Mental Health Literacy and Stigma of Australian Social Work Students: Depression and Suicidal Ideation

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ABSTRACT

This article presents the findings of a study of mental health literacy and stigma of Australian social work students. The aim of the study was to identify levels of knowledge and attitudes and beliefs prior to, and following, course content on mental health literacy. The outcome of this study indicates an increase in knowledge development and reduced rates of stigma following mental health literacy studies. Even though relatively low rates of stigma were recorded amongst these social work students, the study findings do raise the question of what level of stigma, if any, is acceptable within social work education. This has broader implications for service delivery as stigmatising attitudes and beliefs of students and workers might cause harm and deter people from accessing mental health services.

Keywords: *Attitudes and Beliefs; Knowledge and Skills, Stigma; Social Work Education; Mental Health; Mental Health Literacy*

INTRODUCTION

In Australia, *The National Review of Mental Health Programmes and Services* highlights the importance of primary prevention, early intervention and ongoing recovery pathways (National Mental Health Commission, 2014). Priority areas are the development of strategies to reduce stigma and build mental health workforce capacity. Mental health literacy programs have been developed to increase knowledge and skills and reduce stigmatising attitudes and beliefs of members of the general community, including mental health service providers (Jorm et al., 1997). Evaluative studies of Mental Health First Aid (MHFA) programs have generally reported an association between increased mental health knowledge and skills and decreased stigmatising attitudes and beliefs. In their meta-analysis of published evaluations of MHFA programs, Hadlaczky, Hokby, Carli, and Wassmerman (2014) found that increased mental health knowledge decreased negative attitudes. Discipline-specific studies have reported similar findings. A study of the mental health knowledge, attitudes and beliefs of Australian medical and nursing students before and after the Standard MHFA program found decreased stigmatising attitudes towards a person with depression (Bond, Jorm, Kitchener, & Reavley, 2015). A similar finding was reported in a randomised controlled study of third-year Australian pharmacy students that reported higher rates of recognition of mental disorders and reduced stigma in the group that completed studies in the Standard MHFA program (O'Reilly, Bell, Kelly, & Chen, 2011). Likewise, an evaluation study of school teachers before and after the Standard MHFA program found reductions in some aspects of stigma (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). The aim of this study is to evaluate the effectiveness of mental health literacy education for social work students. The main question is: "Do studies in mental health literacy increase knowledge and skills and reduce stigma in social work students?" Mental health literacy is defined, followed by consideration of early intervention barriers with a focus on stigma. A description of the study methodology and presentation of results reveals mental health literacy studies do increase knowledge and skills and reduce stigma in social work students for depression and suicidal ideation. The discussion and conclusion question to what extent, if any, the demonstration of stigmatising attitudes and beliefs towards those experiencing mental health difficulties is acceptable in social work education.

Mental Health Literacy

The term "mental health literacy" was devised by Anthony Jorm who defined it as:

> *…knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking.* (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997, p. 182)

A number of mental health literacy programs are offered by Mental Health First Aid Australia, as well as other organisations including the World Health Organisation (2011) which focuses more on mental health literacy for developing countries. The Youth Mental Health First Aid (YMHFA) program was chosen for incorporation into the curriculum of undergraduate social work degrees offered by the university at which this study was conducted. It was selected due to the focus on prevention and early intervention, consistent

with federal and state government policy directions, and also because the students were predominantly in this age group (Australian Government, 2014; Kelly, Kitchener, & Jorm, 2013; Victorian Government, 2013).

The YMHFA program covers foundational knowledge and skills in how to identify signs and symptoms of common mental health problems and assist a person who may be experiencing a mental health crisis or developing a mental health problem (Kelly, Kitchener & Jorm, 2013). Mental health problems covered include depression, anxiety, psychosis, substance misuse and eating disorders. Crisis situations include panic attacks, traumatic events, severe psychotic states, severe effects of misuse of alcohol and other drugs, self-injury and suicidal thoughts and behaviours. Developmental theory, with a focus on adolescence, is also covered (Mental Health First Aid Australia, 2015). The YMHFA program covers 33 (57%) of the 58 areas of the mental health curriculum prescribed by the professional accrediting body, the Australian Association of Social Workers (AASW, 2012, 11.1; Martin, 2016).

Social work critical theory provides a useful framework for the delivery of mental health literacy courses to social work students due to the focus on reflective practice and consideration of power and broader structural issues from a human rights perspectives (Allan, 2009; Payne, 2014). Areas of possible stigma and discrimination are more likely to be identified by practices that reflect upon the interplay between personal, economic, social and political circumstances and opportunities (McFarlane, 2009). Critical theory highlights the uniqueness and complexity of a person's experience and the potential for multiple disadvantage by exploring possible discrimination beyond mental health including, age, gender, sexuality, race, ethnicity and culture, spiritual beliefs, health status and so on (Bland, Renouf, & Tullgren, 2015). Vulnerable groups are identified, including lesbian, gay, bi-sexual, transgender, intersex and queer youth as well as young people in detention, in out-of-home care or living on the streets (Ranahan, 2010). Reflection on personal experience of internalised and externalised oppression and privilege challenges social workers to live their personal and professional lives in accordance with critical theoretical beliefs (Mullaly, 2010). The social work strengths approach is particularly important for identifying the protective factors and personal resources to assist in a person's recovery, with a focus on creating a safe place, using empowering practices such as believing the person, normalising their circumstances and fostering a sense of personal agency and hope (Martin, 2012).

Early Intervention and Service Barriers: Stigma

The provision of early intervention is well recognised as a mental health protective factor (National Mental Health Commission, 2014; Orygen Youth Health, 2014; Ranahan, 2010). Inadequate knowledge and skills in the recognition of mental health problems and how to respond appropriately present as main barriers to early intervention. An important aspect of early intervention is access to appropriate services. Studies of mental health care for young people in Australia (Cummings & Kang, 2012; Lincoln & McGorry, 1999; Rickwood, Deane, & Wilson, 2007; Scott et al., 2012) and the United States (Dolan & Fein, 2011; Powers, Webber, & Bower, 2014) have identified inadequate child and youth mental health literacy and stigma related to mental illness as barriers to accessing help for young people showing symptoms of mental illness. Stigma is generally defined as a mark of shame or disapproval due to a particular feature or characteristic. In the context of mental

health, "People with mental illness feel diminished, devalued and fearful because of the negative attitude society holds toward them. As a result, people struggling with mental health challenges might not get the help they need for fear they will be discriminated against" (Gluck, 2015, p. 1).

Main barriers have been identified as practitioner- or service-based and include costly, over-medicalised, unfriendly services with inadequate access to, or emphasis on, psychological and social interventions (Scott et al., 2012). Research by the Mental Health Council of Australia (2005, 2011) found high levels of oppression and stigma within mental health services. Differences were observed according to diagnoses with those diagnosed with severe depression receiving compassionate responses and those diagnosed with borderline personality disorder treated with contempt (Mental Health Council of Australia, 2005, 2011). Health professionals have been criticised for engaging in "disrespectful and dehumanising" practices particularly with people experiencing acute mental health difficulties (Bland, 2015, p. 65). Negative attitudes and beliefs, held knowingly or unknowingly, by mental health workers pose as a major threat to effective service provision (Wang, Smith, & Locke, 2014).

In their study of social distancing and stigma amongst social work students in the USA, UK and Australia, Wang, Smith, and Locke (2014) found differences according to diagnosis, with anxiety viewed more favourably than depression. The diagnosis of schizophrenia has been found to attract high levels of stigma amongst students (Miller & Mason, 2006). The Mental Health Commission of Canada has identified a number of educational strategies to address worker stigma. In particular, stories of hope and recovery that demonstrate how students can work collaboratively with consumers to bring about improvements in their lives are important. This includes multiple points of contact with consumers, seeing the person and not the diagnosis, knowledge of the myths of mental illness and awareness of personal prejudices. Seeing people when they are both unwell and well can assist students to be hopeful (Mental Health Commission of Canada, 2012).

METHOD

The aim of the study was to gauge changes in knowledge, attitudes and beliefs on depression and suicidal ideation following studies in mental health literacy. This included an assessment of levels of stigma. Study participants were third-year undergraduate social work students enrolled in a social work degree, undertaking a core face-to-face course in mental health at an Australian university in 2016. The study data were collected as part of the review of the efficacy of the youth mental health literacy studies component of the mental health course. Students were asked to complete exactly the same survey before and after completion of their mental health literacy studies. Each survey had a consent box on the top of the survey for students to indicate *yes* or *no* for the survey responses to be used for research purposes by the author. The author was also the teacher, and coordinator of this course, and was marking the students' work. The research was considered by the university's Ethics Committee and classified as low risk. In accordance with the ethical requirements for research in circumstances when the researcher is also the teacher and person assessing student work, the surveys were not distributed or collected by the researcher and did not include information that would identify student respondents. Students were asked

to insert a unique, anonymous identifier code prior to commencing the surveys so that individual before and after results could be matched for each participant. The benefits of the research were seen to outweigh any risk to participants.

The mental health course had a total enrolment of 99 students. The "before survey" was distributed in class to the 86 students in attendance prior to commencement of the first mental health literacy class, with the "after survey" distributed to the 66 students who attended the fourth and final mental health literacy class. A total of 91 students completed one or both surveys. Fifty-three students completed both surveys and gave consent for their survey responses to be used for research purposes. Ten students completed both surveys but did not provide consent for the survey results to be used for research purposes. This included surveys where the consent box was unchecked. Nineteen students completed one survey only and provided consent with nine completing one survey only without consent provided. Only the 53 surveys that were completed in both the before and after surveys, with consent provided for use for research purposes, were included in the study findings. The overall response rate to the survey was 53.53%. All of the study findings relate to the one mental health condition of depression with suicidal ideation.

Demographic information was also collected on sex, age and language. A Knowledge Questionnaire designed by Mental Health First Aid Australia was used with 16 opinion statements to which participants were asked to respond by indicating "agree", "disagree" or "don't know". These statements were:

1. If a person who is depressed does not want to seek professional help, it is important to force them if you can.

2. Exercise can help relieve depression.

3. Recovery from anxiety disorders requires facing situations which are anxiety provoking.

4. Anti-depressant medications can be an effective treatment for most anxiety disorders.

5. When interacting with a person with psychosis it is best not to offer them choices of how you can help them because it could add to their confusion.

6. A person with a psychotic illness is less likely to relapse if they have a good relationship with their family.

7. A good way to get help for a person with a drug or alcohol problem is to let them know that you strongly disapprove of their substance use.

8. People with mental disorders are much more likely to be smokers.

9. It is not a good idea to ask someone if they are feeling suicidal in case you put the idea in their head.

10. If a person is cutting themselves to cope with emotional distress, you should avoid expressing a strong negative reaction to the self-injury.

11. It is best to get someone having a panic attack to breathe into a paper bag.

12. If someone has a traumatic experience, it is best to make them talk about it as soon as possible.

13. It is best not to try and reason with a person having delusions.

14. If a person is intoxicated with alcohol, it is not possible to make them sober up more quickly by giving them strong coffee, or a cold shower or taking them for a walk.

15. If a person becomes unconscious after taking drugs, it is best to lie them on their back.

16. If a mentally ill person becomes aggressive, they will generally calm down if spoken to firmly.

(Mental Health First Aid Australia, 2014, pp.1-2).

A scenario of a hypothetical person named John was presented in a vignette. This was one of the six vignettes used in the 2011 Australia-wide survey of youth mental health literacy and stigma (Reavely & Jorm, 2011a, 2011b). This vignette was chosen as it had pre-established internal validity and because it was designed for recognition of mental health conditions in young people.

Students were asked the same questions in both the before and after surveys for the same depression and suicidal ideation vignette:

Depression and Suicidal Ideation Vignette
John is a 21 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all of the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him. John feels he will never be happy again and believes his family would be better off without him. He has been thinking of ways to end his life.
(Reavely & Jorm, 2011, pp.135–136)

Following this vignette respondents were asked an open question:

From the information given, what if anything is wrong with John?

Both the before and after surveys included the same nine attitudes and beliefs statements with a five-point ordinal ranking scale from 1 (strongly agree) to 5 (strongly disagree) used previously in a randomised controlled study of stigmatising attitudes towards depression (Griffiths, Christensen, Jorm, Evans, & Groves, 2004).

1. People with a problem like John could snap out of it if they wanted to.
2. A problem like Johns is a sign of weakness.
3. John's problem is not a real medical illness.
4. People with a problem like John are dangerous.
5. It is best to avoid people with a problem like John so that you don't develop this problem.
6. People with a problem like John are unpredictable.
7. If I had a problem like John I would not tell anyone.
8. I would not employ someone if I knew they had a problem like John.
9. I would not vote for a politician if I knew they had suffered a problem like John.

These statement were followed by questions on social stigma with a four point ordinal scale from 1 (definitely willing) to 4 (definitely unwilling).

How willing would you be to:

1. move next door to John?;
2. spend an evening socialising with John?;
3. make friends with John?;
4. have John start working closely with on a job?; or
5. have John marry into your family?

The question on what, if anything, is wrong with John following the vignette allowed for an open-text response with categories added for every new response. In this way, increased information was provided on what John's problem was identified as rather than simply reporting on whether or not the correct mental health condition was identified. This response was deliberately left as open text to avoid the possibility of pre-coded responses acting as prompts.

Numbers and percentages are used for all responses illustrating differences across the results of the "before" and "after" surveys. The attitude statements were collated according to rank on the five-point ordinal scale with "strongly agree" and "agree" combined under the category of "agree" for the presentation of results as all statements in agreement were considered stigmatising. Likewise, for the questions on social stigma "definitely willing" and "willing" were combined into the one category of "willing" in the reporting and analysis of the data.

FINDINGS

Thirty-four (64.15%) of the respondents were 19 to 24 years old with 16 (30.18%) aged between 25 and 30 years and three (5.66%) respondents aged over 30. None of the respondents identified as Aboriginal or Torres Strait Islander and only eight (15.09%) spoke a language other than English as a first language at home. Table 1 shows an increase of 14.74% in knowledge for the Opinion Survey results after the mental health literacy studies.

Table 1. Opinion Statements

OPINION STATEMENTS	CORRECT "BEFORE"	CORRECT "AFTER"	DIFFERENCE
If a person who is depressed does not want to seek professional help, it is important to force them if you can.	39 (73.58%)	42 (79.24%)	+3 (5.66%)
Exercise can help relieve depression.	52 (98.11%)	53 (100.00%)	**+**1 (1.89%)
Recovery from anxiety disorders requires facing situations which are anxiety provoking.	27 (50.94%)	32 (60.37%)	+5 (9.43%)
Anti-depressant medications can be an effective treatment for most anxiety disorders.	17 (32.07%)	27 (50.94%)	+10 (18.87%)
When interacting with a person with psychosis it is best not to offer them choices of how you can help them because it could add to their confusion.	27 (50.94%)	46 (86.79%)	**+**19 (35.85%)
A person with a psychotic illness is less likely to relapse if they have a good relationship with their family.	27 (50.94%)	35 (66.03%)	+8 (15.09%)
A good way to get help for a person with a drug or alcohol problem is to let them know that you strongly disapprove of their substance use.	46 (86.79%)	51 (96.22%)	+5 (9.43%)
People with mental disorders are much more likely to be smokers.	9 (16.98%)	20 (37.73%)	+11 (20.75%)
It is not a good idea to ask someone if they are feeling suicidal in case you put the idea in their head.	40 (75.37%)	48 (90.56%)	+8 (15.19%)
If a person is cutting themselves to cope with emotional distress, you should avoid expressing a strong negative reaction to the self-injury.	25 (47.16%)	39 (73.58%)	+14 (26.42%)
It is best to get someone having a panic attack to breathe into a paper bag.	19 (35.84%)	31 (58.49%)	+12 (22.65%)
If someone has a traumatic experience, it is best to make them talk about it as soon as possible.	41 (77.35%)	45 (84.90%)	+4 (7.58%)
It is best not to try and reason with a person having delusions.	15 (28.30%)	34 (64.15%)	+19 (35.85%)
If a person is intoxicated with alcohol, it is not possible to make them sober up more quickly by giving them strong coffee, or a cold shower or taking them for a walk.	28 (52.83%)	30 (56.60%)	**+**2 (3.77%)
If a person becomes unconscious after taking drugs, it is best to lie them on their back.	44 (83.01%)	50 (94.33%)	+6 (11.32%)
If a mentally ill person becomes aggressive, they will generally calm down if spoken to firmly.	43 (81.13%)	41 (77.35%)	**-**2 (-3.78%)
Total responses	**499 (58.84%)**	**624 (73.58%)**	**+125 (14.74%)**

N=53 Answer key: 1. Disagree, 2. Agree, 3. Agree, 4. Agree, 5. Disagree, 6. Agree, 7. Disagree, 8. Agree, 9. Disagree, 10. Agree, 11. Disagree, 12. Disagree, 13. Agree, 14. Agree, 15. Agree, 16. Disagree

The greatest increase in correct responses (35.58%) was for the two questions on communicating with a person experiencing psychosis, in relation to provisions of choices and reasoning with a person experiencing delusions. These were followed by the avoidance of expressing a strong negative reaction to self-injury (26.42%). The next highest difference between responses for both surveys was for responding appropriately to panic attacks (22.65%), recognition of high rates of smokers (20.75%) and the efficacy of anti-depressant medication for the treatment of anxiety disorders. There was also an increased recognition of the reduced likelihood of relapse if a person has strong family support (15.09%), with the same increase for recognising that, by asking if someone is suicidal, this will not put the idea into the person's head (15.09%). The only question that had a decline in correct responses was the final question that suggested speaking firmly to a person who is mentally ill will calm them down if they are becoming aggressive (-1.04%).

Table 2 reveals that the highest scoring mental health condition for John, in both the before and after surveys, was depression followed by depression with suicidal ideation.

Table 2. Vignette

WHAT IS WRONG WITH JOHN?	BEFORE	AFTER
Depression with suicidal ideation	20 (37.73%)	13 (24.52%)
Depression	24 (45.26%)	29 (54.71%)
Depression and anxiety	5 (9.43%)	3 (5.66%)
Depression and anxiety and suicidal ideation	0	1 (1.88%)
Depression and eating disorder	1 (1.88%)	2 (3.77%)
Depression and psychosis	0	1 (1.88%)
Depression and insomnia	1 (1.88%)	0
Suicidal ideation only	1 (1.88%)	0
Nothing wrong with him	1 (1.88%)	0
No response	0	4 (7.54%)
Total responses	**53**	**49**

All of the completed "after surveys" included John experiencing depression either on its own or combined with something else. Four respondents did not answer this question. When these four surveys are removed from the "after survey" response total the combined percentage for depression with suicidal ideation and depression is 85.71%, slightly higher

than the before survey at 82.99%. The overall number of respondents who agreed to the stigmatising attitudes and beliefs statements was relatively low as can be seen in Table 3.

Table 3. Stigmatising Personal Attitudes and Beliefs

ATTITUDES AND BELIEFS	AGREE "BEFORE"	AGREE "AFTER"	DIFFERENCE
People with a problem like John could snap out of it if they wanted to.	4 (7.54%)	3 (5.66%)	-1 (-1.88%)
A problem like Johns is a sign of weakness.	0	0	
John's problem is not a real medical illness.	2 (3.77%)	0	-2 (-3.77%)
People with a problem like John are dangerous.	1 (1.88%)	2 (3.77%)	+1 (1,89%)
It is best to avoid people with a problem like John so that you don't develop this problem.	0	0	0
People with a problem like John are unpredictable.	7 (13.20)	4 (7.54%)	-3 (-5.66%)
If I had a problem like John I would not tell anyone.	4 (7.54%)	3 (5.66%)	-1 (-1.88%)
I would not employ someone if I knew they had a problem like John.	2 (3.77%)	2 (3.77%)	0
I would not vote for a politician if I knew they had suffered a problem like John.	4 (7.54%)	3 (5.66%)	-1 (-1.88%)
Total responses	**24 (5.03%)**	**17 (3.56)**	**-7 (-1.47%)**

The only statement that recorded an increase after the mental health literacy studies was on "danger". Even though the statement on "unpredictability" saw the greatest decline in the after survey it still had the highest score at 7.54%. This was followed by "could snap out of it"; "would not tell anyone"; and "would not vote for" at 5.66%. Table 4 indicates that most respondents were willing to engage with John in all of the areas listed.

Table 4. Stigmatising Social Behaviours

BEHAVIOUR	WILLING "BEFORE"	WILLING "AFTER"	DIFFERENCE
Move next door to John	41 (77.35%)	46 (86.79%)	+5 (9.44%)
Spend an evening socialising with John	49 (92.45%)	49 (92.45%)	0
Make friends with John	50 (94.33%)	48 (90.56%)	-2 (-3.77%)
Have John start working closely with on a job	42 (79.24%)	44 (83.01%)	+2 (+3.77%)
Have John marry into your family	35 (66.03%)	38 (71.69%)	+3 (5.66%)
Total responses	**217 (81.88%)**	**225 (84.90%)**	**+8 (3.02%)**

The only area that saw a decline was "willing to make friends with John" although this still remained the second-highest-ranking category at 90.56%, following "spend an evening socialising with John" at 92.45%. The lowest-ranking score was for "have John marry into the family" at 71.69%.

LIMITATIONS

The vignettes and surveys were limited in their ability to reflect the complexity of people's lives and individual variations (Hughes, 1998; Leighton, 2010). The surveys and vignettes were originally designed for general population surveys and for use across different disciplines. If they were designed specifically for social work, the language used would reflect the discipline more. It is possible that the responses were subject to social desirability bias in relation to what students thought was acceptable within the social work profession rather than reporting on their actual views and beliefs.

DISCUSSION

The study results indicate that there is an increase in knowledge and skills, and a decrease in stigmatising attitudes and beliefs, for depression and suicidal ideation in social work students following completion of mental health literacy studies. These findings are consistent with research on medicine and nursing (Bond, Jorm, Kitchener, & Reavley, 2015), pharmacy (O'Reilly, Bell, Kelly, & Chen, 2011) and teacher education (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). It is understandable that students are still forming their own views and/or have pre-conceived ideas from their own experiences and that this course contributes to them developing their views and opinions. However, it is concerning that a small number of participants, on completion of the mental health literacy course, held the unsafe view that it was appropriate to leave a person who is unconscious and lying on their back after taking drugs. In order to successfully complete the course, all participants had to demonstrate the recovery position by rolling an unconscious person onto their side, with the dangers of leaving them on their back clearly explained.

A main challenge for educators is to ensure that studies in mental health literacy are directly relevant to social work practice and address both the personal and political aspects of social work practice in mental health (Bland, Renouf, & Tullgren, 2015; McFarlane, 2009). This content needs to be taught at an appropriate level and, as foundational material, is potentially best located in the early years of study. The findings reveal relatively low levels of stigma in the study population, with reductions following mental literacy studies. The highest level recorded was 28.31% for respondents' lack of willingness to have a person with depression and suicidal ideation marry into their family. The focus of critical theory, and in particular structural theory, on integrating anti-discriminatory practises into our daily lives by challenging oppression, is a useful reminder for students to not create a professional gaze that differs from their personal lives (Mullaly, 2010). The study findings give rise to the question of the extent to which stigmatising attitudes and beliefs are acceptable in the classroom, given the devastating effects stigma has on those who use mental health services, particularly if it is inflicted by the service provider (Mental Health Council of Australia, 2005, 2011; Wang, Smith, & Locke, 2014). This has considerable implications for social work education in mental health as well as gatekeeping roles for those students who persist with harmful attitudes and beliefs. The findings also suggests that changes in teaching practices are required that incorporate an increased focus on stigma in relation to depression and suicidal ideation in accordance with the recommendation of the Mental Health Commission of Canada (2012). This includes increased consumer teaching in the classroom, personal reflection on own prejudices and use of scenarios that have positive outcomes.

CONCLUSION

Stigma can have devastating effects on people who are diagnosed with mental health problems, particularly when this discrimination is enacted by workers who are entrusted to provide care and support. The current study findings on the mental health literacy of social work students support those of previous research with medicine, nursing, pharmacy and teaching students, indicating that mental health literacy studies lead to increased knowledge and skills and reductions in stigma. The study findings reported in this article illustrate this for the mental health condition of depression and suicidal ideation. This study has shown that stigmatising attitudes and beliefs, while relatively low in prevalence, existed both before and after studies in mental health literacy. The study findings raise the question of what level of stigma, if any, is acceptable within social work education. This has broader implications for service delivery as the stigmatising attitudes and beliefs of a minority of students and workers might deter people from accessing mental health services and thus cause harm. This is an area that warrants closer scrutiny and further research into educational strategies that eliminate harmful prejudices directed toward people experiencing mental health difficulties.

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