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Embedding Mental Health Literacy on Depression and Suicidal Ideation in Social Work Education

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Abstract

Increasingly there is an emphasis on the mental health literacy of the general population as well as the health and human services workforce including social workers. The research reported in this article aimed to understand the mental health literacy rates of social work students in relation to depression and suicidal ideation. Surveys were administered to third year social work students at an Australian university before and after coursework on Youth Mental Health First Aid. Both surveys included identical questions in relation to a vignette of a young man who was experiencing depression and suicidal ideation. The study findings reveal that respondents had high levels of recognition of depression before and after their studies in youth mental health literacy. However, recognition of suicidal ideation was much lower and decreased following studies in youth mental health literacy. The findings highlight the significance of suicidal thoughts for young people experiencing depression and the importance of recognizing this to provide appropriate professional interventions as well acknowledging the importance of informal support from family and friends.

Keywords: Mental health literacy; Youth; Depression; Suicidal ideation; Support.

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Introduction

Mental health literacy is a whole of population approach that aims to increase knowledge and skills in responding to mental health issues and associated crises. The term mental health literacy was originally defined by Anthony Jorm:

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 [1].

The aim of the study presented in this article was to gain an increased knowledge and understanding of social work students' mental health literacy. The research question was: What knowledge and skills do social work students possess for assisting young people with depression and suicidal ideation before and after studies in youth mental health literacy?

The article begins with consideration of the development of mental health issues in young people and in particular depression and suicidal ideation. Vulnerable populations are identified as well as issues for service delivery. This is followed by a description of the methodology and presentation of findings of a comparative study on youth mental health literacy for depression and suicidal ideation. The discussion provides insights into the relationship between depression and suicidal ideation and the significance of support from family and friends.

Mental health literacy

Since 2000, mental health literacy programs, aimed at early intervention, have been developed in 20 countries around the world by Betty Kitchener and Anthony Jorm, the co-founders of Mental Health First Aid Australia. A range of Mental Health First Aid programs are offered locally in Australia aimed at a whole of population approach to mental health education. At the same time these programs are recommended as pre-requisite studies for all workers in the human services including social workers [2]. Versions of the program on offer include Standard, Youth, Teen, Workplace, Vietnamese and Aboriginal and Torres Strait Islander. Programs have also been developed for nursing, medical and pharmacy students, tertiary students and financial counsellors.

The Youth Mental Health First Aid (YMHFA) program was selected by the university where this study was undertaken due to the focus on young people. Topics covered in this program included depression, anxiety, eating disorders, substance use and psychosis. Mental health crises situations included suicidal thoughts and behaviours, deliberate self-harm, panic attacks, traumatic events, severe effects of alcohol or other

drug use, severe psychotic states and aggressive behaviours. The Mental Health First Aid Action Plan includes skills on approaching, assessing and assisting a person experiencing a mental health issue or crisis, listening non-judgmentally, giving support and information and encouraging professional assistance and other supports [2].

The university where this study was conducted decided to focus on youth mental health literacy as young people, between the ages of 16 and 24 years are at greatest risk of developing a mental illness [3]. Mental health literacy courses are considered particularly helpful in developing skills to provide appropriate assistance to suicidal adolescents as well as preparing students for field practicum [4].

Depression, Suicidal Ideation and Young People

One in four young Australians has a mental health condition with one in 16 experiencing depression. In 2014, in Australia there was 2864 deaths by suicide - eight per day [5]. This is an increase of 22% over the decade 2004 to 2014 [6]. In 2015, suicide was the main cause of death for adolescent males (28.6%) and females (33.9%) aged 15 to 19 years, and male (37.9%) and female deaths (31.4%) for 20 to 24 year olds [7]. Suicidal thoughts, known as suicidal ideation are common amongst young people and most do not carry this out. However, a strong association has been found between depression, suicidal thoughts and actual suicide [8].

Main sources of concern for young people arise from managing stress, difficulties with school and/or studies and body image [9]. Populations with increased levels of vulnerability to depression and suicide include Aboriginal and Torres Strait islanders [10], migrants – with higher rates amongst refugees and asylum seekers, young people in rural areas and lesbian, gay bisexual, trans ad gender diverse and intersex people [11]. Research on university students has found that many students experiencing mental health issues do not reveal these to staff due to fear of discrimination in their studies and future employment [12]. In terms of social work education, the Australian Social Work Education Standards (ASWEAS) stipulate core mental health attitudes and values, knowledge and skills to be covered in accredited social work degrees [13]. A basic knowledge of depression is included as a core requirement (ASWEAS Guideline 1.1: 1.2.1 (d)). Suicide is mentioned under skills, "Assess the likelihood of client self-harm, including suicidal risk, and identify appropriate responses" (ASWEAS Guideline 1.1: 1.3 (5)).

National mental health policies and strategies in Australia emphasise prevention and the provision of care in the community, with hospitalisation to be used as a last resort [14,15]. The combination of prevalence of mental health issues and availability of community based care has been found to influence hospitalisation rates in different primary health networks within Australia [16]. The main interventions for depression are support, psycho-therapy including cognitive behaviour therapy and anti-depressants [17]. The majority of care and support is provided by family and friends with social support and social inclusion consistently found to provide a buffer for aspects of stress that lead to depression.

Models for inter-disciplinary collaboration stress the importance of social workers respecting and including family members as part of the team [18,19]. It is important to acknowledge that family and friends may also experience mental health difficulties [20]. High levels of depression have been found amongst carers who are engaged with mental health and child protection services [21] with highest levels of caregiver stress found in young and solo caregivers [22].

In some communities services are not accessed due to shame and stigma with such a strong taboo that the word suicide is often not spoken [23].This may result in help being sought as a last resort and possibly from respected people in the community who may or may not be trained in mental health. For instance, Muslims often seek assistance from a religious leader for mental health issues [24]. While Imams provide much counselling and assistance for mental health issues they are generally not trained to do so [25]. Likewise, Christian clergy, ministers and priests might not have training in mental health. Since 2014, Christian clergy, ministers and priests have been the preferred government providers of pastoral care in Australian schools under the National School Chaplaincy Program replacing psychologists, social workers and counsellors [26]. Schools play a major role in the early detection and first response to mental health difficulties experienced by young people [27,28].

Method

The methodology was designed to answer the research question of: What knowledge and skills do social work students possess for assisting young people with depression and suicidal ideation before and after studies in youth mental health literacy?

Participants

The study participants were enrolled in year 3 at an Australian university in 2016. A total of 99 students were enrolled in the mental health course. The 12 week, face-to-face mental health course started with a foundational mental health literacy component, the YMHFA program that ran over four weeks. All students were invited to participate in a study to compare mental health literacy before and after completion of the YMHFA program. Of the 99 students enrolled, 86 were in attendance at the first YMHFA class and were invited to participate in the study. The study had human research ethics approval from the university where the study was conducted. This required the surveys not be distributed or collected by the researcher who was also the teacher who would be grading the students' work.

Study design

This study follows a previous exploratory study of mental health literacy of year 3 social work students at the same university in 2015 reported elsewhere [29]. In this 2015 study, knowledge and skills in the six mental health conditions, covered in the Youth Mental Health First Aid program, were

investigated before and after studies in youth mental health literacy. This previous exploratory study was limited in terms of small numbers of participants according to each mental health condition and respondents completing surveys on different mental health conditions before and after their mental health studies. Reviewer feedback suggested increased rigour by (1) studying one mental health condition only, (2) all respondents do the same before and after surveys and (3) each participant to be attributed a unique identifier code. In effect this would test the reliability of the 2015 study results according to one mental health condition. The mental health condition chosen for closer investigation was depression with suicidal ideation. This was selected as in the 2015 study this mental health condition showed a slight increase in stigmatising attitudes and beliefs in the after study. This was not the case in the more comprehensive 2016 study with these findings on stigma to be reported elsewhere. This reviewer advice has been followed and implemented in the 2016 study design.

Data collection

The before survey was administered prior to commencement of the first mental health literacy class and the after survey was administered four weeks later following completion of the final mental health literacy class. The surveys, and a letter of invitation to participate, were placed on a table at the front of the classroom for students to collect and return. The researcher, who was also the teacher, was not present to observe who did and did not collect and return the surveys. This was an important ethical consideration to avoid possible bias in the grading of student work. The letter of invitation explained that support was readily available from the teacher for referrals to the university Counselling Service as well as specialist youth and adult mental health and community services. This information was provided to all students regardless of their participation in the survey in acknowledgment that the course content can be distressing for some students.

Students were asked to provide a unique identifier code that maintained the confidentiality of their identity and to indicate yes or no for consent for the survey responses to be used for research purposes. This unique identifier code consisted of the first three letters of the student's surname, the first two letters of their given name followed by date of birth and gender. A sample code of INSOR08061991F was provided. This coding system was adopted as it was recommended for use by the Victorian Department of Health and Human Services for linked data sets. This same process was followed four weeks later after the final class when the after survey was distributed to the 66 students in attendance. A total of 91surveys were completed. Out of this number, only 53 (53.35%) had been completed by the same respondent in the before and after surveys and had provided consent for the survey responses to be used for research purposes. It was only these 53 surveys that were included in the research findings.

Surveys

Both surveys were identical apart from additional questions on socio-demographic information asked in the first survey. These survey questions were the same as those used in the 2015 study. Demographic question were asked on sex, age and first language spoken at home. Additional questions were asked on respondent's awareness and experience of mental health problems in their daily life used previously in the 2015 study and derived from a study of mental health literacy in a workplace setting [30]. Questions were asked on (1) whether or not the person identified as a mental health consumer, carer and/or worker, (2) family experience of mental health issues and (3) provision of assistance to someone experiencing mental health issues. The first three questions allowed for yes or no responses with question 3 also including "don't know". Question 4 had a five point ordinal scale from "not at all" to extremely" with a four point ordinal scale for Question 6 ranging from "not at all" to "a lot". Question 7 on type of help offered allowed for an open text response.

In both the before and after surveys' respondents were presented a vignette to assess recognition of depression with suicidal ideation. This was one of six vignettes used in the 2015 study and was obtained from the 2011 Australian mental health literacy survey [31,32]. Only one vignette for depression and suicidal ideation was selected to allow for a representative comparative sample with all responses to both the before and after surveys in relation to one mental health condition only. The chosen vignette was:

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 [31].

Respondents were asked to comment on (1) what they thought was problematic for John, if anything, (2) whether or not John needed professional assistance and if so what would be potentially helpful or harmful. Open text responses were collated to identify all responses mentioned with additional categories added for each new response. Question 1 allowed for a yes or no response. For questions on helpful and harmful interventions respondents were asked to tick one response only for each statement of helpful, harmful or neither. These statements were grouped according to person, medication and activity.

A further question was asked to assess respondent's spontaneous intentions if John was someone close to them that they genuinely cared about [30]. This question is considered to be a better indicator of help seeking than views on helpfulness of particular interventions [30,31].

As with the vignette, the intentions question also allowed for an open text response.

Data Analysis

The unique identifier codes allowed for comparisons according to individual respondents before and after the survey as well as aggregate numbers for the entire group with numbers and percentages used to report the data. Open text responses to the vignette and intentions questions were coded according to the main concepts identified, with new categories added each time a new concept arose thereby capturing all the responses provided.

Limitations

The vignette and survey questions were limited in the ability to capture the complexities of everyday life due to a lack of contextual information [33,34]. This limitation was addressed by using a vignette and survey questions that had recognised internal validity from use in previous studies [32]. The mental health literacy course content was delivered by the same teacher to all students. This did not allow for a comparison of student responses according to different teacher experiences.

Findings

Thirteen respondents (24.52%) identified as consumers of mental health services. Three respondents (5.66%), including one person who was also a consumer, were carers for a person with a mental health problem. None of the respondents were working as heath service providers. Thirty respondents (56.60%) reported having experienced a mental health problem with 35 (66.03%) having a family member who has experienced a mental illness. As indicated in the before survey findings, respondents were reasonably confident in their ability to help someone with a mental health problem with 25 (47.16%) moderately confident, 15 (28.30%) quite confident, 10 (18.86%) a little bit confident and only three (5.66%) who were not at all confident. No respondents were extremely confident. Forty respondents had contact with a person experiencing a mental health problem within the past six months with 18 having contact with two people, eight with one person, eight with between three and five people and six with between six and 10 people. Thirty-six respondents had offered help with 19 (35.8%) indicating "some", 14 (26.41%) "a little" and 3 (5.66%) "a lot". Main types of assistance provided are presented in Table 1.

Respondents mostly engaged in conversation with the person encouraging them to talk and to assist them to make sense of their situation. Friendship, comfort and emotional support were provided with the person being listened to and told that they are cared for. Respondents were available and checked in on the person, made themselves available and provided advice, information and recommendations of professional assistance with one respondent visiting the person in hospital. Reassurance and encouragement were provided as well as social support and practical assistance that included help with university work, organising and getting to appointments, reminders of social support networks and assistance available, exercise and the importance of talking with others about problems.

Table 1. *Main types of assistance provided (Multiple responses allowed).*

Type of help	No. of responses
Talking/ having a chat/sense making	18
Friendship/family/comfort/emotional support	16
Listening non-judgmentally	12
Being available/checking in/asking if "okay"	11
Advice/ information	11
Encouraging professional assistance	9
Providing reassurance/encouragement	7
Social support – spend time together	9
Practical assistance	5
Hospital visits	1
Total	99

There was a high level of recognition that John was experiencing depression on its own, or combined with something else, for both surveys. In the after survey, there was an increase in the recognition of depression Before: 24 (45.26%); After: 29 (54.71%). However, there was a decline in the identification of depression and suicidal ideation Before: 20 (37.73%); After: 13 (24.52%). The third highest ranking category was depression and anxiety with this declining from five (9.43%) in the before survey to three (5.66%) in the after survey. In the before survey one (1.88%) response was recorded for depression and insomnia, suicidal ideation only and nothing wrong. No responses were recorded for these categories in the after survey. One response only was recorded in the after survey for depression, anxiety and suicidal ideation and depression and psychosis with these not identified in the before survey. There was an increase in no response from 0 in the before survey to four (7.54%) in the after survey.

All respondents to both the before and after surveys thought that John needed professional help with interventions considered to be helpful shown in Table 2A and those deemed harmful presented in Table 2B.

The responses to both the before and after survey were similar across "helpful" people, medications and other interventions. Those considered to most helpful were social workers, counsellors, close family and friends, clinical psychologists, general practitioners and psychiatrists. Anti-depressants were considered the most helpful medication. Other main helpful interventions included counselling, relaxation, physical activity and going out more. These were followed by CBT, reading about self-help, stopping alcohol and psychotherapy.

It was considered most harmful to try and deal with the problem alone followed by clergy, minister or priest and pharmacist. Medications identified as most harmful were tranquilizers, ant-psychotics, pain relievers and sleeping pills. Electro-convulsive therapy and admission to a psychiatric ward were identified as the main harmful interventions by over half of the respondents to both surveys. Drinking to relax was also considered harmful by approximately one quarter of respondents. The spontaneous intentions responses are presented in Table 3.

Table 2A: *"Helpful" interventions for depression with suicidal ideation.*

Interventions	Depression with suicidal ideation	
	Before	After
Person		
General practitioner	46 (86.79%)	46 (86.79%)
Pharmacist	5 (9.43%)	11 (20.75%)
Counsellor	53 (100%)	50 (94.33%)
Social worker	47 (88.67%)	50 (94.33%)
Telephone counselling	48 (90.56%)	49 (92.45%)
Psychiatrist	40 (75.47%)	43 (81.13%)
Clinical psychologist	51 (96.22%)	46 (86.79%)
Close family	49 (92.45%)	49 (92.45%)
Close friends	49 (92.45%)	49 (92.45%)
Naturopath or herbalist	15 (28.30%)	18 (33.96%)
Clergy/minister/priest	11 (20.75%)	16 (30.18%)
Deal with problem alone	7 (13.20%)	4 (7.54%)
Medication		
Vitamins and minerals	26 (49.05%)	20 (37.73%)
St John's wort	8 (15.09%)	9 (16.98%)
Pain relievers	1 (1.88%)	1 (1.88%)
Anti-depressants	40 (75.47%)	45 (84.90%)
Antibiotics	0 (0%)	1 (1.88%)
Sleeping pills	13 (24.52%)	15 (28.30%)
Anti-psychotics	6 (11.32%)	6 (11.32%)
Tranquillizers	4 (7.54%)	5 (9.43%)
Other interventions		
Physical activity	52 (98.11%)	48 (90.56%)
Read about self-help	46 (86.79%)	44 (83.01%)
Going out more	44 (83.01%)	48 (90.56%)
Relaxation	47 (88.67%)	49 (92.45%)
Stop alcohol	37 (69.81%)	38 (71.69%)
Counselling	52 (98.11%)	50 (94.33%)
CBT	40 (75.47%)	45 (84.90%)
Psychotherapy	31 (58.49%)	37 (69.81%)
Hypnosis	16 (30.18%)	10 (18.86%)
Admit to a psych ward	8 (15.09%)	6 (11.32%)
ECT	5 (9.43%)	4 (7.54%)
Drink to relax	10 (18.86%)	8 (15.09%)
Special diet	20 (37.73%)	21 (39.62%)

Table 2B: *"Harmful" interventions for depression with suicidal ideation.*

Interventions	Depression with suicidal ideation	
	Before	After
Person		
General practitioner	1 (1.88%)	1 (1.88%)
Pharmacist	10 (18.86%)	5 (9.43%)
Counsellor	0 (0%)	0 (0%)
Social worker	0 (0%)	0 (0%)
Telephone counselling	0 (0%)	0 (0%)
Psychiatrist	4 (7.54%)	1 (1.88%)
Clinical psychologist	2 (3.77%)	1 (1.88%)
Close family	0 (0%)	0 (0%)
Close friends	0 (0%)	0 (0%)
Naturopath or herbalist	0 (0%)	2 (3.77%)
Clergy/minister/priest	11 (2.75%)	6 (11.32%)
Deal with problem alone	34 (64.15%)	35 (63.03%)
Medication		
Vitamins and minerals	0 (0%)	2 (3.77%)
St John's wort	2 (3.77%)	2 (3.77%)
Pain relievers	25 (47.16%)	26 (49.05%)
Anti-depressants	5 (9.43%)	2 (3.77%)
Antibiotics	18 (33.96%)	13 (24.52%)
Sleeping pills	32 (60.37%)	21 (39.62%)
Anti-psychotics	32 (60.37%)	32 (60.37%)
Tranquillizers	41 (77.35%)	36 (67.92%)
Other interventions		
Physical activity	0 (0%)	0 (0%)
Read about self-help	0 (0%)	1 (1.88%)
Going out more	0 (0%)	0 (0%)
Relaxation	0 (0%)	0 (0%)
Stop alcohol	1 (1.88%)	2 (3.77%)
Counselling	0 (0%)	0 (0%)
CBT	2 (3.77%)	0 (0%)
Psychotherapy	4 (7.54%)	1 (1.88%)
Hypnosis	5 (9.43%)	3 (5.66%)
Admit to a psych ward	30 (56.60%)	28 (52.83)
ECT	36 (67.92%)	32 (60.37%)
Drink to relax	15 (28.30%)	14 (26.41%)
Special diet	2 (3.77%)	6 (11.32%)

In order of priority the three main spontaneous interventions for both surveys were to encourage professional assistance, talking and trying to make sense of what was happening and providing friendship, comfort and emotional support and encouraging family support. These were followed by provision of social support spending time together engaged in activities, being available and checking in on the person.

Table 3: *Spontaneous intentions (Multiple responses allowed).*

Type of help	Before Survey	After Survey
Talking/ having a chat/sense making	23 (49.39%)	27 (50.94%)
Friendship/comfort/emotional/ family support	18 (33.96%)	20 (37.73%)
Listen non-judgmentally	10 (18.86%)	11 (20.75%)
Being available/checking in/ asking if "okay"	16 (30.18%)	11 (20.75%)
Advice/ information	4 (7.54%)	7 (13.20%)
Encourage professional assistance	35 (66.03%)	38 (71.69%)
Providing reassurance/ encouragement	7 (13.20%)	6 (11.32%)
Social support – spend time together	19 (35.84%)	20 (37.73%)
Practical assistance	6 (11.32%)	11 (20.75%)
Total responses	138	151

Discussion

In response to the research question, respondents had a high level of knowledge and skills in relation to depression prior to commencement of youth mental health literacy studies. However, they were far less likely to identify depression and suicidal ideation with this increasing following studies in youth mental health literacy. This was an unexpected finding and reasons for this low rate of declining recognition are

unclear. It is possible that given the scenario included suicidal ideation rather than suicidal intent respondents did not pick up on it or perhaps assessed the risk of suicide as minimal and therefore did not record it [13]. Respondents may have been thinking in terms of diagnostic categories rather than issues more broadly. It is also possible that the taboo associated with suicide prevented students from raising this, particularly if suicide was not assessed as high risk [23]. It is also possible that not enough emphasis was placed suicidal ideation in the teaching of the course. Whatever the reasons, the findings indicate that an increased focus is needed on depression and suicidal ideation in the university where this study was conducted. This is an area for other universities to explore and to perhaps revisit and further develop the practices and approaches they are already adopting for social work education in mental health. It is also an area for better content alignment in the ASWEAS guidelines that currently do not mention suicidal ideation [13].

Respondents had reasonably high levels of general knowledge of mental health gained from experiences personally, and with family and friends, rather than in a worker capacity. Most respondents were providing a range of helpful assistance to these people including talking about difficulties when ready, friendship, comfort, emotional and social support and encouraging support from family and professional assistance that potentially served as a buffer for depression. These responses were very similar to those for the spontaneous intentions question. The main people identified as helpful highlights the importance of inter-disciplinary collaboration that may include involvement of medical practitioners, social workers, counsellors or psychologists, and family and friends as key people.

The study findings identify the different roles and functions provided by family members, friends and workers and how community care can be enhanced when all of these people collaborate [18,19] The type of assistance provided by family and friends, in particular friendship, comfort, emotional and social support and simply being there for the person, cannot be underestimated or replicated by workers. This highlights the importance of including family and friends in intervention planning where appropriate. This is in accordance with the clauses in the mental health legislation on the provision of information to carers by workers when this is required for the care of the person [35]. However, it is also important to note that those providing and receiving care may not formally identify as such, preferring to be recognised in their relational role of mother, partner, friend and so on [36]. The high level of personal and family experience of mental health issues amongst respondents potentially increased their awareness and empathy when faced with others experiencing similar difficulties. For those who were in a role of carer, particularly as a solo young carer, the additional stress is likely to be significant, highlighting the importance of universities recognising, and having the ability to assess, caregiver needs in relation to engagement and performance in studies and to make adequate provisions and allowances [22].

The importance of community support as a preventive factor in mental health hospital admissions cannot be underestimated and was identified as a protective factor in the review of mental health hospital admissions in Australia for the period 2013 to 2014 [16]. Over 50 per cent of respondents indicated that electro convulsive therapy and admission to a psychiatric ward were harmful. It seems that they would therefore be more likely to consider alternatives in the community with hospital only as a last resort. This is consistent with current national mental health policy and strategies [14]. However, it does raise concerns if respondents are not willing to use these services as a last resort due to perceptions of harm and if they cannot guarantee the safety of the person in the community. This is in recognition that most people admitted to in-patient psychiatric units are experiencing mental health issues and are also a risk to themselves or others [16].

The main people identified as harmful, and least likely to be helpful, in the before and after survey findings were "self" in terms of trying to deal with the problem alone and, clergy, minister or priest and pharmacist. The view of a small number of respondents that interventions by clergy, ministers and priests are harmful suggests that these people may not be considered as valuable members of the multidisciplinary team. The reasons informing these responses are not known. For instance, are they based on subjective experiences or perceptions? It is possible that widespread negative public reporting in the media in the period preceding the study on child abuse within the clergy has informed these views. In particular preliminary findings of the Royal Commission into Institutional Responses to Child Sexual Abuse (2013-2017) reveal how institutions including schools and churches have failed to protect children [37]. This potentially has serious implications for access to services in schools where chaplains are now the preferred providers of pastoral care by the federal government under the National School Chaplaincy Program introduced in 2014 [26]. This is particularly concerning as schools are main providers of early intervention mental health services to young people [28]. Young LGBTIQ people and those who are Muslim may not feel comfortable seeking counsel and services from representatives of the Christian faith and might prefer to see workers who are trained in mental health service provision or a religious person from their own faith background and culture [25]. Culturally diverse strategies and interventions must be relevant to diverse contexts, cultures and identities [38].

Issues are raised for social work professional practice if students graduate with misinformed views such as "it is helpful for a person who is experiencing depression and suicidal ideation "to deal with the problem alone" and/or" to drink alcohol to relax". Even though these views are in a small minority they are still concerning particularly given that suicide risk increases when a person drinks alcohol alone [39]. It is often argued that students are still forming their views and will correct these prior to commencing employment or on the job. However, there is no guarantee of this hence the importance of social work qualifying programs covering this as essential content.

Conclusion

The study findings investigating mental health literacy of social work students before and after studies in YMHFA, reported in this article, indicate an overall increase in knowledge and skills in relation to depression. It is noted that respondents had high levels of experience of mental health issues personally and with family and friends prior to undertaking the course. Recognition of suicidal ideation was lower following the mental health literacy studies suggesting that this is an area requiring further attention in the delivery of the course, education standards and social work curriculum. Most respondents were providing a range of helpful assistance to family and friends who were experiencing mental health issues and these same interventions were reflected in the responses to the intentions question. This study highlights the important contribution to mental health care provided by family and friends and how this kind of support is very different to interventions provided in a professional capacity. This reinforces the importance of including family and friends, who may or not be officially identified as carers, as key members of the multidisciplinary team. Family and friends are most likely to pick up on early warning signs and encourage the person to seek professional assistance. Harnessing this kind of support is essential to preventing death by suicide of young people experiencing depression and suicidal ideation. All thoughts of suicide must be taken seriously and responded to appropriately with support provided by workers, family and friends. This study highlights the importance of education on depression and suicidal ideation as well as research on how to best harness informal supports in assessment and intervention planning with young people who are depressed and have suicidal thoughts of varying intensity.

Disclosure

No potential conflict of interest was reported by the author.

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