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Reducing Stigma and Improving Mental Health Literacy in the Non-Mental Health Workforce Through an Online University Course

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Abstract

Background: Many workers in non-health settings interact with people with living experiences of mental ill-health but have little knowledge about the symptoms, the mental health system, or may hold stigmatising views. Aims: This study evaluated the impact of an online mental health course. It was hypothesised that an increase in mental health literacy would reduce stigmatising beliefs. Methods: Students were invited to complete an online survey pre- and post-course completion as part of a quasi-experimental study with a pre-test–post-test design. Questions were related to demographic data, knowledge on mental ill-health and mental health care, and beliefs towards mental illness. The independent sample *t*-test, Shapiro–Wilks test for normality, and a Mann–Whitney U-test were used to analyse the data. Results: This study found that there was a significant change, with a large effect size, in self-reported knowledge about mental health and the mental health system. There was a small but significant reduction in Belief Towards Mental Illness scores (rank-biserial correlation = 0.2). The results indicated improved perceptions of those with mental ill-health. Conclusions: A specialised online course can effectively educate the non-clinical community workforce and reduce the stigma associated with mental ill-health. This enables people to assist those experiencing mental health distress from a well-informed and less fearful position.

Keywords: mental health education; stigma; mental health literacy; education; lived and living experience

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1. Introduction

Mental health issues are highly prevalent in communities, affecting an estimated one in every eight people at any given time around the world [1]. The impact of mental health in Australia is even higher than the global average, with estimates suggesting that 42.9% Australians aged 16–85 years old have experienced mental ill-health at some stage in their lifetime and 22% in the previous 12 months, according to the 2020–2022 National Study of Mental Health and Wellbeing (NSMHW) [2].

Quality mental health care for good mental health is a basic human right for everyone [1]. Many stakeholders from a wide range of sectors, aside from mental health

clinicians, are often involved in advocating for and supporting people's mental health. However, people accessing appropriate mental health care to support recovery often meet many barriers at multiple layers of society.

The presence and impact of the stigma of mental illness is well known [3–5]. Stigma is a complex sociological concept that includes self, public, and structural components and remains a major barrier for care seeking and participation by those with mental health issues [3,6,7]. It encompasses incorrect social and cognitive structures, stereotyping, and prejudicial attitudes, which lead to discriminatory behaviours towards a person or group [4,5]. Stigmatising beliefs held by the person (self-stigma) or others (public stigma) [5] can influence whether the person attempts to access, and is directed to receive, the care they need. For example, one Australian survey found that when people incorrectly use terms like 'stress' or 'life problems' to normalise their mental health issues, such as depression, it results in them being less likely to seek help and attempt to manage the problem themselves [8]. Similarly, people with more complex disorders, such as schizophrenia, reported that they avoided accessing health care due to fearfully anticipating how others may respond to their mental health problem. This belief was consistent with the general population, who reported more stigmatising beliefs and reluctance for social interactions with people with these conditions. Conversely, positive reactions from family and friends can act as a buffer against self-stigma [1,6,9].

The extent of Australians experiencing mental health-related stigma and discrimination in 2021 was estimated to be four million people [10]. Surprisingly, this behaviour most commonly came from those close to them, i.e., family, friends, and workplaces. The impact of discrimination from stigma can lead to poor access to mental and physical health care, reduced life expectancy, exclusion from higher education and employment, increased risk of contact with the criminal justice system, victimisation, poverty, and homelessness [11,12]. Stigma is a major hurdle for help-seeking and treatment, exacerbating symptoms, compounding poor health, and declining quality of life [1,6,9,12].

Stigma can be subtle or obvious and explicit (consciously expressed) or implicit (internal beliefs and unconscious biases) [5]. Corrigan and Watson [13] describe three elements of stigma: stereotypes, prejudice, and discrimination. Stereotypes are collectively agreed upon beliefs about groups of people, for example, "people with mental illness are violent". Whilst many people may have knowledge of these stereotypes, they may not necessarily agree with them. Prejudicial attitudes require that they endorse these negative stereotypes and have an affective response, such as a belief that "all persons with mental illness are violent and scare me", which can result in discriminatory behaviours, e.g., "I don't want someone with mental illness as my neighbour".

Various factors can influence stereotypes of mental illness and create significant but often unrecognised barriers to accessing health care [14,15]. Whilst most people can relate to symptoms of depression, the less prevalent and more complex illnesses, such as schizophrenia and personality disorders, are less understood in the community [16]. Since most people do not personally know someone with these complex illnesses, stereotypical ideas of mental illness relating to dangerousness, unpredictability, incompetence, and permanence are commonly held [17]. A lack of understanding, education, and awareness of the wide range of mental illnesses perpetuates negative stereotypes and misinformation [14,15,18]. If the person themself lacks knowledge/understanding of mental ill-health, they may not seek professional assistance [19]. Similarly, family members and professionals who may be first responders or anyone who interacts with the public as part of their work can often have inadequate knowledge or training about mental health and the services available to help support people in need. Some groups, such as emergency service personnel, may base their views on their contact with consumers in emergency situations when the consumer

is severely unwell [11] and apply these views to all people with mental ill-health. Low mental health literacy and prevailing beliefs and attitudes can undermine the values placed on mental health and effective care [1] whereas a better understanding of mental health challenges makes it less likely that negative stereotypes are endorsed [3].

Addressing stigma is a long-term process requiring a focus on dispelling often long-held myths and stereotypes [20]. Anti-stigma strategies fall into three categories: 1. Education to provide facts to dispel myths and misinformation. 2. Contact with people living with mental health conditions to reduce negative attitudes. 3. Protest through formal objections [1]. Not surprisingly, the target groups for stigma interventions have been identified on the basis of either high levels of contact with service users, e.g., health care professionals, people in positions of power, such as police officers, or people with potential for changing the future, e.g., students and young people [11]. To successfully address stigma, however, changes need to occur across various contexts such as government policy, health systems, homes, schools, and workplaces [7,9].

Education, central in mental health and suicide prevention policies and frameworks, is one key to changing stigmatising paradigms and behaviours for individuals seeking care and caregivers [7,9]. Education on mental health can improve knowledge and skills to help with the recognition of when a problem is developing and improve help-seeking behaviour [7,9,16,17]. A systematic review conducted by Waqas et al. (2020) [21] found 44 randomised control trials that investigated the effectiveness of anti-stigma interventions used in educational institutes to improve knowledge, attitudes, and beliefs regarding mental health among students. Only five were in non-psychology undergraduate or adult school settings. A mixture of interventions was used, and most were "somewhat successful in reducing both self and public stigma" [21], p. 898. A review of Australian initiatives to reduce stigma also found education and contact with a person with mental illness to be effective [17]. There are no studies to date that have examined the impact of online education courses and a co-production approach on student knowledge and stigma beliefs.

1.1. Background and Context

Australian Federal Government funding in 2020 enabled Monash University to develop a new fit-for-purpose online university certificate course on mental health for the non-mental health workforce. The small multi-disciplinary teaching team consisted of two mental health nurses and psychiatrist, psychologist, occupational therapist, social worker, and consumer and carer lived-experience consultants.

The course for a non-clinical student cohort introduced concepts of mental health and mental health issues, the Australian mental health services, current models of care, and recovery-oriented practices. The aim was to ensure that students were better informed in their daily lives or work when they interact with people with mental health problems [17]. A co-production process [22] involving consumers and carers was undertaken from the initial curriculum development of the four online units to the delivery of the content. Teaching formats included recorded online fireside chats encompassing myth-busting themes between consumer and carer consultants, and Question and Answer panel webinars with consumers, carers, and clinicians. These initiatives ensured that the lived-experience perspectives were embedded in the course content. Students completed written summative assessments in the form of multiple-choice or short-answer questions, with a minimum of 50% for each unit required to pass the course. The first intake of students occurred in Semester 1, 2021.

1.2. Aim

The overarching aim of the current study was to examine changes in student knowledge and perceptions towards those with mental health issues prior to commencement of and post-completion of the undergraduate certificate.

It was hypothesised that there would be a positive change in knowledge of mental health issues and challenges. Additionally, it was hypothesised that there would be a positive difference in beliefs towards mental health issues, as measured by the Belief Towards Mental Illness scale [23] (BTMI), between participants pre-completion and post-completion of the course.

2. Materials and Methods

The study undertook a mixed-method cohort approach using a combination of targeted questions to capture demographic data and current knowledge, along with a validated measure of stigmatising Beliefs Towards Mental Illness (BTMI). The quasi-experimental design used quantitative data pre- and post-course completion. Focus groups for qualitative data were conducted only after course completion. This paper focuses on the quantitative outcome measures, with the qualitative results being reported elsewhere. Ethical approval was obtained from the Monash University Human Research Ethics Committee (Project ID: 29188). The participants were asked to give consent for their data to be used in the research in the explanatory statement.

2.1. Participants

Participants for this study were students enrolled in a 1-year, 4-unit, online university certificate course in mental health in 2021 and 2022. All those enrolled in the course (N = 1505) were potentially eligible to participate. The four units were mental health essentials, contexts for mental health care, concepts in mental health care, and recovery orientation in mental health.

The course was completely online with predominantly scheduled asynchronous content and optional synchronous webinars. The weekly schedule consisted of online teaching materials and online discussion forums where students were asked to respond to specific questions of a reflective nature. Regular live online sessions enabled students to clarify issues regarding the content or assessments. Live webinars were also organised and recorded so students could watch them in their own time if they were not able to attend in person.

Students engaged in the course came from a diverse range of employment settings and were typically not from the specialist mental health workforce. These included paramedics, police, youth workers, and teachers. The minimum educational prerequisite was completion of secondary school studies.

2.2. Procedure

Only students who successfully completed the course were eligible to participate in the study, but there was no minimum attendance rate to be eligible to participate in the study survey. All eligible students were sent an email via Qualtrics to their student email address. The email included a link to the survey with instructions to read the explanatory statement prior to completing the survey. Consent was implied via its completion. Participants could opt out of the survey by closing their browser, and therefore, their data would not be included. The researchers were unable to gather this data. No identifying information on the individual was collected to ensure anonymity and confidentiality. It was not possible for participants to withdraw from the study once the survey was submitted, since it was not possible to link the participant to the data. Survey data was collected at two time points: commencement of the course and again within one year of completion of the course. Data

was aggregated for analysis, and there was no missing data other than what is indicated in the results below. At completion of the two time-points, data was downloaded for analysis by the research team. An analysis was conducted using SPSS 29, IBM Corp., Armonk, NY, USA). Independent sample *t*-tests were conducted for the pre- and post-custom survey data. The Mann–Whitney U-test was used for the BTMI measure due to assumptions of normality being violated.

2.3. Measures

The pre- and post-survey consisted of four components, which included some custom questions and a standard scale (Supplementary File S1)

Part 1 consisted of demographic questions such as age, gender, highest level of education, and ethnicity.

Part 2 consisted of 10 course-related questions, such as reasons for enrolment.

Part 3 consisted of 5 questions asking students to rate their perceived knowledge of areas such as mental illness, mental health systems, and the term lived experience. Questions were rated on a Likert scale with 6 responses from 1 = very poor knowledge to 6 = excellent knowledge.

Part 4 included questions from the standardised 'Beliefs Towards Mental Illness (BTMI)' questionnaire [23]. The BTMI was used to measure the level of stigma associated with mental health issues. The BTMI consists of 21 items with a 6-point Likert scale ranging from 0 = completely disagree to 5 = completely agree, with higher scores reflecting more negative stereotypical views of mental illness. The original authors categorised the 21 items into 3 factors—Factor 1 = dangerousness, Factor 2 = poor social and interpersonal skills, and Factor 3 = incurability. Example items include 'A mentally ill person is more likely to harm others than a normal person' (Factor 1), 'A person with a psychological disorder should have a job with minor responsibilities' (Factor 2), and 'Psychological disorders are unlikely to be cured regardless of treatment' (Factor 3). The original study [23] reported moderate-to-good alphas for three factors (α 0.74 to α 0.85).

2.4. Patient and Public Involvement

The authors would like to thank and acknowledge the consumers with lived experience, carers, and mental health care staff who participated in this project. This paper was written by consumers, carers, staff, and academics who were involved in the delivery of this education programme.

3. Results

3.1. Demographic Data

Table 1 shows the survey response rates. Analysis showed that some of the data was missing completely at random (MCAR) as evidenced in the custom-measured *t*-test data showing 230 complete responses at commencement and 222 complete responses at completion of the course. Similarly, completion of the BTMI indicated a response rate of 212 at commencement and 195 at completion of the course, and appropriate adjustments were made to account for the missing data. Table 2 shows the demographic overview of participants. The majority of the students identified themselves as female, Australian, were over 25 years of age, and were employed full-time. Most were based in the state where Monash University has its main campus. Over half had a tertiary qualification (Table 2).

Table 1. Survey response rate.

	Number invited to Participate at Course Entry	Number responded to Entry Survey	Number invited to Participate at Course Exit	Number responded to Exit Survey
2021	1320	234 (18%)	906	202 (22%)
2022	185	22 (12%)	158	27 (17%)
Total	1505	256 (17%)	1064	229 (22%)
		230(15%) *		222 (21%) *
		212 (BTMI, 14%) *		195 (BTMI, 18%) *

* complete responses included in analysis.

Table 2. Student demographic data.

Gender	Pre-Commencement %	Post-Completion %
Male	30%	34%
Female	67%	65%
Non-binary	2%	1%
Prefer not to say	1%	0%
Age Range		
18–25	5%	4%
26–35	27%	29%
36–45	28%	30%
46–55	30%	26%
55 and over	10%	11%
State		
ACT	0%	0%
South Australia	1.5%	1.5%
Victoria	85%	91.5%
Western Australia	0%	1.5%
Tasmania	0%	0%
Northern Territory	0.5% (1 person)	0.5%
Queensland	10%	3%
New South Wales	3%	2%
Highest Qualification		
High School Graduate	12%	8%
Trade/Technical/Vocational training	5%	5%
College certificate	4%	1.5%
Diploma	27%	35%
Bachelor's degree	40%	35%
Post Graduate Master's degree	11%	15%
PhD	1%	0.5%
Employment Status		
Employed full-time	79%	83%
Employed part-time	11%	13%
Unemployed (looking for work)	1%	0.5%
Unemployed (not looking for work)	1%	0%
Retired	1%	0.5%
Student	1%	0%
Casual employment	6%	3%

Any changes in knowledge, as measured by our customised questions, were normally distributed and analysed using an independent sample *t*-test to examine any change in student knowledge pre- and post-course completion (Table 3).

Table 3. Independent sample *t*-test showing change in student knowledge pre- and post-course completion.

Pre- and Post-Course Survey Questions	Pre (N = 230)		Post (N = 222)		*p*	Cohen's *d*
	M	SD	M	SD		
Please rate your current knowledge on mental health issues and challenges, i.e., what symptoms do people living with depression have? What is the experience of someone living with schizophrenia?	3.76	0.98	4.56	0.83	<0.001	0.88
Please rate your current knowledge of what the term lived experience means.	4.42	1.05	5.11	0.79	<0.001	0.75
Please rate your current knowledge of mental health care system and policy.	3.37	1.04	4.29	0.83	<0.001	0.97
Please rate your current knowledge on the role of different health care professionals working in mental health, i.e., case managers, mental health nurses, occupational health, psychiatrists, psychologists, and social workers.	3.64	1.03	4.61	0.78	<0.001	1.06
Please rate your current knowledge on how to assist someone at work who you know who is having mental health issues or challenges.	3.92	0.97	4.66	0.76	<0.001	0.85

Survey responses—1: very poor, 2: poor, 3: fair, 4: good, 5: very good, and 6: excellent.

3.2. Knowledge

There was a significant change in knowledge for participants after the course. Cohen's d indicated that the effect size from this change was large to very large. The student's baseline knowledge mean was self-rated as "fair" in the pre-survey and improved to "good" or "very good" in the post-survey. The largest shift was in knowledge of the role of different health care professionals and current knowledge on the mental health care system and policy (Supplementary File S2).

3.3. Stigma Beliefs Towards Mental Illness (BTMI)

Due to the data having a non-normal distribution, a Mann–Whitney U test was conducted to investigate the difference in Belief Towards Mental Illness (BTMI) scores between student pre-course attendance (n = 212, median = 32.42, IQR = 15) compared to post-course attendance (n = 195, median = 25, IQR = 17). In the first instance, a Shapiro–Wilk normality test was conducted, revealing that the data were non-normally distributed, justifying the Mann–Whitney test. The test results were statistically significant (U = 15,230.5, $p \leq 0.001$), suggesting a difference in Belief Towards Mental Illness scores between the pre-course attendance students and the post-course attendance students. The rank-biserial correlation, as a measure of effect size, was found to be 0.2, indicating a small-to-moderate effect size. It was concluded that following the course, students had lower BTMI scores compared to at the commencement of the course, suggesting a reduction in negative beliefs towards mental illness. The BTMI scores prior to the start of the course were in the lower end (median = 32.42 from a potential maximum score of 105), which indicated that they did not endorse a high level of stigmatising views.

To assess the significance of changes in three factors (dangerousness, poor social and interpersonal skills, and incurability), a series of Mann–Whitney U tests were performed (Table 4). The Shapiro–Wilk normality test indicated that the data were non-normally distributed.

Table 4. Beliefs Towards Mental Illness Mann–Whitney U test showing changes in the 3 factors of BTMI scores pre-and post-course.

Factor	Pre-Course	Post-Course	Significance and Effect Size
1. Dangerousness	n = 212, median = 11, IQR = 7	n =195, median = 9.6, IQR = 8)	U = 15,133.500, $p < 0.001$ ES = 0.23
2. Poor Social and interpersonal skills	n = 212, median = 11, IQR = 7	n = 195, median = 10, IQR = 8	U = 17,119.500, $p = 0.003$ ES = 0.14
3. Incurability	n = 212, median = 14, IQR = 6	n = 195, median = 11, IQR = 8	U = 15,695.000, $p \leq 0.001$ ES = 0.21

For Factor 1, which examines perceptions of dangerousness, the Mann–Whitney U test compared pre-attendance (n = 212, median = 11, IQR = 7) and post-attendance (n = 195, median = 9.67, IQR = 8) scores. The results were significant (U = 15,133.500, $p < 0.001$), indicating a statistically significant change in perceived dangerousness. The effect size was small.

For Factor 2, which examines perceptions of poor social and interpersonal skills, the Mann–Whitney U test compared pre-attendance (n = 212, median = 11, IQR = 7) and post-attendance (n = 195, median = 10, IQR = 8) scores. The test results were significant (U = 17,119.500, $p = 0.003$), indicating a significant change in perceptions of poor social and interpersonal skills. The effect size was very small (0.14).

For Factor 3, which examines perceptions of incurability, the Mann–Whitney U test compared pre-attendance (n = 212, median = 14, IQR = 6) and post-attendance (n = 195, median = 11, IQR = 8) scores. The test results were significant (U = 15,695.000, $p \leq 0.001$), indicating a small, significant change in perceptions of incurability.

4. Discussion

The aim of the current study was to examine any change in self-reported student knowledge and stigmatising attitudes towards those with mental health issues pre- and post-completion of an online mental health course undertaken over one year. The hypotheses were supported, with participants showing a significantly large change in knowledge of mental health issues. These findings reflect some of the findings of Wong et al. [24], who provided a 12-week face-to-face mental health course to undergraduate students in Hong Kong. In that study, three questionnaires were used to measure students' knowledge about mental health, attitudes towards people with mental health issues, and reported and intended behaviours towards those with symptoms of mental illness. The 49 students who completed both the pre- and post-surveys reported improvements in knowledge but no change in their attitudes or intended behaviour towards people with mental health issues. In contrast, the current study found a positive change in both knowledge and attitude. The different findings may be due to our study having a larger sample size, different content and teaching format, longer course duration, and cultural context.

Randomised controlled trials of educational interventions have demonstrated small-to-medium reductions in stigmatising attitudes [17]. The educational programmes in the 10 studies included in Morgan et al.'s [17] paper were all targeted to schizophrenia or psychosis and ranged in duration from 11 min to 85 h, with a median duration of four hours. The results of the BTMI in the current study also indicated a small but significant reduction in stigmatising beliefs towards those with mental health issues across all three factors. Of the three factors, the effect size was most significant for perceptions of dangerousness and incurability. Although the significant changes had a small effect size, this was not surprising

given that the students ratedendorsing stigmatising views on the lower end at the start of the course. This is consistent with studies that have found mental health literacy to be a predictor of beliefs toward mental health in several groups, such as academic teaching staff [25].

The wider community, which includes family members and employers of consumers and health care staff, has been identified as a population for further stigma intervention research [26]. An important aspect of this current study is that the students came from a variety of backgrounds, many of whom did not directly work in mental health care but may have been involved more broadly with people with mental health issues in their work, such as police and paramedics. Many students had higher degree qualifications, and their low BMTI scores indicated that they did not hold a high level of stigma beliefs at the start of the course. Despite this, the students still reported an increase in knowledge, and there was still a reduction in stigma beliefs.

Various factors may have contributed to the positive changes observed. Firstly, this course was delivered asynchronously online, enabling delivery to a wider audience across Australia. This mode of delivery enabled students, who were mainly of mature age and working, to access the content in their own time. Secondly, the course format may have contributed to positive change. Morgan et al.'s [17]) review of randomised control trials of interventions to reduce stigma in Australia found that education and contact were effective and complementary in reducing stigma. The educational content corrected misunderstandings, whilst the lived-experience stories added human aspects, making the impact of living with a mental illness more tangible. Our course contained both these components together with some of the key ingredients of anti-stigma programmes, e.g., multiple forms of contact and a focus on recovery [11]. The personal testimonies, delivered in multiple formats and points of social contact, together with interactive engagement in myth-busting, were led by team members with lived experiences of mental illness and carers. Additionally, one unit was dedicated to the concept of recovery, including the challenges and approaches that support recovery.

A strength of our course was the employment of non-academic consumers and carers as regular equal collaborators. As valued members of the education team, their contributions were integrated throughout curricula and topic design, content development, and delivery, aligning with the course learning requirements. Earlier studies have shown that innovative collaborations with consumers and carers enrich learning outcomes [17,27,28]). Using consumer and carers' reality helps address stigma, increase understanding and knowledge of mental health, mental health care, the mental health system, and recovery. As the value of lived-experience collaborations grows in educational settings, so also grows awareness of the need to provide appropriate support for potential unintended consequences of emotional labour, where team members are opening up and retelling painful experiences [29]. This course provided support for advancing co-production initiatives where team members with different expertise worked collaboratively from the outset, a key lesson for education programmes within the mental health context [22].

Limitations

We acknowledge that the findings may not be generalisable across the broader community. The sample was predominantly female, highly educated, mostly located in Victoria, and included people who had agreed to participate. Nevertheless, it is still a large cohort of participants.

The students had chosen to undertake this course and therefore may be predicted to be more open to learning and changing their attitudes. The BTMI had a significant result but a small effect size since the scores were low at the start of the course, suggesting a potential

floor effect. Knowledge changes were only self-reported; therefore, the causal association between knowledge and stigma belief change can only be hypothesised. Objective testing of pre- and post-course knowledge would be needed for a more conclusive association.

Future studies could consider a randomised control trial or propensity-matched study, a matched pair design for pre- and post-data collection, or a waitlist control to enable a more robust data analysis, reduce potential bias, and enhance the causal effect. We acknowledge that another limitation was that we gathered the total student sample over time and did not monitor for the effect of the course over time. Future research could investigate changes across multiple cohorts.

There were many elements of the course that could have contributed to the changes observed. Further in-depth analysis of the qualitative data, which was collected but not reported here, may provide more insight into this. The qualitative results will be reported elsewhere and beyond the scope of this paper due to the large volume of qualitative data collected. This study did not collect any quantitative data beyond 12 months post-course completion. Stigma research needs to assess whether changes in attitudes are sustained beyond 12 months and whether courses lead to behavioural changes [17,30]).

This course was not designed to address stigma specifically and may have influenced the magnitude of changes observed. However, the positive outcomes highlight the potential of online courses to reach a large target audience. Further research into the characteristics of educational programmes and the target subpopulation will help advance the field of stigma reduction for sustained benefits for those living with mental illness and the wider community.

5. Conclusions

To our knowledge, this is the first study that has reported on the impact of an online mental health education course in a general community adult student cohort, using a co-production approach. Although the results reflect a positive change in stigma attitudes as measured by the BTMI, this was only a small effect size despite the large gain in self-reported knowledge. There were limitations in the study design and generalisability of the results. However, the results highlight the potential of online courses as a means of change in the wider community and the importance of educating the non-clinical workforce who interact with people living with mental ill-health on mental health issues.

Mental health is essential for social policy and economic development of countries [1]. Building a knowledgeable workforce through providing accessible, evidence-based information on mental health and the mental health care system is vital to confidently respond and care for people experiencing poor mental health. Community leaders and other professionals who regularly interact with people living with mental illness should be mental health-literate [31] A commitment to mental health requires an investment in mental health literacy in order to transform and reshape mental health beliefs in the community.

Anti-stigma education and contact interventions vary in terms of what information they aim to convey, mental health knowledge, or a focus on the rights of people with mental health problems [11]. The current study has shown that an innovative and engaging mental health course, which uses a co-production approach with consumers and carers to provide consistent positive messages around mental health, can improve knowledge and reduce stigmatising beliefs in non-clinical professionals. This has implications for the future of mental health education since it provides evidence that attitudes can be changed when people have access to creative and engaging learning tools. This study also highlights the great interest and importance in learning about mental health amongst other workers outside of the clinical environment.

Supplementary Materials: The following supporting information can be downloaded at https://www.mdpi.com/article/10.3390/psychiatryint6040138/s1, Supplementary File S1: Pre- and post-survey questions; Supplementary File S2: Figure S1: Bar graphs of student knowledge pre- and post-course completion.

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