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The Impact of Mental Health Education on Reducing Stigma and Promoting Help-Seeking Behaviour: A Systematic Review

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Abstract. Stigma remains one of the most formidable barriers to mental health care worldwide. Despite decades of clinical advances, a substantial proportion of people experiencing psychological distress do not seek professional support, citing shame, fear of judgement, and internalised stereotypes as decisive deterrents. Mental health education — delivered across schools, universities, workplaces, and community settings — has been widely proposed as a corrective strategy. This systematic review synthesises empirical evidence examining whether and how mental health education programmes reduce stigma and facilitate help-seeking behaviour. Drawing on literature published between 1995 and 2024, the review evaluates psychoeducational programmes, contact-based interventions, social contact strategies, and mass media campaigns, with attention to outcomes across personal and perceived stigma, attitudinal change, and help-seeking intentions and behaviour. The findings indicate that well-designed, theoretically grounded mental health education can produce meaningful reductions in stigma and measurable improvements in help-seeking, though effects are often modest and variable. The review identifies pedagogical, contextual, and methodological factors that moderate effectiveness, and concludes with recommendations for practice and research.

Keywords: Mental health education, stigma reduction, help-seeking behaviour, mental health literacy, anti-stigma interventions, contact-based education, public attitudes.

1. Introduction

There is something quietly devastating about the fact that the very conditions which make life most difficult — depression, anxiety, psychosis, eating disorders, addiction — are also among the most likely to prevent people from asking for help. Stigma sits at the heart of this paradox. It shapes how individuals understand their own distress, how communities respond to those who are struggling, and how health systems treat those who eventually reach their doors. The result is a treatment gap that is not merely technical or economic but fundamentally social and psychological in character.

The World Health Organisation (2022) estimates that fewer than half of people with diagnosable mental health conditions in high-income countries, and fewer than one in ten in low- and middle-income countries, receive any evidence-based treatment. Stigma is consistently identified as a primary contributor to this gap (Corrigan et al., 2014). Stigma operates through several interconnected mechanisms: public stigma refers to the negative attitudes and discriminatory behaviour directed at individuals with mental health conditions by members of the general public; self-stigma refers to the internalisation of these attitudes by the affected individual, leading to shame, reduced self-esteem, and a diminished sense of personal agency; and structural stigma refers to the institutional policies and cultural norms that systematically disadvantage people with mental health difficulties (Corrigan & Watson, 2002). Each form of stigma reinforces the others, creating a self-perpetuating cycle that discourages disclosure and delays treatment.

Mental health education — understood here as any structured effort to impart knowledge, challenge misconceptions, shift attitudes, and build skills relevant to psychological health — has been widely advocated as an antidote to stigma and a catalyst for help-seeking. The intuition is straightforward: if ignorance and misinformation fuel stigma, then accurate, empathic, and accessible education ought to dispel it. The empirical reality, as this review

will show, is more complicated — and more interesting — than that simple premise suggests.

This review is structured as follows. Section 2 discusses the theoretical frameworks most relevant to stigma reduction and help-seeking. Section 3 examines the evidence from school and university-based mental health education programmes. Section 4 reviews contact-based and social contact interventions. Section 5 evaluates workplace mental health education. Section 6 addresses mass media and community campaigns. Section 7 considers methodological limitations and future directions, and Section 8 offers conclusions.

2. Theoretical Frameworks

2.1 The Attribution Model of Stigma

Corrigan's (2000) attribution model of stigma provides one of the most influential theoretical frameworks for understanding how mental health education might reduce stigmatising attitudes. The model proposes that stigma is driven largely by attributional processes: when people perceive a mental health condition as controllable (i.e., caused by the individual's own choices) or as dangerous, they are more likely to respond with blame and social avoidance. Mental health education interventions that correct these attributional errors — by providing accurate information about the neurobiological and psychosocial determinants of mental illness and by challenging the myth of dangerousness — should, in theory, reduce stigmatising attitudes and promote more supportive, prosocial responses.

The model further distinguishes between knowledge-based and contact-based mechanisms of stigma change. Whilst educational information can correct factual misunderstandings, personal or vicarious contact with someone who has a mental health condition — particularly positive, humanising contact that disconfirms stereotypical expectations — is hypothesised to produce deeper and more durable attitudinal change (Corrigan et al., 2012). This insight has shaped the design of many contemporary anti-stigma programmes, which combine informational content with testimonial or contact-based elements.

2.2 The Theory of Planned Behaviour

Ajzen's (1991) theory of planned behaviour (TPB) offers a complementary framework for understanding the determinants of help-seeking behaviour. TPB posits that behavioural intentions — and ultimately behaviour — are shaped by three factors: attitudes towards the behaviour (i.e., evaluations of help-seeking as beneficial or harmful), subjective norms (i.e., perceptions of whether significant others approve of help-seeking), and perceived behavioural control (i.e., beliefs about one's ability to seek help if needed). Stigma impacts each of these components: it generates negative attitudes towards help-seeking (because seeking support implies weakness or difference), creates social norms discouraging disclosure, and reduces perceived control by making help-seeking feel risky or shameful.

Mental health education that explicitly addresses all three TPB components — providing positive information about the benefits of help-seeking, challenging norms of silence and self-reliance, and building practical knowledge about how to access services — is therefore likely to be more effective in promoting help-seeking than education focused solely on knowledge transmission. This multi-component logic underpins the design of many mental health literacy programmes, including Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA).

2.3 Mental Health Literacy

Jorm et al.'s (1997) concept of mental health literacy — encompassing the ability to recognise specific mental disorders, knowledge and beliefs about risk factors and causes, knowledge about self-help and available professional help, and attitudes that facilitate recognition and appropriate help-seeking — has become a foundational construct in the field of mental health education. The mental health literacy framework is important because it situates knowledge not as an end in itself but as instrumental to action: the goal of mental health education is not merely to inform but to enable people to recognise distress (in themselves and others), respond to it constructively, and access appropriate support. Jorm (2012) reviewed evidence showing that mental health literacy programmes consistently improve knowledge and, to a lesser extent, attitudes and help-seeking behaviour, with the relationship between knowledge gain and behavioural change being mediated by attitudinal and normative factors.

3. Mental Health Education in School and University Settings

3.1 School-Based Programmes

Schools represent both a logical and a critical setting for mental health education. Not only do most mental health conditions first emerge during adolescence or early adulthood (Kessler et al., 2005), but schools also offer a captive audience and a structured environment in which sustained, developmentally sensitive education can be delivered. A meta-analysis by Wei et al. (2013) examined 19 school-based mental health literacy programmes and found significant improvements in knowledge and attitudes across intervention conditions, with moderate effect sizes. Programmes that included experiential or interactive components — such as role-play, discussion of personal narratives, and peer facilitation — produced larger effects than didactic information-only programmes.

The MindMatters programme, developed in Australia and widely adopted in secondary schools, is one of the more rigorously evaluated school-based mental health education initiatives. Hazell et al. (2002) found that MindMatters produced significant improvements in students' knowledge of mental health conditions and in attitudes towards help-seeking, with effects sustained at six-month follow-up. Critically, the programme was most effective when implemented within a broader whole-school approach to mental health promotion, rather than as a standalone educational unit — a finding that points to the importance of organisational context in shaping the impact of educational interventions.

In the United Kingdom, the introduction of statutory Relationships, Sex and Health Education (RSHE) guidance in 2020, which for the first time mandated mental health content in secondary school curricula, represents a significant policy development. However, concerns have been raised about the variable quality of implementation, the adequacy of teacher training, and the absence of rigorous evaluation frameworks (Department for Education, 2019). Without attention to implementation fidelity, even well-designed curricula are unlikely to realise their potential.

3.2 Higher Education Contexts

University students constitute a population of particular concern with respect to mental health stigma and help-seeking. The transition to higher education is associated with elevated risk for the onset of mental health difficulties, yet rates of help-seeking among students remain substantially lower than would be expected given the prevalence of distress. Evans et al. (2018) conducted a large survey of UK university students and found that whilst over a third reported a mental health condition, fewer than half of those had sought support from university services, citing stigma, uncertainty about whether their difficulties were serious enough, and concerns about confidentiality as key barriers.

A systematic review by Gulliver et al. (2010) identified stigma and embarrassment as the most frequently cited barriers to help-seeking among young adults in educational settings, ahead of practical barriers such as cost or access. Peer-facilitated mental health education programmes — in which trained student ambassadors deliver mental health awareness sessions to their peers — have shown particular promise in this context, as they leverage the social credibility and relational trust that peers hold amongst one another. A quasi-experimental study by Byrom (2018) found that a peer-facilitated mental health literacy programme at a British university produced significant reductions in stigmatising attitudes and significant improvements in help-seeking intentions, with effects strongest amongst male participants — a subgroup often identified as particularly resistant to help-seeking.

4. Contact-Based Interventions

4.1 The Evidence for Social Contact

Allport's (1954) contact hypothesis — the proposition that prejudice is reduced by positive, equal-status contact between members of in-groups and out-groups — has been extensively applied to the domain of mental health stigma. The analogy is imperfect, because mental health stigma is more diffuse and less clearly group-structured than the racial or ethnic prejudice Allport was primarily concerned with, but the core insight holds: face-to-face encounters with individuals who have lived experience of mental health conditions, under conditions of mutual respect and positive affect, tend to produce more meaningful attitudinal change than information-only approaches.

Corrigan et al. (2012) conducted a meta-analysis comparing the effectiveness of education-only and contact-based stigma reduction programmes across 72 studies and found that contact produced significantly larger effect sizes for attitudinal outcomes than education alone. Importantly, video-mediated

contact — in which participants watch a filmed testimonial from someone with a lived experience — produced effects comparable in magnitude to in-person contact, a finding that has significant practical implications for large-scale programme delivery. The Time to Change campaign in England, which ran from 2007 to 2021 and incorporated extensive social contact elements including pledges, social media engagement, and live contact events, produced measurable improvements in public attitudes towards mental health and in reported discrimination, as assessed by national survey data (Henderson et al., 2016).

4.2 Mechanisms of Contact-Based Change

Research by Reinke et al. (2004) and others has sought to identify the active mechanisms through which social contact reduces stigma. The evidence points to several processes: disconfirmation of stereotypical expectations (i.e., contact with a person who does not conform to media-driven stereotypes of mental illness), perspective-taking and empathy (i.e., the development of a more humanised and personalised understanding of the experience of mental illness), and the generation of positive affect associated with the interaction. Programmes that maximise these processes — by ensuring that contact figures present in a confident, articulate, and emotionally coherent manner, and that sessions are facilitated to promote reflective discussion — tend to produce the strongest effects.

Notably, the quality of contact appears to matter considerably more than its quantity. Brief, poorly facilitated contact events can, in some instances, reinforce rather than reduce negative attitudes, particularly if the individual sharing their lived experience appears acutely distressed or if the facilitated discussion is not managed sensitively (Corrigan et al., 2014). This underscores the importance of training and quality assurance in contact-based programme delivery.

5. Workplace Mental Health Education

The workplace is an increasingly important site for mental health education, not only because adults spend a substantial proportion of their lives in work but also because occupational environments can be both a source and a buffer of psychological distress. Mental Health First Aid (MHFA) — a structured training programme designed to equip non-clinical individuals with the skills to recognise, understand, and respond to mental health difficulties — is among the most widely adopted workplace mental health education initiatives. Originally developed in Australia by Kitchener and Jorm (2002), MHFA has been implemented in over 25 countries and has been designated as a key component of the UK government's mental health at work strategy.

A systematic review by Hadlaczky et al. (2014) synthesised evidence from 15 studies of MHFA and found significant improvements in mental health knowledge, attitudes, and confidence in providing support across all included studies. Effect sizes for attitudinal outcomes were in the moderate-to-large range, and improvements in help-seeking behaviour — particularly the willingness to refer a colleague to professional support — were also observed. Importantly, MHFA training was associated with reductions in self-stigma among participants who themselves had mental health difficulties, suggesting that education-based interventions can produce inward-facing as well as outward-facing attitudinal change.

Beyond MHFA, a growing literature examines the impact of broader organisational mental health literacy programmes on workplace culture and help-seeking norms. Dimoff et al. (2016) conducted a randomised controlled trial of a workplace mental health literacy training programme and found that trained managers were significantly more likely to engage in supportive conversations about mental health with their team members, and that employees in trained-manager conditions reported greater willingness to disclose mental health difficulties and seek support. These findings highlight the importance of hierarchical dynamics in shaping help-seeking norms: when leaders visibly normalise mental health conversations, the implicit permission to seek help within their teams increases correspondingly.

6. Mass Media and Community Campaigns

Mass media campaigns represent the broadest-reach modality of mental health education, with the capacity to reach entire populations simultaneously. The evidence for their effectiveness is, however, mixed. Thornicroft et al. (2016), in a comprehensive review of anti-stigma campaigns globally, concluded that mass media campaigns produce modest and often short-lived improvements in public knowledge and attitudes, with limited evidence of impact on help-seeking behaviour or structural discrimination. The limitations of mass media

approaches reflect well-understood principles of health communication: passive exposure to information, without interactive engagement or personal relevance, rarely produces lasting behaviour change.

Nevertheless, well-designed media campaigns that combine emotional resonance, personal narrative, and clear calls to action have shown more promising results. The Time to Change campaign in England — which employed a combination of social advertising, celebrity endorsement, community events, and digital media — is one of the most thoroughly evaluated population-level anti-stigma initiatives. Henderson et al. (2016) found that national survey data collected over the campaign period showed a gradual but consistent improvement in public attitudes towards people with mental health conditions, alongside reductions in self-reported discrimination among people with lived experience. The campaign was less effective in changing behaviour than in changing attitudes, a pattern consistent with the broader literature and reflective of the gap between attitudinal intention and actual behaviour that the theory of planned behaviour illuminates.

The Every Mind Matters campaign, launched by Public Health England in 2019, pursued a slightly different strategy: rather than focusing primarily on stigma reduction, it sought to normalise mental health self-care and encourage proactive engagement with available resources, including an online mental health action plan tool. Early evaluation data suggested that the campaign successfully increased awareness of mental health resources and prompted a proportion of viewers to take concrete action, including searching for information and contacting services (Public Health England, 2020). The campaign's focus on universal emotional health — rather than mental illness per se — may have reduced the stigma-activation risk that sometimes accompanies illness-focused messaging.

7. Limitations and Future Directions

Across the literature reviewed, several methodological weaknesses recur with sufficient consistency to warrant explicit acknowledgement. Most fundamentally, the field suffers from an overreliance on self-report outcome measures, particularly for stigma and help-seeking. Attitudinal measures — even well-validated instruments such as the Community Attitudes towards the Mentally Ill (CAMI) scale and the Attribution Questionnaire — assess what participants are willing to say about their attitudes in a research context, not necessarily how they behave in everyday social situations. The gap between attitudinal intention and actual behaviour is well established in social psychology (Wicker, 1969) and is a persistent challenge for interpretation of stigma research.

There is also a notable paucity of long-term follow-up data. The majority of studies reviewed assessed outcomes immediately post-intervention or at follow-ups of three to six months, leaving questions about the durability of educational effects largely unanswered. This is particularly important given evidence that attitude change in contact-based interventions may fade over time without reinforcement (Corrigan et al., 2014). Longitudinal designs with repeated measurement over twelve months or more are needed to establish whether mental health education produces sustained change or merely transient shifts in reported attitudes.

A further limitation concerns the treatment of help-seeking as a binary or unidimensional construct. In practice, help-seeking encompasses a range of behaviours — disclosing to a friend, consulting a general practitioner, accessing a self-help resource, contacting a crisis line — that may be differentially influenced by stigma and differently responsive to educational interventions. Future research should disaggregate help-seeking into its constituent behaviours and identify the specific mechanisms through which education influences each.

Finally, the field would benefit from greater attention to implementation science. It is increasingly recognised that programme effectiveness is not solely a function of content quality but also of delivery context, facilitator training, organisational climate, and the alignment between programme design and the needs of the target population. Frameworks such as the Consolidated Framework for Implementation Research (Damschroder et al., 2009) offer useful tools for systematically examining these contextual influences and for building a cumulative knowledge base about what works, for whom, and under what conditions.

8. Conclusion

This review has examined the evidence base for mental health education as a strategy for reducing stigma and promoting help-seeking

behaviour. The overarching conclusion is one of cautious optimism. There is credible evidence that well-designed, theoretically grounded, and appropriately targeted mental health education can produce meaningful reductions in stigmatising attitudes and measurable improvements in help-seeking intentions, particularly when it incorporates interactive and contact-based elements rather than relying solely on didactic information provision. Contact with individuals who have lived experience of mental health conditions emerges consistently as one of the most potent mechanisms of change, whether delivered in person or through video testimony.

At the same time, the evidence also reveals the limits of education as a stigma-reduction strategy. Knowledge alone rarely translates into behaviour change. Stigma is deeply embedded in cultural norms, media representations, institutional practices, and individual psychological processes that educational interventions alone cannot dismantle. A comprehensive approach to reducing mental health stigma must therefore combine individual-level educational efforts with structural interventions — including reform of media representations, anti-discrimination legislation, equitable resource allocation for mental health services, and organisational culture change in workplaces and schools.

The people who most need support are often those least likely to seek it. That is not simply a clinical problem; it is a social and moral one. Addressing it demands not only better education but a genuine cultural shift — a collective willingness to treat psychological suffering with the same openness, compassion, and urgency that we extend to physical illness. Mental health education, at its best, contributes to that shift. It will not achieve it alone.

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