. Participants offered more direct approaches to resolve this challenge. They suggested that the Federal Government of Nigeria should provide up-to-date data and promote awareness, preventive care, and treatment. Stigma reduction interventions should be mandated and continuous (including MH seminars/workshops and care support services). Essentially, direct interventions of the Federal Government at the grassroots level is required and should not be strictly confined to healthcare settings.

For state governments' support, it is recommended that Lagos State should provide financial support and mandate the integration of MH personnel (MH nurse, social workers, counselor, and psychologists) in schools. Also, to address disparity in service delivery in schools, the State should embark on relationship building between the State and NGOs to link schools to proximate MH community resources. Such services should be comprehensive by integrating physical and mental healthcare services. It is believed that such comprehensive services can reduce shame that prevent people from accessing MH services if integrated in an inclusive manner and made accessible to all.

The state government should also liaise with LGAs for regular follow-ups and monitoring of mental health-related activities in schools. Such activities should address MHSUs' needs. Both the State and Federal agencies coordinating efforts at the grassroots should aim at removing barriers to inclusion, improve access to insurance coverage, providing transport services to support teachers, and supporting disclosure as well as recovery. Providing directives to FMoH to train HR and remove sensitive words that pose as barriers to the utilization of MH resources is recommended.

2. As evident in this study, private schools narrowly use inclusive concepts to define their roles to MH promotion among students, while public schools tend to use it in broader terms to encompass staff and students. Apart from this difference, the perceived level of government support might have contributed substantially to the difference. To resolve the observed differences in the use of the concept of inclusion, the involvement of both sectors in creating a forum can enable them to act with a unified voice. Also, bridging the communication gap between the two sectors, to liaise with community mental health support workers either to give on-site MH support services or referral to self-help groups and professional services in school areas, is recommended. Such relationships can increase the utilization of inclusive services (anti-stigma resources) for MHSUs.

Attitudinal changes on the part of the school management toward MH promotion is essential. Management needs a re-orientation about the need for social support services to remove barriers to MH care and support services. Mandatory regular MH assessment/and support recovery for all workers can help ameliorate the discriminatory barriers to seeking help. School administrators can reach out to MH agencies in their school environments to have access to support services and other available MH resources.

Management can also agitate for workload reduction/and an increase in staff remuneration. Also, dialoguing with school boards on disclosure guidelines to provide confidentiality to MHSUs is recommended. Disclosure starts with providing a safe place for MH conversation and to seek support. Access to support services is crucial; therefore, the nearness of MH resources to schools should be considered. Management should be ready to challenge staff's negative belief

3. The practice of strategic alliance in MH inclusion as revealed in the current study remains at the extreme lowest end of the integration spectrum which is networking and cooperation. This strategy has been adopted since 2013 without much improvement in its application and the services provided. As earlier identified massive investments are required which stresses the importance of involving diverse stakeholders: government, NGOs, organizations (workplaces), religious organizations, community organizations, healthcare organizations, service users, and their families. As revealed in the present study, inputs from key members of MH strategic alliances are missing in this study which reduces the effectiveness of the program. Schools are less active in defining the kind of services they want and how they want them. It is therefore recommended that governments should create enabling mechanisms through which continuous dialogue is promoted. Such platforms should also provide avenues for schools to dialogue on how best they can be served, to express the requisite services in schools, and how and when they should be provided.

4. The minimal application of anti-stigma to remove barriers to MH inclusion in private and public schools weakens and confines the concept to only awareness. Even with that, drug abuse and stress-related issues are prioritized, suggesting that the current application of inclusive mechanisms and services in schools is problematic. The corollary is that the delivery of the programs is stigmatizing in both sectors. The concept of inclusion is holistic in its approach to stigma reduction, emphasising belonging, equity, diversity, active participation, cultural competency and accessibility. However, as revealed in the present study, it is rarely used to define the economic participation of MHSUs in public schools but in general terms to reduce stress among staff. In private schools, its usage is limited to creating awareness on drug-related problems among students. This deliberate or unintentional misuse of the concept may undermine MHSUs' trust and reduce schools' levels of commitment. Hence, the low performance as indicated by school administrators in both sectors was both internal (low motivation from school management) and external due to lack of directives and resources. It is therefore recommended that MHLAP should create a forum or platform for addressing trust-related issues affecting schools' active participation in MH inclusion and situate offices and resources in communities to link MHSUs to the needed service(s). Such platforms should address the gaps between community healthcare workers and schools.

5. Similarly, the differences observed in structures and methods of stigma interventions for supporting MH inclusion in schools as indicated above are best understood from the perspective of differences in organizational values. However, both sectors pursue education for all which is considerably an inclusive agenda. The motives of the two sectors are partially different. When education is perceived as citizens' right and free in the public sector, it is conceived as business in the private sector. This perhaps may explain why private and public schools differ in the mode of implementing MH inclusion. Also, the values attached to the concept reflect where school administrators' trust and commitment lie. The public sector

views inclusion as encompassing both staff and students and is particular about issues affecting staff in and out of the schools which can sometimes cause psychological breakdown. Cases of this nature are common, and the supports needed are lacking as affirmed by participants. In private schools, inclusion is strictly tied to students, and where such services are available, focus is on drug abuse/misuse. Private schools are reluctant to employ MHSUs for fear of displeasing parents or guardians. It is therefore recommended that MH stakeholders should sensitize the private education sector through training, workshops, and motivation. Less punitive but persuasive approaches should be adopted, as Nelissen et al. (2017) and Agovino et al. (2023) suggested that legal enforcement is less effective in enforcing compliance.

NGOs' roles in promoting MH inclusion is crucial and very relevant to schools in bringing services to their doorsteps. Thus, these roles need redefining to meet MH policy goals and schools' needs. The following are recommended as guide to schools when liaising with NGOs. There should be open communication between local MH NGOs and schools. Inclusive promotion by local NGOs such as Tony Marinho Mental Health Initiative, Mentally Aware Initiative of Nigeria (MANI), and Health Strategy and Delivery Foundation (HSDF) have been criticized for focusing mainly on students. School environments should be accommodating and supportive to both learners and staff. Thus, NGO services to schools should be service-oriented, catering for workers and not just students alone. Sustainability and continuity are required as opposed to the one-time approach to MH promotion in schools; follow-up services are equally important. Services should include on-site support. Efforts should entail locating and linking staff to proximate resources. NGOs can work with community mental healthcare to facilitate accessibility and timely treatment. Such support services can include funding a halfway facility that schools can refer MHSUs and others to, which can directly connect an individual to the right resources.

Finally, there should be routine monitoring and evaluation activities for MH programs for all personnel by the public health sector to reduce discrimination. This approach might be helpful to remove barriers to service utilization when such services are mandatory for all. MH services should not be perceived as established for a particular group of people. In addition, MHSUs have a role to play in advocating the kind of service they require, how to be served, and utilizing the resources. Hence, MHSUs should promote personal preventive care: the pursuit of a balanced and healthy life starts with openness in a conducive work environment to facilitate behavioural change and promote a work-life balance. Such measures can include:

Attitudinal change: Stakeholders should improve help-seeking behaviours among MHSUs and school communities. MHSUs should maintain work-life balance (set goals, manage time, prioritize health, set boundary, and minimise work hours). MHSUs should maintain healthy relationships among colleagues to prevent the fear of disclosure. Lastly, MHSUs should seek MH information and locate helpful support services.

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Appendix A: Initial Research Instrument



**UNIVERSITY
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Proposed Survey Questionnaires on the implementation of participation strategies to enhance inclusive workplaces in the public and private educational systems in Lagos State

BY: Felicia O. Owadara

This survey is structured into three sections, A, B and C. Section A covers Personal and demographic information. Section B covers nature of relationships for mental health promotion and types of mental health supports in your school's areas and section C is an open-ended question which allows respondents to express their opinions on mental health promotion.

Section A: Personal and Social Characteristics

Area code.....

1. Which education districts headquarter does your school belong to?
A. Ikeja/Maryland []. B. Eti-Osa []. C. Oshodi. []. Not Sure [].
2. State your school's LGA.....
3. Please specify most frequently occurring income of people living in the school neighborhood

Income per annum of the people living in your school area:	
< N 2.5 million	
N 2.5million – 5,599,999	
N 6 million 8,999,999	
N 9 million- 11,999,999	
N 12 million- 14,999,999	
N15,000, 0000 and above	

4. On a scale of 1 to 5, rate the extent to which you agree that many non-governmental agencies are present in LGA where your school is located?
 - Strongly Disagree [1]
 - Disagree [2]
 - Agree [3]
 - Strongly Agree [4]

5. How long have you been working as part of the administration in your school?
- <5 years []
 - 5 years to 10 years []
 - 10+ years []
6. Are you working in..... ?
- Nursery and primary school []
 - Junior secondary school []
 - Senior secondary school []
7. Which sector is your school in?
- Private []
 - Public []
8. What is the size of the workforce in your school? (including janitorial and clerical staff)
- 0-20 []
 - 21-40 []
 - 41-60 []
 - 61-80 []
 - 81+ []
9. What is this person's gender?
- Female []
 - Male []
 - Or please specify this person's gender.....
 - Not willing to share []
10. Current level of education?
- Diploma/Certificate/ NCE []
 - Graduate (HND, BSC, B. Ed.) []
 - Postgraduate (MSC, M. ED, MSW, MPhil, PhD) []
 - Others (specify).....
11. Which category does your age falls into? Circle as applicable.
- ≤ 25 []
 - 26-35 []
 - 36- 45 []
 - 46 & above []
12. What is your current position at work? Tick as applicable to you
- Human resources manager (HR.) []
 - Principal/ V. principal/ School director/ Head teacher/Proprietor []
 - Head of the Department (HOD.) []

- Other (specify)..... []

13. Use information here to respond to the items below: 1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.

14. Please indicate your level of willingness related to each of the following statements:		1	2	3	4	5
a.	How willing would you be to employ someone if you knew they had a mental illness?					
b.	How willing would you be to have someone with a mental illness start working closely with you on a job?					
c.	How willing would you be to have someone with a mental illness marry into your family?					
d.	How willing would you be to move next door to someone with a mental illness?					
e.	How willing would you be to make friends with someone with a mental illness?					
f.	How willing would you be to spend an evening socializing with someone with a mental illness?					

The following questions aim at determining your knowledge of mental health policy reforms. When responding, use the following categories as a guide:

- 1=Definitely not informed = I am certain that I am NOT aware of the reform
- 2= Uncertain = I think I recognize the reform, but I am not sure.
- 3= Likely informed = I think I know something about the reform, but do not have the full picture
- 4= Definitely well informed= I am certain that I have a full understanding of the reform

Use the information provide above to rate these items		1	2	3	4
14a	I am aware of the recent mental health policy reform of 2013.				
14b	I am of the acceptance of mental health service users as employees in the workplace				
14c	I am aware of the insurance equality for people with mental health & other disabilities				
15a	I am aware of the relationship building to promote mental health				
15b	I am aware of the negative impact of cultural stigma on mental health promotion				

16. Your workplace puts measures in place to prevent discrimination against employees and job applicants with mental health problems.

- Yes. []
- No. []
- I do not know []

17. Your workplace allows workers to disclose their mental health status without fear of dismissal?

- Strongly Agree [] Agree [] Disagree [] Strongly Disagree []

18. To what extent do your organizational values incorporate the following?

0= not at all 1= to a very low degree, 2= to a low degree, 3=to a moderate degree, 4= to a high degree, 5 – to a very high degree

Level of Incorporation

- Equality []
- Diversity []
- Partnership []
- Profit making []
- Integrity []
- Respect for individual persons []

19. When last was an employee in your workplace last terminated because of mental health problem?

- Between 1- 5 months ago. []
- 6 months- to 1 year ago []
- 2 to-3 years ago []
- 4-to 5years []
- 3 years or longer. []
- Never []

20. Indicate all agencies that promote mental health in which your school associates with:

- i. Local non-governmental agency []
- ii. Ministry of Health (at LGA level) []
- iii. International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. []
- iv. Religious organization []
- v. Ministry of Education []
- vi. Others (specify)
- vii. If your school does not associate with any of these agencies, indicate here []

Section B: responds to the items that describe measures that promote mental health (MH) in your school/ LGA and efficiency of those measures.

These items measure your opinion on available network of supports for mental health promotion to your school/ or LGA where your school is located.

Describe your school's level of involvement with other agency(s).	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
21. Provide information on the level at which your school reach out to mental health support service	SD	D	A	SA
i. never engages in any communication with the Ministry of health on mental health promotion related issues				

ii. never interacts with other service providers to improve access to care for mental health (e.g., Insurance/ local support group/ police/ religious organization)				
iii. never employs mental health social worker.				
iv. never liaises with community extension workers.				
v. never allow staff to participate in community mental health outreach programs.				
vi. never receives timely material/ financial support from any agencies (State/NGOs/ Church/ Mosques)				
vii. never reach out to other service providers to improve staff access to mental healthcare				
viii never interacts with community mental health nurse				
ix. never interacts with community extension workers from the LGA on mental health.				
22. Provide information on how often your school is able to participate in mental health promotion.	SD (1)	D (2)	A (3)	SA (4)
x. Occasionally run WHO's Mental Health Leadership Advocacy Program initiated (WHO) & Mental Health Advocacy Action Programme/ or workshop				
xi. Occasionally join other group in seminar/ workshop on mental health awareness in school for Mental Leadership skill and advocacy training organized by government and WHO.				
xii. Occasionally participates in community mental health outreach program				
xiii. Occasionally, receives timely financial supports from the Ministry of Health				
xix. Occasionally receives timely guidance from the Ministry of Health.				
xx. Occasionally receives mental health information/ guidance/ fund from NGOs				
xxi. Occasionally receive professional visit from mental health social worker/ nurse, psychologist/ counsellor/ nutritionist etc)				
23. Provide information on how well your school is able to organize mental health relationship in these areas	SD (1)	D (2)	A (3)	SD(4)
xxii. sometimes participates in consultations convened for governments to make decisions about mental health programs				
xxiii. sometimes works directly with the state Ministry of Health to share ideas on mental health promotion.				

xxiv. sometimes works directly with the state Ministry of Health to receive mental health information.				
xxv. sometimes in contact with community leaders on mental health promotion.				
xxvi. sometimes in contact with community mental health committees to access mental health support for staff.				
xxvii. sometimes receives mental health update on (research outcomes, guide, new programs, funding, training/workshop etc).				
24. Provide information on how representative your school is in the following areas:	SD (1)	D(2)	A(3)	SA(4)
xviii. your school has a representative at the LGA to participate in developing mental health programs, and policy.				
xix. your school has representative that frequently brings mental health information from community to staff.				
xx. your school representative actively involves in developing community mental health resources, and events in your area.				
xxi. your school actively participate in advocating for mental health support.				
xxii. your school actively relates with other service providers to improve staff's access to MH service.				
xxiii. your school is an active member of the WHO's Mental Health Leadership Advocacy Action Programme.				
25. Provide information on how active your school relates with other agencies for mental health awareness	SD (1)	D (2)	A(3)	SA(4)
xxiv. actively pursues healthy working relationship with community leaders in LGA to provide similar mental health guidance across schools in Lagos state.				
xxv. always has a representative in community mental health outreach program that jointly promote support service/or receive support from local NGOs to initiate mental health promotion				
xxvi. always receives extensive guidance from the Ministry of health to support access to basic MH service.				
xxvii. continually engages in workshop, training, & research with Mental Health Leadership Advocacy Action Program.				
xxviii. always receive mental health update on (research outcomes, new programs, funding, training/workshop etc) from community mental health committees within the LGA.				

26. On a scale of 1 to 6, rate the quality of Mental Health (MH) support that the State provides your school						
Rate the support receive from the state for mental health promotion in your school community	Very Poor 1	Poor 2	Fair 3	Good 4	Very good 5	Excellent 6
a. The state's office in the in supporting mental health programs in the school and/or its surrounding community						
b. The state provides periodic information about mental health initiatives						
c. The state includes in its annual budget funds for MH promotion in the school and / or its surrounding community						
d. The state links the school to local resources that promote mental health						
e. The state exhibits dedication to championing well-being and mindfulness programs						
f. The state recruits support workers to promote mental health at the local government area and state levels						
g. The state provides periodic training to support groups to promote mental health in the workplace						
h. The state provides information that links the school as a workplace to advocacy groups						
xxix. employs counsellor/psychologist/ social workers to continually liaise with mental health community extension workers.						
xxx. pursues relationship building as a life goal with mental health providers to improve access to care and material support (e.g., research team, insurance coverage/ funding/ mental health practitioners from community healthcare/ NGOs).						

Please respond to all remaining questions based on your administrative experience and not on the basis of any personal experience you may have with mental health issues: indicate your level of agreement with each of the statements below based on your administrative experience. Where SD=Strongly Disagree (1), D=Disagree (2), A=Agree (3), and SA=Strongly Agree (4)

27. Based on your administrative knowledge of mental health information available in your school, respond to the following items	SD(1)	D(2)	A(3)	SA(4)
a. It is difficult to arrange treatment appointments at my school.				
b. My school provides the opportunity to access information on mental health treatment.				
c. My school encourages sharing personal experiences of mental health treatment with others				
d. My school helps by providing information that reduces mental health stigma, when appropriate.				
e. My school encourages employees to be open-minded about the mental health experiences and feelings of colleagues.				
f. My school responds to employees with mental health problems with empathy.				
g. My school encourages peer support for people with mental health problems.				
h. My school encourages employees with mental health problems to seek help from hospital/s community health programs & support groups.				
28. These items refer to mental health education provide in your school				
i. My school offers educational materials on mental health, treatment, and guidelines (e.g., documents, videos, websites)				
j. My school offers information to staff on hospitals managing mental health symptoms.				
k. My school offers information on stress, mental health and/or available programs.				
l. My school educates staff on treatment plans and return to work arrangements.				
m. My school educate families of employees with mental health problems on support services to manage stress and enhance mental wellbeing.				
n. My school provide access to hotlines to learn support that works.				
29. These items refers to how well your school stand in support of employee's mental health				
o. My school makes it easy to seek help for mental health problems when needed.				
p. My school makes it difficult to ask for help for mental health problems in the workplace.				
q. My school encourages the building and nurturing real-life, face-to-face social connections between employees with mental health problems and other employees.				
r. My school sets and works towards personal, wellness, and work-related goals.				
s. My school links staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in seeking treatment.				
30. These items refer to access to treatment that available to employees				

t. My school plans intervention(s) that allow workers to understand the need for treatments, including medication.				
u. My school promotes outreach programs (assertiveness, learning, social planning, mental health support training), to workers.				
v. My school overlooks the importance of mental health support groups for staff.				
w. My school encourages employee to seek mental health treatment.				
x. My school refers staff to receive treatment and support.				
y. My school conducts home visits to monitor staff's progress on their journey to recovery from mental illness.				
z. My school seeks mental health professional support on behalf of staff				
aa. My school offers support services to link staff to mental health resources, including local support groups.				
bb. My school provides continuous support during and after recovery from mental illness.				

What is the level of your school's commitment to accommodating employees with mental health problems? Please rate each component below on a scale of 1-6. Where 1=very poor, 2= poor, 3= average, 4=good, 5= very good, 6=Excellent.

S/N	Your school:	1	2	3	4	5	6
31.	Makes employees with mental health problems feel valued.						
32.	Reduces the incidence of employees feeling out of place because of their mental health status.						
33	Fosters an environment characterized by respect for employees with mental health problems.						
34	Is committed to the mental wellbeing of employees.						
35	Is committed to work-life balance for employees.						
36	Ensures that mental health service user employees feel supported in their roles						
37	Is supportive of employees in seeking mental health treatment						
38	Provides better support for employee during recovery related to mental health conditions.						
39	Supports employee to return to work after recovery from mental illness.						
40	Encourages openness about mental health problems.						
41	Makes respect part of the workplace cultures.						
42	Is consistent in providing educational awareness programs on stress and mental wellbeing.						
43	Dismisses employees living with mental illness from their positions.						

Section C: Your personal opinion about these two questions is crucial to an understanding of state of mental health programs in Lagos state.

A. What would you consider as greatest challenges in promoting mental health programs in workplace?

B. What specific changes would you like to see to improve the quality of supports for persons with mental health problems in your workplace?

C. Is there anything else that you would like to tell us that we have not asked about?

Thank You Sir/Ma for Your Participation

Appendix B: Validated Research Instrument



**UNIVERSITY
OF MANITOBA**

Survey Questionnaires on the Implementation of Participation Strategies to Enhance Inclusive Workplaces in the Public and Private Educational Systems in Lagos State

BY: Felicia O. Owadara

This survey is structured into three sections, A, B and C. Section A covers Personal and demographic information. Section B covers nature of relationships for mental health promotion and types of mental health supports in your school’s areas and section C is an open-ended question which allows respondents to express their opinions on mental health promotion.

Section A: Personal and Social Characteristics

Area code.....

1. Which education districts headquarter does your school belong to?
 B. Ikeja/Maryland []. B. Eti-Osa []. C. Oshodi. []. Not Sure [].
2. State your school’s LGA.....
3. Please specify most frequently occurring income of people living in the school neighborhood

Income per annum of the people living in your school area:	
< N 2.5 million	
N 2.5million – 5,599,999	
N 6 million 8,999,999	
N 9 million- 11,999,999	
N 12 million- 14,999,999	
N15,000, 0000 and above	

4. On a scale of 1 to 4, rate the extent to which you agree that many non-governmental agencies are present in LGA where your school is located?
 - Strongly Disagree [1]
 - Disagree [2]
 - Agree [3]
 - Strongly Agree [4]
5. How long have you been working as part of the administration in your school?
 - <5 years []
 - 5 years to 10 years []

- 10+ years []
6. Are you working in..... ?
- Nursery and primary school []
 - Junior secondary school []
 - Senior secondary school []
7. Which sector is your school in?
- Private []
 - Public []
8. What is the size of the workforce in your school? (including janitorial and clerical staff)
- 0-20 []
 - 21-40 []
 - 41-60 []
 - 61-80 []
 - 81+ []
9. What is this person's gender?
- Female []
 - Male []
 - Or please specify this person's gender.....
 - Not willing to share []
10. Current level of education?
- Diploma/Certificate/ NCE []
 - Graduate (HND, BSC, B.Ed.) []
 - Postgraduate (MSC, M. ED, MSW, MPhil, Ph.D.) []
 - Others (specify).....
11. Which category does your age falls into? Circle as applicable.
- ≤ 25 []
 - 26-35 []
 - 36- 45 []
 - 46 & above []
12. What is your current position at work? Tick as applicable to you
- Human resources manager (HR.) []
 - Principal/ V. principal/ School director/ Head teacher/Proprietor []
 - Head of the Department (HOD.) []
 - Other (specify)..... []
13. Use information here to respond to the items below: 1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.

Please indicate your level of willingness related to each of the following statements:		1	2	3	4	5
a.	How willing would you be to employ someone if you knew they had a mental illness?					
b.	How willing would you be to have someone with a mental illness start working closely with you on a job?					
c.	How willing would you be to have someone with a mental illness marry into your family?					
d.	How willing would you be to move next door to someone with a mental illness?					
e.	How willing would you be to make friends with someone with a mental illness?					
f.	How willing would you be to spend an evening socializing with someone with a mental illness?					

14. The following questions aim at determining your knowledge of mental health policy reforms. When responding, use the following categories as a guide:

1= Definitely not informed = I am certain that I am NOT aware of the reform

2= Uncertain = I think I recognize the reform, but I am not sure.

3= Likely informed = I think I know something about the reform, but do not have the full picture

4= Definitely well informed= I am certain that I have a full understanding of the reform

Use the information provide above to rate these items		1	2	3	4
14a	I am aware of the recent mental health policy reform of 2013.				
14b	I am aware of the acceptance of mental health service users as employees in the workplace				
14c	I am aware of the insurance equality for people with mental health & other disabilities				
15a	I am aware of the relationship building to promote mental health				
15b	I am aware of the negative impact of cultural stigma on mental health promotion				

16. Your workplace puts measures in place to prevent discrimination against employees and job applicants with mental health problems.

- Yes. []
- No. []
- I do not know []

17. Your workplace allows workers to disclose their mental health status without fear of dismissal?

- Strongly Agree []
- Agree []
- Disagree []
- Strongly Disagree []

18. To what extent do your organizational values incorporate the following?

0= not at all 1= to a very low degree, 2= to a low degree, 3=to a moderate degree, 4= to a high degree, 5 – to a very high degree

Level of Incorporation

- Equality []
- Diversity []
- Partnership []
- Profit making []
- Integrity []
- Respect for individual persons []

19. When last was an employee in your workplace last terminated because of mental health problem?

- Between 1- 5 months ago. []
- 6 months- to 1 year ago []
- 2 to-3 years ago []
- 4-to 5years []
- 6 years or longer. []
- Never []

20. Indicate all agencies that promote mental health in which your school associates with:

- viii. Local non-governmental agency []
- ix. Ministry of Health (at LGA level) []
- x. International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. []
- xi. Religious organization []
- xii. Ministry of Education []
- xiii. Others (specify)
- xiv. If your school does not associate with any of these agencies, indicate here []

Section B: responds to the items that describe measures that promote mental health (MH) in your school/ LGA and efficiency of those measures.

These items measure your opinion on available network of supports for mental health promotion to your school/ or LGA where your school is located.

Key: Strongly Disagree = SD, Disagree = D, Agree = A, Strongly Agree = SA

Describe your school's level of involvement with other agency(s)				
21. Provide information on the level at which your school reach out to mental health support service	SD	D	A	SA
i. never engages in any communication with the Ministry of health on mental health promotion related issues				
ii. never interacts with other service providers to improve access to care for mental health (e.g., Insurance/ local support group/ police/ religious organization)				
iii. never employs mental health social worker.				
iv. never liaises with community extension workers.				
v. never allow staff to participate in community mental health outreach programs.				
vi. never receives timely material/ financial support from any agencies (State/NGOs/ Church/ Mosques)				
vii. never reach out to other service providers to improve staff access to mental healthcare				
viii never interacts with community mental health nurse				

ix. never interacts with community extension workers from the LGA on mental health.				
22. Provide information on how often your school is able to participate in mental health promotion.	SD	D	A	SA
x. Occasionally run WHO's Mental Health Leadership Advocacy Program initiated (WHO) & Mental Health Advocacy Action Programme/ or workshop				
xi. Occasionally join other group in seminar/ workshop on mental health awareness in school for Mental Leadership skill and advocacy training organized by government and WHO.				
xii. Occasionally participates in community mental health outreach program				
xiii. Occasionally, receives timely financial supports from the Ministry of Health				
xix. Occasionally receives timely guidance from the Ministry of Health.				
xx. Occasionally receives mental health information/ guidance/ fund from NGOs				
xxi. Occasionally receive professional visit from mental health social worker/ nurse, psychologist/ counsellor/ nutritionist etc)				
23. Provide information on how well your school is able to organize mental health relationship in these areas	SD	D	A	SA
xxii. sometimes participates in consultations convened for governments to make decisions about mental health programs				
xxiii. sometimes works directly with the state Ministry of Health to share ideas on mental health promotion.				
xxiv sometimes works directly with the state Ministry of Health to receive mental health information.				
	SD	D	A	SA
xxv. sometimes in contact with community leaders on mental health promotion.				
xxvi. sometimes in contact with community mental health committees to access mental health support for staff.				
xxvii. sometimes receives mental health update on (research outcomes, guide, new programs, funding, training/workshop etc).				
24. Provide information on how representative your school is in the following areas:	SD	D	A	SA
xviii. your school has a representative at the LGA to participate in developing mental health programs, and policy.				
xix. your school has representative that frequently brings mental health information from community to staff.				
xx. your school representative actively involves in developing community mental health resources, and events in your area.				
xxi. your school actively participate in advocating for mental health support.				
xxii. your school actively relates with other service providers to improve staff's access to MH service.				
xxiii. your school is an active member of the WHO's Mental Health Leadership Advocacy Action Programme.				
25. Provide information on how active your school relates with other agencies for mental health awareness	SD	D	A	SA
xxiv. actively pursues healthy working relationship with community leaders in LGA to provide similar mental health guidance across schools in Lagos state.				

xxv. always has a representative in community mental health outreach program that jointly promote support service/or receive support from local NGOs to initiate mental health promotion				
xxvi. always receives extensive guidance from the Ministry of health to support access to basic MH service.				
xxvii. continually engages in workshop, training, & research with Mental Health Leadership Advocacy Action Program.				
xxviii. always receive mental health update on (research outcomes, new programs, funding, training/workshop etc) from community mental health committees within the LGA.				
xxix. employs counsellor/psychologist/ social workers to continually liaise with mental health community extension workers.				
xxx. pursues relationship building as a life goal with mental health providers to improve access to care and material support (e.g., research team, insurance coverage/ funding/ mental health practitioners from community healthcare/ NGOs).				

26. On a scale of 1 to 6 where 1= Very Poor, 2= Poor, 3= Fair, 4= Good, 5 = Very good, 6 = Excellent, rate the quality of Mental Health (MH) support that the State provides your school

Rate the support receive from the state for mental health promotion in your school community	Very poor	Poor	Fair	Good	Very good	Excellent
a. The state's office in the in supporting mental health programs in the school and/or its surrounding community						
b. The state provides periodic information about mental health initiatives						
c. The state includes in its annual budget funds for MH promotion in the school and / or its surrounding community						
d. The state links the school to local resources that promote mental health						
e. The state exhibits dedication to championing well-being and mindfulness programs						
f. The state recruits support workers to promote mental health at the local government area and state levels						
g. The state provides periodic training to support groups to promote mental health in the workplace						
h. The state provides information that links the school as a workplace to advocacy groups						

27. Please respond based on your administrative experience: indicate your level of agreement with each of the statements below based on your administrative experience. Where SD=Strongly Disagree (1), D=Disagree (2), A=Agree (3), and SA=Strongly Agree (4)

These items refer to mental health information available in your school	SD(1)	D(2)	A(3)	SA(4)
a. It is difficult to arrange treatment appointments at my school				
b. My school provides the opportunity to access information on mental health treatment.				
c. My school encourages sharing personal experiences of mental health treatment with others				

d. My school helps by providing information that reduces mental health stigma, when appropriate.				
e. My school encourages employees to be open-minded about the mental health experiences and feelings of colleagues.				
f. My school responds to employees with mental health problems with empathy.				
g. My school encourages peer support for people with mental health problems.				
h. My school encourages employees with mental health problems to seek help from hospital/s community health programs & support groups.				
28. These items refer to mental health education provide in your school				
i. My school offers educational materials on mental health, treatment, and guidelines (e.g., documents, videos, websites)				
j. My school offers information to staff on hospitals managing mental health symptoms.				
k. My school offers information on stress, mental health and/or available programs.				
l. My school educates staff on treatment plans and return to work arrangements.				
m. My school educate families of employees with mental health problems on support services to manage stress and enhance mental wellbeing.				
n. My school provide access to hotlines to learn support that works.				
29. These items refers to how well your school stand in support of employee's mental health	SD	D	A	SA
o. My school makes it easy to seek help for mental health problems when needed.				
p. My school encourages the building and nurturing real-life, face-to-face social connections between employees with mental health problems and other employees.				
q. My school sets and works towards personal, wellness, and work-related goals.				
r. My school links staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in seeking treatment.				
30. These items refer to access to treatment that available to employees	SD	D	A	SA
s. My school plans intervention(s) that allow workers to understand the need for treatments, including medication.				
t. My school promotes outreach programs (assertiveness, learning, social planning, mental health support training), to workers.				
u. My school overlooks the importance of mental health support groups for staff.				
v. My school encourages employee to seek mental health treatment.				
w. My school refers staff to receive treatment and support.				
x. My school conducts home visits to monitor staff's progress on their journey to recovery from mental illness.				
y. My school seeks mental health professional support on behalf of staff				
z. My school offers support services to link staff to mental health resources, including local support groups.				
aa. My school provides continuous support during and after recovery from mental illness.				

31. What is the level of your school’s commitment to accommodating employees with mental health problems? Please rate each component below on a scale of 1-6. Where 1=very poor, 2= poor, 3= average, 4=good, 5= very good, 6=Excellent.

S/N	Your school:	1	2	3	4	5	6
31.	Makes employees with mental health problems feel valued.						
32.	Reduces the incidence of employees feeling out of place because of their mental health status.						
33	Fosters an environment characterized by respect for employees with mental health problems.						
34	Is committed to the mental wellbeing of employees.						
35	Is committed to work-life balance for employees.						
36	Ensures that mental health service user employees feel supported in their roles						
37	Is supportive of employees in seeking mental health treatment						
38	Provides better support for employee during recovery related to mental health conditions.						
39	Supports employee to return to work after recovery from mental illness.						
40	Encourages openness about mental health problems.						
41	Makes respect part of the workplace cultures.						
42	Is consistent in providing educational awareness programs on stress and mental wellbeing.						
43	Dismisses employees living with mental illness from their positions.						

Section C: Your personal opinion about these two questions is crucial to an understanding of state of mental health programs in Lagos state.

A. What would you consider as greatest challenges in promoting mental health programs in workplace?

B. What specific changes would you like to see to improve the quality of supports for persons with mental health problems in your workplace?

C. Is there anything else that you would like to tell us that we have not asked about?

Thank You Sir/Ma for Your Participation.

Appendix C: Coding Book

Variable Name	Label	Coding
ID		
Area_Code		
District		1=Ikeja/Maryland 2=Eti-Osa 3=Oshodi 4=Not Sure
LG		
Socioeconomic s	Social economic status of the school's area	1= < N 2.5 million 2=N 2.5million – 5,599,999 3= N 6 million -8,999,999 4=N 9 million- 11,999,999 5=N 12 million- 14,999,999 6=N15,000, 0000 and above
NGOs	Availability of NGOs in the school area/LA	1= SD 2= D 3=A 4=SA
Yr_experience	Experience as administrator	1= <5 years 2=5 years to 10 years 3=10+ years
Workplace	Place of work	1= Nursery and primary school 2= Junior secondary school 3=Senior secondary school
Sector	Educational sector that you work	1=Private 2=Public
Workforce	Size of your school's workplace	1= 0-20 2= 21-40 3=41-60 4=61-80 5=81+
Gender	Gender	1=Female 2= Male 3=Or please specify this person's gender.....
Education	Educational qualification	4=Not willing to share 1=Diploma/Certificate/ NCE 2=Graduate (HND, BSC, B.Ed.) 3=Postgraduate (MSC, M.ED, MSW, MPhil, PhD) 4=Others (specify).....

Age	Age	1= ≤ 25 2=26-35 3= 36- 45 4=46 & above
Jobposition	Position at workplace	1=Human resources manager (HR.) 2=Principal/ V. principal/ School director/ Head teacher/Proprietor 3=Head of the Department (HOD.) 4= Other (specify).....
Knowl_MH1	Willingness to employ MHSUs	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_MH2	Willingness to work closely with MHSUs	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_MH3	Willingness to marry MHSUs into the family	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_MH4	Willingness to live next door with MHSUs	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_MH5	Willingness to be friend MHSUs	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_MH6	Willingness to socialize with MHSUs	1= Definitely unwilling 2= Probably unwilling 3= Neither willing/or unwilling 4= Probably willing 5= Definitely willing.
Knowl_NMHP a	Awareness of MHP Reform of 2013	1=Definitely not informed 2= Uncertain 3= Likely informed 4= Definitely well informed
Knowl_NMPH b1	Acceptance of MHSUs in workplace	1=Definitely not informed 2= Uncertain 3= Likely informed 4= Definitely well informed

Knowl_NMHP b2	Insurance parity	1=Definitely not informed 2= Uncertain 3= Likely informed 4= Definitely well informed
Knowl_NMHP b3	Relationship building for MH promotion	1=Definitely not informed 2= Uncertain 3= Likely informed 4= Definitely well informed
Knowl_NMHP b4	Cultural stigma	1=Definitely not informed 2= Uncertain 3= Likely informed 4= Definitely well informed
Knowl_DP	Discrimination program in workplace	1=Yes. 2= No. 3=I do not know
Knowl_Disclos	Disclosure in workplace	4=Strongly Agree 3=Agree 2= Disagree 1=Strongly Disagree
Org_value1	Equity	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree
Org_values2	Diversity	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree
Org_values3	Partnership	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree
Org_values4	Profit making	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree

Org_values5	Integrity	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree
Org_values6	Respect for individual	0= not at all 1= to a very low degree 2= to a low degree 3=to a moderate degree 4= to a high degree 5 = to a very high degree
Dismissal	Knowledge of dismissing of MHSUs in your school/LGA	1=Between 1- 5 months ago. 2=6 months- to 1 year ago 3=2 to-3 years ago 4=4-to 5years 5= 6 years or longer. 6= Never
MH_Link1	MH agency that associate with your school	1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here
MH_Link2	MH agency that associate with your school	1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here

MH_Link3	MH agency that associate with your school	<p>1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here</p>
MH_Link4	MH agency that associate with your school	<p>1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here</p>
MH_Link5	MH agency that associate with your school	<p>1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here</p>
MH_Link6	MH agency that associate with your school	<p>1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here</p>

MH_Link7	MH agency that associate with your school	1=Local non-governmental agency 2=Ministry of Health (at LGA level) 3=International NGOs e.g., Clinton Foundation, UNICEF, WHO etc. 4=Religious organization 5= Ministry of Education 6=Others (specify) 7=If your school does not associate with any of these agencies, indicate here
Nt1	never engages in any communication with the Ministry of health on mental health promotion related issues	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt2	never interacts with service providers on insurance & support ser.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt3	never interacts with other service providers to improve access to care for mental health (e.g., Insurance/ local support group/ police/ religious organization)	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt4	never employs mental health social worker.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt5	never liaises with community extension workers.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt6	never allow staff to participate in community mental health outreach programs.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt7	never receives timely material/ financial support from any agencies (State/NGOs/ Church/ Mosques)	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt8	never reach out to other service providers to improve staff access to mental healthcare	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
Nt9	never interacts with community mental health nurse	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)

coop1	Occasionally run WHO's Mental Health Leadership Advocacy Program initiated (WHO) & Mental Health Advocacy Action Programme/ or workshop	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop2	Occasionally join other group in seminar/ workshop on mental health awareness in school for Mental Leadership skill and advocacy training organized by government and WHO.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop3	Occasionally participates in community mental health outreach program	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop4	Occasionally, receives timely financial supports from the Ministry of Health	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop5	Occasionally receives timely guidance from the Ministry of Health.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop6	Occasionally receives mental health information/ guidance/ fund from NGOs	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coop7	Occasionally receive professional visit from mental health social worker/ nurse, psychologist/ counsellor/ nutritionist etc)	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coord1	sometimes participates in consultations convened for governments to make decisions about mental health programs	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coord2	sometimes works directly with the state Ministry of Health to share ideas on mental health promotion	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coord3	sometimes works directly with the state Ministry of Health to receive mental health information.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coord4	sometimes in contact with community leaders on mental health promotion	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coord5	sometimes in contact with community mental health committees to access mental health support for staff.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)

coord6	sometimes receives mental health update on (research outcomes, guide, new programs, funding, training/workshop etc).	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal1	your school has a representative at the LGA to participate in developing mental health programs, and policy	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal2	your school has representative that frequently brings mental health information from community to staff.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal3	your school representative actively involves in developing community mental health resources, and events in your area.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal4	your school actively participate in advocating for mental health support.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal5	your school actively relates with other service providers to improve staff's access to MH service.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
coal6	your school is an active member of the WHO's Mental Health Leadership Advocacy Action Programme	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab1	actively pursues healthy working relationship with community leaders in LGA to provide similar mental health guidance across schools in Lagos state.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab2	always has a representative in community mental health outreach program that jointly promote support service/or receive support from local NGOs to initiate mental health promotion	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab3	always receives extensive guidance from the Ministry of health to support access to basic MH service.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab4	continually engages in workshop, training, & research with Mental Health Leadership Advocacy Action Program.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)

collab5	always receive mental health update on (research outcomes, new programs, funding, training/workshop etc) from community mental health committees within the LGA	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab6	employs counsellor/psychologist/ social workers to continually liaise with mental health community extension workers.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
collab7	pursues relationship building as a life goal with mental health providers to improve access to care and material support (e.g., research team, insurance coverage/ funding/ mental health practitioners from community healthcare/ NGOs).	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
govtsupport_M H1	The state's office in the in supporting mental health programs in the school and/or its surrounding community	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupport_M H2	The state provides periodic information about mental health initiatives	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupport_M H3	The state includes in its annual budget funds for MH promotion in the school and / or its surrounding community	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupportor_M H4	The state links the school to local resources that promote mental health	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupport_M H5	The state exhibits dedication to championing well-being and mindfulness programs	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent

govtsupport_M H6	The state recruits support workers to promote mental health at the local government area and state levels	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupport_M H7	The state provides periodic training to support groups to promote mental health in the workplace	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
govtsupport_M H8	The state provides information that links the school as a workplace to advocacy groups	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
antistigma_info 1	It is difficult to arrange treatment appointments at my school	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 2	My school provides the opportunity to access information on mental health treatment.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 3	My school encourages sharing personal experiences of mental health treatment with others	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 4	My school helps by providing information that reduces mental health stigma, when appropriate	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 5	My school encourages employees to be open-minded about the mental health experiences and feelings of colleagues	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 6	My school responds to employees with mental health problems with empathy	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_info 7	My school encourages peer support for people with mental health problems.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)

antistigma_info8	My school encourages employees with mental health problems to seek help from hospital/s community health programs & support groups.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_pysed1	My school offers educational materials on mental health, treatment, and guidelines (e.g., documents, videos, websites)	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_psyed2	My school offers information to staff on hospitals managing mental health symptoms.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_psyed3	My school offers information on stress, mental health and/or available programs.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_psyed4	My school educates staff on treatment plans and return to work arrangements.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_psyed5	My school educate families of employees with mental health problems on support services to manage stress and enhance mental wellbeing.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_psyed6	My school provide access to hotlines to learn support that works.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_advoc1	My school makes it easy to seek help for mental health problems when needed.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_advoc2	My school encourages the building and nurturing real-life, face-to-face social connections between employees with mental health problems and other employees.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_advoc3	My school sets and works towards personal, wellness, and work-related goals.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_advoc4	My school links staff with other agencies (e.g., media, NGOs) to reduce resistance due to stigma in seeking treatment.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp1	My school plans intervention(s) that allow workers to understand the need for treatments, including medication	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)

antistigma_tp2	My school promotes outreach programs (assertiveness, learning, social planning, mental health support training), to workers.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp3	My school overlooks the importance of mental health support groups for staff.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp4	My school encourages employee to seek mental health treatment.	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp5	My school refers staff to receive treatment and support	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp6	My school conducts home visits to monitor staff's progress on their journey to recovery from mental illness	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp7	My school seeks mental health professional support on behalf of staff	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp8	My school offers support services to link staff to mental health resources, including local support groups	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
antistigma_tp9	My school provides continuous support during and after recovery from mental illness	Strongly Disagree = SD (1) Disagree = D (2) Agree = A (3) Strongly Agree = SA (4)
commitment1	Makes employees with mental health problems feel valued	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commitment2	Reduces the incidence of employees feeling out of place because of their mental health status	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commitment3	Fosters an environment characterized by respect for employees with mental health problems.	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good

		6 = Excellent
commtiment4	Is committed to the mental wellbeing of employees	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment5	Is committed to work-life balance for employees	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment6	Ensures that mental health service user employees feel supported in their roles	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment7	Is supportive of employees in seeking mental health treatment	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment8	Provides better support for employee during recovery related to mental health conditions	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment9	Supports employee to return to work after recovery from mental illness.	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commtiment10	Encourages openness about mental health problems.	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent

commtiment11	Makes respect part of the workplace cultures	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commitment12	Is consistent in providing educational awareness programs on stress and mental wellbeing	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
commitment13	Dismisses employees living with mental illness from their positions	1= Very Poor 2= Poor 3= Fair 4= Good 5 = Very good 6 = Excellent
opinion1		
opinion2		
opinion3		

Appendix D: Population Distribution for Public Primary, Junior & Secondary School, Lagos State /Per Education Districts

Education Districts	LGA	Pry	Junior	Sec.
District I: C/o Diary Farm Primary Schools Complex, Agege, Lagos	Agege	50	13	8
	Alimosho	75	34	25
	Ifako-Ijaye	26	11	8
District II: Maryland Schools Complex, Maryland, Ikeja.	Ikorodu	61	31	28
	Kosofe	40	14	14
	Shomolu	47	9	14
District III: St. George's Primary School, Opposite Falomo Shopping Complex, 123, Awolowo Road, Falomo, Ikoyi, Lagos.	EPE	74	27	27
	Eti-Osa	35	19	19
	Ibeju-Lekki	40	9	9
District IV: Domestic Science Centre, 8, McEwen Road	Lagos Island	32	11	11
	Sabo-Yaba	63	31	28
	Apapa	24	6	6
District V: Agboju Schools' Complex, Agboju-Lagos	Surulere	63	29	29
	Lagos Mainland	57	14	9
	Ajeromobi/Ifelodun	71	19	20
District VI: Ewenla Street, Near Charity Bus-stop, Oshodi-Lagos.	Amuwo-Odofin	43	19	20
	Badagry	55	14	14
	Ojo	54	17	15
Total	Ikeja	32	13	12
	Mushin	77	16	16
	Oshodi/Isolo	56	25	22
Total		1,015	350	322

Retrieved: Population Distribution for Private Primary and Secondary School, Lagos State (Still not available)

Appendix E. Formula for Calculating Study Sample Size

Formula : $\hat{\mu} = \frac{\sum y_i}{n}$

$$\hat{U}_{r(\mu)} = \frac{1}{n(n-1)} \sum (\bar{y} - \hat{\mu})^2$$

$$\bar{y} = \frac{\sum_{1=j}^n \sum_{1=j}^m y_{ij}}{n_m}$$

Where:

U means Universe of PSU,

U_i represents universe of elements in PSU_i (i=subscript)

M means Number of the PSU in the universe

N_i denotes number of elements in the population universe of PSU i,

N equates Total number of elements in the populations

π_i = selection probability of PSU i; π_{ij} = joint selection probability of PSUs i

m_i denote numbers of samples PSU

n_i = number of sample elements in PSU_i

s = set of samples PSUs, while s_i represent set of sample elements in PSU i

y_k indicates analysis variable for element k in PSU i (subscript i is implied).

\bar{y}_U denotes mean per element in the population y.

\bar{y}_{U_i} denotes mean per element in the population in PSU i

$$\bar{y} = \frac{\sum_{1=j}^n \sum_{1=j}^m y_{ij}}{n_m}$$

$$=(63+31+28)+(25+19+19)+(32+13+12)/849$$

=252/849

=.0296 is proportionate population mean for public schools (there are three blocks in each cluster, pre/primary, junior and senior secondary schools). The same procedure is followed to get .070 for private sector (note: for private sector, only two blocks are represented in each cluster (nursery and primary school, and secondary schools). A brief explanation on how samples were drawn.

By using simple random sample without replacement, three primary units (Districts 2,3, and 6) are selected at the first phase, the second phase (secondary units), involved sampling randomly three LGAs from the three districts which comprised eleven LGAs, At the third phase (tertiary units) , Ikorodu, Eti-Osa and Ikeja LGA are randomly selected from the 11 LGAs., using a binomial variable, the probability of being selected was represented as (1), and for not being selected was represented by (0).. For example, for public school Ikorodu LGA was selected among four LGAs, denoted as with $y_i = (1+0+0+0)/4$, $y_{ii} = (0+0+1+0)/4$, and $y_{iii} = ((0+1+0+0)/3$. The population for each selected LGA are public sector: Ikorodu-68, 35, 28) was selected from cluster 2, cluster The effect size was calculated by calculating the difference between the two samples means for the private and public schools (e.g., the mean of Public-school group minus the mean of the Private-school group) and dividing it by the standard deviation of one of the groups to indicate the difference between the two groups.

Procedure for calculating effect size is as followed:

Standard deviation (SD) formula used for calculating SD for the two populations:

$$\sigma = \sqrt{\frac{1}{N} \sum_{i=1}^N (x_i - \mu)^2}$$
$$\sigma^2 = \frac{\sum(x_i - \mu)^2}{N}$$
$$= \frac{(63-27.6)^2 + \dots + (19-27.6)^2}{N}$$
$$= \frac{(63 - 27.6)^2 + \dots + (19 - 27.6)^2}{N}$$

10

$$\begin{aligned}
&= \frac{1972.4}{10} \\
&= 197.24 \\
\sigma &= \sqrt{197.24} \\
&= 14.044215891249
\end{aligned}$$

Application of Hedge's g formula to calculate effect size.

$$\text{Hedge's } g = \frac{\bar{x}_1 - \bar{x}_2}{\sqrt{\frac{(n_1 - 1)s_1^2 + (n_2 - 1)s_2^2}{n_1 + n_2 - 2}}}$$

Where :

x1, x2: The sample 1 mean and sample 2 mean, respectively.

n1, n2: The sample 1 size and sample 2 size, respectively

s12, s22: The sample 1 variance and sample 2 variance, respectively

(x1 sample 1 mean =29, SD1 =14.04, Sample1 =50)

(X2 sample2 mean =70.35, SD2 =59.4, Sample2= 101)

$$29.06 - 70.35 / \sqrt{(50-1) \times (14.04)^2 + (101-1) \times (59.4)^2} / (50+101) = 2$$

Therefore, Cohen's d =0.83

$$g_s = d_s \left(1 - \frac{3}{4(n_1 + n_2) - 9} \right)$$

$$g_s = 0.83 \left(1 - \frac{3}{4(50+101) - 9} \right)$$

$$g_s = 0.83 \left(1 - \frac{3}{4(151) - 9} \right)$$

$$= 0.83 \left(1 - \frac{3}{595} \right)$$

$$g_s = 0.825$$

Appendix F: Research Implementation Timetable

Felicia Owadara

Timetable for data collection: the implementation of participation strategies to enhance inclusive workplaces in the public and private educational systems in Lagos State

Goals	Date & Days	Assignment details and comments
Ethics approval	09/04/2023	University of Manitoba Ethics approval granted
Lagos state approval	09/18/2023	Visit to the secretariat office at Alausa Ikeja for protocol submission to receive access to the field
Field instruction	09/25/2023	Organizing field training for research assistants
Lagos State Approval letter	09/26/2023	Granted approval letter
Visit to Education Districts	09/26/2023	Submission of approval letter to Eti-osa, Maryland/Ikeja and Oshodi education districts headquarters.
Pasting of research advert	09/26/2023	Advert at three district headquarters
Data gathering (pilot-test) study	10/03/2023 to 10/7/2023	Primary data gathering (pilot-testing) at Oshodi
Returned to field for survey form collection	10/03/2023	Returning to the field to collect the survey forms back (pilot-study).
Preliminary analysis	10/10/2023	Coding, and data imputation. Testing scale reliability
Data analysis & reporting the outcome	10/10/2023 10/11/2023	Analysis & Storing of preliminary results analytical phase Sending report of the pilot test to research supervisor
Returned to the field for final data administration and collection	10/11/2023 to 11/06/2023	Final data collection
Data analysis	11/07/2023 to 11/19/2023	Data imputation/ running descriptive/ inferential statistics. Report to supervisor
Editing & Final write-up	11/20/2023 11/27/2023	Editorial work and final write-up
IAuthenticate, Submission & Research feedback	11/28/2023 to 12/15/2023	Run plagiarism on IAuthenticate, submission on the University of Manitoba 'my space' and sending research feedback to participants and Office of the permanent secretary.

Appendix G(i): University of Manitoba REB Approval Letter



University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry
206-194 Dalton Road
Winnipeg, MB R5T 2N2
T: 204 474 8872
humaneethics@umanitoba.ca

PROTOCOL APPROVAL

Effective: September 5, 2023

Expiry: September 4, 2024

Principal Investigator: Felicia Owadara
Advisor(s): Sidney Frankel
Protocol Number: HE2023-0185
Protocol Title: *A survey of the implementation of participation strategies to enhance inclusive workplaces in private and public educational system in Lagos State*

Hai Luo, Chair, REB1

Research Ethics Board 1 has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

This approval is subject to the following conditions:

- i. Approval is granted for the research and purposes described in the protocol only.
- ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.
- iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.
- iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.
- v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.
- vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans*: [Ethics of Research Involving Humans](#) policies and procedures.



LAGOS STATE GOVERNMENT

LS/C.530/S. I/VII/149

26th September, 2023

Tutor-General/Permanent Secretary
Education District II
Maryland Schools Complex,

Tutor-General/Permanent Secretary
Education District III
St. George's Primary School,

Tutor-General/Permanent Secretary
Education District VI
Ewenla Street

LETTER OF INTRODUCTION

RE: REQUEST FOR AN APPROVAL FOR DATA COLLECTION IN PRIVATE AND PUBLIC SCHOOLS IN EDUCATION DISTRICTS II, III AND VI IN LAGOS STATE

I have the directive of the Head of Service to introduce to you **Felicia Owadara**, a Ph. D Student in the Faculty of Social work, University of Manitoba, Canada.

2. **Felicia Owadara** is conducting a Research on ""**The Implementation of Participation Strategies to Enhance Inclusive Workplaces in the Public Educational System in Lagos State**". The aim of the Research is to appraise the structure of relationship that promote mental health in Public Primary Schools in Lagos State.

3. On the basis of the foregoing, the Researcher is requesting for permission to gather information/data by administering questionnaires to facilitate the retrieval of relevant and comprehensive data from your Education District.

4. I am to respectfully ask that you accord the Researcher all necessary assistance towards the successful implementation of the Research project.

5. Kindly note **Felicia Owadara**, can be contacted on [REDACTED]

6. Thank you.

[REDACTED]

Ligali F.A

For: Permanent Secretary

PUBLIC SERVICE OFFICE
OFFICE OF THE HEAD OF SERVICE

Block 20, The Secretariat, Obafemi Awolowo Way, Ikeja Lagos. PMB 21530, Ikeja. Tel:08191478681
Email: pso@lagosstate.gov.ng Website: www.lagosstate.gov.ng

Appendix G(ii): Lagos State Approval Letter

Appendix H: Consent Form



SURVEY'S CONSENT FORM

Title: The implementation of participation strategies to enhance inclusive workplaces in the public and private educational systems in Lagos State

Principal Investigator: Felicia O. Owadara (B.Ed., MSW, MRes, PhD Candidate). 410B, Faculty of Social Work, University of Manitoba, Fort Gary, Winnipeg, CA

Supervisor: Sid Frankel (PhD) Associate Professor, Faculty of Social Work, University of Manitoba, Winnipeg, CA

Sponsors: Faculty of Social Work Endowment Fund & Educare Trust

A copy of this consent form will be left with you for your records and reference. It offers a basic idea about the study and what your participation will involve. Feel free to ask for clarity. Please take the time to read this carefully and to understand any accompanying information.

Purpose. The purpose of this study is to describe strategies used by educational workplaces to accommodate mental health service user employees, and senior administrators' views of the effectiveness of these strategies.

Procedures. This survey is meant to be completed by the senior administrative staff in pre-primary, primary, and secondary schools in Eti-Osa, Ikeja, Ikorodu, and Oshodi Local Government Areas (LGAs), Lagos State.

The consent form and survey will be given to each participant in an unsealed A4 envelope, to fill out and sign if they wish to participate. The survey will be available in two formats: a fillable pdf electronic format and a paper format. Participants can choose either format. To receive an electronic survey, provide your e-mail address on the last page of the consent form. Upon completion of the consent form and paper copy (for those who have chosen the paper format rather than PDF format), participants will be expected to seal the envelope and return it to the research team. The research team will return in approximately ten days to collect the completed consent form and survey form from participants in the original sealed envelope

provided. Participants are asked to tick ✓) if the envelope contains a completed survey, and mark X in the box at the back of the envelope if it does not contain a completed survey. If you choose to complete the consent form immediately when it is received, the research team will collect it that same day.

. A bi-weekly reminder email will be sent to participants for the next six weeks. The questionnaire is in three parts, section A covers sociodemographic information, section B measures support networks, anti-stigma programs and the effectiveness of support your school receives to promote mental health. Section C seeks to understand your thoughts on challenges in promoting mental health and suggestions for improvement across schools in Lagos State.

It will take most participants about 35 minutes to complete the survey.

Benefits: Participation in the study offers participants the opportunity to provide their opinions and, perhaps, contribute to the improvement of policies and practices.

Risks: Some participants may become somewhat upset while completing the survey. In the event that that occurs we suggest that you contact Lagos Lifeline at 09090006463.

Confidentiality: Information provided in the study will only be used for completing the research. The data provided will be coded and analyzed aggregately. No personal information provided will be directly linked to you or the information you provide. Your personal details will never be shared in any publication of the study's outcomes. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. In addition, people who know you may be able to guess your identity based on quotations from your responses to open-ended questions.

All the signed consent forms and completed survey forms will be placed in a sealed large envelope and kept in a locked cabinet until January 31st, 2024. This information will be shredded and destroyed after the expiration of the stipulated time. Data will also be encrypted to increase security. SharePoint on the University of Manitoba Drive will be used to transfer data. Encrypted data will also be transferred on a password protected laptop. The laptop will be in the custody of the student researcher. The research team will physically visit the research study areas to receive the completed forms, and a bag secured with padlocks will be provided to transport the paper copies.

Dissemination: The results of the research may be published as articles in professional journals or presented at conferences or workshops. They may also be published in book form to promote knowledge.

A three pages summary will be submitted to all LGAs involved and to the office of the Permanent Secretary Lagos state via research electronic email by 15th December.

Some data and information from this study may be sent outside of the University of Manitoba to other researchers, and organizations, or made publicly available. This is for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you.

Remuneration for participating: Participants will be presented with a gift (souvenir items) valued at no more than 2,500 Nigerian naira. This gift will be handed to each participant when she or he signs the consent form.

Voluntary Participation: Completion of the survey is completely voluntary, and no consequences will be experienced by deciding not to participate.

Withdrawal Procedure: Participants have the right to withdraw from the study and have their information removed. To withdraw their completed survey from the study participants should email the researcher with the school address and the LGA. The deadline for the withdrawal of participants' information will be October 31, 2023.

Participants: A summary of the study's outcomes (not more than one page) will be emailed or mailed to participants who wish to receive it not later than December 2023. If you wish to receive the summary, please provide your e-mail or mailing address.

Your signature on this form indicates that you have read, understood, and agreed to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named people or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

----- Provide for Signatures as Required: -----

Participant's Signature: _____ Date: _____

Researcher and/or Delegate's Signature: _____ Date: _____

Participant's email address: _____

(Note: Your email will strictly be used for sending reminders, survey forms and study outcomes by the student researcher only).

Appendix I: Advertisement for Research Participants



**UNIVERSITY
OF MANITOBA**

**Would you like to make your voice count by
participating in a survey of workplace mental health
promotion and inclusion?**

Dear Prospective Research Participants,

Your voluntary participation in an ongoing “Survey of the Implementation of Participation Strategies to Enhance Inclusive Workplaces in the Public and Private Educational Systems in Lagos State” is highly solicited.

The survey will be conducted in education districts I, II and VI. Specifically, eligible participants are senior administrative staff in selected schools and Human Resource managers across the following LGAs: Eti-Osa, Ikeja, Ikorodu and Oshodi.

The goal is to increase positive mental health discussions in workplaces and enhance access to employment for service users. I, Felicia Owadara conducting the study in partial fulfillment of the award of a doctoral degree.

Your choice to take part in this research will not affect your employment.

If you decide to participate, kindly reach out to the research team via this email address
.....

Your voluntary participation is highly crucial to the completion of this study and would be appreciated.

Best Regards,

Felicia Owadara (PI)
(Candidate for PhD)

Dr. Sid Frankel
Research Supervisor Faculty of Social Work, University of
Manitoba,
Tier 5 Building, R3T 2N2
Fort Gary Campus, Winnipeg, Manitoba, Canada.

Appendix J: Research Assistant' Authorization Letter



UNIVERSITY
OF MANITOBA

10/10/2023

Dear Sir/Ma,

Letter of Authorization

I, Felicia Owadara hereby authorize Ms/Mr/Mrs/Dr _____
as a research assistant to administer survey questionnaire in education districts II, III and VI in
Lagos State Nigeria on my research study titled: **“A Survey of the implementation of
participation strategies to enhance inclusive workplaces in the public and private
educational systems in Lagos State”**. I humbly seek for your kind cooperation.

Best Regards,
Felicia Owadara

Endowment Fund (Available)	\$3,000	The fund will cover part of the cost of executing the doctoral thesis (data collection and analysis, proof reading and printing).
Educare Trust Fund	\$3,500	
Deficit will be covered by the researcher.	+\$6,500 \$8,025 -\$1,525	

Appendix L: Descriptive Analysis of Participant's Responses to Items on Discrimination Scale

S/N	Items	DU		PU		NW/U		PW		DW		N/R	
		n	%	n	%	n	%	n	%	n	%	n	%
a.	How willing would you be to employ someone if you knew they had a mental illness?	164	48.8	84	25.0	29	8.6	46	13.7	13	3.9	-	-
b.	How willing would you be to have someone with a mental illness start working closely with you on a job?	118	35.1	104	31.0	46	13.7	65	19.3	3	.9	-	-
c.	How willing would you be to have someone with a mental illness marry into your family?	190	56.5	80	23.8	52	15.5	7	2.1	7	2.1	-	-
d.	How willing would you be to move next door to someone with a mental illness?	110	32.7	106	31.5	61	18.2	54	16.1	3	.9	2	.6
e.	How willing would you be to make friends with someone with a mental illness?	72	21.4	89	26.5	71	21.1	84	25.0	18	5.4	2	.6
f.	How willing would you be to spend an evening socializing with someone with a mental illness?	93	27.7	75	22.3	55	16.4	80	23.8	33	9.8	-	-

Key: DU=Definitely Not Willing, PU= Probably Unwilling, NW/U=Neither Willing/ or Unwilling, PW= Probably Willing, DW=Definitely Willing, N/R=No Response (Missing value)

Appendix M: Descriptive Analysis of Participant’s Responses to Items on Policy Awareness Scale

S/N	Items	DNI		UN		LI		DWI		N/R	
		n	%	n	%	n	%	n	%	n	%
14a.	I am aware of the recent mental health policy reform of 2013.	149	44.3	59	17.6	106	31.5	15	4.5	7	2.1
14b.	I am aware of the acceptance of mental health service users as employees in the workplace	131	39.0	78	23.2	106	31.5	20	6.0	1	.3
14c.	I am aware of the insurance equality for people with mental health & other disabilities	104	31.0	95	28.3	87	25.9	48	14.3	2	.6
15a.	I am aware of the relationship building to promote mental health	75	22.3	59	17.6	123	36.6	78	23.2	1	.3
15b.	I am aware of the negative impact of cultural stigma on mental health promotion	52	15.5	45	13.4	82	24.4	154	45.8	3	.9

Key: DNI= Definitely Not Informed, UN=Uncertain, LI=Likely Informed, DWI=Definitely Well Informed, N/R= No Response

Appendix N: Descriptive Analysis of Participant's Responses to Items on Organization Value and NGOs' Involvement Scale

	Private		Public		Full Sample	
	n	%	n	%	n	%
Measures Against Discrimination at Workplace						
Yes	77	33.5	21	19.8	98	29.2
No	68	29.6	42	39.6	110	32.7
I do not know	82	35.7	39	36.8	121	36.0
No Response (NR)	3	1.3	4	3.8	7	2.1
Disclosure at Workplace						
Strongly Disagree	25	10.9	6	5.7	31	9.2
Disagree	56	24.3	43	40.6	99	29.5
Agree	96	41.7	47	44.3	143	42.6
Strongly Agree	44	19.1	9	8.5	53	15.8
No Response (NR)	9	3.9	1	.9	10	3.0
Level of Incorporation						
Equality						
Not at all	9	3.9	5	4.7	14	4.2
To a very low degree	7	3.0	4	3.8	11	3.3
To a low degree	9	3.9	17	16.0	26	7.7
To a moderate degree	68	29.6	24	22.6	92	27.4
To a high degree	56	24.3	27	25.5	83	24.7
To a high degree	42	18.3	13	12.3	55	16.4
No Response (NR)	39	17.0	16	15.1	55	16.4
Diversity						
Not at all	10	4.3	3	2.8	13	3.9
To a very low degree	12	5.2	5	4.7	17	5.1
To a low degree	14	6.1	14	13.2	28	8.3
To a moderate degree	58	25.2	28	26.4	86	25.6
To a high degree	52	22.6	24	22.6	76	22.6
To a high degree	34	14.8	10	9.4	44	13.1
No Response (NR)	50	21.7	22	20.8	72	21.4
Partnership						
Not at all	11	4.8	2	1.9	13	3.9
To a very low degree	4	1.7	2	1.9	6	1.8
To a low degree	19	8.3	4	3.8	23	6.8
To a moderate degree	48	20.9	24	22.6	72	21.4
To a high degree	46	20.0	30	28.3	76	22.6
To a high degree	52	22.6	25	23.6	77	22.9
No Response (NR)	50	21.7	19	17.9	69	20.5
Profit making						
Not at all	19	8.3	28	26.4	47	14.0
To a very low degree	8	3.5	7	6.6	15	4.5

To a low degree	12	5.2	8	7.5	20	6.0
To a moderate degree	44	19.1	12	11.3	56	16.7
To a high degree	45	19.6	21	19.8	66	19.6
To a high degree	58	25.2	11	10.4	69	20.5
No Response (NR)	44	19.1	19	17.9	63	18.8
Integrity						
Not at all	1	.4	1	.9	2	.6
To a very low degree	1	.4	1	.9	2	.6
To a low degree	4	1.7	3	2.8	7	2.1
To a moderate degree	32	13.9	12	11.3	44	13.1
To a high degree	58	25.2	29	27.4	87	25.9
To a high degree	98	42.6	43	40.6	141	42.0
No Response (NR)	36	15.7	17	16.0	53	15.8
Respect for individual						
Not at all	2	.9	1	.9	3	.9
To a very low degree	2	.9	2	1.9	4	1.2
To a low degree	7	3.0	3	2.8	10	3.0
To a moderate degree	26	11.3	11	10.4	37	11.0
To a high degree	57	24.8	33	31.1	90	26.8
To a high degree	108	47.0	49	46.2	157	46.7
No Response (NR)	28	12.2	7	6.6	35	10.4
When last was an employee in your workplace last terminated because of mental health problem?						
Between 1-5 months ago	4	1.7	3	2.8	7	2.1
6 months- to 1 year ago	1	.4	-	-	1	.3
2 to-3 years ago	1	.4	2	1.9	3	.9
4-to 5years	4	1.7	1	.9	5	1.5
6 years or longer.	9	3.9	5	4.7	14	4.2
Never	199	86.5	92	86.8	291	86.6
No Response (NR)	12	5.2	3	2.8	15	4.5
MH agency that associates with your school						
Local non-governmental agency	50	21.7	36	34.0	86	25.6
Ministry of Health (at LGA level)	87	37.8	55	51.9	142	42.3
International NGOs e.g., Clinton Foundation, UNICEF, WHO etc.	43	18.7	37	34.9	80	23.8
Religious organization	53	23.0	34	32.1	87	25.9
Ministry of Education	93	40.4	58	54.7	151	44.9
No Association	64	27.8	16	15.1	80	23.8

Appendix O1: Assumptions Testing for Research Question 4 and Hypothesis

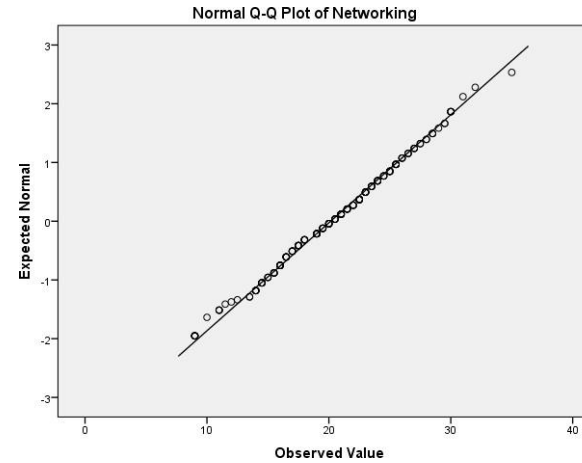
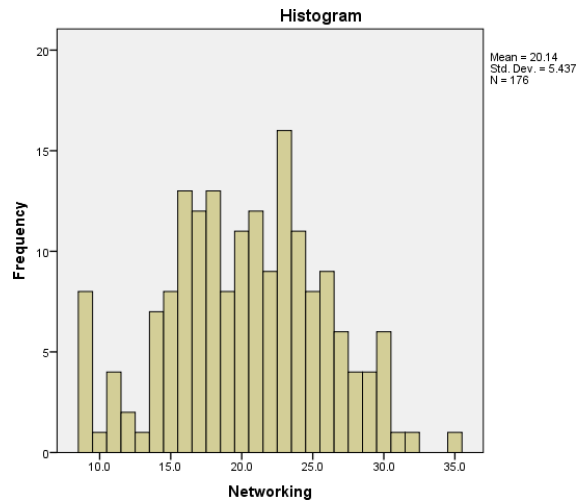
1. Strategic-Alliance

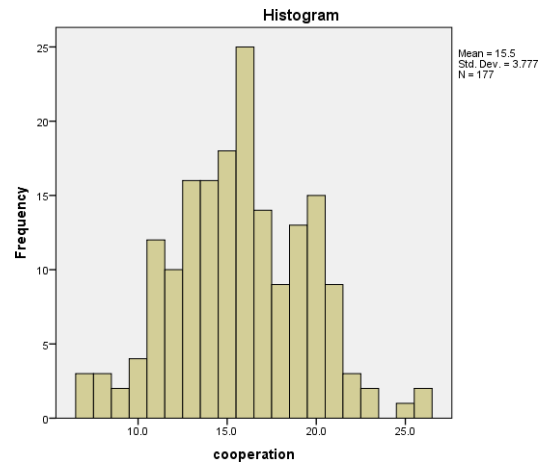
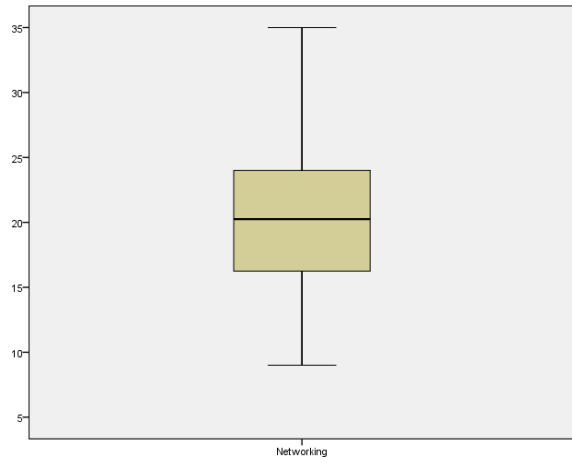
Tests of Normality

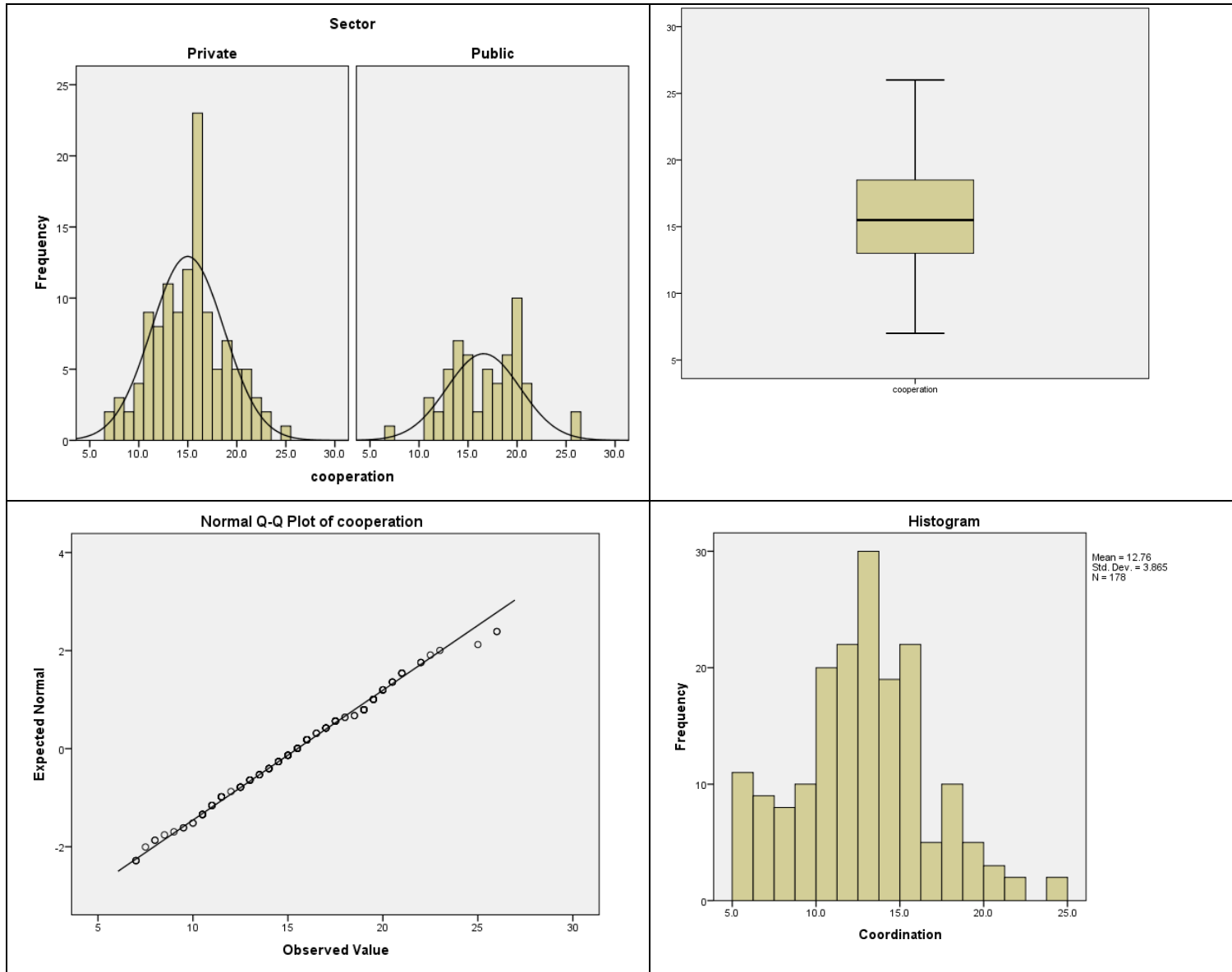
	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Networking	.048	176	.200*	.989	176	.207
cooperation	.066	177	.059	.991	177	.310
Coordination	.068	178	.044	.977	178	.005
Coalition	.085	178	.003	.980	178	.012
Collaboration	.088	178	.002	.971	178	.001

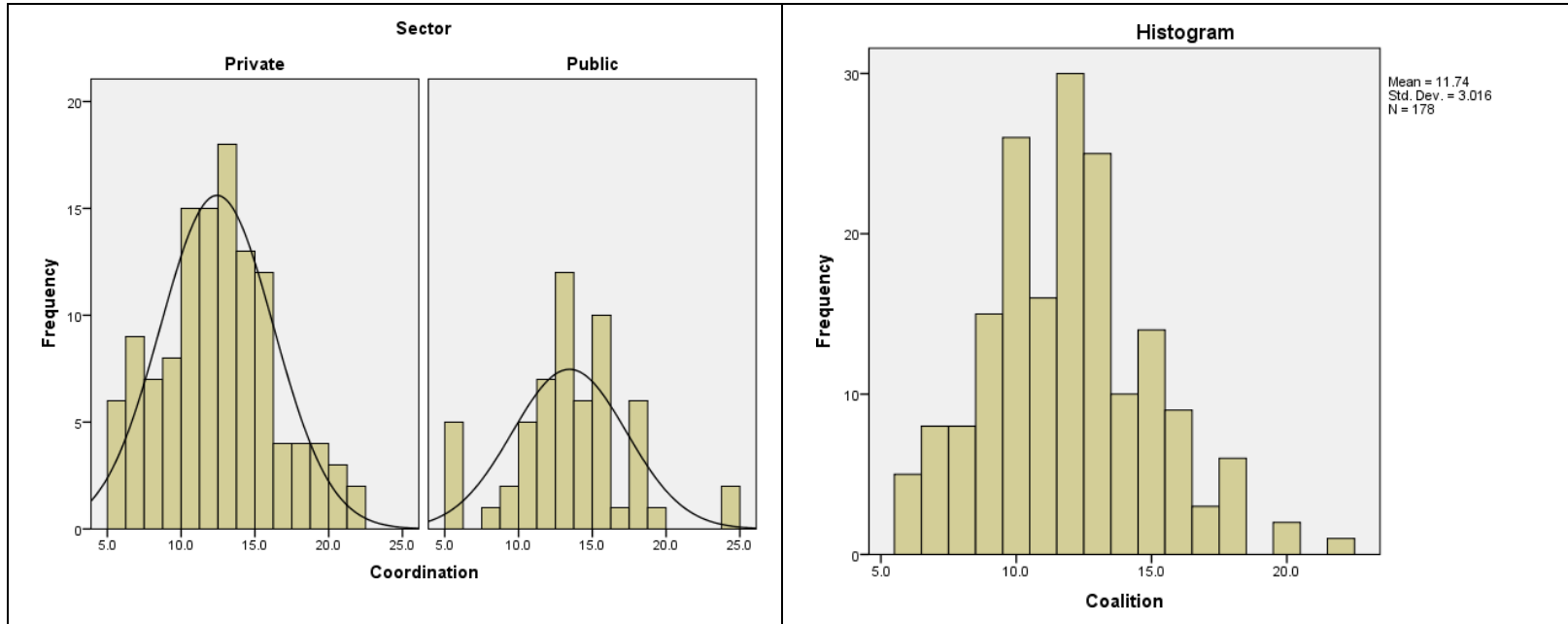
*. This is a lower bound of the true significance.

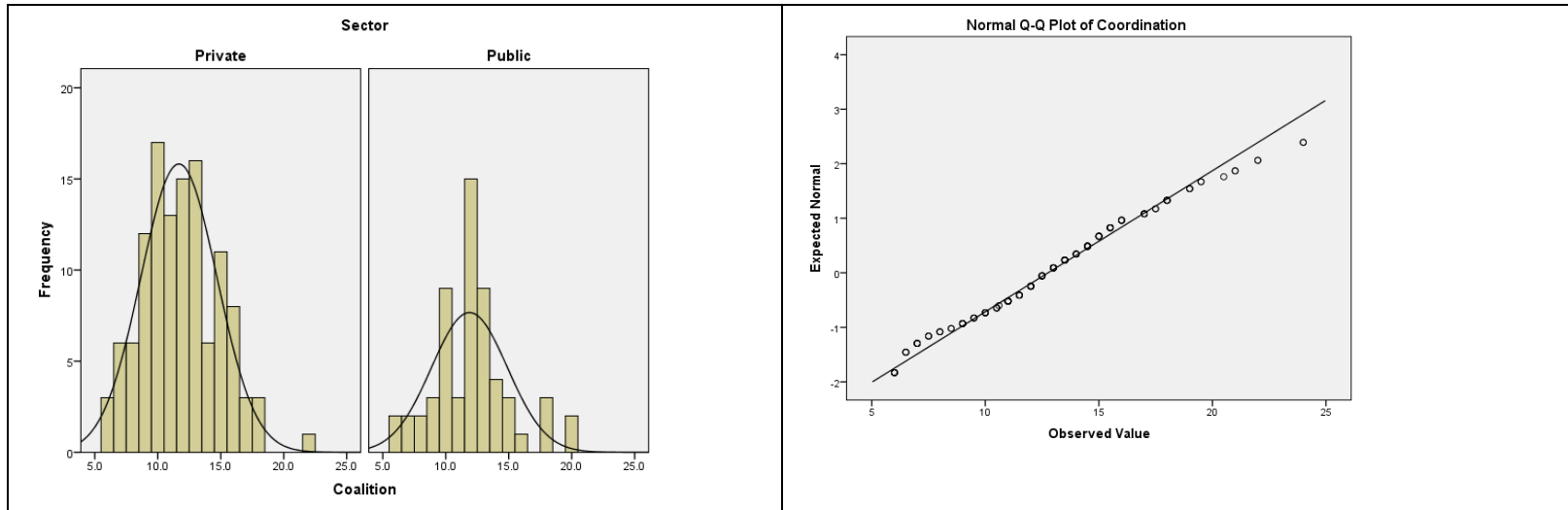
a. Lilliefors Significance Correction

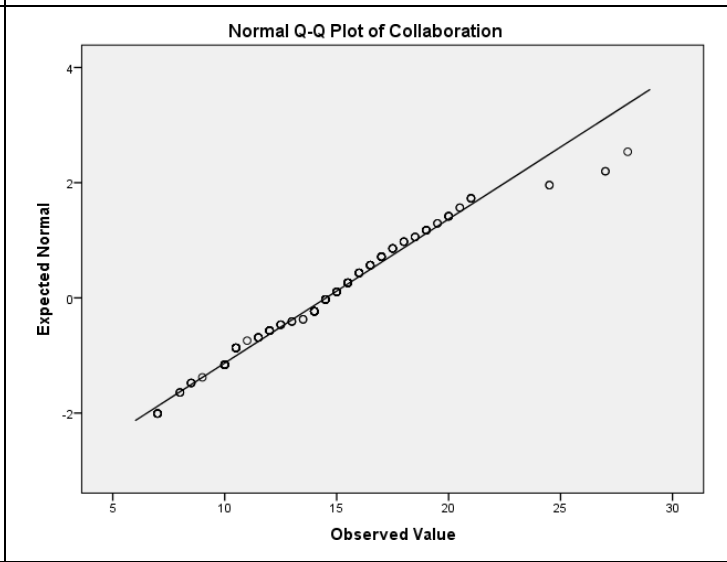
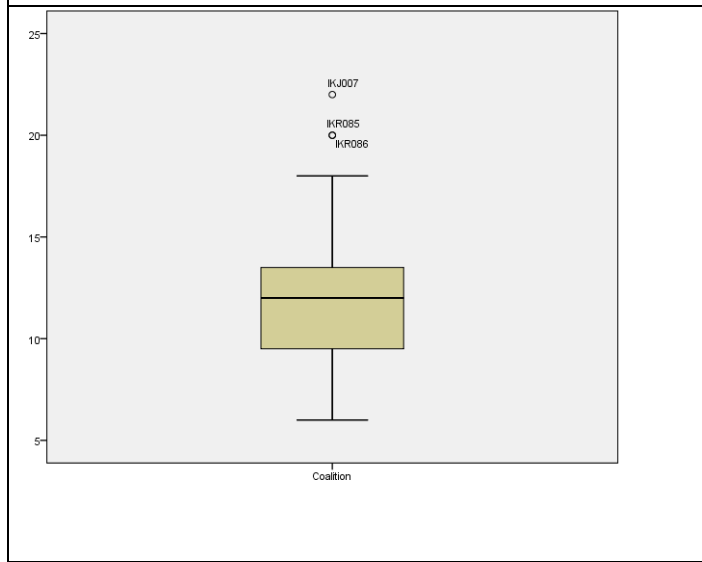
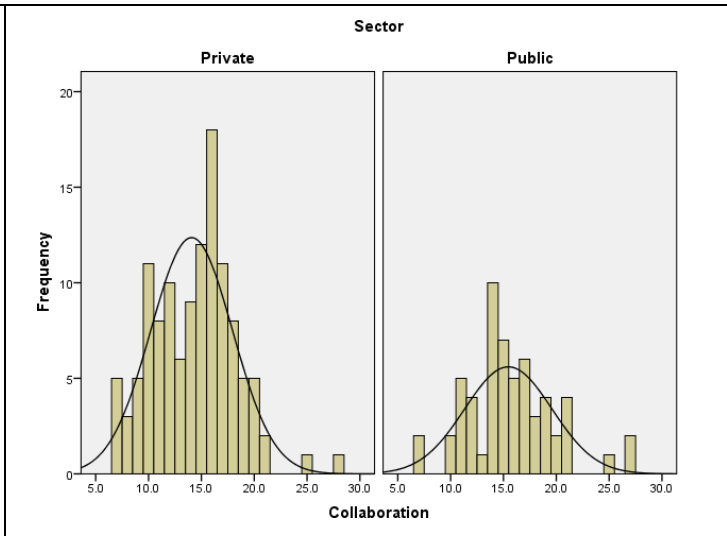
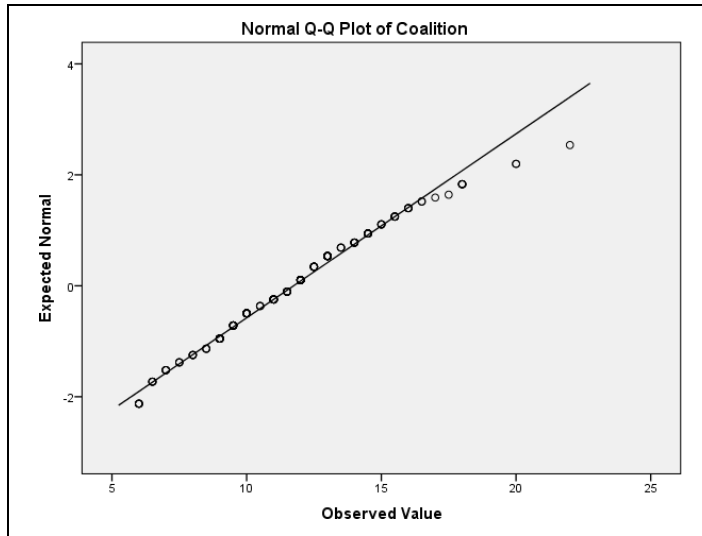


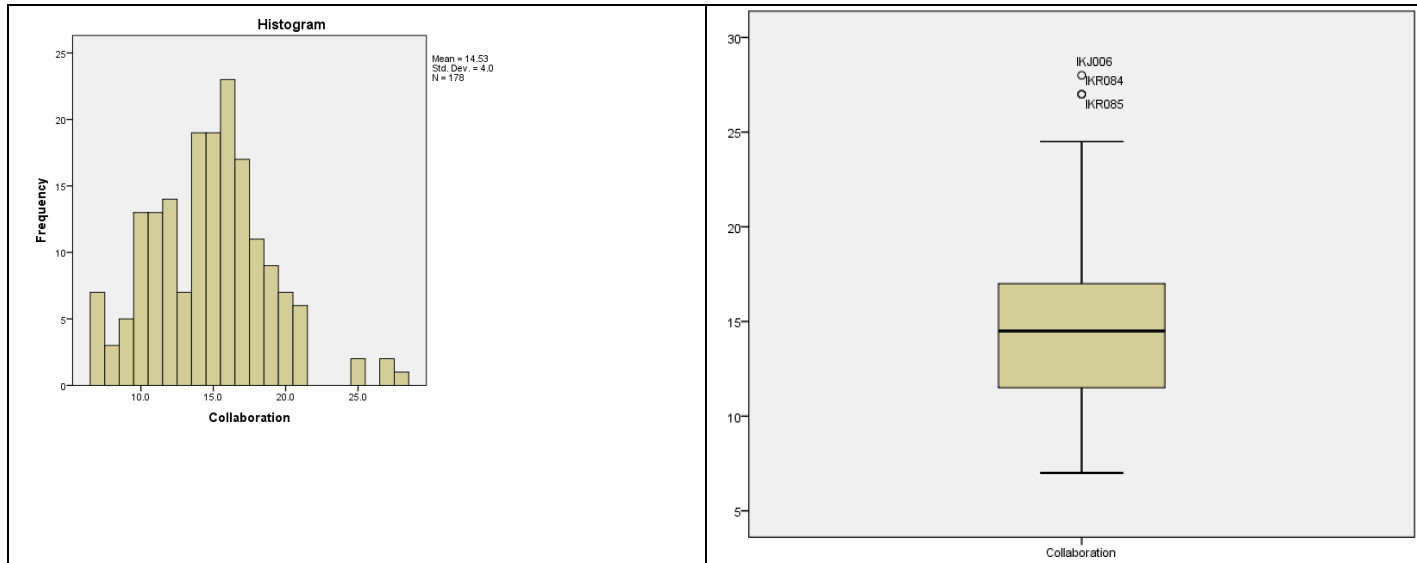


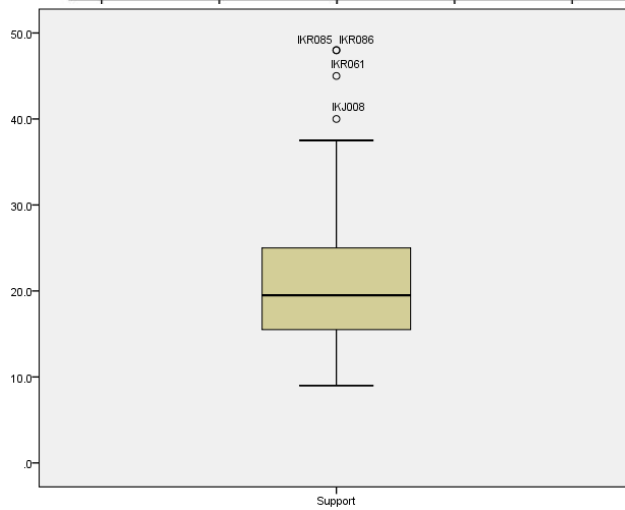
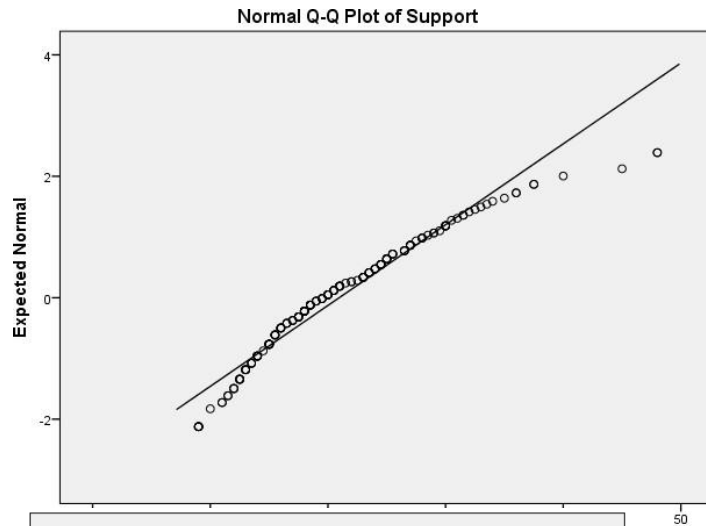










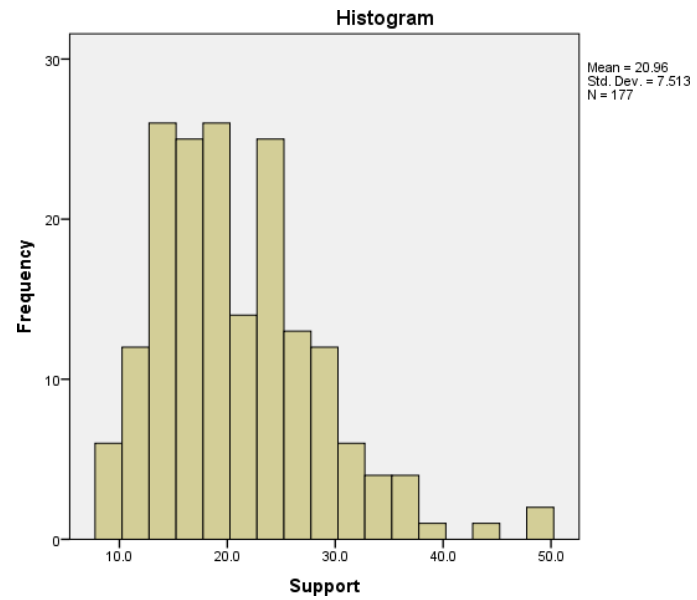


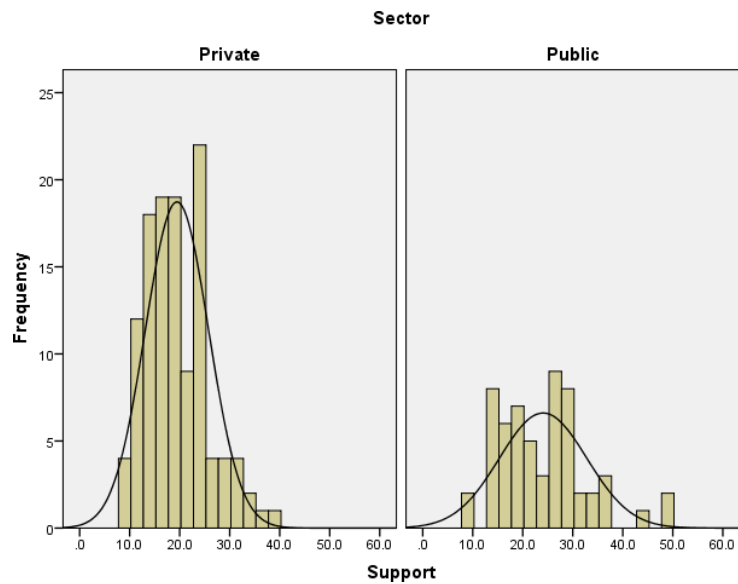
2. Support Variable

Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Support	.097	177	.000	.942	177	.000

a. Lilliefors Significance Correction



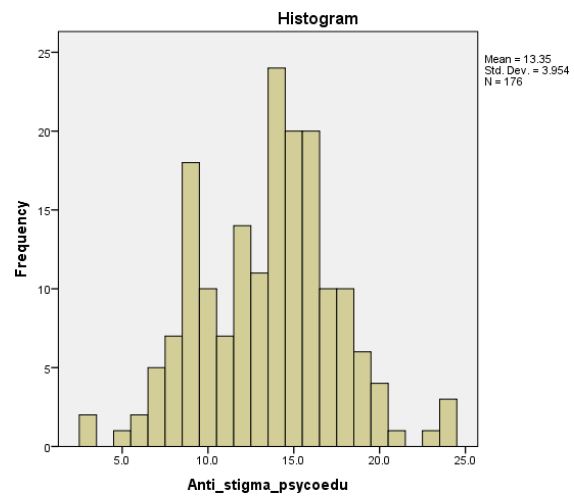
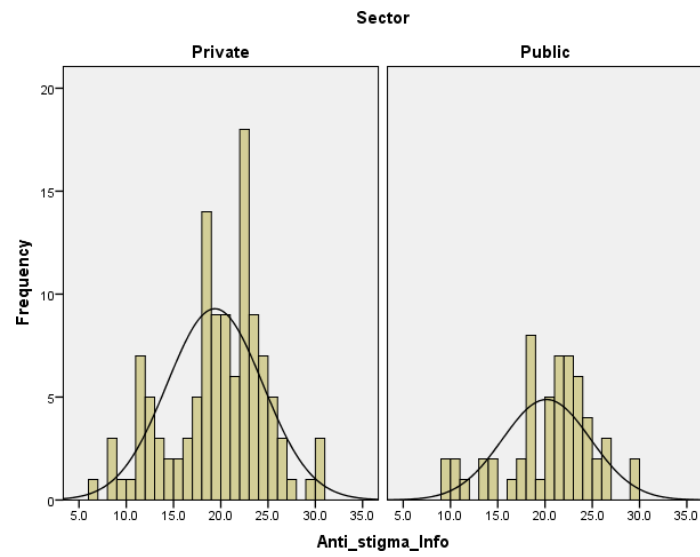
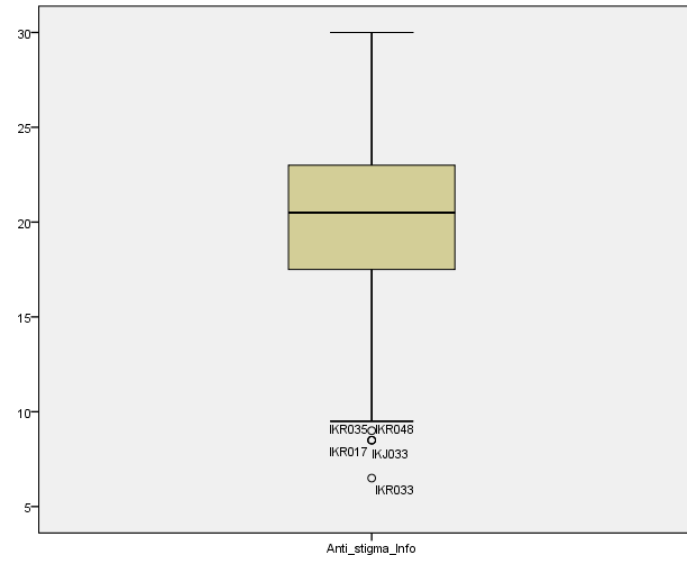
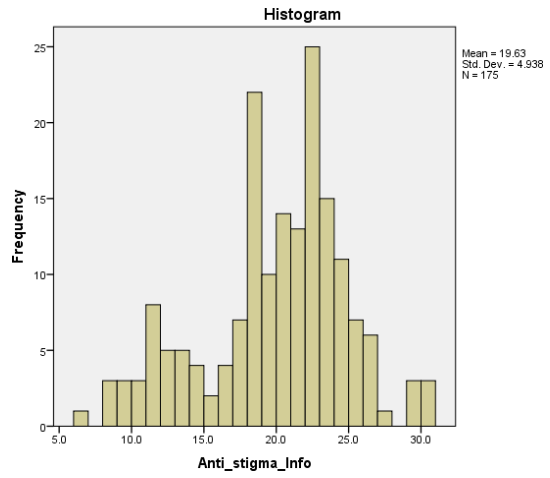


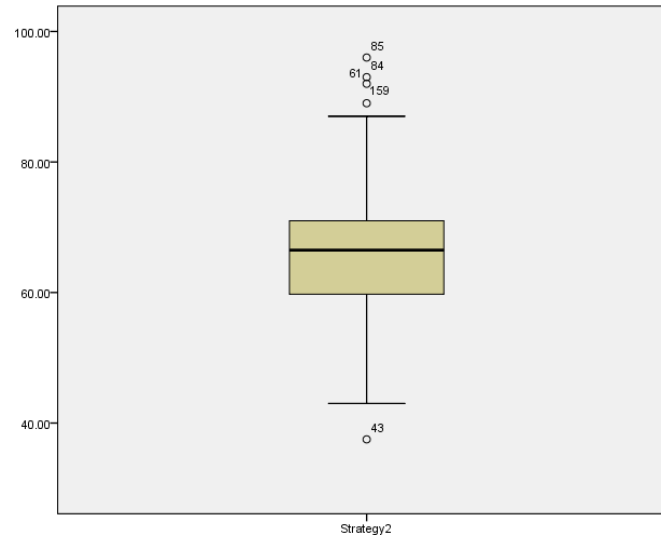
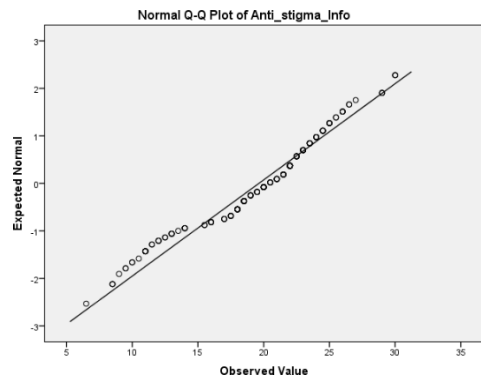
3. ANTI-STIGMA

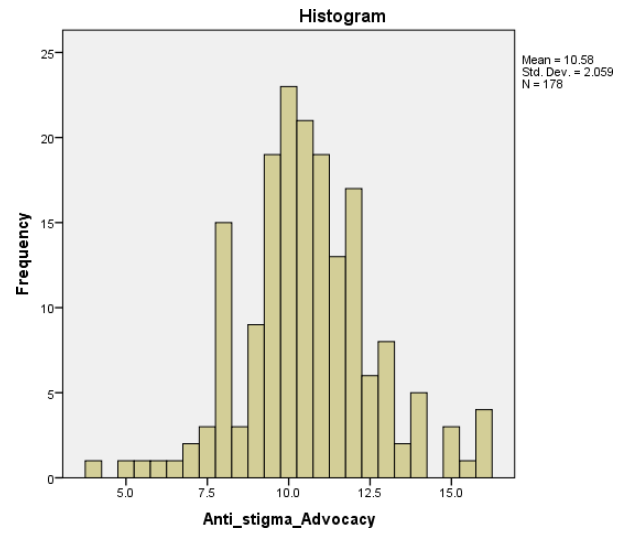
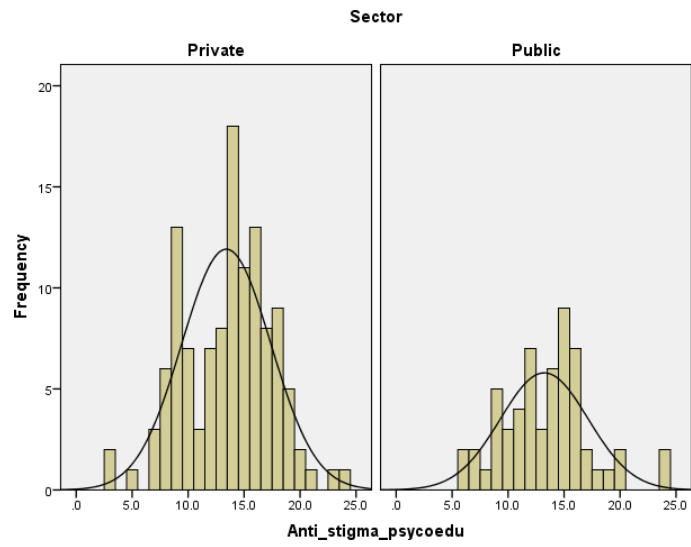
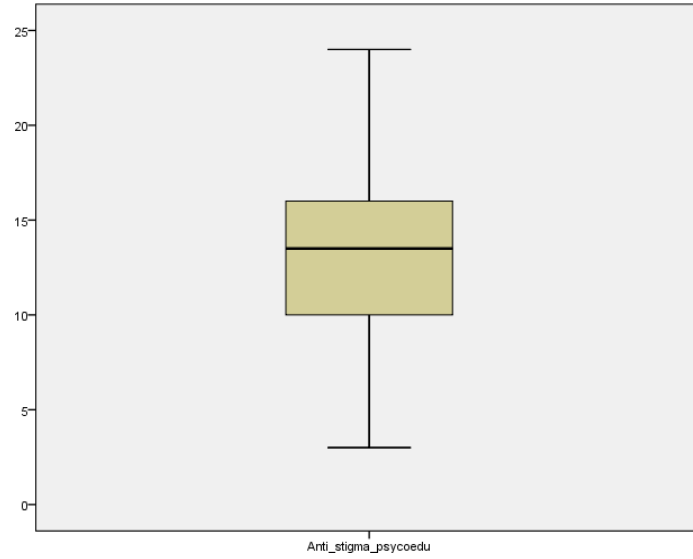
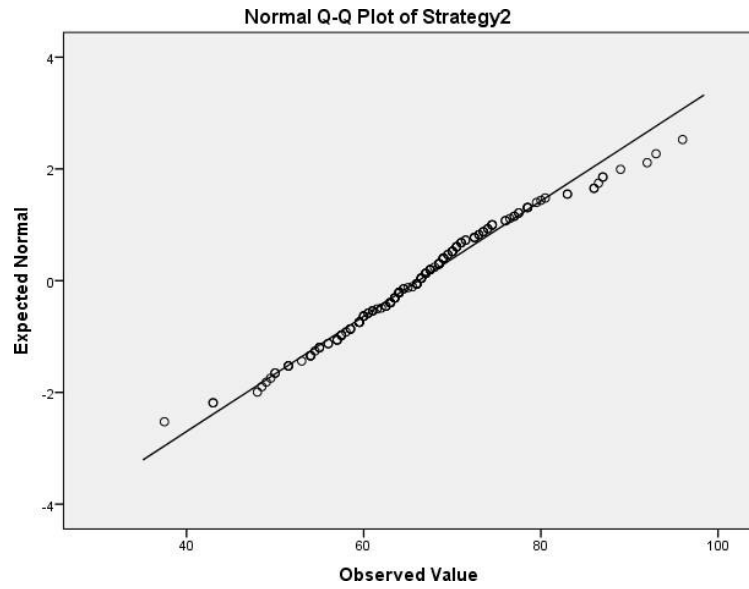
Tests of Normality

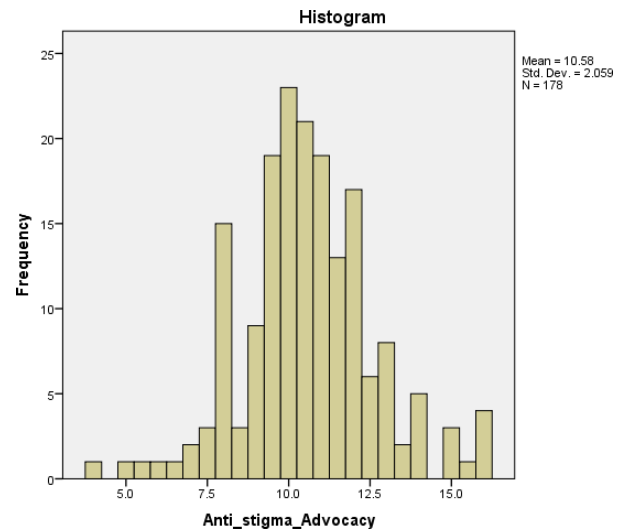
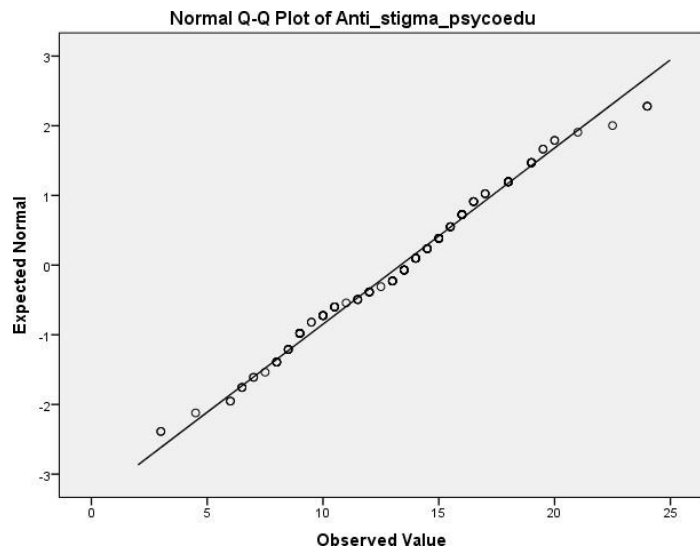
	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Anti_stigma_Info	.113	175	.000	.962	175	.000
Anti_stigma_psycoedu	.084	176	.004	.987	176	.095
Anti_stigma_Advocacy	.091	178	.001	.977	178	.004
Anti_stigma_Treatment	.071	177	.031	.985	177	.048

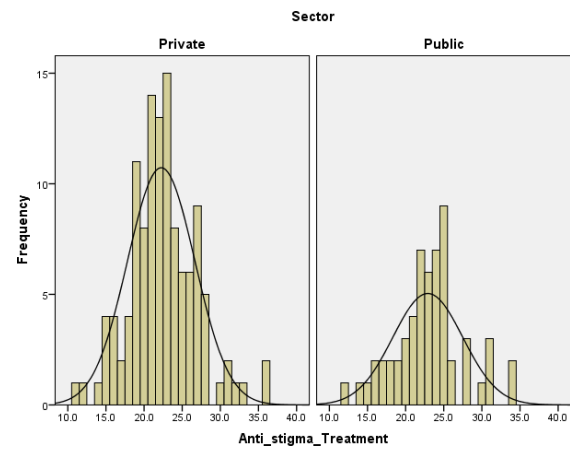
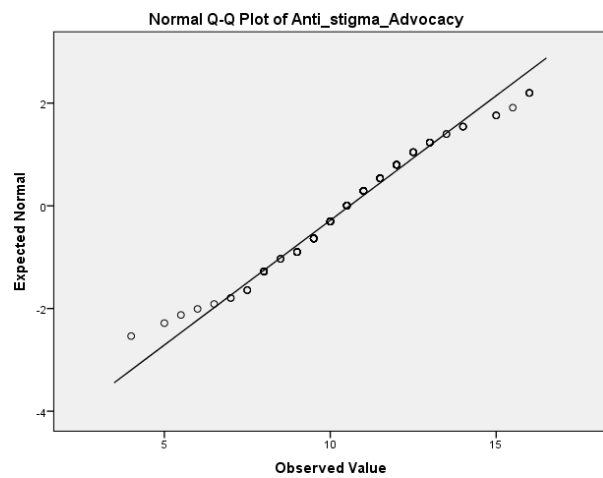
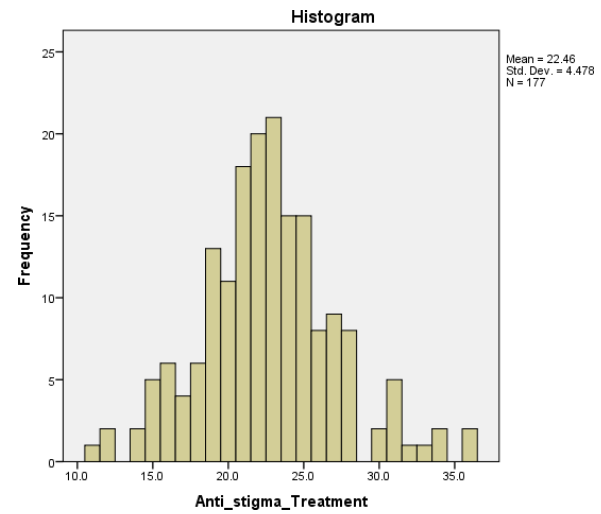
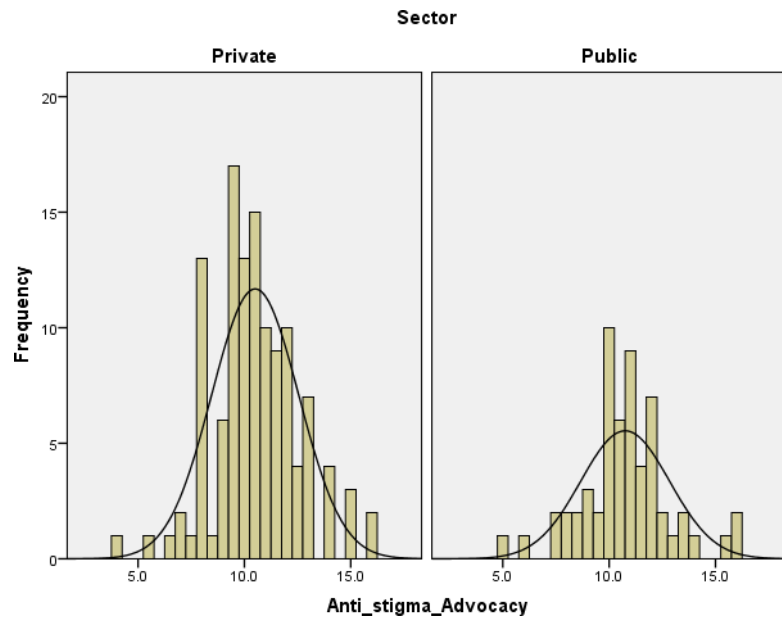
a. Lilliefors Significance Correction

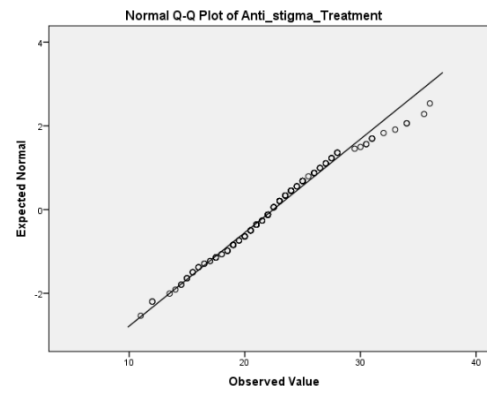
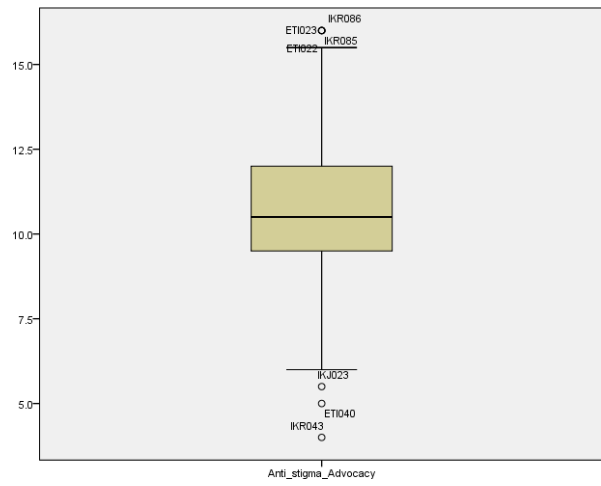


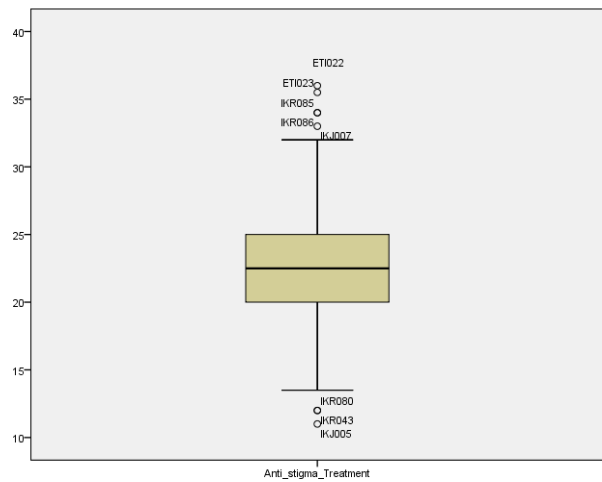








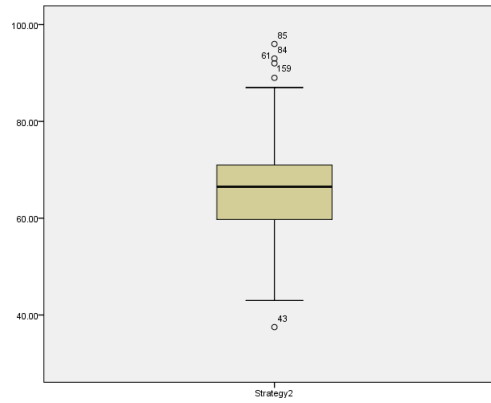
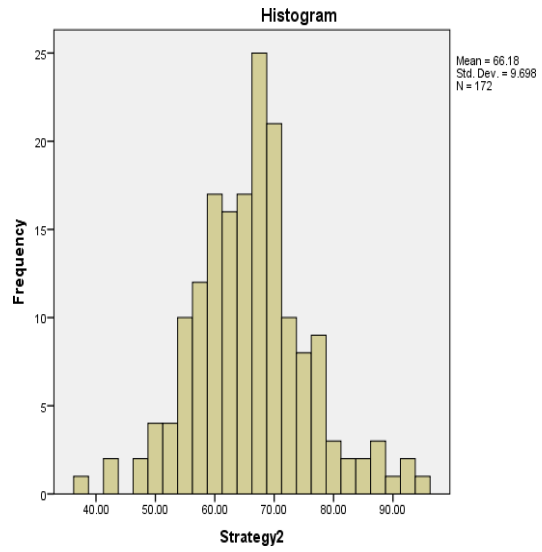




Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Strategy2	.072	172	.029	.986	172	.081

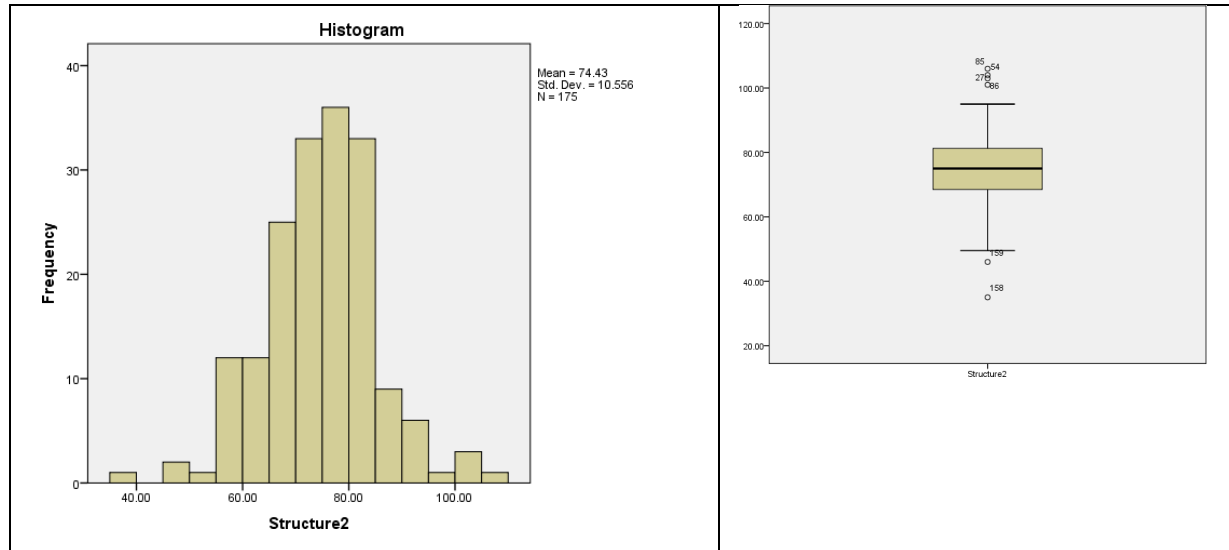
a. Lilliefors Significance Correction



Structure

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Structure2	175	98.3%	3	1.7%	178	100.0%

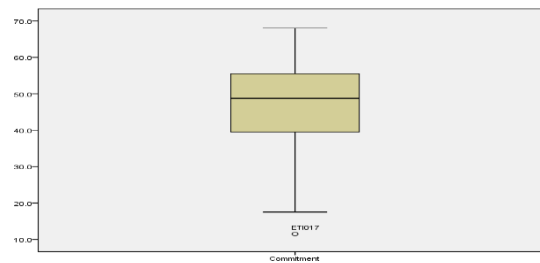
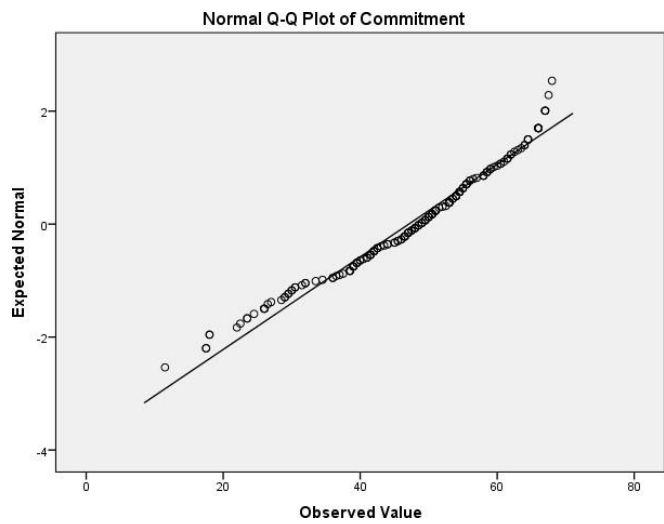
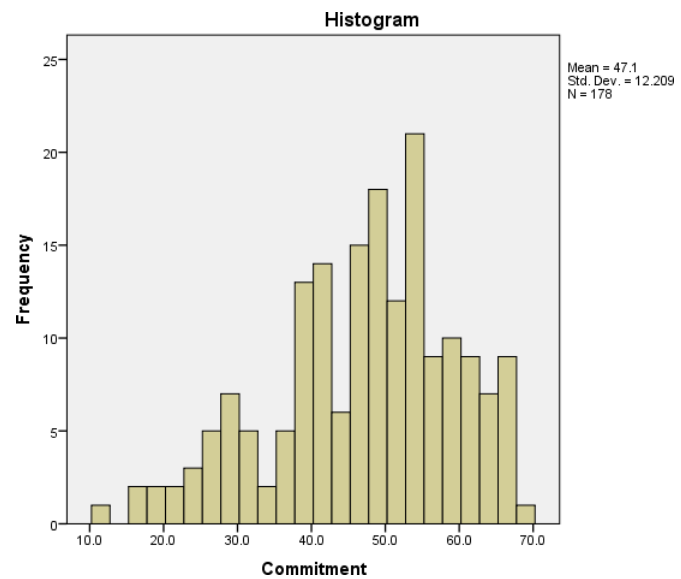
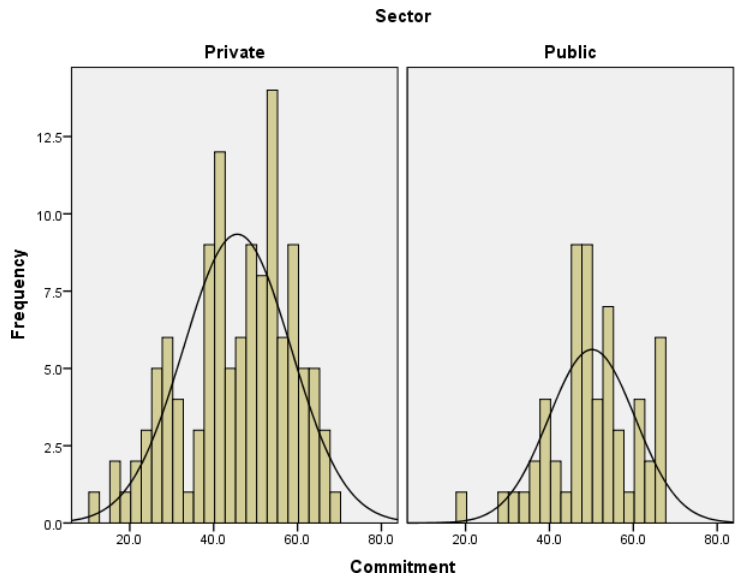


4. COMMITMENT

Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Commitment	.082	178	.006	.970	178	.001

a. Lilliefors Significance Correction



Appendix O2: SPSS V.21 OUTPUT: REGRESSION ANALYSIS FOR RESEARCH QUESTION 4

```

Private= Sector=1

USE ALL.
COMPUTE filter_$=(Sector = 1).
VARIABLE LABELS filter_$ 'Sector = 1 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
REGRESSION
  /DESCRIPTIVES MEAN STDDEV CORR SIG N
  /MISSING PAIRWISE
  /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT Commitment
  /METHOD=ENTER Anti_stigma_Info Anti_stigmaPsycoedu Anti_stigma_Advocacy Anti_stigma_Treatment
  /SCATTERPLOT=(*ZRESID ,*ZPRED)
  /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID)
  /CASEWISE PLOT(ZRESID) OUTLIERS(3)
  /SAVE MAHAL COOK.

```

Regression

Notes

Output Created	11-NOV-2023 12:28:13
Comments	
Input	
Data	C:\Users\F.O\Desktop\FELI PhD Data\FO PRIMARY DATA FOR HYPOTHESIS- 180.sav
Active Dataset	DataSet1
Filter	Sector = 1 (FILTER)
Weight	<none>

	Split File	<none>	
	N of Rows in Working Data File		120
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.	
	Cases Used	Correlation coefficients for each pair of variables are based on all the cases with valid data for that pair. Regression statistics are based on these correlations.	
Syntax		REGRESSION	
		/DESCRIPTIVES MEAN STDDEV CORR SIG N /MISSING PAIRWISE /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP /CRITERIA=PIN(.05) POUT(.10) /NOORIGIN /DEPENDENT Commitment /METHOD=ENTER Anti_stigma_Info Anti_stigmaPsycoedu Anti_stigmaAdvocacy Anti_stigmaTreatment /SCATTERPLOT=(*ZRESID ,*ZPRED) /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID) /CASEWISE PLOT(ZRESID) OUTLIERS(3) /SAVE MAHAL COOK.	
Resources	Processor Time		00:00:00.36

	Elapsed Time	00:00:00.39
	Memory Required	2788 bytes
	Additional Memory Required for	888 bytes
	Residual Plots	
Variables Created or Modified	MAH_3	Mahalanobis Distance
	COO_3	Cook's Distance

[DataSet1] C:\Users\F.O\Desktop\FELI PhD Data\FO PRIMARY DATA FOR HYPOTHESIS-180.sav

Descriptive Statistics

	Mean	Std. Deviation	N
Commitment	45.629	12.8119	120
Anti_stigma_Info	19.377	5.0670	118
Anti_stigmaPsycoedu	13.408	3.9835	119
Anti_stigma_Advocacy	10.504	2.0493	120
Anti_stigma_Treatment	22.244	4.4254	119

Correlations

		Commitment	Anti_stigma_Info	Anti_stigmaPsycoedu	Anti_stigma_Advocacy	Anti_stigma_Treatment
Pearson Correlation	Commitment	1.000	.012	.163	.148	.047
	Anti_stigma_Info	.012	1.000	-.113	.209	.153
	Anti_stigmaPsycoedu	.163	-.113	1.000	.070	.085
	Anti_stigma_Advocacy	.148	.209	.070	1.000	.770

Sig. (1-tailed)	Anti_stigma_Treatment	.047	.153	.085	.770	1.000
	Commitment	.	.451	.038	.053	.306
	Anti_stigma_Info	.451	.	.113	.012	.050
	Anti_stigma_psyc edu	.038	.113	.	.226	.180
	Anti_stigma_Advocacy	.053	.012	.226	.	.000
	Anti_stigma_Treatment	.306	.050	.180	.000	.
N	Commitment	120	118	119	120	119
	Anti_stigma_Info	118	118	117	118	117
	Anti_stigma_psyc edu	119	117	119	119	118
	Anti_stigma_Advocacy	120	118	119	120	119
	Anti_stigma_Treatment	119	117	118	119	119

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	Anti_stigma_Treatment, Anti_stigma_psyc oedu, Anti_stigma_Info, Anti_stigma_Advo cacy ^b	.	Enter

a. Dependent Variable: Commitment

b. All requested variables entered.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.242 ^a	.058	.025	12.6527	.058	1.734	4	112	.147	1.869

a. Predictors: (Constant), Anti_stigma_Treatment, Anti_stigmaPsycoedu, Anti_stigma_Info, Anti_stigma_Advocacy

b. Dependent Variable: Commitment

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1110.645	4	277.661	1.734	.147 ^b
	Residual	17930.168	112	160.091		
	Total	19040.813	116			

a. Dependent Variable: Commitment

b. Predictors: (Constant), Anti_stigma_Treatment, Anti_stigmaPsycoedu, Anti_stigma_Info, Anti_stigma_Advocacy

Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF

	(Constant)	32.208	8.248		3.905	.000	15.864	48.551					
	Anti_stigma_Info	-.001	.239	.000	-.005	.996	-.475	.473	.012	.000	.000	.940	1.064
1	Anti_stigma_psycoedu	.512	.299	.159	1.716	.089	-.079	1.104	.163	.160	.157	.976	1.025
	Anti_stigma_Advocacy	1.712	.908	.274	1.886	.062	-.086	3.511	.148	.175	.173	.399	2.507
	Anti_stigma_Treatment	-.513	.416	-.177	-1.232	.221	-1.338	.312	.047	-.116	-.113	.407	2.460

a. Dependent Variable: Commitment

Collinearity Diagnostics^a

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions				
				(Constant)	Anti_stigma_Info	Anti_stigma_psycoedu	Anti_stigma_Advocacy	Anti_stigma_Treatment
	1	4.844	1.000	.00	.00	.00	.00	.00
	2	.083	7.645	.00	.20	.65	.00	.00
1	3	.049	9.935	.00	.56	.12	.06	.08
	4	.016	17.389	1.00	.23	.23	.05	.04
	5	.008	23.928	.00	.01	.00	.89	.87

a. Dependent Variable: Commitment

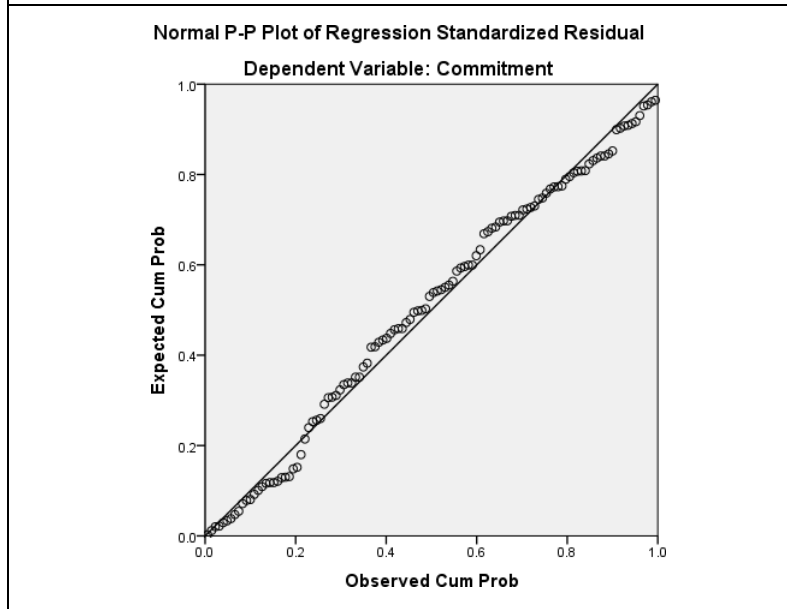
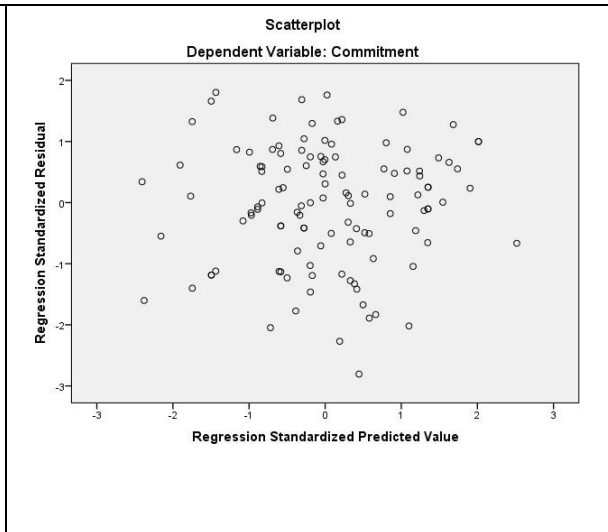
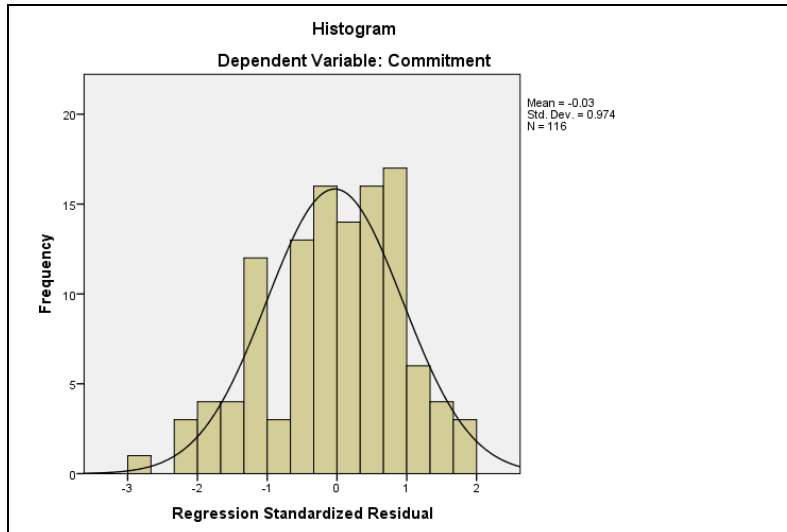
Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	38.184	53.419	45.725	3.1180	116
Std. Predicted Value	-2.406	2.517	.031	1.008	116
Standard Error of Predicted Value	1.275	5.308	2.502	.770	116

Adjusted Predicted Value	37.755	55.216	45.749	3.1914	116
Residual	-35.5033	22.8157	-4.104	12.3224	116
Std. Residual	-2.806	1.803	-.032	.974	116
Stud. Residual	-2.864	1.853	-.033	.996	116
Deleted Residual	-36.9894	24.0940	-4.345	12.8810	116
Stud. Deleted Residual	-2.962	1.874	-.036	1.003	116
Mahal. Distance	.187	19.420	3.970	3.122	116
Cook's Distance	.000	.070	.009	.014	116
Centered Leverage Value	.002	.167	.034	.027	116

a. Dependent Variable: Commitment

Charts



Public = Sector = 2

```
USE ALL.
COMPUTE filter_$=(Sector = 2).
VARIABLE LABELS filter_$ 'Sector = 2 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
REGRESSION
  /DESCRIPTIVES MEAN STDDEV CORR SIG N
  /MISSING PAIRWISE
  /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT Commitment
  /METHOD=ENTER Anti_stigma_Info Anti_stigma_psyoedu Anti_stigma_Advocacy Anti_stigma_Treatment
  /SCATTERPLOT=(*ZRESID ,*ZPRED)
  /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID)
  /CASEWISE PLOT(ZRESID) OUTLIERS(3)
  /SAVE MAHAL COOK.
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Regression

Notes

Output Created	11-NOV-2023 12:28:55
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Missing Value Handling	Filter	Sector = 2 (FILTER)	
	Weight	<none>	
	Split File	<none>	
	N of Rows in Working Data File		58
	Definition of Missing	User-defined missing values are treated as missing.	
Cases Used	Correlation coefficients for each pair of variables are based on all the cases with valid data for that pair. Regression statistics are based on these correlations.		

Syntax		<pre> REGRESSION /DESCRIPTIVES MEAN STDDEV CORR SIG N /MISSING PAIRWISE /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP /CRITERIA=PIN(.05) POUT(.10) /NOORIGIN /DEPENDENT Commitment /METHOD=ENTER Anti_stigma_Info Anti_stigma_psycoedu Anti_stigma_Advocacy Anti_stigma_Treatment /SCATTERPLOT=(*ZRESID ,*ZPRED) /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID) /CASEWISE PLOT(ZRESID) OUTLIERS(3) /SAVE MAHAL COOK. </pre>
Resources	Processor Time	00:00:00.34
	Elapsed Time	00:00:00.37
	Memory Required	2828 bytes
	Additional Memory Required for	888 bytes
	Residual Plots	
Variables Created or Modified	MAH_4	Mahalanobis Distance
	COO_4	Cook's Distance

[DataSet1] C:\Users\F.O\Desktop\FELI PhD Data\FO PRIMARY DATA FOR HYPOTHESIS-180.sav

Descriptive Statistics

	Mean	Std. Deviation	N
Commitment	50.138	10.3075	58
Anti_stigma_Info	20.158	4.6571	57
Anti_stigmaPsycoedu	13.228	3.9235	57
Anti_stigma_Advocacy	10.750	2.0885	58
Anti_stigma_Treatment	22.905	4.5916	58

Correlations

		Commitment	Anti_stigma_Info	Anti_stigmaPsycoedu	Anti_stigma_Advocacy	Anti_stigma_Treatment
Pearson Correlation	Commitment	1.000	.226	.132	.355	.408
	Anti_stigma_Info	.226	1.000	.147	.096	.145
	Anti_stigmaPsycoedu	.132	.147	1.000	.187	.195
	Anti_stigma_Advocacy	.355	.096	.187	1.000	.694
	Anti_stigma_Treatment	.408	.145	.195	.694	1.000
Sig. (1-tailed)	Commitment	.	.046	.163	.003	.001
	Anti_stigma_Info	.046	.	.140	.240	.141
	Anti_stigmaPsycoedu	.163	.140	.	.082	.073
	Anti_stigma_Advocacy	.003	.240	.082	.	.000
N	Anti_stigma_Treatment	.001	.141	.073	.000	.
	Commitment	58	57	57	58	58

Anti_stigma_Info	57	57	56	57	57
Anti_stigma_psycoedu	57	56	57	57	57
Anti_stigma_Advocacy	58	57	57	58	58
Anti_stigma_Treatment	58	57	57	58	58

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	Anti_stigma_Treatment, Anti_stigma_Info, Anti_stigma_psycoedu, Anti_stigma_Advocacy ^b	.	Enter

a. Dependent Variable: Commitment

b. All requested variables entered.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.454 ^a	.206	.143	9.5398	.206	3.302	4	51	.018	2.119

- a. Predictors: (Constant), Anti_stigma_Treatment, Anti_stigma_Info, Anti_stigma_psycoedu, Anti_stigma_Advocacy
 b. Dependent Variable: Commitment

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1201.966	4	300.491	3.302	.018 ^b
	Residual	4641.443	51	91.009		
	Total	5843.409	55			

- a. Dependent Variable: Commitment
 b. Predictors: (Constant), Anti_stigma_Treatment, Anti_stigma_Info, Anti_stigma_psycoedu, Anti_stigma_Advocacy

Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics		
	B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF	
1	(Constant)	19.875	8.926		2.227	.030	1.956	37.795					
	Anti_stigma_Info	.371	.281	.168	1.318	.193	-.194	.935	.226	.181	.164	.964	1.037
	Anti_stigma_psycoedu	.071	.338	.027	.210	.834	-.607	.749	.132	.029	.026	.942	1.061
	Anti_stigma_Advocacy	.678	.857	.137	.791	.432	-1.043	2.400	.355	.110	.099	.516	1.938
	Anti_stigma_Treatment	.636	.392	.283	1.619	.112	-.152	1.423	.408	.221	.202	.510	1.963

- a. Dependent Variable: Commitment

Collinearity Diagnostics^a

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions				
				(Constant)	Anti_stigma_Info	Anti_stigma_psycoedu	Anti_stigma_Advocacy	Anti_stigma_Treatment
1	1	4.863	1.000	.00	.00	.00	.00	.00
	2	.062	8.839	.01	.03	.96	.02	.02
	3	.047	10.156	.00	.68	.00	.07	.06
	4	.016	17.314	.94	.27	.04	.01	.17
	5	.011	20.919	.05	.02	.00	.90	.75

a. Dependent Variable: Commitment

Casewise Diagnostics^a

Case Number	Std. Residual	Commitment	Predicted Value	Residual
174	-3.351	18.0	49.967	-31.9674

a. Dependent Variable: Commitment

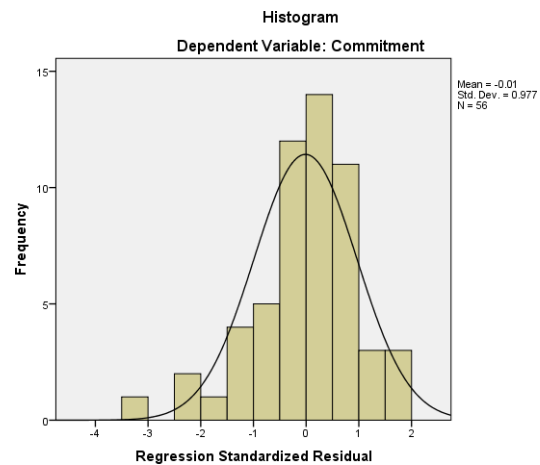
Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	39.784	62.198	50.161	4.7430	56
Std. Predicted Value	-2.215	2.580	.005	1.015	56
Standard Error of Predicted Value	1.443	5.174	2.711	.906	56
Adjusted Predicted Value	38.672	63.242	49.990	4.7195	56

Residual	-31.9674	16.6242	-.1248	9.3245	56
Std. Residual	-3.351	1.743	-.013	.977	56
Stud. Residual	-3.395	1.886	-.005	1.015	56
Deleted Residual	-32.8233	19.4681	.0461	10.0759	56
Stud. Deleted Residual	-3.822	1.936	-.014	1.054	56
Mahal. Distance	.276	15.195	3.945	3.320	56
Cook's Distance	.000	.122	.017	.025	56
Centered Leverage Value	.005	.276	.072	.060	56

a. Dependent Variable: Commitment

Charts



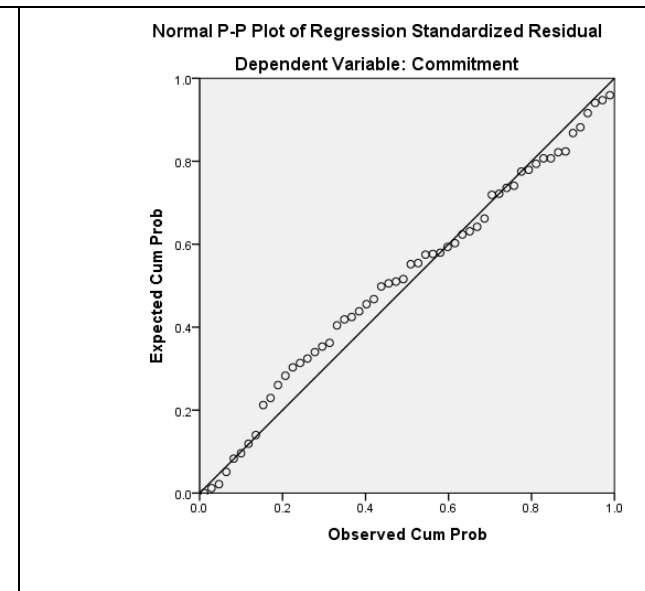
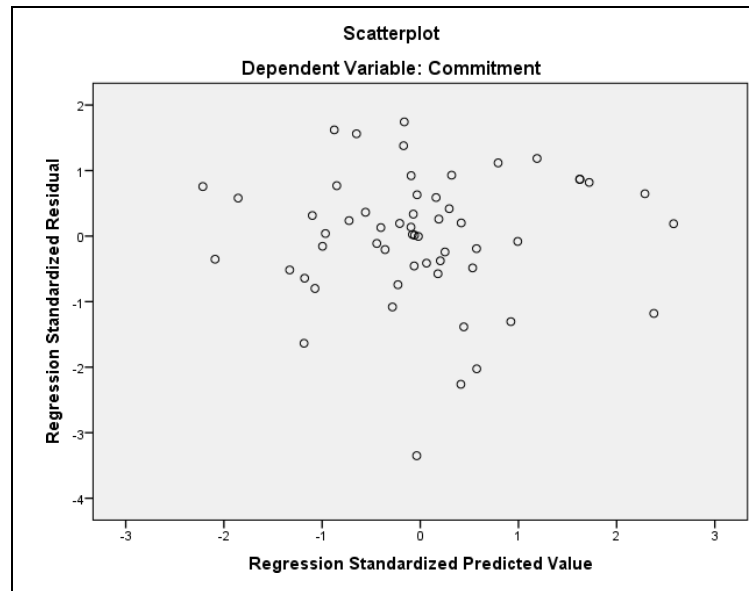
Hypothesis Testing

1. STRATEGIES

GLM Networking cooperation Coordination
Coalition Collaboration BY Sector WITH
Socio_Economic

```

/METHOD=SSTYPE(3)
/INTERCEPT=INCLUDE
/EMMEANS=TABLES(Sector)
WITH(Socio_Economic=MEAN) COMPARE
ADJ(BONFERRONI)
/PRINT=DESCRIPTIVE ETASQ HOMOGENEITY
/CRITERIA=ALPHA(.05)
/DESIGN=Socio_Economic Sector.
    
```



General Linear Model

Notes

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Between-Subjects Factors

	Value Label	N
Sector	1 Private	118
	2 Public	57

Descriptive Statistics

	Sector	Mean	Std. Deviation	N
Networking	Private	20.042	4.8497	118
	Public	20.395	6.5641	57
	Total	20.157	5.4506	175
cooperation	Private	14.835	3.5380	118
	Public	16.579	3.7354	57
	Total	15.403	3.6850	175
Coordination	Private	12.302	3.7333	118
	Public	13.474	3.9010	57
	Total	12.683	3.8175	175
Coalition	Private	11.542	2.8529	118
	Public	11.877	3.0433	57
	Total	11.651	2.9118	175
Collaboration	Private	14.076	3.8700	118
	Public	15.482	4.1629	57
	Total	14.534	4.0106	175

**Box's Test of Equality of
Covariance Matrices^a**

Box's M	32.021
F	2.056
df1	15
df2	51704.990
Sig.	.009

Tests the null hypothesis
that the observed
covariance matrices of the
dependent variables are
equal across groups.

a. Design: Intercept +
Socio_Economic + Sector

Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.873	230.339 ^b	5.000	168.000	.000	.873
	Wilks' Lambda	.127	230.339 ^b	5.000	168.000	.000	.873
	Hotelling's Trace	6.855	230.339 ^b	5.000	168.000	.000	.873
	Roy's Largest Root	6.855	230.339 ^b	5.000	168.000	.000	.873
Socio_Economic	Pillai's Trace	.114	4.313 ^b	5.000	168.000	.001	.114
	Wilks' Lambda	.886	4.313 ^b	5.000	168.000	.001	.114
	Hotelling's Trace	.128	4.313 ^b	5.000	168.000	.001	.114
	Roy's Largest Root	.128	4.313 ^b	5.000	168.000	.001	.114
Sector	Pillai's Trace	.100	3.729 ^b	5.000	168.000	.003	.100

Wilks' Lambda	.900	3.729 ^b	5.000	168.000	.003	.100
Hotelling's Trace	.111	3.729 ^b	5.000	168.000	.003	.100
Roy's Largest Root	.111	3.729 ^b	5.000	168.000	.003	.100

a. Design: Intercept + Socio_Economic + Sector

b. Exact statistic

Levene's Test of Equality of Error Variances^a

	F	df1	df2	Sig.
Networking	10.165	1	173	.002
cooperation	.520	1	173	.472
Coordination	.002	1	173	.965
Coalition	.308	1	173	.580
Collaboration	.003	1	173	.957

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Socio_Economic + Sector

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Networking	293.718 ^a	2	146.859	5.181	.007	.057
	cooperation	141.304 ^b	2	70.652	5.470	.005	.060
	Coordination	69.369 ^c	2	34.684	2.419	.092	.027
	Coalition	6.296 ^d	2	3.148	.369	.692	.004

Intercept	Collaboration	91.188 ^e	2	45.594	2.896	.058	.033
	Networking	9988.480	1	9988.480	352.363	.000	.672
	cooperation	3665.673	1	3665.673	283.810	.000	.623
	Coordination	3286.935	1	3286.935	229.226	.000	.571
	Coalition	2493.423	1	2493.423	291.958	.000	.629
	Collaboration	3326.388	1	3326.388	211.308	.000	.551
Socio_Economic	Networking	288.946	1	288.946	10.193	.002	.056
	cooperation	24.377	1	24.377	1.887	.171	.011
	Coordination	16.577	1	16.577	1.156	.284	.007
	Coalition	1.987	1	1.987	.233	.630	.001
	Collaboration	15.190	1	15.190	.965	.327	.006
	Networking	1.843	1	1.843	.065	.799	.000
Sector	cooperation	121.881	1	121.881	9.436	.002	.052
	Coordination	49.840	1	49.840	3.476	.064	.020
	Coalition	4.020	1	4.020	.471	.494	.003
	Collaboration	79.147	1	79.147	5.028	.026	.028
	Networking	4875.711	172	28.347			
	cooperation	2221.545	172	12.916			
Error	Coordination	2466.353	172	14.339			
	Coalition	1468.941	172	8.540			
	Collaboration	2707.606	172	15.742			
	Networking	76273.750	175				
	cooperation	43881.250	175				
	Coordination	30687.860	175				
Total	Coalition	25232.500	175				
	Collaboration	39766.750	175				
	Networking	5169.429	174				
Corrected Total							

cooperation	2362.849	174			
Coordination	2535.722	174			
Coalition	1475.237	174			
Collaboration	2798.794	174			

- a. R Squared = .057 (Adjusted R Squared = .046)
- b. R Squared = .060 (Adjusted R Squared = .049)
- c. R Squared = .027 (Adjusted R Squared = .016)
- d. R Squared = .004 (Adjusted R Squared = -.007)
- e. R Squared = .033 (Adjusted R Squared = .021)

Estimated Marginal Means

Sector

Estimates					
Dependent Variable	Sector	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Networking	Private	20.086 ^a	.490	19.118	21.054
	Public	20.305 ^a	.706	18.912	21.698
cooperation	Private	14.822 ^a	.331	14.169	15.475
	Public	16.605 ^a	.476	15.665	17.545
Coordination	Private	12.312 ^a	.349	11.624	13.000
	Public	13.452 ^a	.502	12.461	14.443
Coalition	Private	11.546 ^a	.269	11.015	12.077
	Public	11.870 ^a	.387	11.105	12.634
Collaboration	Private	14.066 ^a	.365	13.345	14.788

Public	15.503 ^a	.526	14.465	16.541
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a. Covariates appearing in the model are evaluated at the following values: Socio_Economic = 1.51.

Pairwise Comparisons

Dependent Variable	(I) Sector	(J) Sector	Mean Difference (I-J)	Std. Error	Sig. ^b	95% Confidence Interval for Difference ^b	
						Lower Bound	Upper Bound
Networking	Private	Public	-.219	.860	.799	-1.916	1.478
	Public	Private	.219	.860	.799	-1.478	1.916
cooperation	Private	Public	-1.783*	.580	.002	-2.928	-.637
	Public	Private	1.783*	.580	.002	.637	2.928
Coordination	Private	Public	-1.140	.612	.064	-2.347	.067
	Public	Private	1.140	.612	.064	-.067	2.347
Coalition	Private	Public	-.324	.472	.494	-1.255	.608
	Public	Private	.324	.472	.494	-.608	1.255
Collaboration	Private	Public	-1.437*	.641	.026	-2.701	-.172
	Public	Private	1.437*	.641	.026	.172	2.701

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Bonferroni.

Multivariate Tests

	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Pillai's trace	.100	3.729 ^a	5.000	168.000	.003	.100
Wilks' lambda	.900	3.729 ^a	5.000	168.000	.003	.100

Hotelling's trace	.111	3.729 ^a	5.000	168.000	.003	.100
Roy's largest root	.111	3.729 ^a	5.000	168.000	.003	.100

Each F tests the multivariate effect of Sector. These tests are based on the linearly independent pairwise comparisons among the estimated marginal means.

a. Exact statistic

Univariate Tests

Dependent Variable		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Networking	Contrast	1.843	1	1.843	.065	.799	.000
	Error	4875.711	172	28.347			
cooperation	Contrast	121.881	1	121.881	9.436	.002	.052
	Error	2221.545	172	12.916			
Coordination	Contrast	49.840	1	49.840	3.476	.064	.020
	Error	2466.353	172	14.339			
Coalition	Contrast	4.020	1	4.020	.471	.494	.003
	Error	1468.941	172	8.540			
Collaboration	Contrast	79.147	1	79.147	5.028	.026	.028
	Error	2707.606	172	15.742			

The F tests the effect of Sector. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

2. STRUCTURES

```
GLM Anti_stigma_Info Anti_stigmaPsycoedu Anti_stigma_Advocacy Anti_stigma_Treatment BY Sector WITH Socio_Economic
/METHOD=SSTYPE(3)
/INTERCEPT=INCLUDE
/EMMEANS=TABLES(Sector) WITH(Socio_Economic=MEAN) COMPARE ADJ(BONFERRONI)
/PRINT=DESCRIPTIVE ETASQ HOMOGENEITY
/CRITERIA=ALPHA(.05)
/DESIGN=Socio_Economic Sector.
```

General Linear Model

Notes

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Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data for all variables in the model.

Syntax	<pre> GLM Anti_stigma_Info Anti_stigmaPsycoedu Anti_stigma_Advocacy Anti_stigma_Treatment BY Sector WITH Socio_Economic /METHOD=SSTYPE(3) /INTERCEPT=INCLUDE /EMMEANS=TABLES(Sector) WITH(Socio_Economic=MEAN) COMPARE ADJ(BONFERRONI) /PRINT=DESCRIPTIVE ETASQ HOMOGENEITY /CRITERIA=ALPHA(.05) /DESIGN=Socio_Economic Sector. </pre>				
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Between-Subjects Factors

	Value Label	N
Sector	1 Private	116
	2 Public	56

Descriptive Statistics

	Sector	Mean	Std. Deviation	N
--	--------	------	----------------	---

Anti_stigma_Info	Private	19.513	5.0019	116
	Public	20.286	4.5973	56
	Total	19.765	4.8740	172
Anti_stigmaPsycoedu	Private	13.448	3.9953	116
	Public	13.304	3.9170	56
	Total	13.401	3.9591	172
Anti_stigma_Advocacy	Private	10.534	2.0448	116
	Public	10.759	2.1234	56
	Total	10.608	2.0672	172
Anti_stigma_Treatment	Private	22.198	4.4672	116
	Public	22.848	4.6631	56
	Total	22.410	4.5286	172

**Box's Test of Equality of
Covariance Matrices^a**

Box's M	6.445
F	.625
df1	10
df2	57365.857
Sig.	.794

Tests the null hypothesis
that the observed
covariance matrices of the
dependent variables are
equal across groups.

a. Design: Intercept +
Socio_Economic + Sector

Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.824	194.778 ^b	4.000	166.000	.000	.824
	Wilks' Lambda	.176	194.778 ^b	4.000	166.000	.000	.824
	Hotelling's Trace	4.693	194.778 ^b	4.000	166.000	.000	.824
	Roy's Largest Root	4.693	194.778 ^b	4.000	166.000	.000	.824
Socio_Economic	Pillai's Trace	.027	1.169 ^b	4.000	166.000	.327	.027
	Wilks' Lambda	.973	1.169 ^b	4.000	166.000	.327	.027
	Hotelling's Trace	.028	1.169 ^b	4.000	166.000	.327	.027
	Roy's Largest Root	.028	1.169 ^b	4.000	166.000	.327	.027
Sector	Pillai's Trace	.010	.431 ^b	4.000	166.000	.786	.010
	Wilks' Lambda	.990	.431 ^b	4.000	166.000	.786	.010
	Hotelling's Trace	.010	.431 ^b	4.000	166.000	.786	.010
	Roy's Largest Root	.010	.431 ^b	4.000	166.000	.786	.010

a. Design: Intercept + Socio_Economic + Sector

b. Exact statistic

Levene's Test of Equality of Error Variances^a

	F	df1	df2	Sig.
Anti_stigma_Info	.613	1	170	.435
Anti_stigma_psyc edu	.030	1	170	.863
Anti_stigma_Advocacy	.000	1	170	.997

Anti_stigma_Treatment	.033	1	170	.857
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Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Socio_Economic + Sector

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Anti_stigma_Info	77.421 ^a	2	38.710	1.642	.197	.019
	Anti_stigmaPsycoedu	38.116 ^b	2	19.058	1.219	.298	.014
	Anti_stigmaAdvocacy	1.946 ^c	2	.973	.226	.798	.003
	Anti_stigmaTreatment	16.364 ^d	2	8.182	.396	.674	.005
Intercept	Anti_stigma_Info	5542.052	1	5542.052	235.045	.000	.582
	Anti_stigmaPsycoedu	3659.790	1	3659.790	234.087	.000	.581
	Anti_stigmaAdvocacy	1880.925	1	1880.925	436.156	.000	.721
	Anti_stigmaTreatment	8606.489	1	8606.489	416.703	.000	.711
Socio_Economic	Anti_stigma_Info	54.866	1	54.866	2.327	.129	.014
	Anti_stigmaPsycoedu	37.325	1	37.325	2.387	.124	.014
	Anti_stigmaAdvocacy	.044	1	.044	.010	.920	.000
	Anti_stigmaTreatment	.411	1	.411	.020	.888	.000
Sector	Anti_stigma_Info	26.081	1	26.081	1.106	.294	.007
	Anti_stigmaPsycoedu	1.412	1	1.412	.090	.764	.001
	Anti_stigmaAdvocacy	1.926	1	1.926	.447	.505	.003
	Anti_stigmaTreatment	15.665	1	15.665	.758	.385	.004
Error	Anti_stigma_Info	3984.793	169	23.579			

Total	Anti_stigmaPsycoedu	2642.204	169	15.634		
	Anti_stigmaAdvocacy	728.814	169	4.313		
	Anti_stigmaTreatment	3490.489	169	20.654		
	Anti_stigmaInfo	71251.750	172			
	Anti_stigmaPsycoedu	33570.000	172			
	Anti_stigmaAdvocacy	20084.250	172			
	Anti_stigmaTreatment	89885.750	172			
Corrected Total	Anti_stigmaInfo	4062.214	171			
	Anti_stigmaPsycoedu	2680.320	171			
	Anti_stigmaAdvocacy	730.760	171			
	Anti_stigmaTreatment	3506.853	171			

- a. R Squared = .019 (Adjusted R Squared = .007)
- b. R Squared = .014 (Adjusted R Squared = .003)
- c. R Squared = .003 (Adjusted R Squared = -.009)
- d. R Squared = .005 (Adjusted R Squared = -.007)

Estimated Marginal Means

Sector

		Estimates			
Dependent Variable	Sector	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Anti_stigmaInfo	Private	19.494 ^a	.451	18.603	20.384
	Public	20.326 ^a	.649	19.044	21.608
Anti_stigmaPsycoedu	Private	13.464 ^a	.367	12.739	14.189

Anti_stigma_Advocacy	Public	13.271 ^a	.529	12.227	14.315
	Private	10.534 ^a	.193	10.153	10.915
Anti_stigma_Treatment	Public	10.760 ^a	.278	10.212	11.308
	Private	22.200 ^a	.422	21.367	23.033
	Public	22.845 ^a	.608	21.645	24.045

a. Covariates appearing in the model are evaluated at the following values: Socio_Economic = 1.52.

Pairwise Comparisons

Dependent Variable	(I) Sector	(J) Sector	Mean Difference (I-J)	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
						Lower Bound	Upper Bound
Anti_stigma_Info	Private	Public	-.832	.791	.294	-2.394	.730
	Public	Private	.832	.791	.294	-.730	2.394
Anti_stigma_psycosedu	Private	Public	.194	.644	.764	-1.078	1.465
	Public	Private	-.194	.644	.764	-1.465	1.078
Anti_stigma_Advocacy	Private	Public	-.226	.338	.505	-.894	.442
	Public	Private	.226	.338	.505	-.442	.894
Anti_stigma_Treatment	Private	Public	-.645	.740	.385	-2.106	.817
	Public	Private	.645	.740	.385	-.817	2.106

Based on estimated marginal means

a. Adjustment for multiple comparisons: Bonferroni.

Multivariate Tests

	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Pillai's trace	.010	.431 ^a	4.000	166.000	.786	.010
Wilks' lambda	.990	.431 ^a	4.000	166.000	.786	.010
Hotelling's trace	.010	.431 ^a	4.000	166.000	.786	.010
Roy's largest root	.010	.431 ^a	4.000	166.000	.786	.010

Each F tests the multivariate effect of Sector. These tests are based on the linearly independent pairwise comparisons among the estimated marginal means.

a. Exact statistic

Univariate Tests

Dependent Variable		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Anti_stigma_Info	Contrast	26.081	1	26.081	1.106	.294	.007
	Error	3984.793	169	23.579			
Anti_stigma_psycoeu	Contrast	1.412	1	1.412	.090	.764	.001
	Error	2642.204	169	15.634			
Anti_stigma_Advocacy	Contrast	1.926	1	1.926	.447	.505	.003
	Error	728.814	169	4.313			
Anti_stigma_Treatment	Contrast	15.665	1	15.665	.758	.385	.004
	Error	3490.489	169	20.654			

The F tests the effect of Sector. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

Appendix P: Output of the key variable in the study (Pre-test)

Statistics

		Anti_stigma_Info	Anti_stigma_psy coedu	Anti_stigma_Adv ocacy	Anti_stigma_Tre atment
N	Valid	25	25	26	26
	Missing	1	1	0	0
Mean		19.900	12.860	10.942	23.577
Median		21.500	13.500	10.750	23.250
Std. Deviation		4.5917	3.3245	1.8403	3.5488
Variance		21.083	11.053	3.387	12.594
Skewness		-.765	-.149	-.109	.626
Std. Error of Skewness		.464	.464	.456	.456
Kurtosis		-.042	.097	1.750	.356
Std. Error of Kurtosis		.902	.902	.887	.887

Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Networking	.156	25	.120	.920	25	.051
cooperation	.163	25	.087	.929	25	.081
Coordination	.108	25	.200*	.972	25	.699
Coalition	.265	25	.000	.874	25	.005
Collaboration	.199	25	.012	.938	25	.132

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Collaboration

Kolmogorov-Simron test= .108, M=15, SD, 3.5 (p = .200) which is not statistically significant.

Descriptives

			Statistic	Std. Error
Networking	Mean		21.620	1.2567
	95% Confidence Interval for	Lower Bound	19.026	
	Mean	Upper Bound	24.214	
	5% Trimmed Mean		21.861	
	Median		23.500	
	Variance		39.485	
	Std. Deviation		6.2837	
	Minimum		9.0	
	Maximum		30.0	
	Range		21.0	
	Interquartile Range		9.0	
	Skewness		-.721	.464
	Kurtosis		-.457	.902
	cooperation	Mean		15.740	.6783
95% Confidence Interval for		Lower Bound	14.340	
Mean		Upper Bound	17.140	
5% Trimmed Mean			15.700	
Median			14.500	
Variance			11.503	
Std. Deviation			3.3915	

	Minimum		10.5	
	Maximum		22.0	
	Range		11.5	
	Interquartile Range		6.3	
	Skewness		.239	.464
	Kurtosis		-1.114	.902
	Mean		12.920	.6926
	95% Confidence Interval for	Lower Bound	11.490	
	Mean	Upper Bound	14.350	
	5% Trimmed Mean		12.956	
	Median		12.500	
	Variance		11.993	
Coordination	Std. Deviation		3.4631	
	Minimum		6.0	
	Maximum		19.5	
	Range		13.5	
	Interquartile Range		5.3	
	Skewness		-.110	.464
	Kurtosis		-.181	.902
	Mean		12.540	.6204
	95% Confidence Interval for	Lower Bound	11.259	
	Mean	Upper Bound	13.821	
	5% Trimmed Mean		12.522	
Coalition	Median		12.000	
	Variance		9.623	
	Std. Deviation		3.1021	
	Minimum		7.0	
	Maximum		18.0	

	Range		11.0	
	Interquartile Range		2.8	
	Skewness		.675	.464
	Kurtosis		-.189	.902
	Mean		15.020	.7050
	95% Confidence Interval for Mean	Lower Bound	13.565	
		Upper Bound	16.475	
	5% Trimmed Mean		14.872	
	Median		14.500	
	Variance		12.427	
Collaboration	Std. Deviation		3.5251	
	Minimum		8.5	
	Maximum		24.5	
	Range		16.0	
	Interquartile Range		3.3	
	Skewness		.740	.464
	Kurtosis		1.174	.902

Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Anti_stigma_Info	.158	24	.127	.920	24	.057
Anti_stigma_psycoedu	.100	24	.200*	.973	24	.736
Anti_stigma_Advocacy	.136	24	.200*	.955	24	.346

Anti_stigma_Treatment	.134	24	.200*	.938	24	.149
-----------------------	------	----	-------	------	----	------

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Descriptives

			Statistic	Std. Error
Anti_stigma_Info	Mean		20.188	.9093
	95% Confidence Interval for Mean	Lower Bound	18.306	
		Upper Bound	22.069	
	5% Trimmed Mean		20.449	
	Median		21.500	
	Variance		19.844	
	Std. Deviation		4.4546	
	Minimum		9.5	
	Maximum		26.0	
	Range		16.5	
	Interquartile Range		5.8	
	Skewness		-.913	.472
	Kurtosis		.505	.918
Anti_stigmaPsycoedu	Mean		13.021	.6726
	95% Confidence Interval for Mean	Lower Bound	11.629	
		Upper Bound	14.412	
	5% Trimmed Mean		13.037	
	Median		13.500	
	Variance		10.858	
	Std. Deviation		3.2952	

	Minimum		6.0	
	Maximum		20.0	
	Range		14.0	
	Interquartile Range		4.3	
	Skewness		-.244	.472
	Kurtosis		.336	.918
	Mean		10.979	.3895
	95% Confidence Interval for	Lower Bound	10.173	
	Mean	Upper Bound	11.785	
	5% Trimmed Mean		11.000	
	Median		10.750	
	Variance		3.641	
Anti_stigma_Advocacy	Std. Deviation		1.9081	
	Minimum		6.0	
	Maximum		15.5	
	Range		9.5	
	Interquartile Range		2.0	
	Skewness		-.165	.472
	Kurtosis		1.517	.918
	Mean		23.500	.7524
	95% Confidence Interval for	Lower Bound	21.944	
	Mean	Upper Bound	25.056	
	5% Trimmed Mean		23.426	
Anti_stigma_Treatment	Median		23.000	
	Variance		13.587	
	Std. Deviation		3.6860	
	Minimum		17.0	

Maximum	31.0	
Range	14.0	
Interquartile Range	3.9	
Skewness	.677	.472
Kurtosis	.206	.918

Appendix: Q1: DATA SCREENING PRETEST-CFA OUTPUT OF THE KEY VARIABLES IN THE STUDY

Theoretical equation modelling for Anti-stigma strategy and structure of collaboration parameters is $X=t+e$. Where X is measured variable, t is true score, and e is measurement error ($0 \neq \text{Mean of the error-s systematic error}$ or $0 = \text{Mean of the error} = \text{random error}$.)

$1/2s(s+1) = e$ Where s is the number of the observed variance, e-measurement errors, I is constant.

Estimated Latent Indicator: Strategy	Estimated Latent Indicator: Structure
Information: $\frac{1}{2} 8(8+1) = e$ $\frac{1}{2} 8(9) = e$ $e=36$	Networking: $\frac{1}{2} 9(9+1) = e$ $\frac{1}{2} 9(10) = e$, therefore, $e=45$
Psychoéducation: $\frac{1}{2} 6(6+1) = e$ $\frac{1}{2} 6(7) = e$ $e = \frac{1}{2} 6(7)$, $e=21$	Cooperation : $\frac{1}{2} 7(7+1) = e$ $\frac{1}{2} 7(8) = e$, therefore, $e=26$
Advocacy: $\frac{1}{2} 5(5+1) = e$ $\frac{1}{2} 5(6) = e$, therefore, $e=15$	Coordination: $\frac{1}{2} 6(6+1) = e$ $\frac{1}{2} 6(7) = e$, therefore, $e= 21$
Treatment/referral: $\frac{1}{2} 9(9+1) = e$ $\frac{1}{2} 9(10) = e$. therefore, $e=45$	Coalition: $\frac{1}{2} 6(6+1) = e$ $\frac{1}{2} 6(7) = e$, therefore, $e= 21$
	Collaboration: $\frac{1}{2} 7(7+1) = e$ $\frac{1}{2} 7(8) = e$, therefore, $e= 26$

--	--

STRATEGIC ALLIANCE (Collaborative Structure)
NETWORKING

(1) [Nt1]Ntw = 1						
OIM						
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
Nt1 <-						
Ntw	.6181129	.039592	15.61	0.000	.5405139	.6957119
_cons	2.286932	.1057924	21.62	0.000	2.079583	2.494282
-----+-----						
Nt2 <-						
Ntw	.6891395	.035044	19.66	0.000	.6204545	.7578246
_cons	2.27172	.1051933	21.60	0.000	2.065545	2.477895
-----+-----						
Nt3 <-						
Ntw	.6767977	.035636	18.99	0.000	.6069524	.7466429
_cons	2.472324	.1120619	22.06	0.000	2.252687	2.691961
-----+-----						
Nt4 <-						
Ntw	.7100158	.0351385	20.21	0.000	.6411455	.778886
_cons	2.407409	.1098461	21.92	0.000	2.192115	2.622704
-----+-----						
Nt5 <-						
Ntw	.5750546	.042859	13.42	0.000	.4910526	.6590567

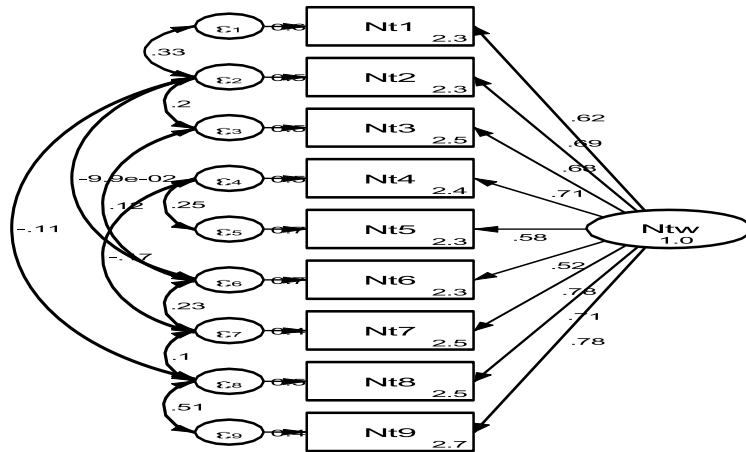
_cons	2.270366	.1052386	21.57	0.000	2.064102	2.47663
-----+-----						
Nt6 <-						
Ntw	.5203733	.0483161	10.77	0.000	.4256754	.6150711
_cons	2.257475	.1048829	21.52	0.000	2.051909	2.463042
-----+-----						
Nt7 <-						
Ntw	.7801769	.030093	25.93	0.000	.7211957	.8391581
_cons	2.456217	.1114614	22.04	0.000	2.237756	2.674677
-----+-----						
Nt8 <-						
Ntw	.7082686	.0363495	19.48	0.000	.637025	.7795123
_cons	2.483243	.1123433	22.10	0.000	2.263054	2.703432
-----+-----						
Nt9 <-						
Ntw	.7770329	.0285018	27.26	0.000	.7211705	.8328954
_cons	2.670065	.1188779	22.46	0.000	2.437069	2.903062
-----+-----						
Variance						
e.Nt1	.6179365	.0489447			.529082	.7217133
e.Nt2	.5250867	.0483005			.4384627	.6288244
e.Nt3	.5419449	.0482367			.4551898	.6452348
e.Nt4	.4958776	.0498978			.4071197	.603986
e.Nt5	.6693122	.0492925			.5793496	.7732443
e.Nt6	.7292117	.0502848			.6370252	.8347388
e.Nt7	.391324	.0469557			.3093137	.4950782
e.Nt8	.4983555	.0514904			.4069983	.6102193
e.Nt9	.3962198	.0442936			.3182584	.4932788

Ntw	1	.	.				
Covariance							
e.Nt1							
e.Nt2	.3279857	.0530659	6.18	0.000	.2239785	.4319928	
	-----+-----						
e.Nt2							
e.Nt3	.201448	.0565233	3.56	0.000	.0906643	.3122318	
e.Nt6	-.0993044	.0563827	-1.76	0.078	-.2098125	.0112037	
e.Nt8	-.1074098	.0494648	-2.17	0.030	-.2043591	-.0104606	
	-----+-----						
e.Nt3							
e.Nt6	.1153216	.0603773	1.91	0.056	-.0030158	.233659	
	-----+-----						
e.Nt4							
e.Nt5	.2517194	.060812	4.14	0.000	.1325302	.3709087	
e.Nt7	-.1669136	.0711088	-2.35	0.019	-.3062843	-.0275429	
	-----+-----						
e.Nt6							
e.Nt7	.2260428	.0656458	3.44	0.001	.0973794	.3547062	
	-----+-----						
e.Nt7							
e.Nt8	.1039575	.0584722	1.78	0.075	-.010646	.218561	
	-----+-----						
e.Nt8							
e.Nt9	.5109745	.0514293	9.94	0.000	.410175	.611774	

LR test of model vs. saturated: $\chi^2(17) = 26.27$, Prob > $\chi^2 = 0.0697$

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(17)	26.269	model vs. saturated
p > chi2	0.07	
chi2_bs(36)	1432.829	baseline vs. saturated
p > chi2	0	
Population error		
RMSEA	0.041	Root mean squared error of approximation
90% CI, lower bound	0	
upper bound	0.07	
pclose	0.655	Probability RMSEA ≤ 0.05
Information criteria		
AIC	6680.816	Akaike's information criterion
BIC	6820.589	Bayesian information criterion
Baseline comparison		
CFI	0.993	Comparative fit index
TLI	0.986	Tucker-Lewis index
Size of residuals		

SRMR	0.021	Standardized root mean squared residual
CD	0.871	Coefficient of determination



Cooperation (Cpt)

(1) [cpt1]Cpt =					
1					
OIM					
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]
Measurement					
cpt1 <-					
Cpt	.7027964	.0435674	16.13	0.000	.6174058 .788187

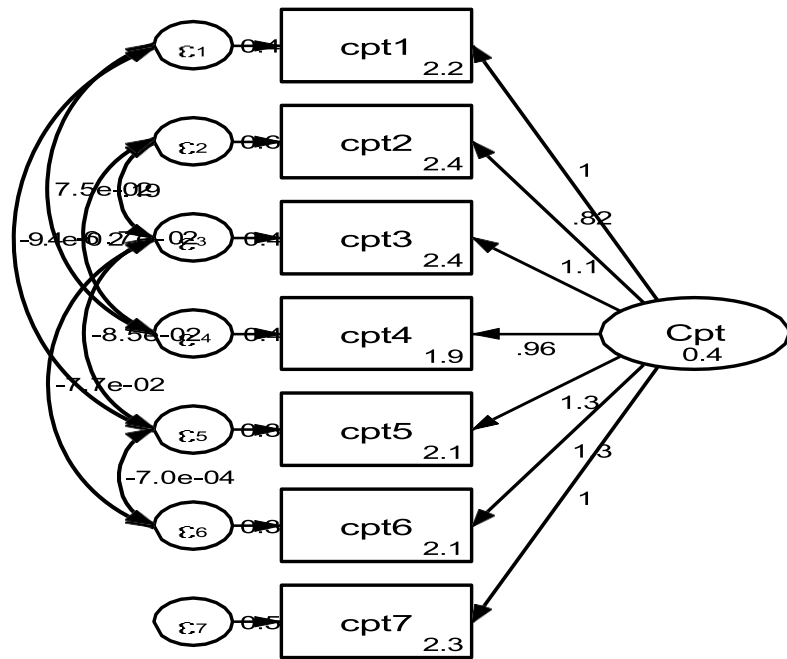
_cons	2.481615	.1112464	22.31	0.000	2.263576
	2.699654				
-----+-----					
cpt2 <-					
Cpt	.5595959	.0437482	12.79	0.000	.4738511
	.6453407				
_cons	2.6512	.1177611	22.51	0.000	2.420393
	2.882008				
-----+-----					
cpt3 <-					
Cpt	.6396187	.0397376	16.10	0.000	.5617343
	.7175031				
_cons	2.692525	.1187906	22.67	0.000	2.459699
	2.92535				
-----+-----					
cpt4 <-					
Cpt	.6660788	.0480544	13.86	0.000	.5718938
	.7602637				
_cons	2.142297	.1001656	21.39	0.000	1.945976
	2.338618				
-----+-----					
cpt5 <-					
Cpt	.7469929	.0408122	18.30	0.000	.6670023
	.8269834				
_cons	2.232086	.1031835	21.63	0.000	2.02985
	2.434322				
-----+-----					
cpt6 <-					
Cpt	.7877711	.0353624	22.28	0.000	.718462
	.8570802				

_cons 2.326363 .1062955 21.89 0.000 2.118028 2.534698						
-----+-----						
cpt7 <-						
Cpt .719733 .0381765 18.85 0.000 .6449085 .7945576						
_cons 2.416489 .1093176 22.11 0.000 2.202231 2.630748						
Variance						
e.cpt1 .5060772 .0612381 .3992242 .6415297						
e.cpt2 .6868524 .0489626 .5972899 .7898447						
e.cpt3 .5908879 .0508339 .4992023 .699413						
e.cpt4 .5563391 .0640161 .4440119 .697083						
e.cpt5 .4420017 .0609729 .3372896 .5792217						
e.cpt6 .3794167 .055715 .2845265 .5059529						
e.cpt7 .4819844 .0549538 .3854629 .6026751						
Cpt 1 . .						
Covariance						
e.cpt1						
e.cpt3 .1533476 .0598973 2.56 0.010 .0359511 .2707441						
e.cpt4 .1452303 .0739435 1.96 0.050 .0003037 .2901569						
e.cpt5 -.1936253 .0874259 -2.21 0.027 -.364977 - .0222737						
e.cpt7 -.1528939 .0934837 -1.64 0.102 -.3361185 .0303308						

-----+-----						
e.cpt2						
e.cpt3	.4547405	.0464159	9.80	0.000	.363767	
	.5457141					
e.cpt4	-.1977321	.0550844	-3.59	0.000	-.3056956	-
	.0897687					
-----+-----						
e.cpt4						
e.cpt5	.091187	.0946104	0.96	0.335	-.094246	
	.2766199					
e.cpt6	.0417265	.1005635	0.41	0.678	-.1553742	
	.2388273					
-----+-----						
e.cpt5						
e.cpt6	.1580592	.0999477	1.58	0.114	-.0378347	
	.3539531					
LR test of model vs. saturated: chi2(5) = 7.27, Prob > chi2 = 0.2012						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(5)	7.271	model vs. saturated
p > chi2	0.201	
chi2_bs(21)	1024.752	baseline vs. saturated
p > chi2	0	
Population error		

RMSEA	0.037	Root mean squared error of approximation
90% CI, lower bound	0	
upper bound	0.091	
pclose	0.579	Probability RMSEA \leq 0.05
Information criteria		
AIC	5103.253	Akaike's information criterion
BIC	5217.044	Bayesian information criterion
Baseline comparison		
CFI	0.998	Comparative fit index
TLI	0.99	Tucker-Lewis index
Size of residuals		
SRMR	0.015	Standardized root mean squared residual
CD	0.866	Coefficient of determination



CORD

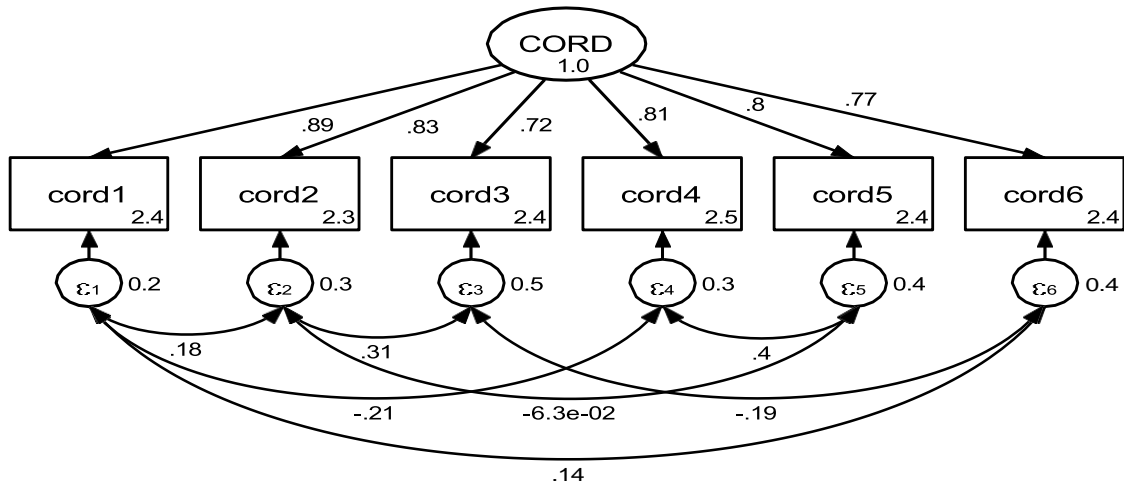
(1) [cord1]CORD = 1	
OIM	
Standardized	Coef. Std. Err. z P>z [95% Conf. Interval]
Measurement	
cord1 <-	
CORD	.887026 .023808 37.26 0.000 .840363 .9336889

_cons	2.368901	.1077087	21.99	0.000	2.157796	2.580007
-----+-----						
cord2 <-						
CORD	.8302272	.0261881	31.70	0.000	.7788995	.8815549
_cons	2.283591	.1048668	21.78	0.000	2.078056	2.489127
-----+-----						
cord3 <-						
CORD	.7190764	.0314361	22.87	0.000	.6574627	.7806901
_cons	2.371342	.1078091	22.00	0.000	2.16004	2.582644
-----+-----						
cord4 <-						
CORD	.8080931	.0263861	30.63	0.000	.7563774	.8598088
_cons	2.453662	.1105751	22.19	0.000	2.236938	2.670385
-----+-----						
cord5 <-						
CORD	.8010862	.0261375	30.65	0.000	.7498576	.8523148
_cons	2.437172	.1100113	22.15	0.000	2.221554	2.65279
-----+-----						
cord6 <-						
CORD	.7695489	.0292677	26.29	0.000	.7121853	.8269126
_cons	2.406618	.1089776	22.08	0.000	2.193026	2.62021
-----+-----						
Variance						
e.cord1	.213185	.0422367			.1445821	.3143393
e.cord2	.3107228	.0434841			.2361847	.4087846
e.cord3	.4829291	.04521			.4019732	.5801891
e.cord4	.3469855	.0426448			.2727081	.4414938
e.cord5	.3582609	.0418768			.284907	.4505009
e.cord6	.4077944	.0450459			.3284095	.5063687

CORD	1	.	.	.		
Covariance						
e.cord1						
e.cord2	.1825511	.0876402	2.08	0.037	.0107796	.3543226
e.cord4	-.2124382	.0928051	-2.29	0.022	-.3943329	-.0305435
e.cord6	.1358909	.095738	1.42	0.156	-.0517521	.3235339
-----+-----						
e.cord2						
e.cord3	.3108129	.0631279	4.92	0.000	.1870845	.4345414
e.cord5	-.06288	.0659594	-0.95	0.340	-.192158	.066398
-----+-----						
e.cord3						
e.cord6	-.1891224	.0616299	-3.07	0.002	-.3099149	-.06833
-----+-----						
e.cord4						
e.cord5	.4031792	.0637248	6.33	0.000	.2782808	.5280776
LR test of model vs. saturated: chi2(2) = 1.89, Prob > chi2 = 0.3882						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(2)	1.892	model vs. saturated
p > chi2	0.388	
chi2_bs(15)	1454.267	baseline vs. saturated
p > chi2	0.000	

Population error		
RMSEA	0.000	Root mean squared error of approximation
90% CI, lower bound	0.000	
upper bound	0.108	
pclose	0.631	Probability RMSEA <= 0.05
Information criteria		
AIC	3733.841	Akaike's information criterion
BIC	3828.666	Bayesian information criterion
Baseline comparison		
CFI	1.000	Comparative fit index
TLI	1.001	Tucker-Lewis index
Size of residuals		
SRMR	0.005	Standardized root mean squared residual
CD	0.913	Coefficient of determination



COALITION

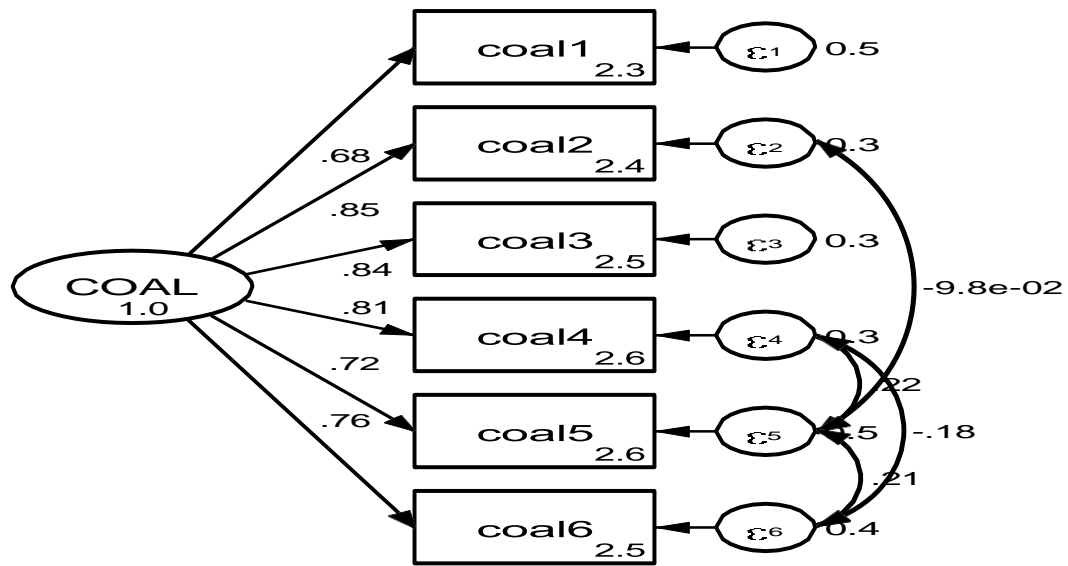
(1) [coal1]COAL = 1					
OIM					
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]
Measurement					
coal1 <-					
COAL	.6796989	.032411	20.97	0.000	.6161746 .7432232
_cons	2.308267	.1044265	22.10	0.000	2.103595 2.512939
-----+-----					
coal2 <-					

COAL	.8509187	.0195444	43.54	0.000	.8126124
	.889225				
_cons	2.44071	.1088158	22.43	0.000	2.227435
	2.653985				
-----+-----					
coal3 <-					
COAL	.8447886	.019757	42.76	0.000	.8060655
	.8835117				
_cons	2.530319	.1118201	22.63	0.000	2.311156
	2.749483				
-----+-----					
coal4 <-					
COAL	.808218	.0240075	33.67	0.000	.7611641
	.8552719				
_cons	2.592603	.1139235	22.76	0.000	2.369317
	2.815889				
-----+-----					
coal5 <-					
COAL	.7158621	.0344377	20.79	0.000	.6483654
	.7833588				
_cons	2.634862	.1153441	22.84	0.000	2.408792
	2.860932				
-----+-----					
coal6 <-					
COAL	.7560969	.0283064	26.71	0.000	.7006174
	.8115765				
_cons	2.476567	.1100148	22.51	0.000	2.260942
	2.692192				

Variance					
e.coal1	.5380094	.0440594		.4582285	.6316807
e.coal2	.2759374	.0332614		.2178748	.3494733
e.coal3	.2863322	.033381		.2278431	.359836
e.coal4	.3467837	.0388066		.2784874	.4318292
e.coal5	.4875415	.0493053		.3998795	.5944208
e.coal6	.4283174	.0428048		.3521268	.5209936
COAL	1	.	.		
.					
Covariance					
e.coal2					
e.coal5	-.0982827	.0720051	-1.36	0.172	-.2394101
	.0428446				
-----+-----					
e.coal4					
e.coal5	.2229843	.0687405	3.24	0.001	.0882555
	.3577132				
e.coal6	-.1822145	.0747388	-2.44	0.015	-.3286998
	.0357292				
-----+-----					
e.coal5					
e.coal6	.2070237	.0670826	3.09	0.002	.0755442
	.3385032				
LR test of model vs. saturated: chi2(5) = 3.23, Prob > chi2 = 0.6647					

Fit statistic	Value	Description
---------------	-------	-------------

Likelihood ratio		
chi2_ms(5)	3.229	model vs. saturated
p > chi2	0.665	
chi2_bs(15)	1189.93	baseline vs. saturated
p > chi2	0.000	
Population error		
RMSEA	0.000	Root mean squared error of approximation
90% CI, lower bound	0.00	
upper bound	0.06	
pclose	0.909	Probability RMSEA <= 0.05
Information criteria		
AIC	3569.124	Akaike's information criterion
BIC	3653.1	Bayesian information criterion
Baseline comparison		
CFI	1.000	Comparative fit index
TLI	1.005	Tucker-Lewis index
Size of residuals		
SRMR	0.008	Standardized root mean squared residual
CD	0.911	Coefficient of determination



COLLAB

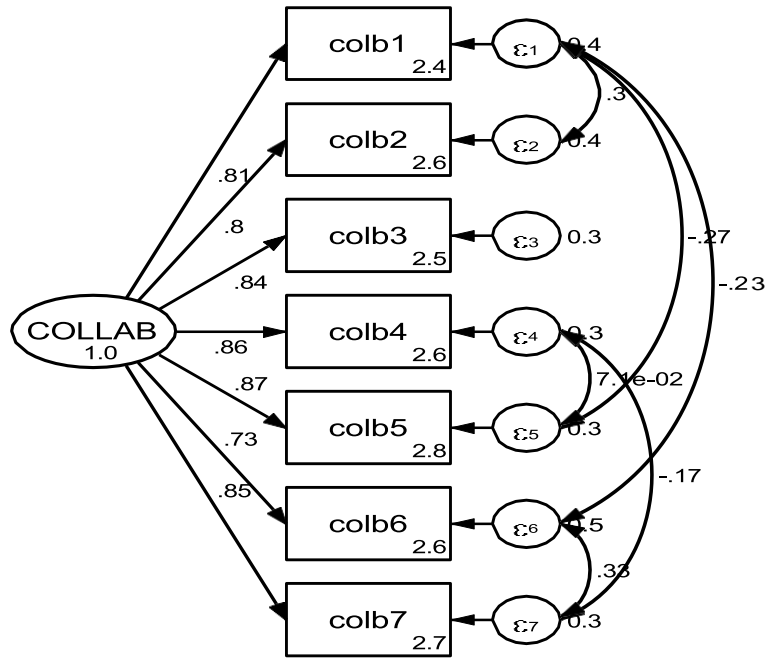
OIM						
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
colb1 <-						
COLLAB	.8059967	.023167	34.79	0.000	.7605902	.8514031
_cons	2.401261	.1082283	22.19	0.000	2.189138	2.613385
-----+-----						
colb2 <-						

COLLAB	.8028967	.0225958	35.53	0.000	.7586098	.8471835
_cons	2.634401	.1163854	22.64	0.000	2.40629	2.862512
-----+-----						
colb3 <-						
COLLAB	.8407038	.0186231	45.14	0.000	.8042031	.8772045
_cons	2.545083	.1133341	22.46	0.000	2.322953	2.767214
-----+-----						
colb4 <-						
COLLAB	.8635364	.0187244	46.12	0.000	.8268372	.9002355
_cons	2.644236	.1167293	22.65	0.000	2.415451	2.873021
-----+-----						
colb5 <-						
COLLAB	.8655146	.0182701	47.37	0.000	.829706	.9013233
_cons	2.810474	.1224621	22.95	0.000	2.570452	3.050495
-----+-----						
colb6 <-						
COLLAB	.7339445	.0283378	25.90	0.000	.6784033	.7894856
_cons	2.570421	.1140938	22.53	0.000	2.346801	2.794041
-----+-----						
colb7 <-						
COLLAB	.8471676	.0187677	45.14	0.000	.8103837	.8839516
_cons	2.666689	.1175033	22.69	0.000	2.436387	2.896991
-----+-----						
Variance						
e.colb1	.3503694	.037345			.2843142	.4317712
e.colb2	.355357	.0362841			.2909055	.434088
e.colb3	.2932171	.0313131			.2378418	.3614851
e.colb4	.2543049	.0323384			.1982042	.3262848
e.colb5	.2508844	.031626			.1959625	.3211992

e.colb6	.4613255	.0415968			.3865951	.5505016
e.colb7	.282307	.0317987			.2263827	.3520465
COLLAB	1	.	.			
.						
Covariance						
e.colb1						
e.colb2	.298173	.061993	4.81	0.000	.176669	.419677
e.colb5	-.2748781	.0694164	-3.96	0.000	-.4109317	-.1388244
e.colb6	-.2288433	.0554493	-4.13	0.000	-.3375219	-.1201646
-----+-----						
e.colb4						
e.colb5	.0705372	.0874984	0.81	0.420	-.1009565	.242031
e.colb7	-.1738825	.0697151	-2.49	0.013	-.3105216	-.0372435
-----+-----						
e.colb6						
e.colb7	.3340041	.0588035	5.68	0.000	.2187513	.4492569
LR test of model vs. saturated: chi2(8) = 13.30, Prob > chi2 = 0.1021						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(8)	13.295	model vs. saturated
p > chi2	0.102	
chi2_bs(21)	1879.581	baseline vs. saturated
p > chi2	0.00	

Population error		
RMSEA	0.045	Root mean squared error of approximation
90% CI, lower bound	0.00	
upper bound	0.086	
pclose	0.527	Probability RMSEA <= 0.05
Information criteria		
AIC	3763.747	Akaike's information criterion
BIC	3866.323	Bayesian information criterion
Baseline comparison		
CFI	0.997	Comparative fit index
TLI	0.993	Tucker-Lewis index
Size of residuals		
SRMR	0.013	Standardized root mean squared residual
CD	0.943	Coefficient of determination



ANTI-STIGMA INTERVENTIONS VARIABLES INFORMATION

OIM						
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
info1 <-						
INFO	.0166134	.0434365	0.38	0.702	-.0685206	.1017474
_cons	2.505806	.1154006	21.71	0.000	2.279625	2.731987
-----+-----						

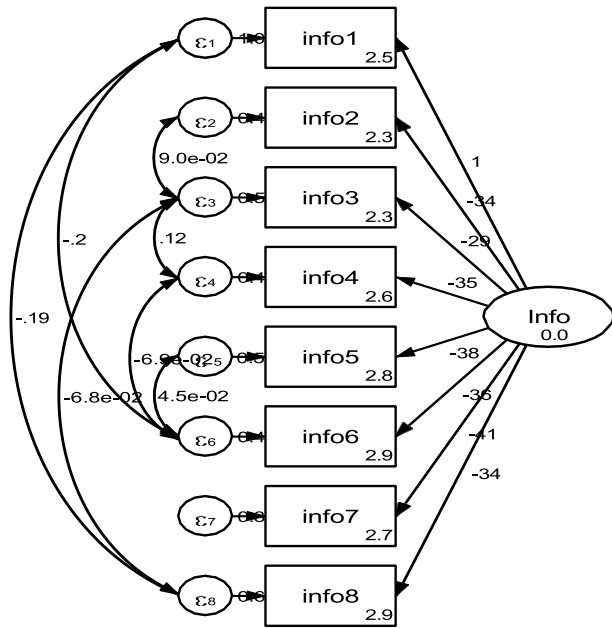
info2 <-	
INFO	-.6584378 .038335 -17.18 0.000 -.733573 -.5833027
_cons	2.650181 .1218208 21.75 0.000 2.411417 2.888945
-----+-----	
info3 <-	
INFO	-.5532384 .0470506 -11.76 0.000 -.6454559 -.4610209
_cons	2.682439 .1224956 21.90 0.000 2.442352 2.922526
-----+-----	
info4 <-	
INFO	-.6781454 .0386767 -17.53 0.000 -.7539504 -.6023403
_cons	3.044626 .1360843 22.37 0.000 2.777906 3.311346
-----+-----	
info5 <-	
INFO	-.682154 .0378254 -18.03 0.000 -.7562903 -.6080176
_cons	2.980869 .1338007 22.28 0.000 2.718625 3.243114
-----+-----	
info6 <-	
INFO	-.6887702 .0384821 -17.90 0.000 -.7641937 -.6133468
_cons	3.209834 .1411539 22.74 0.000 2.933177 3.486491
-----+-----	
info7 <-	
INFO	-.8050067 .028043 -28.71 0.000 -.8599699 -.7500436
_cons	3.182565 .1412324 22.53 0.000 2.905754 3.459375
-----+-----	
info8 <-	
INFO	-.5885928 .0424232 -13.87 0.000 -.6717408 -.5054448
_cons	3.032505 .1348836 22.48 0.000 2.768139 3.296872
-----+-----	
Variance	

e.info1	.999724	.0014433			.9968993	1.002557
e.info2	.5664596	.0504824			.4756753	.6745704
e.info3	.6939273	.0520604			.599038	.8038473
e.info4	.5401189	.0524569			.4464982	.6533696
e.info5	.534666	.0516054			.4425123	.6460107
e.info6	.5255956	.0530106			.4313215	.6404752
e.info7	.3519641	.0451495			.2737205	.4525739
e.info8	.6535585	.04994			.5626549	.7591487
INFO	1	.	.	.	.	.
Covariance						
e.info1						
e.info6	-.3061788	.0565459	-5.41	0.000	-.4170068	-.1953508
e.info8	-.2399113	.0548113	-4.38	0.000	-.3473394	-.1324832
e.info2						
e.info3	.1885188	.0589241	3.20	0.001	.0730296	.3040079
e.info3						
e.info4	.2660591	.0595697	4.47	0.000	.1493047	.3828135
e.info8	-.1200517	.0577561	-2.08	0.038	-.2332517	-.0068518
e.info4						
e.info6	-.1691595	.0675665	-2.50	0.012	-.3015875	-.0367316
e.info5						
e.info6	.1036857	.0711691	1.46	0.145	-.0358032	.2431747

LR test of model vs. saturated: $\chi^2(13) = 17.09$, Prob > $\chi^2 = 0.1951$

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(13)	17.092	model vs. saturated
p > chi2	0.195	
baseline vs. saturated		
chi2_bs(28)	825.909	
p > chi2	0.000	
Population error		
RMSEA	0.032	Root mean squared error of approximation
90% CI, lower bound	0.000	
upper bound	0.069	
pclose	0.747	Probability RMSEA ≤ 0.05
Information criteria		
AIC	5672.059	Akaike's information criterion
BIC	5787.287	Bayesian information criterion
Baseline comparison		
CFI	0.995	Comparative fit index
TLI	0.989	Tucker-Lewis index
Size of residuals		
SRMR	0.024	Standardized root mean squared residual

CD	0.863	Coefficient of determination
----	-------	------------------------------



PSCYCHO EDU

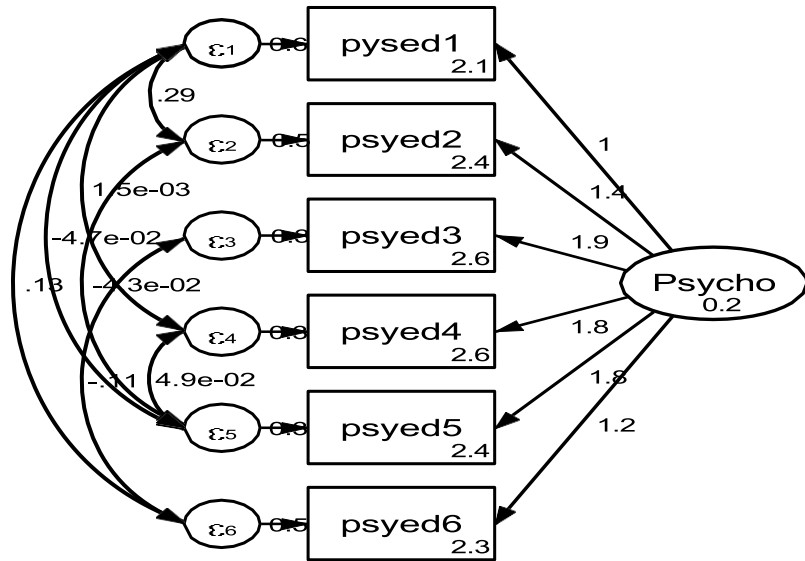
OIM						
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
pysed1 <-						
PSYCHO	.4789819	7.673725	0.06	0.950	-14.56124	15.51921
_cons	2.416402	.112695	21.44	0.000	2.195524	2.63728
-----+-----						

psyed2 <-						
PSYCHO	.656908	10.52388	0.06	0.950	-19.96953	21.28334
_cons	2.634966	.1210819	21.76	0.000	2.39765	2.872282
-----+-----						
psyed3 <-						
PSYCHO	.8284295	13.27155	0.06	0.950	-25.18333	26.84019
_cons	2.723943	.1242677	21.92	0.000	2.480383	2.967503
-----+-----						
psyed4 <-						
PSYCHO	.8001934	12.81923	0.06	0.950	-24.32504	25.92542
_cons	2.810656	.1273906	22.06	0.000	2.560975	3.060337
-----+-----						
psyed5 <-						
PSYCHO	.8240741	13.20177	0.06	0.950	-25.05093	26.69908
_cons	2.585453	.119319	21.67	0.000	2.351592	2.819314
-----+-----						
psyed6 <-						
PSYCHO	.5755701	9.220738	0.06	0.950	-17.49674	18.64788
_cons	2.672786	.1224331	21.83	0.000	2.432821	2.91275
-----+-----						
Variance						
e.pysed1	.7705764	7.35115		5.84e-09		1.02e+08
e.psyed2	.5684719	13.82645		1.13e-21		2.87e+20
e.psyed3	.3137045	21.98909		6.79e-61		1.45e+59
e.psyed4	.3596906	20.51573		1.01e-49		1.28e+48
e.psyed5	.3209019	21.75848		6.19e-59		1.66e+57
e.psyed6	.6687191	10.61436		2.06e-14		2.17e+13
PSYCHO	1	.	.	.		
-----+-----						

Covariance						
e.pysed1						
e.psyed2	.5253105	6.338386	0.08	0.934	-11.8977	12.94832
e.psyed4	.0222578	22.58508	0.00	0.999	-44.24368	44.28819
e.psyed5	-.1243196	30.24023	-0.00	0.997	-59.39407	59.14544
e.psyed6	.2334649	.7413833	0.31	0.753	-1.21962	1.686549
-----+-----						
e.psyed2						
e.psyed4	.0417126	35.5489	0.00	0.999	-69.63286	69.71628
e.psyed5	-.1339341	46.77882	-0.00	0.998	-91.81874	91.55087
-----+-----						
e.psyed3						
e.psyed4	.1280126	.8481123	0.15	0.880	-1.534257	1.790282
e.psyed6	-.2921544	45.91341	-0.01	0.995	-90.28078	89.69647
-----+-----						
e.psyed4						
e.psyed5	.233475	47.61428	0.00	0.996	-93.08881	93.55576

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(0)	0.610	model vs. saturated
p > chi2	.	
chi2_bs(15)	923.797	baseline vs. saturated
p > chi2	0.000	
Population error		
RMSEA	0.000	Root mean squared error of approximation
90% CI, lower bound	0.000	

upper bound	0.000	
pclose	1.000	Probability RMSEA <= 0.05
Information criteria		
AIC	3969.242	Akaike's information criterion
BIC	4069.691	Bayesian information criterion
Baseline comparison		
CFI	1.000	Comparative fit index
TLI	1.000	Tucker-Lewis index
Size of residuals		
SRMR	0.006	Standardized root mean squared residual
CD	0.881	Coefficient of determination



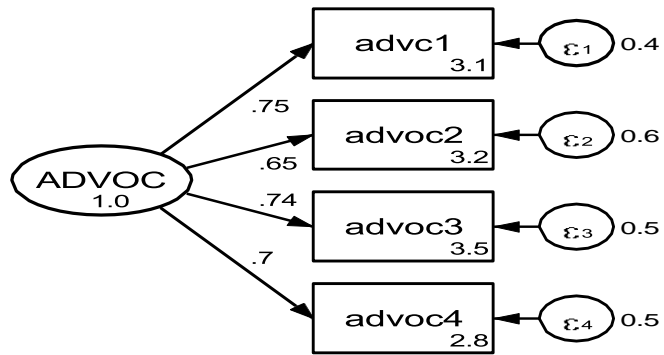
ADVOCACY

OIM					
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]
Measurement					
advc1 <-					
ADVOC	.7514779	.0341021	22.04	0.000	.6846391 .8183167
_cons	3.075136	.1305692	23.55	0.000	2.819226 3.331047
-----+-----					
advoc2 <-					

ADVOC	.6531656	.0394916	16.54	0.000	.5757636	
	.7305677					
_cons	3.19011	.1346114	23.70	0.000	2.926276	3.453943
-----+-----						
advoc3 <-						
ADVOC	.7383008	.0346648	21.30	0.000	.6703592	
	.8062425					
_cons	3.480318	.1449169	24.02	0.000	3.196286	3.76435
-----+-----						
advoc4 <-						
ADVOC	.7013465	.0368407	19.04	0.000	.62914	.773553
_cons	2.764587	.1197899	23.08	0.000	2.529803	2.99937
Variance						
e.advoc1	.435281	.0512539			.3455744	.5482742
e.advoc2	.5733747	.0515891			.4806757	.6839508
e.advoc3	.4549119	.051186			.3648811	.567157
e.advoc4	.5081131	.0516762			.4162855	.6201968
ADVOC	1	.	.	.	.	.
LR test of model vs. saturated: chi2(2) = 1.35, Prob > chi2 = 0.5086						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(2)	1.352	model vs. saturated
p > chi2	0.509	
chi2_bs(6)	405.406	baseline vs. saturated

p > chi2	0.000	
Population error		
RMSEA	0.000	Root mean squared error of approximation
90% CI, lower bound	0.000	
upper bound	0.096	
pclose	0.729	Probability RMSEA <= 0.05
Information criteria		
AIC	2986.053	Akaike's information criterion
BIC	3031.859	Bayesian information criterion
Baseline comparison		
CFI	1.000	Comparative fit index
TLI	1.005	Tucker-Lewis index
Size of residuals		
SRMR	0.008	Standardized root mean squared residual
CD	0.808	Coefficient of determination



TREATMENT

OIM						
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
tp1 <-						
TREAT	.577329	.0394244	14.64	0.000	.5000586	.6545993
_cons	2.872282	.1245769	23.06	0.000	2.628116	3.116449
-----+-----						
tp2 <-						
TREAT	.6117777	.0402822	15.19	0.000	.5328261	.6907294
_cons	2.97739	.1285479	23.16	0.000	2.725441	3.22934
-----+-----						
tp3 <-						
TREAT	-.0453986	.0576617	-0.79	0.431	-.1584133	.0676162
_cons	2.907034	.1266053	22.96	0.000	2.658892	3.155176
-----+-----						

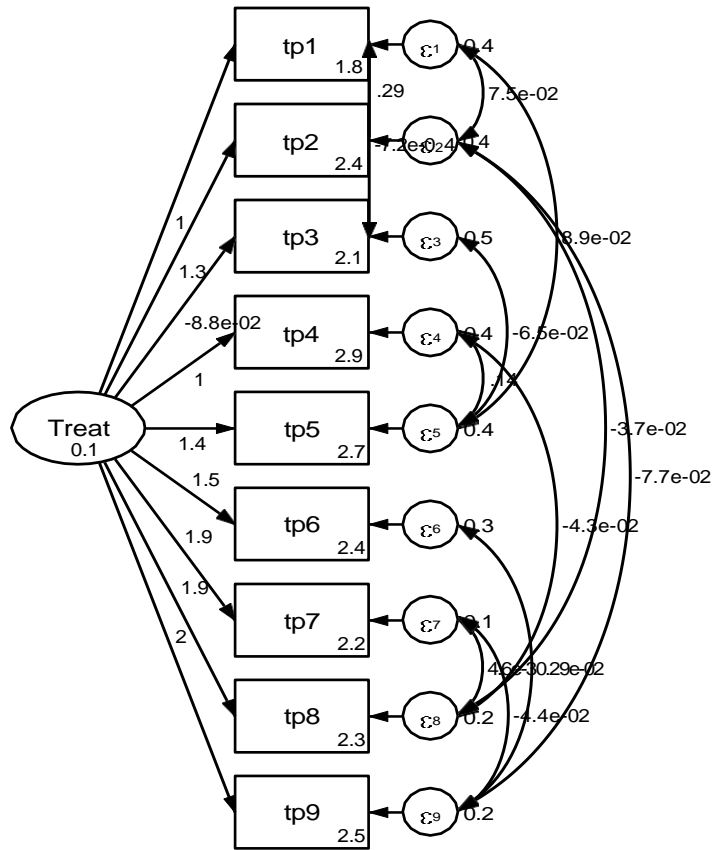
tp4 <-	
TREAT	.5245431 .0435833 12.04 0.000 .4391215 .6099647
_cons	4.046252 .1677595 24.12 0.000 3.71745 4.375055
-----+-----	
tp5 <-	
TREAT	.6383323 .0358197 17.82 0.000 .5681269 .7085376
_cons	3.290954 .1401034 23.49 0.000 3.016357 3.565552
-----+-----	
tp6 <-	
TREAT	.7224799 .0319663 22.60 0.000 .6598271 .7851326
_cons	3.026629 .1308331 23.13 0.000 2.7702 3.283057
-----+-----	
tp7 <-	
TREAT	.8804044 .0245322 35.89 0.000 .8323221 .9284866
_cons	2.820866 .1235915 22.82 0.000 2.578631 3.0631
-----+-----	
tp8 <-	
TREAT	.8550747 .0249915 34.21 0.000 .8060923 .904057
_cons	2.775325 .1219184 22.76 0.000 2.536369 3.014281
-----+-----	
tp9 <-	
TREAT	.8464893 .0250941 33.73 0.000 .7973059 .8956728
_cons	2.838885 .1242124 22.86 0.000 2.595433 3.082337
-----+-----	
Variance	
e.tp1	.6666913 .0455217 .5831828 .7621576
e.tp2	.625728 .0492875 .5362138 .7301856
e.tp3	.997939 .0052355 .9877301 1.008253

e.tp4	.7248546	.0457226			.6405581	.8202443
e.tp5	.5925319	.0457298			.5093528	.6892945
e.tp6	.4780229	.04619			.3955483	.5776939
e.tp7	.2248882	.0431965			.1543362	.3276917
e.tp8	.2688473	.0427391			.1968741	.3671324
e.tp9	.2834558	.0424837			.2113047	.3802432
TREAT	1	.	.	.	.	.
Covariance						
e.tp1						
e.tp2	.4354652	.0470067	9.26	0.000	.3433338	.5275966
e.tp5	.2103398	.0447579	4.70	0.000	.1226158	.2980637
-----+-----						
e.tp2						
e.tp8	-.1106662	.0620956	-1.78	0.075	-.2323713	.0110389
e.tp9	-.2258655	.0751016	-3.01	0.003	-.373062	-.078669
-----+-----						
e.tp3						
e.tp5	-.1397788	.0505219	-2.77	0.006	-.2387999	-.0407577
-----+-----						
e.tp4						
e.tp5	.3589316	.0494229	7.26	0.000	.2620646	.4557987
e.tp8	-.1675483	.0567436	-2.95	0.003	-.2787637	-.0563328
-----+-----						
e.tp6						
e.tp9	.1609025	.0825007	1.95	0.051	-.0007959	.3226009
-----+-----						
e.tp7						

e.tp8	.2728757	.1091534	2.50	0.012	.0589389	.4868125
e.tp9	-.251189	.1048243	-2.40	0.017	-.4566408	-.0457372
LR test of model vs. saturated: chi2(17) = 27.75, Prob > chi2 = 0.0480						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(17)	27.748	model vs. saturated
p > chi2	0.048	
chi2_bs(36)	1550.745	baseline vs. saturated
p > chi2	0.000	
Population error		
RMSEA	0.044	Root mean squared error of approximation
90% CI, lower bound	0.004	
upper bound	0.073	
pclose	0.597	Probability RMSEA <= 0.05
Information criteria		
AIC	5567.835	Akaike's information criterion
BIC	5707.951	Bayesian information criterion
Baseline comparison		
CFI	0.993	Comparative fit index
TLI	0.985	Tucker-Lewis index
Size of residuals		

SRMR	0.026	Standardized root mean squared residual
CD	0.926	Coefficient of determination



GOVT SUPPORT

OIM	
Standardized	Coef. Std. Err. z P>z [95% Conf. Interval]

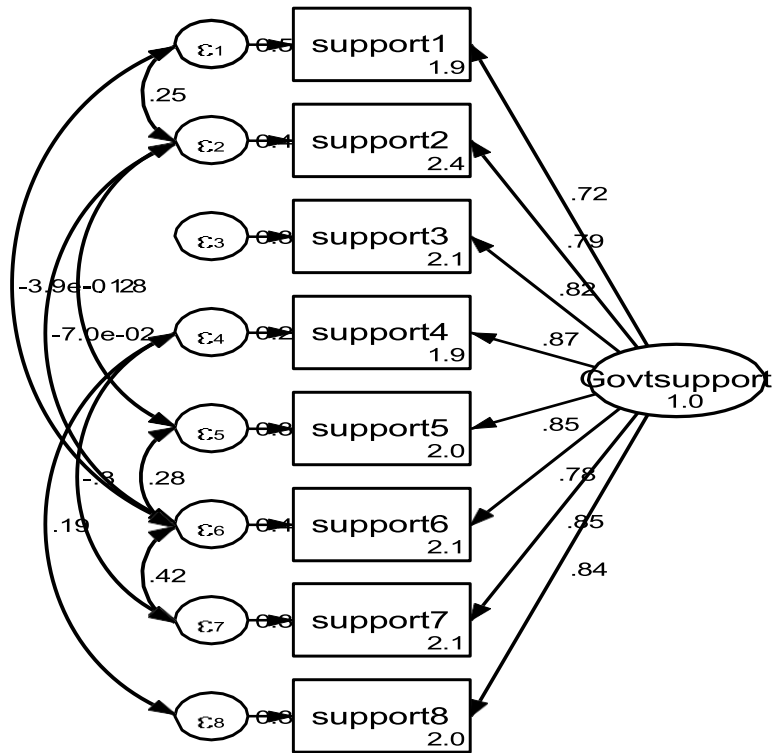
Measurement	
support1 <-	
Govtsupport	.7218118 .0282205 25.58 0.000 .6665005 .777123
_cons	1.879899 .0907477 20.72 0.000 1.702036 2.057761
-----+-----	
support2 <-	
Govtsupport	.7859959 .0240262 32.71 0.000 .7389055 .8330863
_cons	2.364937 .1062628 22.26 0.000 2.156665 2.573208
-----+-----	
support3 <-	
Govtsupport	.8211678 .0201047 40.84 0.000 .7817632 .8605723
_cons	2.062062 .0964558 21.38 0.000 1.873012 2.251112
-----+-----	
support4 <-	
Govtsupport	.8689012 .0176727 49.17 0.000 .8342634 .9035391
_cons	1.907326 .0916585 20.81 0.000 1.727678 2.086973
-----+-----	
support5 <-	
Govtsupport	.8496904 .0178663 47.56 0.000 .8146731 .8847077
_cons	2.03348 .0955485 21.28 0.000 1.846208 2.220752
-----+-----	
support6 <-	
Govtsupport	.7760549 .0251332 30.88 0.000 .7267948 .825315
_cons	2.125869 .0983599 21.61 0.000 1.933087 2.31865
-----+-----	
support7 <-	
Govtsupport	.8466342 .0186847 45.31 0.000 .8100128 .8832555
_cons	2.079939 .0969356 21.46 0.000 1.889949 2.269929
-----+-----	

support8 <-							
Govtsupport	.8361167	.0196617	42.53	0.000	.7975805	.8746529	
_cons	1.951696	.0929759	20.99	0.000	1.769466	2.133925	
Variance							
e.support1	.4789878	.0407398			.4054398	.5658777	
e.support2	.3822104	.0377689			.3149121	.4638908	
e.support3	.3256835	.0330187			.2669921	.3972766	
e.support4	.2450106	.0307116			.1916409	.3132431	
e.support5	.2780262	.0303617			.2244558	.3443822	
e.support6	.3977388	.0390094			.3281813	.4820389	
e.support7	.2832106	.0316382			.2275199	.3525329	
e.support8	.3009089	.0328789			.2429004	.3727708	
Govtsupport	1	.	.	.	.	.	.
Covariance							
e.support1							
e.support2	.2501075	.0577756	4.33	0.000	.1368695	.3633456	
e.support6	-.0386786	.053009	-0.73	0.466	-.1425744	.0652172	
-----+-----							
e.support2							
e.support5	-.1776876	.066905	-2.66	0.008	-.308819	-.0465561	
e.support6	-.0700896	.0588428	-1.19	0.234	-.1854195	.0452402	
-----+-----							
e.support4							
e.support7	-.3000243	.0663203	-4.52	0.000	-.4300097	-.170039	
e.support8	.1915489	.0724565	2.64	0.008	.0495369	.333561	
-----+-----							
e.support5							

e.support6	.2760026	.0527499	5.23	0.000	.1726147	.3793906
-----+-----						
e.support6						
e.support7	.4199699	.0523568	8.02	0.000	.3173523	.5225874
LR test of model vs. saturated: chi2(12) = 25.95, Prob > chi2 = 0.0109						

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(12)	25.945	model vs. saturated
p > chi2	0.011	
chi2_bs(28)	2232.347	baseline vs. saturated
p > chi2	0.000	
Population error		
RMSEA	0.059	Root mean squared error of approximation
90% CI, lower bound	0.027	
upper bound	0.09	
pclose	0.286	Probability RMSEA <= 0.05
Information criteria		
AIC	6725.096	Akaike's information criterion
BIC	6847.244	Bayesian information criterion
Baseline comparison		
CFI	0.994	Comparative fit index
TLI	0.985	Tucker-Lewis index

Size of residuals		
SRMR	0.014	Standardized root mean squared residual
CD	0.944	Coefficient of determination



COMMITMENT

OIM	
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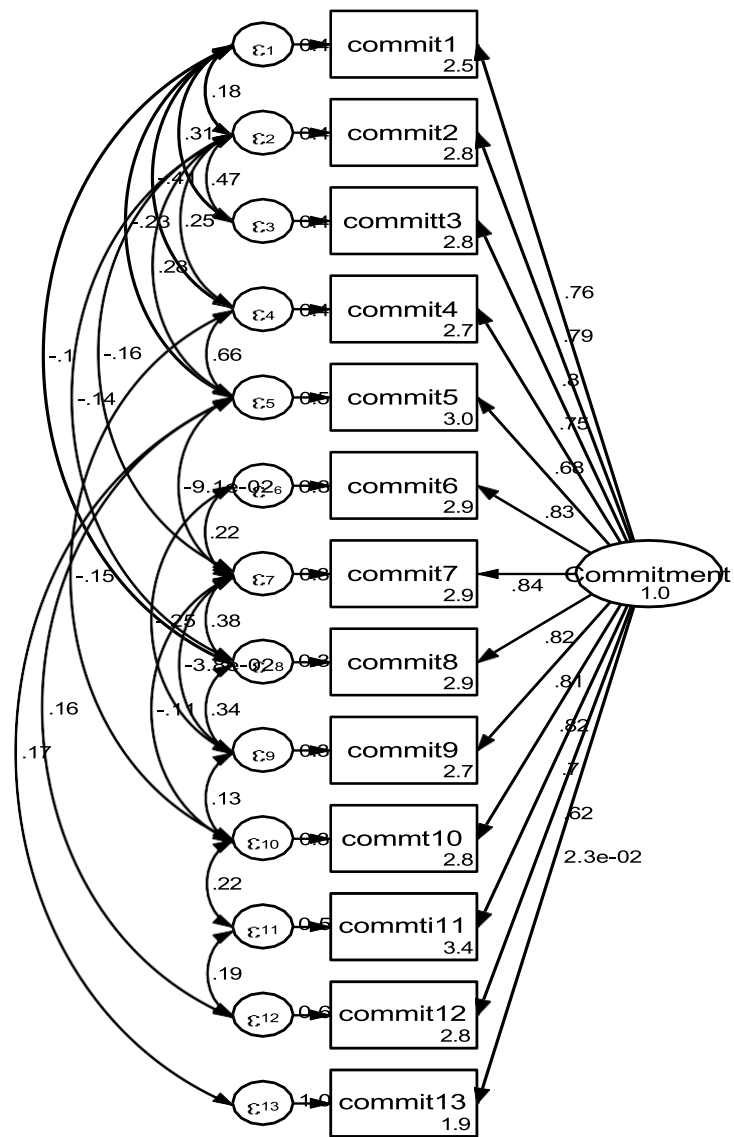
Standardized	Coef.	Std. Err.	z	P>z	[95% Conf. Interval]	
Measurement						
commit1 <-						
Commitment	.7630648	.0271087	28.15	0.000	.7099328	.8161968
_cons	2.538996	.1164553	21.80	0.000	2.310748	2.767245
-----+-----						
commit2 <-						
Commitment	.7911349	.0240804	32.85	0.000	.7439382	.8383316
_cons	2.767325	.1232699	22.45	0.000	2.52572	3.008929
-----+-----						
committ3 <-						
Commitment	.7998305	.0234439	34.12	0.000	.7538814	.8457796
_cons	2.824178	.126037	22.41	0.000	2.57715	3.071206
-----+-----						
commit4 <-						
Commitment	.7536911	.0283836	26.55	0.000	.6980603	.809322
_cons	2.684022	.1208044	22.22	0.000	2.44725	2.920794
-----+-----						
commit5 <-						
Commitment	.6786342	.0332109	20.43	0.000	.613542	.7437263
_cons	3.012694	.1315839	22.90	0.000	2.754794	3.270594
-----+-----						
commit6 <-						
Commitment	.8291782	.0205521	40.35	0.000	.7888967	.8694596
_cons	2.946575	.1304225	22.59	0.000	2.690952	3.202199
-----+-----						
commit7 <-						
Commitment	.8407968	.0203027	41.41	0.000	.8010043	.8805893

_cons	2.850907	.1268127	22.48	0.000	2.602358	3.099455	
-----+-----							
commit8 <-							
Commitment	.8212119	.0221474	37.08	0.000	.7778038	.8646199	
_cons	2.889339	.1284378	22.50	0.000	2.637605	3.141072	
-----+-----							
commit9 <-							
Commitment	.8097042	.0237423	34.10	0.000	.7631701	.8562384	
_cons	2.740577	.123213	22.24	0.000	2.499084	2.98207	
-----+-----							
commt10 <-							
Commitment	.8180195	.0218452	37.45	0.000	.7752037	.8608353	
_cons	2.812991	.1257348	22.37	0.000	2.566555	3.059426	
-----+-----							
commti11 <-							
Commitment	.696717	.0312171	22.32	0.000	.6355327	.7579013	
_cons	3.444806	.1483965	23.21	0.000	3.153954	3.735657	
-----+-----							
commit12 <-							
Commitment	.61906	.0368541	16.80	0.000	.5468273	.6912928	
_cons	2.791781	.1250697	22.32	0.000	2.546649	3.036913	
-----+-----							
commit13 <-							
Commitment	.0227964	.0583277	0.39	0.696	-.0915238	.1371166	
_cons	1.853769	.0930418	19.92	0.000	1.67141	2.036128	
-----+-----							
Variance							
e.commit1	.4177321	.0413713			.3440303	.5072232	
e.commit2	.3741055	.0381017			.3064089	.4567586	

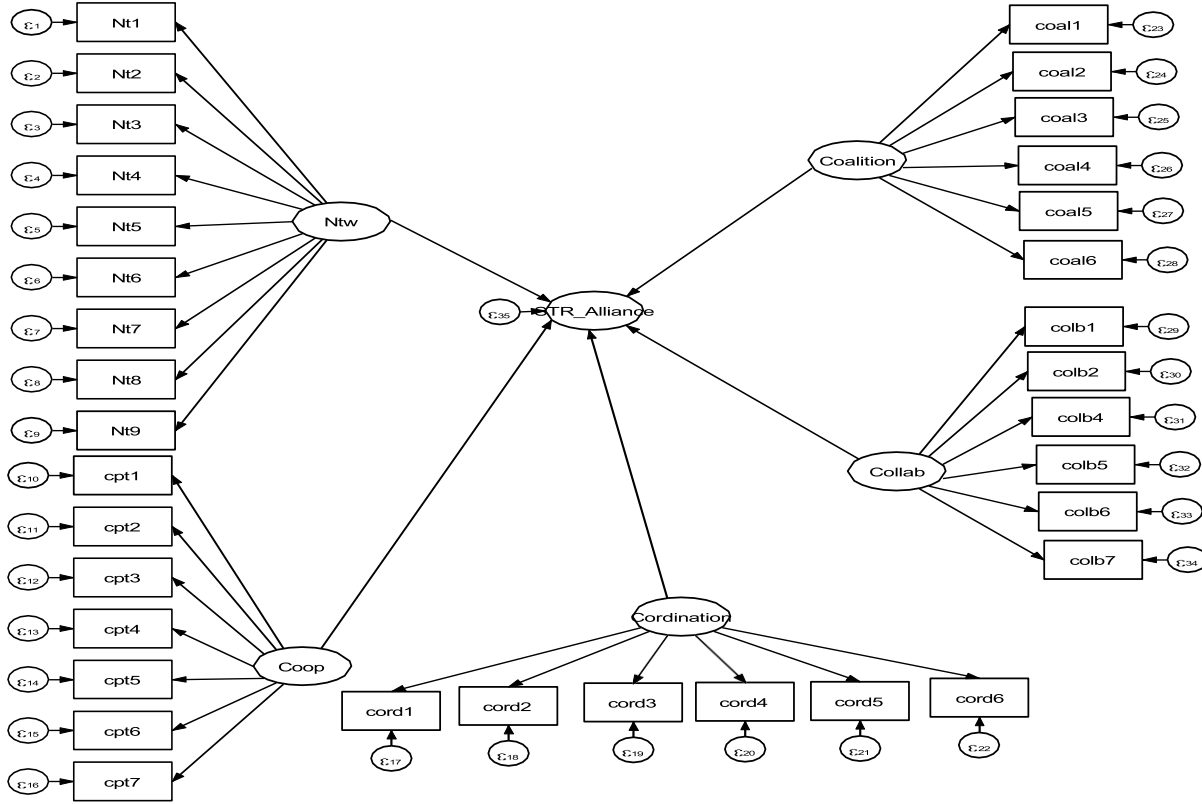
e.committ3	.3602712	.0375022			.2937814	.4418094
e.commit4	.4319497	.0427849			.3557304	.5244997
e.commit5	.5394557	.0450761			.4579633	.6354492
e.commit6	.3124635	.0340828			.2523204	.3869424
e.commit7	.2930607	.0341409			.2332355	.3682311
e.commit8	.3256111	.0363754			.261582	.4053129
e.commit9	.3443791	.0384486			.2766964	.4286176
e.commt10	.3308441	.0357396			.2677146	.4088602
e.commti11	.5145854	.0434989			.4360173	.6073111
e.commit12	.6167647	.0456298			.5335136	.7130066
e.commit13	.9994803	.0026593			.9942817	1.004706
Commitment	1	.	.	.	.	.
Covariance						
e.commit1						
e.commit2	.1751699	.0641278	2.73	0.006	.0494817	.3008581
e.committ3	.3133102	.0591173	5.30	0.000	.1974425	.4291779
e.commit4	-.405359	.0560021	-7.24	0.000	-.515121	-.2955969
e.commit5	-.2315333	.0550022	-4.21	0.000	-.3393356	-.1237309
e.commit8	-.1035783	.0503066	-2.06	0.039	-.2021774	-.0049793
-----+-----						
e.commit2						
e.committ3	.4715899	.0489019	9.64	0.000	.3757439	.5674359
e.commit4	.250576	.0528967	4.74	0.000	.1469004	.3542516
e.commit5	.275388	.0483948	5.69	0.000	.180536	.3702401
e.commit7	-.1560975	.0552065	-2.83	0.005	-.2643002	-.0478948
e.commit8	-.1383079	.0493757	-2.80	0.005	-.2350825	-.0415334
-----+-----						
e.commit4						

e.commit5	.6578986	.0347592	18.93	0.000	.5897718	.7260254
e.commt10	-.1468092	.0470739	-3.12	0.002	-.2390723	-.0545461
-----+-----						
e.commit5						
e.commit7	-.0910915	.0393014	-2.32	0.020	-.1681209	-.0140621
e.commit12	.1560294	.0396352	3.94	0.000	.0783458	.233713
e.commit13	.1659086	.0406029	4.09	0.000	.0863284	.2454889
-----+-----						
e.commit6						
e.commit7	.2232724	.0597847	3.73	0.000	.1060965	.3404484
e.commit9	-.2471809	.064295	-3.84	0.000	-.3731969	-.1211649
-----+-----						
e.commit7						
e.commit8	.3847277	.0559511	6.88	0.000	.2750656	.4943899
e.commit9	-.0380137	.0769631	-0.49	0.621	-.1888586	.1128312
e.commt10	-.1061982	.0623091	-1.70	0.088	-.2283218	.0159255
-----+-----						
e.commit8						
e.commit9	.3407608	.0597637	5.70	0.000	.2236261	.4578955
-----+-----						
e.commit9						
e.commt10	.1279373	.0619722	2.06	0.039	.006474	.2494005
-----+-----						
e.commt10						
e.commti11	.2160684	.057001	3.79	0.000	.1043486	.3277882
-----+-----						
e.commti11						
e.commit12	.1891083	.05348	3.54	0.000	.0842895	.2939272

Fit statistic	Value	Description
Likelihood ratio		
chi2_ms(41)	98.286	model vs. saturated
p > chi2	0.000	
chi2_bs(78)	3371.224	baseline vs. saturated
p > chi2	0.000	
Population error		
RMSEA	0.067	Root mean squared error of approximation
90% CI, lower bound	0.05	
upper bound	0.084	
pclose	0.051	Probability RMSEA <= 0.05
Information criteria		
AIC	10729.839	Akaike's information criterion
BIC	10966.05	Bayesian information criterion
Baseline comparison		
CFI	0.983	Comparative fit index
TLI	0.967	Tucker-Lewis index
Size of residuals		
SRMR	0.028	Standardized root mean squared residual
CD	0.942	Coefficient of determination



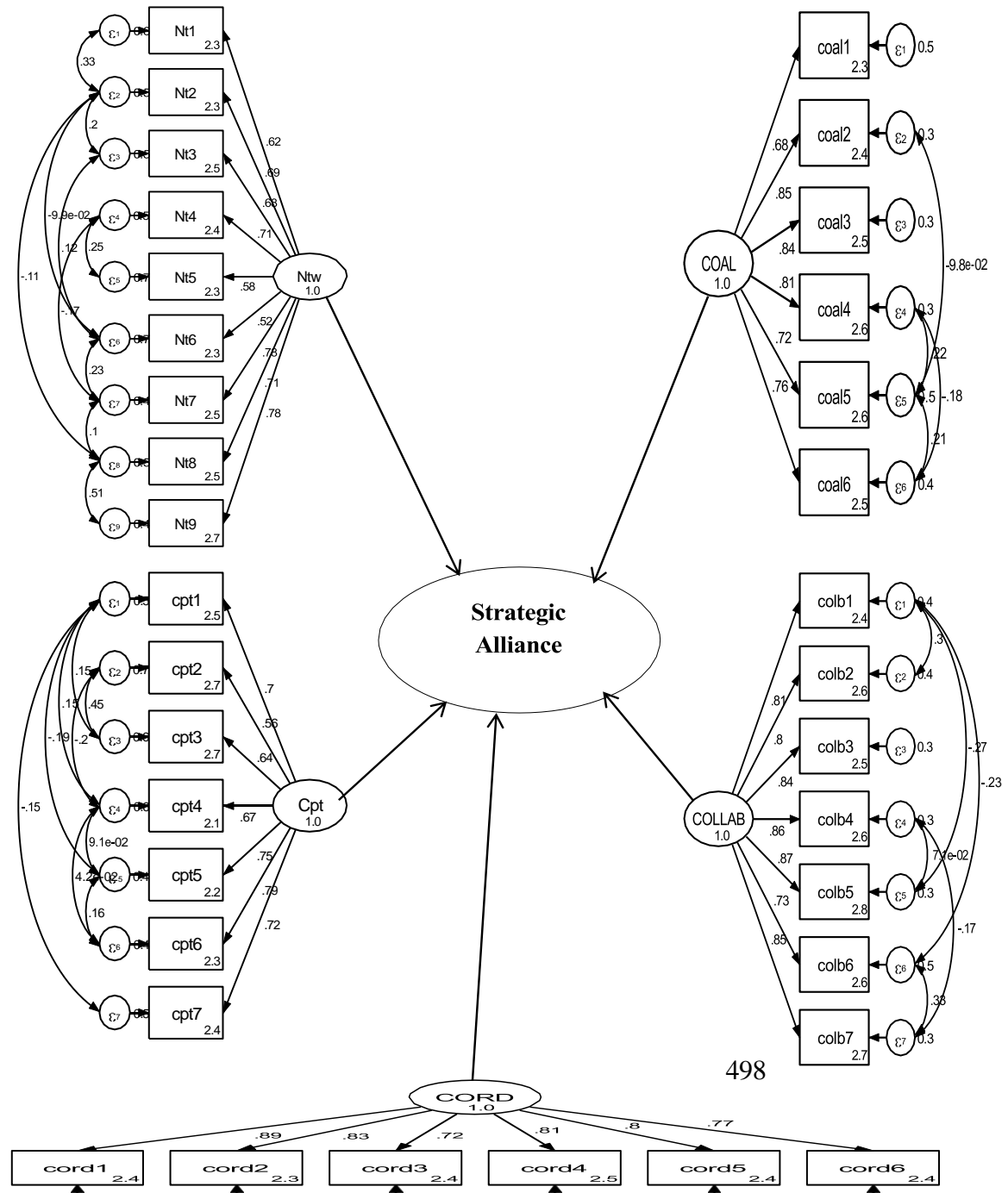
Appendix Q2: Five-Factor CFA Modelling Strategic Alliance in Mental Health Promotion



The above hypothesized structure comprised of five factors depicting five levels of strategic alliance in mental health promotion. Each factor contained a set of items ranging from four to nine. Item 21 is a subscale has seven items that measured networking (Nt1, Nt2, ..., Nt9), the lowest

level of the strategic alliance model, and described minimal relationships among schools, ministry of health (LGA), and other support groups. It was hypothesized that these nine items should load highly under factor 1 (Ntw). Item 22 a subscale of strategic alliance has seven items measuring cooperation (Cpt) and items covered information on minimal participation in mental health promotion (e.g., receiving occasional training, materials, visit from community mental health healthcare worker etc.) It is proposed that Cp1, Cpt2... Cpt7 should load highly under factor 2. Item 23, is also a subscale with six items measuring questions on coordination (ranging from having a joint relationship when organizing seminar, promoting support, and providing mental health feedback). It was hypothesized that Cord1, Cord2 ... Cord6 would load highly under factor3 (coordination). Item 24, as a subscale contained six items on Coalition for program development (factor4), research, decision, and advocacy, measuring. It was hypothesized that Coal1, Coal2 ... Coal6 would load highly under factor4. Item 25, a subscale measuring collaboration (factor5) has seven items on MH leadership roles, providing/receiving guidance, active participation in program/ policy dialogue, etc. It was proposed that these seven items, Colb1, Colb2 ... Colb7, would load highly on factor5. The tested model is shown in figure 4b below.

Q3: Tested Five Factor CFA Modelling Strategic Alliance in Mental Health Promotion



Report of Model Fit Statistic Summary for the tested Model for five Factor CFA Strategic Alliance

Sub-scale	Chi-Square	RMSEA	CFI	TLI
Networking	26.269, $p > 0.05$ (0.07)	.041	.97	.99
Cooperation	7.27, $p > 0.05$ (0.2012)	.037	.99	.99
Coordination	1.89, $p > 0.05$ (0.388)	.00	1.00	1.00
Coalition	3.23, $p > 0.05$ (0.6647)	.00	1.00	1.00
Collaboration	13.30, $P > 0.05 =$ (0.1021)	.04	.99	.99

RMSEA= Root Mean Square Error of Approximation

CFI= Comparative fit index

TLI=Tucker-Lewis Index

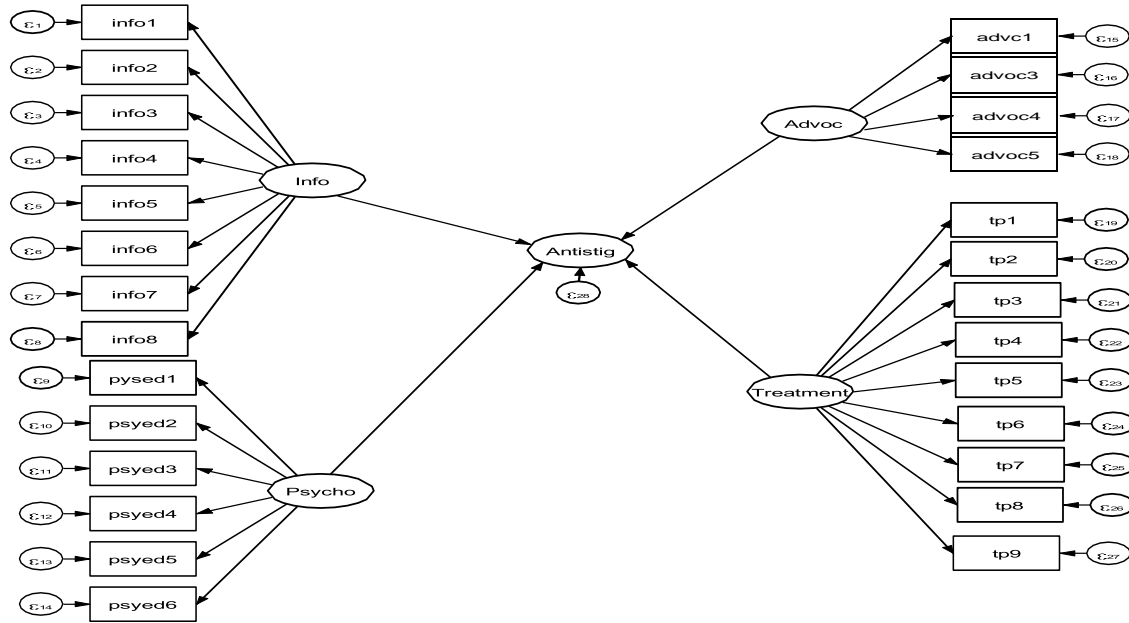
The results in table 5 showed that each of the factor demonstrated a good fit considering the criteria given by Browne and Cudeck (1993) where a good model fit (RMSEA <0.05), adequate fit (RMSEA between 0.05 and 0.08), poor fit (RMSEA >0.1), P-value >0.05, CFI>0.95 and TLI >0.95.

Hypothesized Structure of Anti-stigma

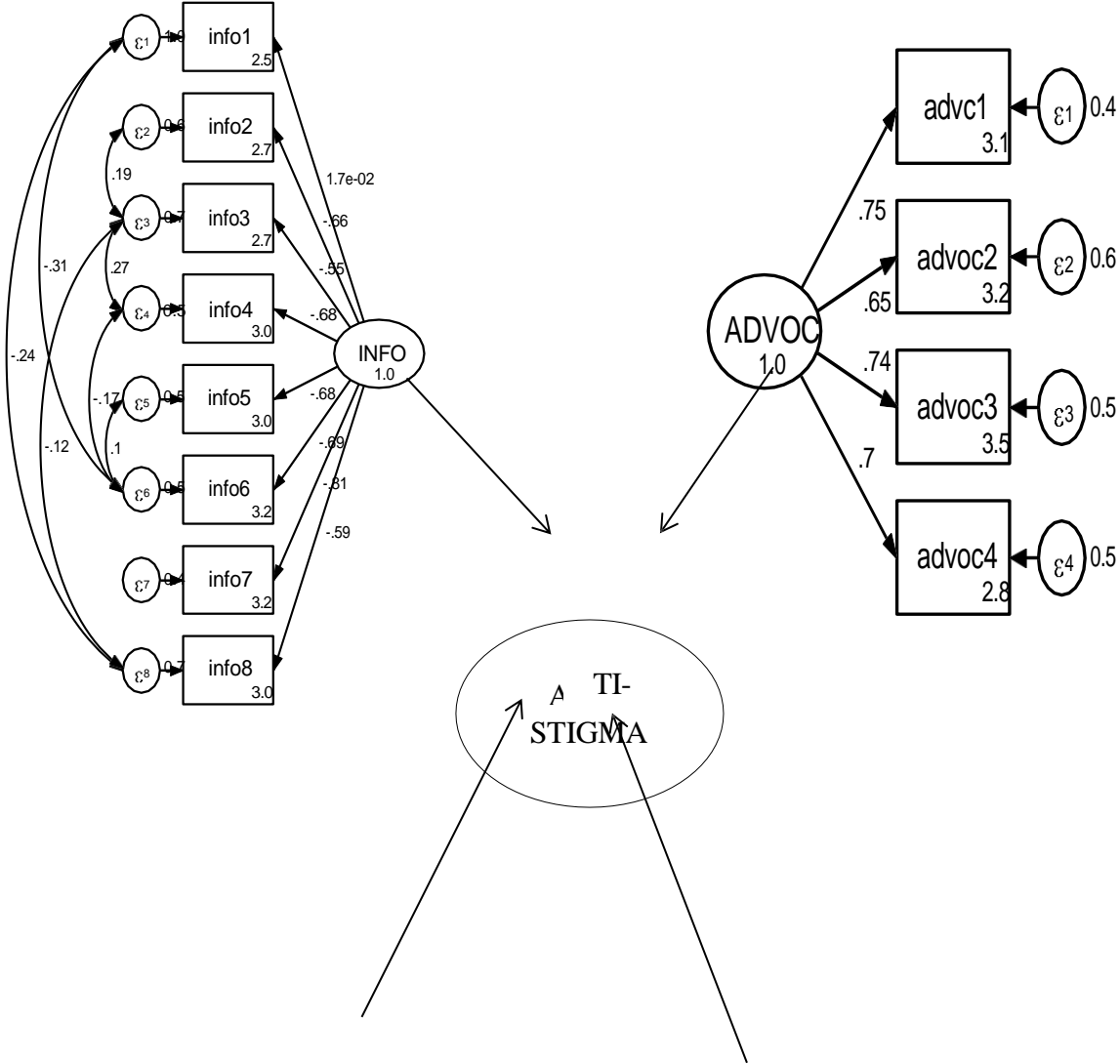
The hypothesized structure is a four factors model of stigma reduction programs. Items 27-29 are subscales of this hypothesized structure which represents factor 1, factor2... factor4. Specifically, item 27 contained eight items and measures information availability. This subscale addressed participants' opinion about access to mental health information, support groups, platforms to share experience, etc. It was hypothesized that these eight items "info1, info2.... Info8 would load highly under factor1 that characterized information availability than on another factor that makes up an anti-stigma construct. Item 28 as a subscale of anti-sigma contained six items measuring psychoeducation, and sought information on available mental health education (training/workshop/seminar, treatment program, educating staff on stress management, etc.) It was proposed

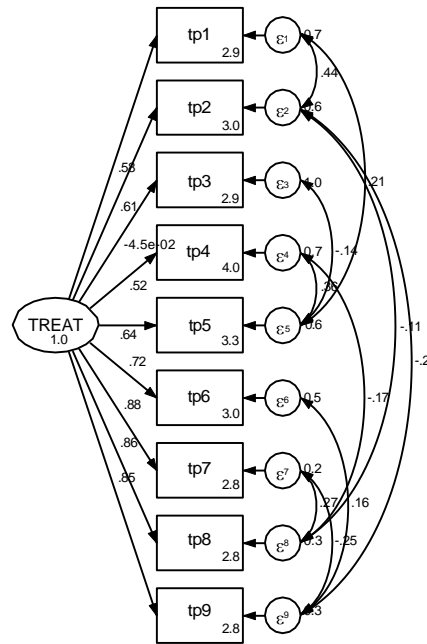
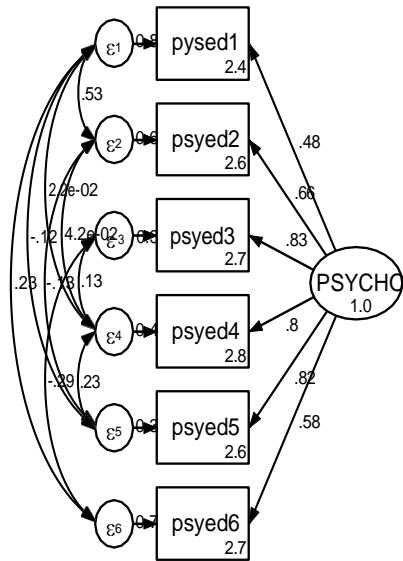
that psyed1, psyed2... psyed6 would load highly under factor2. Item 29, a subscale of anti-stigma has five items measuring advocacy (e.g., access to local support groups, linking staff with community resources, promotion of social interaction, etc.). It was hypothesized that advo1, advo2 ... advo4 would load more highly under factor3 than any other factor that measured anti-stigma. Item 30 consisted of nine items and a subscale of anti-stigma; denoted as referral/adherence in the original scale but was specified as treatment in the present study and represented factor 4. These items ask about planning intervention, treatment adherence, support system-peer support, etc. and coded as treat1 to treat9. It was hypothesized that tpt1, tp2, tp3... tp9 should load highly under factor 4.

Q4: Hypothesized Structure of Concept of Anti-stigma Programs



Appendix Q5: Tested four factor modelling CFA modelling anti-stigma programs.





Report of Model Fit Statistic Summary for the tested Model for Four Factor CFA Modelling Anti-stigma Programs

Sub-scale	Chi-Square	RMSEA	CFI	TLI
Information	17.09, $p > 0.05$ (0.19)	.032	.99	.99
Psychoeducation	0.610, $p > 0.05$ (0.996)	.00	1.00	1.00
Advocacy	1.35, $p > 0.05$ (0.5086)	.00	1.01	1.01
Treatment	27.75, $p > 0.05$ (0.044)	.04	.99	.99

RMSEA= Root Mean Square Error of Approximation

CFI= Comparative fit index

TLI=Tucker-Lewis Index

The results as presented above showed that each of the factor demonstrated a good fit considering the criteria given by Browne and Cudeck (1993) where a good model fit (RMSEA <0.05), adequate fit (RMSEA between 0.05 and 0.08), poor fit (RMSEA >0.1), P-value >0.05, CFI>0.95 and TLI >0.95.

Statistics

		Networking	cooperation	Coordination	Coalition	Collaboration
N	Valid	26	25	26	26	26
	Missing	0	1	0	0	0
Mean		21.481	15.740	12.885	12.519	14.981
Median		23.250	14.500	12.250	12.000	14.500
Std. Deviation		6.1975	3.3915	3.3980	3.0413	3.4597
Variance		38.410	11.503	11.546	9.250	11.970
Skewness		-.654	.239	-.078	.707	.785
Std. Error of Skewness		.456	.464	.456	.456	.456
Kurtosis		-.492	-1.114	-.085	-.055	1.345
Std. Error of Kurtosis		.887	.902	.887	.887	.887

Descriptive Statistics

	Mean	Std. Deviation	N
Networking	21.481	6.1975	26
cooperation	15.740	3.3915	25
Coordination	12.885	3.3980	26
Coalition	12.519	3.0413	26

Collaboration	14.981	3.4597	26
---------------	--------	--------	----

Intercorrelations among Variables in the Regression Analysis

Variables	M	SD	1	2	3	4	5
1 Networking	21.48	6.19	-				
2 Cooperation	15.7	3.39	.259	-			
3 Coordination	12.88	3.39	-.236	.584	-		
4 Coalition	12.51	3.04	-.228	.574	.702**	-	
5 Collaboration	14.98	3.45	-.185	-.174	-.044	.024	-

* $p < .05$, ** $p < .01$

Variables	Skewness	Kurtosis
Information	-.76	-.04
Psychoeducation	-.15	.09
Advocacy	-.1	1.7
Treatment	.62	.35

Intercorrelations among Variables in the Regression Analysis

Variables	M	SD	1	2	3	4
-----------	---	----	---	---	---	---

1	Information	19.9	4.59	-			
2	Psychoeducation	12.86	3.32	.484*	-		
3	Advocacy	10.58	1.84	.375**	-.295	-	
4	Treatment	22.46	3.54	.472*	.140	.658**	-

* $p < .05$, ** $p < .01$

Appendix R: Table of reliability

Reliability Coefficients for IPS Subscales

Subscales	<i>M</i>	<i>SD</i>	<i>No of Items</i>	<i>Range</i>	<i>Cronbach's α</i>
A. Discrimination	13.1	4.7	6	6-30	.82
B. Mental Health Policy Knowledge	12.0	3.5	5	5-20	.74
C. Strategic Alliance					
Networking	23.0	5.9	9	9-36	.86
Cooperation	16.0	4.0	7	7-28	.86
Coordination	13.1	3.2	6	6-24	.84
Coalition	12.5	3.7	6	6-24	.91
Collaboration	15.8	4.5	7	7-28	.91
D: Support	21.4	9.0	8	8-48	.94
E. Anti-Stigma					
Information	21.0	5.0	8	8-32	.85

Psychoeducation	13.3	4.0	6	6-24	.87
Advocacy	10.7	2.7	4	4-16	.78
Treatment	21.8	4.7	9	9-72	.84
F. Commitment	47.7	11.6	13	13-78	.93

Results in Table4 showed the Cronbach's Alpha (α) for each subscale of the Implementation of Participation Strategies (IPS) survey questionnaire. The outcomes showed that the discrimination subscale consisted of 6 items ($\alpha = .82$) and mental health policy knowledge with 5 items ($\alpha = .74$). The five subscales on strategic alliance showed that the networking has 9 items ($\alpha = .86$); cooperation with 7 items ($\alpha = .86$); coordination with 6 items ($\alpha = .86$); coalition with 6 items ($\alpha = .91$); collaboration with 7 items ($\alpha = .91$) and the nine items developed to measure government support ($\alpha = .94$). Also, the four subscales that measured anti-stigma showed that the information subscale has 8 items ($\alpha = .88$); psychoeducation with 6 items ($\alpha = .87$); advocacy with 4 items ($\alpha = .78$); treatment with 9 items ($\alpha = .84$) while the 13 items developed to measure government commitment yielded a Cronbach's alpha of .93. the obtained reliability coefficients for each sub-scale of the instruments were found high enough to be adequate for the use of this study.

Appendix S: Test of variance for the two sample

(a). Mean and Standard deviation for the two group

Variables in the Study	Private			Public		
	M	SD	σ^2	M	SD	σ^2
Networking	20.0	4.9	23.5	20.0	6.5	42.4
Cooperation	14.9	3.7	13.7	16.5	3.7	13.9
Coordination	12.4	3.8	14.7	13.4	3.8	14.9
Coalition	11.6	3.0	9.1	11.8	3.0	9.0
Collaboration	14.0	3.8	14.9	15.4	4.1	17.0

(b). Independent-Samples Test result to validate assumption about Unequal variance for sample two-group.

		Independent Samples Test							
		Levene's Test for Equality of Variances		t-test for Equality of Means					
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	9
Networking	Equal variances assumed	7.180	.008	-.356	174	.722	-.3111	.8741	
	Equal variances not assumed			-.322	89.071	.748	-.3111	.9648	
Cooperation	Equal variances assumed	.168	.683	-2.664	175	.008	-1.5914	.5974	
	Equal variances not assumed			-2.656	109.276	.009	-1.5914	.5992	
Coordination	Equal variances assumed	.153	.696	-1.655	176	.100	-1.0183	.6151	
	Equal variances not assumed			-1.650	111.812	.102	-1.0183	.6172	
Coalition	Equal variances assumed	.758	.385	-.423	176	.673	-.2043	.4834	
	Equal variances not assumed			-.423	113.100	.673	-.2043	.4829	
Collaboration	Equal variances assumed	.000	.991	-2.183	176	.030	-1.3819	.6329	
	Equal variances not assumed			-2.134	106.498	.035	-1.3819	.6474	

Appendix T1: T-test results of individual strategic alliance constructs

(b): the results of the independent sample t-test for the two sectors. For networking, the private sector score ((M=20.042, SD=4.85) and public sector's score (M= 20.35, SD6.51); $t(174) = -.356, p=.72$ (two-tailed). The magnitude of mean difference = $-.31, 95\% \text{ CI: } -1.5 \text{ to } 1.4$. eta squared = 0.002, shows a very small effect size.

Cooperation, private sector score is (M= 14.99. SD= 3.70), public sector's score (M=16.58, SD=3.73); $t(109)= -2.65, p=.009$ (two tailed). The magnitude of mean difference = $-1.59. 95\% \text{ CI: } .2.2 \text{ to } -.40$

Coordination, private (M=12.43, SD. 3.83), public (M=13.44, SD= 3.87); $t(176)= -1.66, p=.10$ (two-tailed). The magnitude of mean difference

Coalition, private schools (M=11.67, SD=3.03) public schools (M=11.88, Sd= 3.02); $t(176)= -.42, p= .67$. The magnitude of mean difference

Collaboration, private schools (M=14.08, SD=3.87), public schools (M=15.46, SD= 4.13); $t(176)= -2.18, p=.03$. The magnitude of mean difference

CIF, degrees of freedom, two-tailed probability) for

Appendix T2: Differences in Networking Structures for MH Inclusion in Public and Private School Administrative Systems in Lagos State

S/N	My School...	PRIVATE		PUBLIC		t(334)	p
		M	SD	M	SD		
i	never engages in any communication with the Ministry of Health on mental health promotion related issues.	2.49	1.11	2.25	1.00	2.020	.045*
ii.	never interacts with other service providers to improve access to care for mental health (e.g., Insurance/ local support group/ police/ religious organization)	2.25	1.04	2.26	.97	-.136	.892
iii.	never employs mental health social workers.	2.48	1.03	2.66	1.05	-	.145
iv.	never liaises with community extension workers.	2.16	.90	2.24	.98	-.688	.492
v.	never allows staff to participate in community mental health outreach programs.	1.83	.87	1.99	.88	-	.104
vi.	never receives timely material/ financial support from any agency (State/NGOs/ Church/ Mosque).	2.59	1.12	2.30	1.06	2.181	.030*
vii.	never reaches out to other service providers to improve staff access to mental healthcare.	2.30	.93	2.18	.94	1.139	.255
viii	never interacts with community mental health nurses.	2.22	.94	2.33	.91	-.993	.321
ix	never interacts with community extension workers from the LGA on mental health.	2.30	.85	2.45	.93	-	.150
						1.442	

* $p < .05$.

The results in Table T1 showed the differences in collaborative structures adopted in the public and private schools in Lagos State. As shown in Table T1, a significant difference was observed in terms of engagement in communication with the Ministry of Health on mental health promotion related issues: private ($M=2.49$, $SD= 1.11$), public ($M=2.25$, $SD= 1.00$), $t= 2.020$, $p < .01$ (*two-tailed*). Similarly, a significant difference was also noted in terms of receiving timely material/financial support from any agency (State/NGOs/Church/Mosque): private ($M=2.59$, $SD= 1.12$) and public ($M=2.30$, $SD= 1.06$), $t= 2.181$, $p < .01$ (*two-tailed*).

Appendix T3: Differences in Cooperative Structure for MH Inclusion in Public and Private School Administrative Systems in Lagos State..

S/N	My School...	PRIVATE		PUBLIC		t(334)	p
		M	SD	M	SD		
x.	occasionally run WHO's Mental Health Leadership Advocacy Program initiated (WHO) & Mental Health Advocacy Action Programme/ or workshop	2.13	.87	2.23	.88	-.956	.340
xi.	xi. Occasionally join other group in seminar/ workshop on mental health awareness in school for Mental Leadership skill and advocacy training organized by government and WHO.	2.39	.92	2.43	.92	-.395	.693
xii.	occasionally participates in community mental health outreach program	2.30	.91	2.43	.82	-1.254	.211
xiii.	occasionally, receives timely financial supports from the Ministry of Health	1.75	.85	2.07	.87	-3.172	.002*
xiv.	occasionally receives timely guidance from the Ministry of Health.	1.98	.94	2.50	.91	-4.775	.000*
xv.	occasionally receives mental health information/ guidance/ fund from NGOs.	2.04	.92	2.31	.89	-2.491	.013*
xvi.	occasionally receive professional visits from mental health social workers/ nurses, psychologists/ counselor/ nutritionists etc.).	2.15	.97	2.48	.82	-3.061	.002*

* $p < .05$.

The results in Table in the appendix T2 showed the differences in cooperation structures of relationships designed for anti-stigma interventions by the public and private school administrative systems in Lagos State. As shown in Table T2 out of the seven (7) key relationships used in measuring cooperation, significant differences were observed in four such as the receipt of timely financial supports from the Ministry of Health: private ($M=1.75$, $SD= .85$), public ($M=2.07$, $SD= .87$), $t= -3.172$, $p < .01$; receipt of timely guidance from the Ministry of Health, private ($M=1.98$, $SD= .94$), public ($M=2.50$, $SD= .91$), $t= -4.775$, $p < .01$; receipt of mental health information/guidance/fund from NGOs, private ($M=2.04$, $SD= .92$), public ($M=2.31$, $SD= .89$), $t=-2.491$, $p < .01$, and receipt of professional visits from mental health social workers/nurses, psychologists/counselor/ nutritionists, etc.), private ($M=2.15$, $SD= .97$), public ($M=2.48$, $SD= .82$), $t= -3.061$, $p < .01$. This outcome suggests that public schools in Lagos State experienced higher and significant cooperation of the structures of relationships designed for anti-stigma interventions than their counterparts in private schools.

Appendix T4: Differences in Coordination Structure Collaborative Structure for MH Inclusion in Public and Private School Administrative Systems in Lagos State

S/N	My School...	PRIVATE		PUBLIC		<i>t</i> (334)	<i>p</i>
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
xvii	sometimes participates in consultations convened for governments to make decisions about mental health programs	2.18	.96	2.20	.84	-.142	.887
viii.	sometimes works directly with the State Ministry of Health to share ideas on mental health promotion.	2.14	1.00	2.25	.84	-.909	.364
xix.	sometimes works directly with the State Ministry of Health to receive mental health information.	2.00	.89	2.26	.82	-2.540	.012*
xx.	sometimes in contact with community leaders on mental health promotion.	2.07	.89	2.19	.83	-1.161	.246
xxi.	sometimes in contact with community mental health committees to access mental health support for staff.	2.03	.85	2.13	.83	-.982	.327
xxii.	sometimes receives mental health updates on (research outcomes, guides, new programs, funding, training/workshops etc.).	2.13	.93	2.19	.81	-.598	.550

* $p < .05$.

The results in Table T3 show the differences in coordination structures of relationships designed for anti-stigma interventions by the public and private school administrative systems in Lagos State. As shown in Table T3 out of the six (6) key activities used in measuring coordination, a significant difference was only observed in terms of working directly with the State Ministry of Health to receive mental health information, private ($M=2.00$, $SD= .89$), public ($M=2.26$, $SD= .82$), $t= -2.2540$, $p < .01$; and it was in favour of the public schools. This outcome therefore suggests that the experience of private and public schools was similar in relation to cooperation structures of relationships designed for anti-stigma interventions in Lagos State.

Appendix T5: Differences in Coalition Structures for MH Inclusion in Public and Private School Administrative Systems in Lagos State

S/N	My School...	PRIVATE		PUBLIC		t(334)	p
		M	SD	M	SD		
Xxiii	has a representative at the LGA to participate in developing mental health programs, and policy.	1.78	.80	1.74	.68	.471	.638
Xxiv	has representative that frequently brings mental health information from community to staff.	1.92	.80	1.94	.78	-.280	.780
Xxv	representative actively involves in developing community mental health resources, and events in your area.	1.89	.75	1.99	.79	-1.112	.267
Xxvi	actively participate in advocating for mental health support.	2.17	.86	2.17	.80	-.047	.963
Xxvii	actively relates with other service providers to improve staff's access to MH service.	2.07	.82	2.13	.73	-.670	.503
Xxvii i	is an active member of the WHO's Mental Health Leadership Advocacy Action Programme.	1.80	.72	1.85	.77	-.569	.570

The results in Table T4 show the differences in coalition structures of relationships designed for anti-stigma interventions by the public and private primary administrative systems in Lagos State. As shown in Table T4, out of the six (6) key activities used in measuring coalition, no significant difference was observed in any of the coalition activities. This outcome suggests that the experience of private and public schools was similar in relation to coalition structures of relationships designed for anti-stigma interventions in Lagos State.

Appendix T6: Differences in Collaboration Structure for MH Inclusion in Public and Private School Administrative Systems in Lagos State

S/N	My School...	PRIVATE		PUBLIC		t(334)	p
		M	SD	M	SD		
Xxix	actively pursues healthy working relationships with community leaders in LGA to provide similar mental health guidance across schools in Lagos State.	2.08	.93	2.19	.77	-1.106	.269
Xxx	always has a representative in community mental health outreach program that jointly promote support service/or receive support from local NGOs to initiate mental health promotion	2.02	.81	2.12	.70	-1.152	.251
Xxxi	always receives extensive guidance from the Ministry of health to support access to basic MH service.	1.93	.79	2.22	.81	-3.127	.002*
Xxxii	continually engages in workshop, training, & research with Mental Health Leadership Advocacy Action Program.	2.02	.79	2.23	.82	-2.181	.030*
Xxxii	always receive mental health updates (research outcomes, new programs, funding, training/workshop etc.) from community mental health committees within the LGA.	2.02	.74	2.17	.75	-1.691	.092
Xxxi	employs counsellor/psychologist/ social workers to continually liaise with mental health community extension workers.	2.14	.87	2.35	.86	-2.015	.045*
Xxxv	pursues relationship building as a life goal with mental health providers to improve access to care and material support (e.g., research team, insurance coverage/ funding/ mental health practitioners from community healthcare/ NGOs).	2.07	.81	2.27	.81	-2.092	.037*

* $p < .05$.

Results in Table T5 show the differences in collaboration structures in the public and private schools in Lagos State. As shown in Table T5, out of the seven (7) key activities used in measuring collaboration, significant differences were observed in four such as the receipt of extensive guidance from the Ministry of Health to support access to basic MH service: private ($M=1.93$, $SD=.79$), public ($M=2.22$, $SD=.81$), $t= -3.127$, $p < .01$; continual engagement in workshop, training, and research with Mental Health Leadership Advocacy Action Program, private ($M=2.02$, $SD= .79$), public ($M=2.23$, $SD= .82$), $t= -2.181$, $p < .01$; the employment of counsellor/psychologist/social workers to continually liaise with mental health community extension workers, private ($M=2.14$, $SD=.87$), public ($M=2.35$, $SD=.86$), $t= -2.015$, $p < .01$; the pursuit of relationship building as a life goal with MH providers to improve access to care and material support (for example, research team, insurance coverage/funding/mental health practitioners from community healthcare/NGOs), and the receipt of professional visits from mental health social workers/nurses, psychologists/counselor/nutritionists, etc.), private ($M=2.07$, $SD= .81$), public ($M=2.27$, $SD= .81$), $t= -2.092$, $p < .01$. This outcome suggests that public schools in Lagos State experienced higher and significant collaboration of the structures of relationships designed for anti-stigma interventions than their counterparts in private schools.

Appendix U: Permission for Copyright



March 21, 2024

Felicia Owadara
University of Manitoba
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From A Model of Internalized Stigma and Its Effects on People With Mental Illness, Psychiatric Services 2013, 64:3, Figure 1, pages 264-269

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March 21, 2024

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I will appreciate it if I am permitted to adapt figure 1 of the text: “Proposed structural equation model of internalized stigma for persons with serious mental illness” in my dissertation. This figure will be included in my literature review as an explanatory model of the relationship between internal and external stigma, and a way of re-examining the current approach to intervention that target exclusion based on stigma related to mental illness.

Thanks, in anticipation of your timely response.

Sincerely,

Candidate for PhD,

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