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Mental Health Awareness, Stigma and Suicidality in A Peri-Urban Community of Nepal

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Abstract

Stigma toward mental health conditions remains widespread globally and in Nepal. Although awareness of mental health is increasing, discrimination and stigma continue across gender, age, education level, and urban or rural settings. This community-based survey aimed to assess awareness of mental health and mental health services, examine stigma-related barriers, and estimate the prevalence of suicide-related experiences in a peri-urban community of Lalitpur district. A total of 221 respondents were selected through convenience sampling and completed a questionnaire covering knowledge of mental health and professionals, barriers to seeking care, community suicide incidents, and respondents' suicidality. The findings showed that 63.3% of respondents were aware of mental health, 81.9% of mental diseases, 61.5% of psychiatrists, and 38% of counseling services. Although 84.9% agreed that mental health professionals should be consulted when needed, 54.8% reported stigma-related barriers to seeking help. Nearly one-fifth (19%) reported suicidal ideation, with higher rates among females. The study concludes that awareness exists, but it is stronger for medication-based treatment than for psychosocial support or counseling. Stigma remains a major obstacle, and suicidality is a significant concern in the community. Further research should assess the national impact of mental health programs and campaigns on mental well-being, level of knowledge and attitudes towards mental health problems and professional support. Likewise, preparedness of local health facilities to offer mental health services for proper diagnosis and treatment of mental health problems can also be studied.

Keywords: community mental health, suicide, mental health knowledge, stigma, mental health services

Introduction

According to the World Health Organization (WHO) nearly 1 in 7 people worldwide, most of them in Low and Middle-Income Countries (LMICs), is living with a mental health condition, with the prevalence increasing the most among young adults aged 20-29 years. It reported that 71% of people with severe mental disorders do not get mental health services while on average less than 2% health budgets in LMICs are allotted for mental health (WHO, 2025). WHO also identifies suicide to be a global public health issue that affects individuals across age groups, sexes and regions. In 2021 it reported that 727, 000 people die by suicide every year, with estimated 20 attempts for each death by suicide. 73% of suicides take place in LMICs (WHO, 2024).

Nepalis have greater risk of experiencing mental health issues due to traumatic experiences of 10 years of armed conflict, devastating 2015 earthquake, COVID-19 pandemic, continuous political instability and greater susceptibility to natural disasters such as earthquake, flood and landslide (Chaulagain, 2025; National Health Research Council [NHRC], 2021). National Mental Health Survey 2020 revealed that 10% of the adult population suffer from mental disorders in their lifetime, with 4.3% currently living with some form of mental disorder. It showed that the 40-49 years age group was found to have the highest lifetime (13.3%) and current prevalence (6.3%) of mental disorders. While males had higher prevalence of lifetime mental disorders (12.4%), females had higher prevalence of current mental disorders (5.1%). 7.2% of the population has suicidality, 6.5% have current suicidal ideations and 1.1% have attempted suicide at some point in their lives. Suicidality was high in the 50-59 years age group and in females. Data collected between April 2009, and March 2020 shows that the average yearly suicide rate in Nepal is 14.8 per 100,000 populations per year (Gurung et al., 2025). In the fiscal year 2023-24, there were 7,194 reported cases in Nepal, where 55.5% male compared to 32.7% female died by suicide (Nepal Police, 2024). The total disease burden of mental disorder in Nepal has increased 3 times more in 2019 than in 1990, with Disability-Adjusted Life Years (DALYs) due to mental health condition caused primarily by major depressive disorders, followed by anxiety disorders, idiopathic developmental intellectual disability, and schizophrenia (Dhungana et al., 2023).

The stigma towards mental health conditions is still widespread across the world, despite their economic standing (Poudel et al., 2024). National mental health survey 2020 reported that among the people suffering from mental health conditions, attitudinal (non-stigma related) barriers were more prevalent than the institutional (non-stigma related) barriers and stigma related barriers. The most reported attitudinal barriers were – wanting to solve the problem on their own (23.5%); thinking the problem would get better by itself (23.5%) and thinking they didn't have a problem (21.6%). The commonly reported institutional (non-stigma related) barrier was not knowing where to get professional help (7.2%) and the most prevalent stigma related barrier was concern about what family might think, say, do or feel (2.5%) (NHRC, 2021). Various studies in Nepal shows that there is awareness on mental illness and mental health, especially in urban communities (Das et al., 2013; Singh et al., 2013; Parajuli et al., 2015; Jha & Mandal, 2021; Karki et al., 2023; Acharya, 2025). However, the findings are mixed in terms of stigma as some studies report presence of stigma related to mental health in the society (Das et al., 2013; Parajuli et al., 2015; Pokhrel & Pokhrel, 2018; Jha & Mandal, 2021) while others report of comparatively less stigma, especially in the urban settings (Singh et al., 2013; Karki et al., 2023). Still other studies showed that the lack of awareness and stigma on mental health is still prevalent regardless of gender, age, education, type of setting (urban/rural), history of mental illness or knowing someone with mental illness (Nepal et al., 2021; Acharya, 2025; Poudel et al., 2024).

Apart from stigma and discrimination being a barrier to seek mental health services, studies have also found personal, societal, financial as well as organizational factors to be the barriers that prevent individuals from using mental health services (Devkota et al., 2021, Luitel et al., 2020, Luitel et al., 2015, Das et al., 2013). Female sex, low economic status, lack of education, burden of household chores, neglect and lack of from family and friends towards the person with mental health issues, inadequate awareness in family and community on mental health and treatment of mental illness, neglect from the community regarding treatment of mental health conditions and perceiving medication as the only treatment for mental health issues have been found to cause barriers in getting mental health

services (Devkota et al., 2021, Luitel et al., 2015). Similarly, poor access to mental health facilities, lack of information and knowledge on availability of mental health services, different modalities for treatment (medication, therapy) for mental health diseases and belief that medication is the only way to treat the mental illnesses has also been identified as barriers to use of mental health services (Devkota et al., 2021, Das et al., 2013). However, support from family members, close acquaintances and neighbors by providing information, helping to reach health facility and access health services, ability to identify signs and symptoms of mental health issues, awareness on consequences of absence of treatment, involvement of Female Community health Volunteers (FCHVs), use of case detection in the community, mobilization of adequately trained psychosocial counselors and financial support for mental health treatment from ward/municipality facilitated the utilization of mental health services (Devkota et al., 2021. Luitel et al., 2020). Along with promoting mental health literacy and reducing stigma and discrimination to develop positive attitude towards mental health and enhance treatment seeking behaviors, effective program and policy implementation is also essential for preparing the health system to lower the ever-increasing burden of mental illnesses (Poudel et al., 2024, Dhungana et al., 2023).

The past two decades showed some development in the matters of mental health in Nepal. First ever National mental health policy was developed in 1996, but it was not implemented and Mental Health Act also never came into existence (Rai et al., 2021). The Ministry of Health and Population (MoHP) developed the Community Mental Health Care Package in 2017 to integrate mental health services into the primary health care system, which has now been replaced by the National Mental Health Care Programme 2022 (MoHP, 2022). Ministry of Health and Planning established Nepal's first and only national suicide prevention helpline 1166 with the assistance of the World Health organization Nepal in collaboration with the Mental Hospital, Lagankhel, as and Transcultural Psychosocial Organization (TPO) Nepal, which has been in operation since May 2021 (WHO, 2022). The government of Nepal has gradually increased the availability of mental health services in the primary and community health care systems; however, accessibility of mental health service alone is not sufficient to increase the help-seeking for mental health issues (Dhungana et al., 2023). Community-level interventions to increase mental health awareness, improving understanding of need for mental health care and minimizing stigma and discrimination related to mental health should be developed for the promotion of mental health and prevention of mental disorders (Dhungana et al., 2023, Luitel et al., 2020).

SOP The National Mental Health Strategy and Action Plan 2020 aimed to integrate the basic mental health service into primary health care service and increase the accessibility of specialized mental health service to the general public through collaboration, coordination and cooperation with various governmental, non-governmental and private sectors. The focus of National Mental Health Care Programme 2022 is to deliver the basic package of mental health services at the Primary Health Care (PHC) level and collaborate with communities through a PHC oriented model of service delivery. The Ministry of Health and Population (MoHP) Nepal has launched a 3 month long Healthy Mind, Healthy life: Mental Health Awareness Campaign from December 10, 2025 with the slogan Mann ko kura garaun (Let's talk about what's in our hearts). The campaign aims to increase awareness, improve access to quality services, and strengthen national commitment in promoting mental well-being across the nation (DevPulse, 2025). Even though the local municipalities in the valley claimed to be unaware of that campaign and cited lack of budget to run it, MoHP-Nepal has been publishing online informative materials in Nepali language for mental health awareness (The Kathmandu Post, 2025, MoHP, 2026). The government still need to allocate substantial budget for mental health, integrate faith and traditional healing systems

into the current health system, build the capacity of available human resources, work to generate and recruit qualified human resources, create safe environment to motivate people to disclose and treat mental illness and extend collaborations with nongovernmental sectors to improve access and service for mental health (Khanal et al., 2023).

Basic Health Service Centers (BHSCs) in different communities in urban settings around July 2023 still lacked service providers who could identify and refer to the cases of mental health issues to specialists. The earlier studies showed that while some people were aware about mental health, others still lacked adequate mental health awareness and that the discrimination and stigma related to mental health was still present in the society (Das et al., 2013; Singh et al., 2013, Parajuli et al., 2015; Pokharel & Pokharel, 2018; NHRC, 2021, Jha & Mandal, 2021; Nepal et al., 2021). A small survey was conducted among the residents of Ward 22, Lalitpur Metropolitan City.

Research Objective

The objective of this study was to assess community awareness of mental health and mental health services, examine stigma-related barriers to seeking mental health care, and identify the prevalence of suicide and suicidal ideation among residents of a peri-urban community in Lalitpur district.

Methodology

Sample Population

The survey sample consisted of residents of Ward no. 22 in Lalitpur Metropolitan City. The participants were selected using a convenience sampling method. A total of 221 residents who were 18 years and above participated in this survey, which was conducted from 24 July to 7 August 2023. The research team obtained approval from the Ward office before carrying out the survey.

The participants were approached based on their ability to respond to the research team. Before beginning they were informed about the subject and purpose of the survey and written consent was acquired for their voluntary participation. In case of the illiterate respondents, they were read out the purpose of the survey and answered any questions they had and after they expressed their willingness for voluntary participation, their thumbprint was taken.

Data Collection Tool

For the survey the research team developed a questionnaire in Nepali language. The questionnaire contained questions related to knowledge of mental health and mental health professionals, barriers and incidents of suicide in the community as well as suicidal behavior of the respondents.

Table 1

Questionnaire Used in The Survey

Knowledge of Mental Health and Professionals					
Have you heard of mental health?	Yes		No		
Have you heard of mental diseases?	Yes		No		
Have you heard of psychiatrists?	Yes		No		
Have you heard about counseling?	Yes		No		
Do you think one needs to visit mental health professionals for mental health related issues?	Yes		No		
Barriers to Seek Mental Health Services					
Reasons for not visiting a professional despite needing help/treatment? (You can choose more than one)	May be labeled crazy	May be called weak	Will feel embarrassed	Family will feel bad	Others (financial, lack of company)

Suicidality		
Have you ever thought of suicide in your life?	Yes	No
Have you made plans on suicide?	Yes	No
Have you made any suicide attempts?	Yes	No

Table 1 shows the questions used in the survey. The first section of the questionnaire covers if the respondents know about mental health, mental diseases, psychiatrists, counseling services and it also takes opinion of respondents if someone with mental health issue needs to visit the related professionals. The second section of the questionnaire is about the why people may not want to get professional service when they require it. The third section is about suicidal ideations, plans and attempts made by the respondents.

Results and Discussion

Let's describe the sample distribution to show that the people in the study reasonably represent the target population as shown in table number 2.

Table 2

Sample Distribution by Age Group, Gender, Marital Status and Education

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Male	102	46.2
	Female	119	53.8
Age Group (Years)	18–24	30	13.6
	25–34	29	13.1
	35–44	53	24.0
	45–54	47	21.3
	55–64	38	17.2
	65 and above	24	10.9
Education Level	Illiterate	46	20.8
	Basic level education or less	78	35.3
	Higher secondary or less	62	28.0
	Bachelor's degree and above	35	15.8
Total		221	100.0

The table above shows that 53.8% are female and 46.2% are male. Age wise the largest number of respondents (24.0%) belong to the 35-44 age group. The respondents with basic level education or less are higher in number at 35.3% than those with other educational qualifications.

Table 3

Knowledge of Mental Health and Mental Health Services

Variables	Awareness of Mental Health and Mental Health Services									
	Aware About Mental Health		Aware about Mental Diseases		Aware About Psychiatrist		Aware About Counseling		Need to Visit Professionals	
	n	%	n	%	n	%	n	%	n	%
Total	140	63.3	181	81.9	136	61.5	84	38.0	186	84.9
Gender										
Male	73	71.6	88	86.3	64	62.7	43	42.2	87	86.1
Female	67	56.3	93	78.2	72	60.5	41	34.5	99	83.9
Age Group										
18-24	23	76.7	24	80.0	19	63.3	14	46.7	23	76.7
25-34	23	79.3	26	89.7	22	75.9	21	72.4	28	96.6
35-44	40	75.5	51	96.2	38	71.7	23	43.4	47	90.4
45-54	25	53.2	38	80.9	27	57.4	14	29.8	41	87.2
55-64	22	57.9	29	76.3	20	52.6	11	28.9	32	86.5
65+	7	29.2	13	54.2	10	41.7	1	4.2	15	62.5
Education										
Illiterate	11	24.4	30	66.7	20	44.4	7	15.6	33	73.3
Basic or less	48	60.8	63	79.7	45	57.0	16	20.3	70	88.6
High Sec or less	50	80.6	53	85.5	40	64.5	32	51.6	51	85.0
Bachelors+	31	88.6	35	100	31	88.6	29	82.9	32	91.4

Table 3 shows that 63.3% are aware about mental health, 81.9% and 61.5% are aware about mental diseases and psychiatrists respectively. Gender wise, more male respondents reported being aware about mental health (71.6%), mental diseases (86.3%), psychiatrists (62.7%) compared to female respondents. Age wise, the majority of the respondents belonging to the 18-44 years age group reported having awareness of mental health, mental disease and psychiatrists in comparison to other age groups. Similarly, most respondents who reported being aware of mental health, mental disease and psychiatrist had more than basic level education.

The data reveals that 38% of the respondents were aware about counseling. More male respondents (42.2%) were aware about counseling in comparison to female respondents (34.5%). The age group with the largest number of respondents (72.4%) who were aware of counseling was the 25-34 years age group. Less than half of the respondents in other age groups reported awareness about the counseling. 82.9% of respondents who had university level education were aware about counseling and 15.6% respondents with no education mentioned being aware about counseling.

Likewise, 84.9% responded that one must visit mental health professionals for mental health related issues. Across the gender, age and education level, more than 60% of the respondents replied positively to seeking help from professionals when needed. 86.1% males responded positively to visiting mental health professionals when and if needed compared to 83.9% females. Many of the respondents in all age groups reported needing to visit a mental health professional when required. More than 70% of people in all categories of education levels replied positively to visiting a professional when faced with mental health issues.

Table 4

Barriers to Seek Mental Health Services

Variables	Barrier to Seek Mental Health Services													
	Total Stigma Barrier		Stigmas								Other (Non-Stigma) Barriers		No Barrier	
			Labeled Crazy		Called Weak		Feel Embarrass		Family Feels Bad					
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Total	121	54.8	49	22.2	18	8.1	31	14.0	53	24.0	68	30.8	100	45.2
Gender														
Male	54	52.9	21	20.6	11	10.8	14	13.7	18	17.6	29	28.4	48	47.1
Female	67	56.3	28	23.5	7	5.9	17	14.3	35	29.4	39	32.8	52	43.7
Age Group														
18-24	15	50.0	6	20.0	3	10.0	4	13.3	4	13.3	11	36.7	15	50.0
25-34	16	55.2	10	34.5	3	10.3	3	10.3	4	13.8	10	34.5	13	44.8
35-44	35	66.0	10	18.9	3	5.7	12	22.6	20	37.7	14	26.4	18	34.0
45-54	31	66.0	13	7.7	3	6.4	6	12.8	18	38.3	12	25.5	16	34.0
55-64	17	44.7	7	18.4	4	10.5	4	10.5	7	18.4	13	34.2	21	55.3
65+	7	29.2	3	12.5	2	8.3	2	8.3	0	0	8	33.3	17	70.8
Education														
Illiterate	18	40.0	6	13.3	2	4.3	3	6.7	10	22.2	14	31.1	27	60.0
Basic or less	40	50.6	18	22.8	3	3.8	10	12.7	19	24.1	32	40.5	39	49.4
High Sec or less	42	67.7	16	25.8	10	16.1	11	17.7	17	27.4	14	22.6	20	32.3
Bachelors+	21	60.0	9	25.7	3	8.6	7	20.0	7	20.0	8	22.9	14	40.0

Table 4 has data on the barriers that prevent people from seeking mental health services. Among the five categories of barriers, 4 of them are related to stigma towards mental health while one of them is non-stigma related. The total stigma barrier column indicates the number of respondents that reported one or more stigma related barriers for seeking service. In the non-stigma related barrier, they have stated financial reasons, lack of person to accompany them, lack of time and knowledge about institutions providing mental health services as the reasons that prevent people from seeking mental health services. 45.2% of the respondents mentioned that if there are issues that need professional help then there will be no barrier to stop a person from taking the service. While 54.8% of respondents chose stigma related barriers, 30.8% of the respondents reported non-stigma related barriers to be the reasons that prevent them to seek support for mental health issues. 70.8% respondents above 65 years of age reported that there will be no barrier to seek mental health services while only 34% of those between 35-44 years and 45-54 years of age reported there will be no barrier. 60% of respondents with no education mentioned there will be no barrier in contrast to 32.3% and 40.0% with Higher secondary or less education and university level education respectively.

10.8% of male responded to the fear of being called weak as a barrier to seek mental health services compared to 5.8% female. Only 17.6% male reported that worry about family feeling bad

could prevent a person to seek support in contrast to 28.4% female. 32.8% female reported non-stigma barriers compared to 28.4% male. The groups with the highest number of respondents who reported non-stigma barriers are 18-24 age group (36.7%) and those with basic or less education level (40.5%). Among the stigma related barriers, fear of being labeled crazy (22.2%) and family feeling bad (24.0%) are the ones that have been reported by a higher number of respondents.

Table 5

Suicidal Ideation, Plan and Attempts

Variables	Suicidal Behavior in the Community					
	Suicidal Thoughts in Lifetime		Planned Suicide		Attempted Suicide	
	n	%	n	%	n	%
Total	42	19.0	14	6.3	5	2.3
Gender						
Male	12	11.8	6	5.9	3	2.9
Female	30	25.2	8	6.7	5	4.2
Age Group						
18-24	9	30.0	4	13.3	3	10.0
25-34	9	31.0	1	3.4	1	3.4
35-44	9	17.0	4	7.5	2	3.8
45-54	10	21.3	3	6.4	2	4.2
55-64	4	10.5	2	5.3	0	0
65+	1	4.2	0	0	0	0
Education						
Illiterate	1	2.2	1	2.2	0	0
Basic or less	22	28.2	7	9.0	4	5.1
High Sec or less	16	25.8	6	9.7	4	6.5
Bachelors+	3	8.6	0	0	0	0

Table 5 shows that more than around 60% of the respondents know about incidents of suicide in the community. This number is consistent across gender, age and education level except for 65+ age group where only around 40% reported hearing about people dying by suicide in their community. 19% of the respondents reported ever having suicidal ideation with higher number of females (25.2%) having suicidal thoughts compared to males (11.87%). The suicidal ideation was highest in 25-34 age group (31.0%) and 18-24 age group (30.0%) and lowest in 65+ age group (4.2%). Similarly, those with basic level or less education (28.2%) are the large number of respondents who reported having suicidal ideation while those with no education (2.2%) are smallest number of respondents to ever have suicidal ideation in their lives.

The data shows 6.3% of people have planned committing suicide with 6.7% female having planned compared to 5.9% male. The highest number of respondents in 18-24 years age group (13.3%) reported having planned their suicide while no one in 65+ age group reported so. 2.3% of

the respondents have attempted suicide with more females (4.2%) having done so than males (2.9%). 10% of respondents in 18-24 age group were found to have attempted suicide, the highest proportion across the age group while no one belonging to 55-64 and 65+ age group reported having done so. The ones with basic or less education (5.1%) and higher secondary or less education (6.5%) had attempted suicide, while no one with no education and with university level education had attempted suicide.

The findings suggest that the majority of the respondents are aware about mental health, psychiatrists and that they need professional help for support. The study also revealed that mental health related stigma as well as suicidality is pervasive in the community.

The result shows that the community residents are aware of mental health, its services and seeking help from the professionals when required. However, they seem more familiar with medication-based treatment for mental health issues than counseling as a comparatively lesser number of respondents reported being aware of counseling. This is consistent with a study by Devkota et al., (2021), which reported that the knowledge about different modalities of treatment for mental diseases was insufficient and believed medicines to be the one and only treatment available. Gender difference in the awareness was found as more male participants reported to have awareness on mental health, related services and the necessity of getting professional help. Differences in awareness were also noted in terms of age as a larger number of those in young adulthood and early mid-adulthood (18-44 years) were found to be aware of mental health and its services. This finding corresponds with earlier studies which also showed that people have awareness of mental illness and mental health (Das et al., 2013; Singh et al., 2013; Parajuli et al., 2015; Jha & Mandal, 2021; Nepal et al., 2021; Karki et al., 2023; Acharya, 2025). The smaller number of respondents in the 18-24 years age group and those above 65 years of age group reported the need to seek professional help. In regard to awareness about counseling, the majority of the participants in the 25-34 years age group and those with university level education were more aware than those in other groups. The level of education also seemed to be an important factor in awareness of mental health, services and needing to get professional support. The lowest number of respondents who had awareness in the matters of mental health belonged to those with no education while the highest number of respondents with such awareness were those with university level education. This is also supported by other research (Karki et al., 2023; Nepal et al., 2021).

It has been found that mental health related stigma was still prevalent in the society as more than half of the respondents mentioned stigma-related barriers such as being labeled crazy, being called weak, feelings of embarrassment, family feeling bad to be reasons that may prevent a person from seeking mental health services. This finding agrees with other research that also reported on the prevalence of mental health stigma in the community (Jha et al., 2021; Poudel et al., 2024; Acharya, 2025). Respondents with no education and those above 65 years of age were the largest respondents to have reported there would be no barrier if a person really needed to get professional help. These groups of respondents are the ones with the lowest population group with awareness of mental health and related services. Perhaps it is because of less knowledge of mental health, they are reporting there would be no barrier. This is a contradiction to results that showed that knowledge on mental health is positively associated with positive attitude towards mental health (Karki et al., 2023; Nepal et al., 2021). The major stigma was fear of family feeling bad and being labeled crazy. Among the various groups of respondents, females, those in the 25-34 years age group and those with higher secondary or less education level were more concerned about being labeled crazy. Female respondents, 45-54 years age group and those with higher secondary or less education level

reported family's feeling to be a factor that can prevent a person from seeking help. The results indicate respondents were less concerned about being called weak across all variables.

Suicidal ideation was higher in female respondents, 25-34 years age group, and those with basic or less education level. Plans of suicide and attempts of suicide were found to be higher in females, 18-24 years age group and those with higher secondary or less education level. While some findings (Gurung et al., 2025) report higher suicide attempts by male population and by people who are literate but without formal education, NHRC (2021) reported higher suicidal ideation and attempt rates in female and in 40-49 years age group, while WHO (2024) reported higher suicide rates in 25-29 years age group for low and middle-income countries. Those who reported having suicidal ideations were asked about recency, if they were currently getting any professional help and few of them were referred to seeking professional support immediately. Those who reported plans of suicide were also asked about the recency of the plan, but they reported having made such plans more than 2 years ago and not having any plans currently. Some of those respondents also mentioned getting mental health treatment from a psychiatrist. The surveyors made sure that those who had attempted suicide had received mental health support after the incident.

Conclusion

The study shows that despite being aware of mental health and services related to mental health, there is widespread stigma on mental health in the community, regardless of gender, age and education. The rate of suicidal behavior in the community was also found to be of concern. Even though they were aware of psychiatrists, they didn't have sufficient awareness of other modalities of treatment like psychosocial interventions or mental health counseling. In spite of the National Mental Health Care Programme got introduced in 2022, its objectives had not come into effect at the time of this survey as there were no government appointed counselors available at the local levels in the valley at the time of this survey. However, on a positive note, Kathmandu Metropolitan City and Lalitpur Metropolitan City offices have now appointed psychosocial counselors who provide need-based services to the community residents through Primary Health Centers in the municipalities. Future studies can focus on assessing nationwide impact of implementation of National Mental Health Care Program 2022 and recent mental health campaign on the level of knowledge on mental health, various treatment modalities, attitudes towards mental illness and rate of suicide.

Future Research Prospects

National Mental Health Survey 2020 is the only major study that incorporated the representative population from all over Nepal. It might be beneficial to conduct more of such country wide surveys. It is might also be helpful to examine the impact of National Mental Health Care Program 2022 and recent mental health campaign on status of mental well-being, level of knowledge and attitudes towards mental health issues and services. Other significant area of study could be to examine the readiness of health facilities located in communities to provide mental health services, availability of trained staff, adequate physical infrastructures (private rooms for counseling and consultation), clinical as well as policy guidelines and essential skills, tools and medicines for appropriate diagnosis and treatment (Acharya et al., 2025; Devkota et al., 2021).

National Mental Health Survey 2020 is the only major study that incorporated the representative population from all over Nepal. It might be beneficial to conduct more of such country wide surveys. It is might also be helpful to examine the impact of National Mental Health Care Program 2022 and recent mental health campaign on status of mental well-being, level of knowledge and attitudes towards mental health issues and services. Other significant area of study could be

to examine the readiness of health facilities located in communities to provide mental health services, availability of trained staff, adequate physical infrastructures (private rooms for counseling and consultation), clinical as well as policy guidelines and essential skills, tools and medicines for appropriate diagnosis and treatment (Acharya et al., 2025; Devkota et al., 2021).

Future research should move beyond awareness studies to examine how ethical workplace culture, HR practices, and supportive supervision affect employees' mental well being, help seeking, and stigma (Mishra & Aithal, 2023). Comparative studies across sectors and settings are needed to clarify differences in access, attitudes, and service use (Mishra, 2022).

Research should target high risk, labor intensive workplaces—assessing how workplace hazards, safety implementation, and preventive measures influence anxiety, burnout, and distress (Lama et al., 2019; Mishra et al., 2019). Studies should also focus on casual and informal workers in physically demanding, insecure jobs, given links between employment conditions, stress, and support access (Mishra & Shrestha, 2017).

An interdisciplinary agenda connecting mental health with communication, consumer behavior, and social perception would help address stigma and care seeking (Mishra, 2024). Prioritize mixed methods, comparative, and intervention studies that provide evidence for policy, workplace reform, and community support. (Mishra, 2022).

Limitations

This study has several limitations. The sampling method was convenient sampling, which means the sample taken may not have been representative of the larger population. The survey also did not use any standardized questionnaire, the reliability and validity of the questionnaire used was not tested. The questions on awareness of mental health and its services were general and not specific, and it also did not assess the level of awareness.

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