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Utilization of Social Support Center on Depression and Suicidal Ideation among Undergraduates in a Tertiary Institution, Benin City

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Abstract

Background: Social support consists of a network of people drawn from the community members that promote mental health wellbeing, as inadequate social support gives rise to various mental illnesses such as depression and this has a negative influence on the life of students which can increases the risk of suicidal ideation. **Aim**: This study aims to access the utilization of social support among undergraduate students residing in halls of residence at University of Benin. **Methods**: A descriptive cross-sectional non-experimental research design was used for the study. A total of 380 participants was employed using convenient sampling and a self-structured questionnaire was used to collect data. Data were analyzed using descriptive statistics and hypothesis were tested using ANOVA, ANCOVA, Independent T-test, and Multivariate logistic regression model at a 5% level of significance.. All the analyses were done using the Statistical Package for Social Sciences (SPSS) version 20.0. **Results:** Findings from this study showed that most 226(59.5%) of the respondents recorded a fair level of knowledge of social support on depression and suicidal ideation. The majority 266(70%) of the respondents had a good level of utilization of social support. Factors that promote the use of social support among undergraduates were nearness to residence (2.50 ± 0.90), availability of time (4.01 ± 0.31), awareness of social support centers (3.90 ± 0.52), free of cost/charges (3.90 ± 0.42), less time-consuming process (4.01 ± 0.21), and concern from family (2.72 ± 0.92). There was a statistically significant difference in the mean knowledge level based on the hall of residence of respondents ($F = 6.033$, $p < 0.001$). On the effect of the covariate "Level of respondent" on the outcome variable "Knowledge of social support". The association between the class level of respondents and their knowledge of social support was not statistically significant ($F_{1,7} = 0.576$, $p = 0.448$), while the association between hall of residence and knowledge of social support was statistically significant ($F_{6,7} = 6.121$, $p < 0.001$). **Conclusion**: Although the level of utilization of social support services in the present study is encouraging there is a need for improvement as the level of knowledge is poor. Better knowledge of social support services can translate into good utilization among the students. The researchers, therefore, recommend that more sensitization, seminars, conferences, and workshops on the importance of social support services should be organized from time to time to update the students' knowledge and create awareness on the various social support services available both physical and online

Keywords: *Social support, Utilization, Knowledge, Factors promoting, Suicidal ideation, Depression.*

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Introduction

Suicide account for the leading cause of death among young individuals aged 15-29 years with the highest and almost 79% of all cases found in high-income and low-and-middle-income countries respectively (World Health Organization (WHO), 2019). Despite being a major public health problem, suicidal ideations and behaviors have not significantly reduced (Franklin *et al.,* 2017). Recently, there is a high focus on the increasing suicide cases among adults in Nigeria. More recent

statistics show that the suicide rate in Nigeria is 9.5 per 100,000 people, also, current trends suggest that Nigerian students in Tertiary Institution are more susceptible to commit suicide compared to other groups in the general population (Muanya et al, 2019).

The factors that predict suicide attempts among students having suicidal ideation are based on their suicide capability. These risk factors as found in individuals with suicidal ideation were poor at differentiating between suicidal and non-suicidal self-harm. (Klonsky et al 2017). Previous studies discovered an increase in the prevalence of suicidal ideation in male students when compared with female medical students (Sun et al, 2017), as regards the relationship between suicidal ideation and level of study, it has been discovered that students in higher levels had an increased prevalence of suicidal ideation than those in lower levels (Adhikari *et al.,* 2017). The factors that are mostly related to suicidal ideation in medical students were depression and depressive symptoms, low financial status, feeling of being neglected by parents, dissatisfaction with academic grades as a primary concern, and staying alone (Torres et al, 2018).

Depression is a debilitating and pernicious cluster of symptoms that may persist for weeks, months or even years. It is an affective disorder that is characterized by depressed mood, lack of interest, decreased energy, feeling of guilt or low self-worth, disturbed sleep or appetite, and poor concentration (Baile, et al, 2017). Studies have discovered that students, who felt that they lack knowledge on social support find it difficult to discuss their emotional issues and they are at the highest risk for suicidal ideation and attempts (McDermott, et al 2017). This indicates that the greatest risk factor as regards depression and suicidal ideation is lack of social support.

Social support consists of a network of people drawn from family, friends, and the community in which one belongs (Awang, et al, 2017), a lack of social support gives rise to depressive symptoms (Bukhari & Afzal, 2017) and this has a negative influence on the life of students. Adequate social support could moderate the significance of stress, whereas low social support can contribute to depression and suicidal ideation (Liu, et al, 2017). Utilization of social support depends on the knowledge level, availability, and accessibility to the student. The condition implies that knowledge, availability, and accessibility must be satisfied for utilization to be achieved (Nwachukwu, et al, 2014).

Suicide is an intricate issue, it's a result of several factors which include mental illness, substance abuse, financial difficulties, relationship issues, academic stress. People die by suicide globally each year (World Health Organization (WHO), 2017). Suicide is a leading cause of death, the rate of suicidal ideation warrants a particular concern among youths as a result of the increase in the number of death caused by suicide throughout the life span (WHO, 2017). According to Fidelis, et al (2019), there were many cases of suicide reported in various universities across the country; in Kogi, A 100-Level student of the Kogi State University (KSU), committed suicide over a breakup with her alleged boyfriend on the 18th of April, 2019. It was reported that the deceased drank sniper. A Medical Student of the Benue State University, Makurdi, committed suicide on July 26, 2015, in controversial circumstances after receiving the news of his withdrawal after spending 10 years in medical school. A national diploma student of public administration reportedly attempted committing suicide by drinking 'sniper' insecticide on October 2, 2017 in Nasarawa. In **Kano**, about six victims were recorded, according to police statistics. The six cases had to do with depression, the police further said; A 400 level student of Bayero University Kano, was among those that took their lives. A 300-level student of the Abubakar Tafawa Balewa University, Bauchi, reportedly hanged himself on November 25, 2017. Similar cases were reported among

students in the higher institutions in Bayelsa, Port Harcourt, Delta, Enugu, and Lagos: in **Benin City,** A 300 level Medical Laboratory student of the University of Benin (UNIBEN) was discovered dead in her hostel after taking some deadly substance "sniper" to end her life. According to Michael (2019), a final year student of the department of Actuarial science, University of Benin committed suicide by jumping off a faculty building on 16 July 2019 over failed courses (Aloba, et al, 2018).

Although in the various cases, most of the students had a note indicating the reason for the suicide, why did the student not utilize social support centers in their various schools on notice he/she is passing through depression or having suicidal ideation? Could it be that these students lack knowledge of social support centers within their various institutions? Or are these centers non-functional in their school? Or are there no social support centers in these school? All these questions are begging for answers, hence, this research accessed the utilization of social support centers on depression and suicidal ideation among undergraduate students in halls of residence at the University of Benin. The specific objectives of the study are to; assess the level of knowledge of social support on depression and suicidal ideation among undergraduate students in halls of residence at University of Benin, ascertain the level of utilization of social support among students in halls of residence at the University of Benin, and to determine the factors that promote the use of social support among undergraduate students in halls of residence in the University of Benin.

Materials and Method

Research design/setting: This study adopted a descriptive cross-sectional design. The study was conducted in the University of Benin located in Ovia North Local Government Area of Edo State, Nigeria. It is a federal government own university established in 1970 with an estimate of 75,000 students. **Study population**: The population of the study consists of all undergraduate students residing in the various halls of residence. There are seven (7) halls of residence and they include: hall 1 = 1,440, hall 2 = 2560, hall 3 = 2560, hall 4 = 400, hall 5 = 100, hall 6 = 400, and NDDC = 897 students with total number of 8477 students.

Sample size: The sample size will be estimated using the formula (Taro Yamane, 1967).
(TARO YAMANE, 1967) Where n = sample size, N = population size, D = level of precision (confidence interval)

$n=N/ 1 + N (d)^2$, $n= 8477/ 1 + 8477 (0.05)^2$
$=8477/ 1 + 8477(0.0025) =8477/ 22.1925$
$=382$

Proportion of distribution of sample size to various halls of residence
Hall 1: 1440/8477 × 382/1=65
Hall 2: 2560/8477 × 382/1=115
Hall 3: 2240/8477 × 382/1= 101
Hall 4: 840/8477 × 382/1= 38
Hall 5: 100/8477 × 382/1= 5
Hall 6: 400/8477 × 382/1= 18
NDDC: 897/8477 × 382/1= 40
Total= 65+115+101+38+5+18+40=382

Sampling technique: A convenience sampling technique was adopted for the study. This method was considered appropriate because there was no way the researcher could gather all the students together at a particular time.
An instrument for Data Collection: The instrument for data collection was a self-structured questionnaire. The questionnaire was were divided into four (4) sections. Section A; It contains the demographic data of the participant

Section B; Knowledge of social support on depression and suicidal ideation with ten (10) items questions, each question carrying 1mk with a total of 10 marks. It was classified as good knowledge (scored 10-7), fair knowledge (score 6-4), and poor knowledge (score 3-1). Section C; The level of utilization of social support, this section consist of the

question relating to the utilization of social support centers. It has variables with the following weighted scores always (10), sometimes (6), rarely (2), and never (0) and an average mean of 4.5. An item with an average mean of 4.5 or a total score of 50% and above was regarded as good utilization while below 4.5 average mean or below total score below 50% score was poor utilization. Section D; The factors that promote the use of social support. In this section, a Likert-scale was used ranging from strongly agree (4) to strongly disagree (1). An item with an average mean of 2.5 and above is regarded as a factor while below 2.5 is not a factor.

Validity/Reliability of study: The questionnaire was subjected to face and content validity by two experts in the field of clinical psychology and guidance and counseling from the University of Benin. A pilot study was conducted using 10% of the population among students from another University. Data generated were analyzed using a split half reliability test. Cronbach alpha values of 0.74, 0.79, and 0.94 respectively were obtained for sections B, C, and D thus indicating that the research instrument was reliable**.**

Method of data collection: the questionnaires were administered with the help of four (4) trained research assistants. Four (4) assistants were stationed in a different halls of residence. Questions were administered in the evening between 6-8 pm when the student might have returned from classes. Each questionnaire takes an average of 10minites to complete and was retrieved immediately. This was done each day throughout the period of data collection.

Method of data analysis: The data collected was analyzed, using descriptive and inferential statistics and presented using frequency count and percentages. The values were put in tables. The hypothesis was tested using Chi-square, ANCOVA, Post HOC, Independent T-test, and Multivariate logistic regression model. All the analyses were done using the Statistical Package for Social Sciences (SPSS) version 20.0.

Ethical consideration: Ethical clearance certificate with protocol number CMS/REC/2012/180 was obtained from the research and ethical committee of the College of Medical Sciences, University of Benin. Informed consent was also obtained from the respondents after a Careful explanation of the purpose, content, and implication were made known to the respondents. The respondents were given assurance that the information given was going to be confidential, by so doing; there was no disclosure of information such as names to the other respondents as the information obtained was personal and private.

Results

Table 1: *Socio-demographic Characteristics of Respondents*

Variables	**Frequency (n = 380)**	**Percent**
Age group (years)		
16 – 20	45	11.8
21 – 25	213	56.1
26 – 30	108	28.5
31 – 35	14	3.7
Mean age ± SD = **24.2 ± 4.6 years**		
Gender		
Male	161	42.4
Female	219	57.6
Marital Status		
Single	380	100.0

Variables	Frequency (n = 380)	Percent
Age group (years)		
Married	0	0.0
Divorced	0	0.0
Widowed	0	0.0
Level		
100	112	29.5
200	108	28.4
300	65	17.1
400	66	17.4
500	21	5.5
600	8	2.1
Religion		
Christianity	315	82.9
Islam	65	17.1
African Traditional Religion	0	0.0
Hall of Residence		
Hall 1	64	16.8
Hall 2	115	30.3
Hall 3	101	26.6
Hall 4	38	10.0
Hall 5	4	1.1
Hall 6	18	4.7
NDDC	40	10.5

The table above that most 213(56.1%) of the respondents were within the age range of 21-25 years, with a mean age of 24.2 ± 4.6 years. 161(42.4%) were males, while 219(57.6%) were females. All 380 (100.0%) were single, in addition, the majority 315(82.9%) were Christians,

Table 2: *Knowledge of social support on depression and suicidal ideation among respondents n=380*

Variables	Correct responses f(%)	Wrong responses f(%)
1. **Which of the following best describes social support?** (a). Social support consists of a network of people drawn from family, friends, and the community to one belongs (b). Social support is help from friends (c).All of the above (d).None of the above	180(47.4)	200(52.6)
2. **The following are categories of social support except?** (a)Emotional support (b)Tangible support (c)Informational support (d)Corrective support	237(62.4)	143(37.6)
3. **Which of the following is correct about the types of Social support?** (a)Enacted social support plays an important role in depression and suicidal ideation (b)Perceived social support plays an important role in depression and suicidal ideation (c)Enacted social support is superior (d)Perceived social support is the same as enacted social support	203(53.4)	177(46.6)

Variables	Correct responses f(%)	Wrong responses f(%)
4. **Do you know social support could help overcome depression and suicidal ideation?** (a)I don't know (b)I am not sure (c)I know (d)I doubt	64(16.8)	316(83.2)
5. **Which of the following is a form of social support in the school environment?** (a)Classroom (b)Library (c)Counselling unit (d)None of the above	330(86.8)	50(13.2)
6. **Social support is helpful against** (a)Stressors (b)Sleepiness (c)Anger (d)All of the above	25(6.6)	325(93.4)
7. **A lack of social support is a determining factor of** (a)Mental Health (b)Depression (c)Communication (d)Relationship	9(2.4)	371(97.6)
8. Social support can be (a)Enacted (b)Perceived (c)All of the above	106(27.9)	274(72.1)
9. **In the development stage of adolescence, which of the following is a more crucial source of social support?** (a)Friends (b)Family (c)School (d)None of the above	16(4.2)	364(95.8)
10. **Social support serves as a buffer against the following except** (a)Depression (b)Suicidal ideation (c)Relationship (d)Belief	4(1.1)	376(98.9)
Mean responses	117(30.78%)	263(69.22%)

Overall knowledge classification

Classifications	Score range	Frequency (f)	Percentage (%)
Poor	1-3(0=30%)	153	40.3
Fair	4-6(40-60%)	226	59.5
Good	7-10(70-100%)	1	0.2
Total		380	100

The table above shows the Knowledge of social support on depression and suicidal ideation among respondents. Only 180(47.4%) of respondents got the correct definition of social support. 117(30.78%) of the respondents answered correctly the question on knowledge of social support while 263(69.22%) of respondents' responses were wrong. The overall knowledge classification shows that 153(40.3%), had poor knowledge, 226(59.5%) had fair knowledge while only 1(0.2%) had good knowledge of social support.

Table 3: *Level of the utilization of social support center among respondents* *n=380*

Variable	SA=4 F (%)	A=3 F (%)	D=2 F (%)	SD=1 F (%)	Mean	SD	Remark
1.I use the social support center in school	0 (0.0)	193 (50.8)	23 (6.0)	164 (43.2)	2.07	0.406	Poor
2.The social support center is easily accessible	0 (0.0)	277 (72.9)	98 (25.8)	5 (1.3)	2.71	0.372	Good
3. I don't use the social support center because the staffs are unfriendly	67 (17.6)	286 (75.3)	7 (1.8)	20 (5.3)	3.05	0.356	Good

Variable	SA=4 F (%)	A=3 F (%)	D=2 F (%)	SD=1 F (%)	Mean	SD	Remark
4. I don't have time to visit the social support center because of academic activities	71 (18.7)	207 (54.5)	64 (16.8)	38 (10.0)	2.81	0.368	Good
5.I use support from friends	4 (1.0)	52 (13.7)	272 (71.6)	52 (13.7)	2.02	0.408	Poor
6. I am shy to share my problems so it affects my use of the social support center in school	0 (0.0)	375 (98.7)	3 (0.8)	2 (0.5)	2.98	0.359	Good
7. The consulting time in the social support center is time-consuming and exhausting	3 (0.8)	243 (63.9)	130 (34.2)	4 (1.1)	2.64	0.376	Good
8. I do not visit social support centres as I am afraid my friends will mock me	0 (0.0)	2 (0.5)	3 (0.8)	375 (98.7)	1.02	0.460	Poor
9.I use support from family	197(51.8)	77 (20.3)	104 (27.4)	2 (0.5)	3.23	0.346	Good
10.Distance prevents my utilization of social support	221(58.2)	93 (24.5)	64 (16.8)	2 (0.5)	3.40	0.337	Good
Grand mean average					**2.59**	**0.343**	

Level of utilization

Classification	Ratio of poor/ good utilization	Percentage translation (%)	Frequency of respondents
Poor utilization	3	3/10x100=30	114
Good utilization	7	7/10x100=70	266

Grand mean average± SD = 2.59 ± 0.343; Mean cut-off = 2.5, SA (strongly agree), A (agree), D (disagree), SD (strongly disagree)

This table above show that the respondents have a good level of utilization in seven items (items 2, 3, 4, 6,7,9, and 10) with an average mean of >2.5 while poor utilization was reported in items 1,5 and 8 with an average mean of > 2.5. though the grand mean of 2.59 ± 0.343 indicates a general level of good utilization of social support system among the respondents when translated into frequency according to the ratio of poor to good utilization, it shows that 266(70%) of the respondents had a good level of utilization while 114(30%) had poor utilization. social support among respondents.

Table 4: *Factors That Promote the Use of Social Support center among Respondents*

Variable	SA=5 F (%)	A=3 F (%)	D=2 F (%)	S D=1 F (%)	Mean	SD	Remark
Nearness to residence	103 (27.1)	5 (1.3)	252 (66.3)	20 (5.3)	2.50	0.90	*F*
Availability of staff	22 (5.8)	166 (43.7)	50 (13.2)	142 (37.3)	2.21	1.01	*NF*
Availability of time	369 (97.1)	7 (1.8)	3 (0.8)	1 (0.3)	4.01	0.31	*F*
Awareness of social support centers	347 (91.3)	12 (3.2)	19 (5.0)	2 (0.5)	3.91	0.52	*F*
Free of cost/charges	358 (94.2)	7 (1.8)	14 (3.7)	1 (0.3)	3.90	0.42	*F*
Less time-consuming process	375 (98.6)	3 (0.8)	1 (0.3)	1 (0.3)	4.01	0.21	*F*

Variable	SA=5 F (%)	A=3 F (%)	D=2 F (%)	S D=1 F (%)	Mean	SD	Remark
Free access to the social support	10 (2.6)	70 (18.4)	164 (43.2)	136 (35.8)	1.91	0.81	*NF*
Concern from family	79 (20.8)	143 (37.6)	117 (30.8)	41 (10.8)	2.72	0.92	*F*
Concern from friends	2 (0.5)	8 (2.1)	165 (43.5)	205 (53.9)	1.50	0.61	*NF*
Positive review from others	2 (0.5)	0 (0.0)	21 (5.6)	357 (93.9)	1.11	0.30	*NF*

Grand mean ± SD = 2.8 ± 1.10; Mean cut-off = 2.5 SA(Strongly agree), A(Agree), D(Disagree) and SD (Strongly disagree) . F(factor), NF (not factor)

This table shows the factors that promote the use of social support among respondents, and the major factors include nearness to residence (2.50 ± 0.90), availability of time (4.01 ± 0.31), awareness of social support centers (3.90 ± 0.52), free of cost/charges (3.90 ± 0.42), less time-consuming process (4.01 ± 0.21), and concern from family (2.72 ± 0.92).

Table 5: *Mean comparison of knowledge of social support among undergraduate students based on hall of residence; (ANOVA, ANCOVA, and POST-HOC test)*
Table 5(a) ANOVA TABLE

	Hall 1	Hall2	Hall 3	Hall 4	Hall 5	Hall 6	NDDC	F	p
Knowledge of social support	0.52±0.50	0.68±0.47	0.70±0.48	0.63±0.49	1.00±0.00	0.44±0.51	0.25±0.44	6.033	<0.001

The above table shows that there is a statistically significant difference in the mean knowledge level based on the hall of residence of respondents ($F = 6.033$, $p < 0.001$).

Table 5(b): ANCOVA Table – I

Tests of Between-Subjects Effects

Dependent Variable: KNOWLEDGE_CAT

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	8.376[a]	7	1.197	5.247	.000	.090
Intercept	25.236	1	25.236	110.671	.000	.229
LEVEL	.131	1	.131	.576	.448	.002
HALL_OF_RESIDENCE	8.374	6	1.396	6.121	.000	.090
Error	84.824	372	.228			
Total	230.000	380				
Corrected Total	93.200	379				

a. R Squared = .090 (Adjusted R Squared = .073)

This table shows the effect of the covariate "Level of respondent" on the outcome variable "Knowledge of social support". The association between the level of respondents and their knowledge of social support was not statistically significant ($F_{1,7} = 0.576$, $p = 0.448$), while the association between hall of residence and knowledge of social support was statistically significant ($F_{6,7} = 6.121$, $p < 0.001$)

Table 5 (c): *ANCOVA Table – II*

Estimates

Dependent Variable: KNOWLEDGE_CAT

			95% Confidence Interval	
Hall of Residence	Mean	Std. Error	Lower Bound	Upper Bound
Hall 1	.520[a]	.060	.402	.638
Hall 2	.680[a]	.045	.593	.768
Hall 3	.704[a]	.048	.611	.798
Hall 4	.627[a]	.078	.474	.780
Hall 5	.993[a]	.239	.523	1.463
Hall 6	.434[a]	.113	.212	.657
NDDC	.243[a]	.076	.094	.393

a. Covariates appearing in the model are evaluated at the following values: Level = 2.47.

This table shows the adjusted means of the independent variable "halls of residence" having taken into consideration the effect of the covariate "Level of respondent". Only mean values for "Hall 6" and "NDDC" are different from the original means, others were however the same. A Tukey Post-HOC test revealed that the level of knowledge of social support on depression and suicidal ideation was significantly higher among respondents residing in Hall 2 compared to NDDC (0.4 ± 0.1, $p < 0.001$), Hall 3 compared to NDDC (0.5 ± 0.1, $p < 0.001$), and Hall 4 compared to NDDC (0.4 ± 0.1, $p = 0.009$).

Table 6: *Multivariate Logistic Regression Model for the Level of Utilization of Social Support Among Respondents*

PREDICTOR	B (regression co-efficient)	ODDS RATIO	95% CI for OR Lower	Upper	P - VALUE
Age	- 0.237	0.789	0.318	1.957	0.609
Gender					
Male	0.584	1.793	0.250	12.848	0.561
Female*		1			
Level	2.834	17.006	1.998	144.716	0.009
Religion					
Christianity	0.425	1.529	0.726	3.219	0.264
Islam*		1			
Hall of Residence					
Hall 1	3.826	45.885	9.227	228.189	< 0.001
Hall 2	3.742	42.173	9.120	195.014	< 0.001
Hall 3	0.416	- 1.516	0.336	6.840	0.588
Hall 4	- 20.360	0.000	0.000	0.000	0.997
Hall 5	- 20.483	0.000	0.000	0.000	0.999
Hall 6	- 19.033	0.000	0.000	0.000	0.998
NDDC*		1			

******Reference category* R^2 *= 45.0% – 60.1% CI= Confidence Interval*

The variables in this model accounted for 45.0% - 60.1% of the observations observed in the outcome variable (Level of the utilization of social support). A year decrease in age increased the level of utilization of social support centers by 0.237 and this was more likely by an odds ratio of 0.789. This association was however not statistically significant ($p = 0.609$). Males were 1.793 times more likely to have good utilization of

social support when compared to females. This relationship was not statistically significant (p = 0.561). An increase in a level increased respondents' utilization of social support by 2.834, this was more likely by an odds ratio of 17.006 and this relationship was statistically significant (p = 0.009). Also, respondents residing in Hall 1 had a higher level of utilization (3.826) of social support centers when compared with respondents from NDDC hostel, with an odds ratio of 45.885. This relationship was statistically significant.

Discussion of Findings

Findings from the study showed that the majority 226(59.5%) of the respondents had fair Knowledge of social support on depression and suicidal ideation. quite a large number 153(40.3%) of the respondents also had poor knowledge. These findings agree with that of Miller, et al. (2015) in Virginia, where the majority (64%) of the respondents had fair knowledge on social support, while 36% had low knowledge of social support. Also, Zamani-Alavijeh, et al (2017) in England also reported that 60.3% of their respondents had poor knowledge of social support. Other studies that reported poor knowledge of social support among their respondents are Ibimiluyi (2020) in Southwest, Nigeria, and Szymona-Pałkowska et al, (2016) in Poland. However, Babalola, rt al (2019) in Ile-Ife, Osun state reported that 139(16.4%) had good knowledge of social support. This level reported is higher than 0.2% of the present study. Freshteh, et al, (2017) in England, also reported a higher level (39.7%) of good knowledge compared to the present study. The poor level of knowledge reported in the present study may be attributed to low awareness and sensitization programmes in the institution regarding social support services.

Findings from the study show that the majority 266(70%) of the respondents had a good level of utilization social support services. Supporting these findings are is Mohammed & Suleiman (2016) in Zaria, Nigeria which reported that majority of students knew about social support with good utilization. However, these findings do not agree with the study of Aniwada, et al (2019) in Enugu State, Nigeria, where it was reported that the majority 138 (57.5%) of the students had poor utilization of social support. Also, Jenny, et al (2016) in California, showed that 30.9% utilized some form of social support, while 69.1% had poor utilization of social support. Also, different are the findings of Alkhawaldeh (2017) in Jordan, where about 102 (42.5%) of the students had good utilization of social support and the majority 138 (57.5%) had poor utilization of social support.

The high-level utilization reported in the present study could be due to the effectiveness of the social support centers available within and outside the school or community in which the individual belongs, it could also be due to the presence of competent friends and family as a form of social support. Furthermore, the absence of stigmatization among students in the institution could also be one of the reasons for high utilization in the present study. Stigmatization both from the staff and students particularly in our present society where individuals relate anything including suicidal attempts to spirituality, thinking that these individuals are possessed, might make students withdraw from friends leading to loss of friends as a form of social support. Though the level of knowledge reported in the present study was poor, it appears there is good awareness among the students which also indicate a high level of sensitization in the university community hence these good level of utilization were reported.

Another reason for the good utilization could be due to easy access to the internet, as most young individuals tend to source solutions to their problems. Some of these support services are online and can easily be accessed by the student thereby finding a solution to her/her problem without voicing out to avoid stigmatization. More also, the present study institution is known for its student friendly

nature this could have contributed to the high-level utilization reported. It is therefore pertinent for the institution to cultivate the habit of being students friendly, this will help the student to voice out their problems instead of keeping them for fear of being reprimanded.

Major factors that promote the use of social support among respondents in the present study were; nearness to the residence, availability of time, awareness of social support centers, free of cost/charges, less time-consuming process, and concern from family. A similar factor was also advanced by Kevin & Martins (2015) in the United States, where Social connection, availability of time, free of cost/charges, and positive reviews from others were listed. Contrary to the present study, Malvin, et al (2015) in Spain, reported that positive factors, both social (relationships with teachers and classmates) and personal (emotional intelligence and orientation to happiness), were responsible for the utilization of social support system in the university.

Multivariate Logistic Regression Model for the Level of Utilization of Social Support among respondents shows that an increase in the level of study increased respondents' utilization of social support by 2.834, this was more likely by an odds ratio of 17.006 and this relationship was statistically significant ($p = 0.009$). Also, respondents residing in Hall 1 had a higher level of utilization (3.826) of social support centers when compared with respondents from NDDC hostel, with an odds ratio of 45.885. This relationship was statistically significant. NDDC hostel accommodates mainly medical students, nursing students, and other allied health professional students. It is shocking to note that this student who are supposed to know the importance of social support services due to their profession don't even utilize the services. A simple explanation for this finding could be that these students may think that they can solve their problem themselves haven been exposed to medical courses/training in this line. Therefore they may not see any reason to meet anyone for help or voice their problem. As logical as these may sound it is not good and should be discouraged in its totality because resulting in self-help with half-baked knowledge may lead to a castratophic end result.

Conclusion/ Recommendations

Suicide is an intricate issue, it is a leading cause of death, the rate of suicidal ideation warrants a particular concern among youths especially students in higher institutions. Adequate social support could moderate the significance of stress, whereas low social support can contribute to depression and suicidal ideation. Utilization of social support depends on the knowledge level, availability, and accessibility to the student. Although there is a good utilization of social support in the present study the knowledge is poor. Therefore much is still needed to be done to achieve 100% utilization and reduce the rate of suicide, suicidal attempt, and suicidal ideation among the students. This could be achieved if more effort is geared toward improving the knowledge of social support among the students. This could be achieved through sensitization and education of the students on the importance of social support and extracurricular activities associated with preventive strategies of depression. Seminars, conferences, and workshops should be organized from time to time in-campus to update the students' knowledge and create awareness on the various social support services available both physically and online. Funds should be made available to establish social support services centers while existing ones are renovated and upgraded.

References

Adhikari, A., Dutta, A., Sapkota, S., Chapagain, A., Aryal, A. & Pradhan, A. (2017). Prevalence of poor mental health among medical students in Nepal: a cross-sectional study. *BMC Medical Education; 17*(1): 232.

Aloba, O., Adefemi, S., & Aloba, T. (2018). Positive and Negative Suicide Ideation (PANSI) Inventory: initial

psychometric properties as a suicide risk screening tool among Nigerian university students. Clinical Medicine Insights: Psychiatry, 9, 1179557317751910

Alkhawaldeh A. & Utilisation of university health care center services among university students. Int J Health Sci Res. 2017; 7(4):340-345.

Aniwada E C, Ndu A. C, Okoye C.J, Okoye P.C, Okpala A.C, & Okpala C.V, (2019). Utilization of tertiary institutions social health insurance programme (TISHIP) among undergraduate students in Enugu State. *Nigerian Journal of Medicine*, Vol. 28 No. 4 p 413-422 DOI: 10.4103/1115-2613.278633

Awang, M.M., Kutty, F.M. & Ahmed, A.R. (2017). Perceived social support and well-being: First-year student experience in university. *International Education Studies*; *7*(13). doi:10.5539/ies.v7n13p261.

Babalola, T.M., Omoteso. B.A., & Enyi. J.O. (2019). Social support as a correlate of the mental health status of undergraduate students of Obafemi Awolowo University, ile-ife,osun state. *American Journal of Creative Education*: Vol. 2, No. 2, 93-100,2019. *e –ISSN*: 2706-6088.

Bukhari, S.R. & Afzal, F. (2017). Perceived social support predicts psychological problems among university students. *The International Journal of Indian Psychiatry*; 4(2): 2349-3429.

Franklin J.C, Ribeiro J.D, Fox K.R, Bentley K.H, Kleiman E.M, Huang X, Musacchio K.M, Jaroszewski A.C, Chang B.P, & Nock M.K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychol Bull*. Feb;143(2):187-232. doi: 10.1037/bul0000084. Epub 2016 Nov 14. PMID: 27841450.

Fidelis, M., Haruna, I., & Umar, S. (2019). Student's top list as 42 Nigerians commits suicide in 6 months: Daily Trust Sunday 23 June 2019 from https://www.dailytrust.com.ng/students-top-list-as-42-nigerians-commits-suicide-in-6-months.html.

Hyun J. K., Quinn B.C, Madon T & Lustig S (2006). Graduate Student Mental Health: Needs Assessment and Utilization of Counseling Services. *Journal of College Student Development* vol 47 no 3

Ibimiluyi, F.O. (2020). Social support and depression among adolescents in southwest, Nigeria. *International Journal of Academic Research in Business, Arts and Science. ISSN 2664-7354(*online) &ISSN 2708-2687 (print). Volume*: 2*, Issue: 5, page:14-27, 2020.

Klonsky, E.D, Qui, T. & Saffer, B.Y. (2017). Recent advances in differentiating suicide attempters from suicide ideators. *Current opinions on psychiatry*; *30*: 15-20.

Liu, Y., Niu, L., Wang, M., Chen, X., Xiao, S. & Luo, D. (2017). Suicidal behaviours among newly diagnosed people living with HIV in Changsha, China. *AIDS care*; *229*(11): 1359-1363.

McDermott, E., Hughes, E. & Rawlings, V. (2017). The social determinants of lesvian, gay, bisexual and transgender youth suicidality in England: A mixed methods study. *Journal of public health; 3*: 1-8. doi:10.1093/pubmed/fdx135.

Michaael, E. (2019) UNIBEN student dies after jumping from faculty building. From http://guardian.ng/news/uniben-student-dies-after-jumping-from-faculty-building/.

Miller A.B., Esposito-Smythers C, & Leichtweis R.N (2015) Role of social support in adolescent suicidal ideation and suicide attempts. Journal of adolescent health xxx (2015) 1-7 doi. http://dx.doi.org/10.1016/j.jadohealth.2014.10.265

Muanya, C., Akpunonu, S., & Onyenucheya, A . (2019, May). Addressing rising cases of suicide among teenagers in Nigeria . The Guardian .

https://guardian .ng/features/ addressing-rising-cases-of-suicide-among-teenagers-in- nigeria/

Nwachukwu, V.N., Abdulsalami T. L., & Salami P.F., (2014). Availability, Accessibility and Use of Information Resources and Services among Information Seekers of Lafia Public Library in Nasarawa State Information and Knowledge Management. www.iiste.org ISSN 2224-5758 (Paper) ISSN 2224-896X (Online)

Szymona-Pałkowska K, Janowski K, Pedrycz A, Mucha D, Ambroży T, Siermontowski P, Adamczuk J, Sapalska M, Mucha D, & Kraczkowski J. (2016). Knowledge of the Disease, Perceived Social Support, and Cognitive Appraisals in Women with Urinary Incontinence. *Biomed Res Int*. doi: 10.1155/2016/3694792. Epub 2016 Dec 21. PMID: 28097132; PMCID: PMC5209598

Sun, L., Zhou, C., Xu, L., Li, S., Kong, F., & Chu, J. (2017). Suicidal ideation, plans, and attempts among medical college students in China. The effects of their parental characteristics. *Psychiatry Res*., *247*:139-143.

Torres, A.R., Campos, L.M., Lima, M.C.P., & Ramos-Cerqueira, A.T.A. (2018). Suicidal ideation among medical students: prevalence and predictors. *Journal of Nervous Mental Disorder*; *206*: 160-168.

World Health Organisation, (2017). Disease and injury country mortality estimates from http://www.who.int/healthinfo/global-burden-disease/estimates/en/index/.html.

Zamani-Alavijeh, F., Dehkordi, F. R., & Shahry, P. (2017). Perceived social support among students of medical sciences. *Electronic physician*, *9*(6), 4479–4488. https://doi.org/10.19082/4479