



Social Determinants of Mental Health in People with Disabilities: A Reflective Commentary



Manil Raj Maharjan

Manil Raj Maharjan is the Adjunct Lecturer of Psychology at Tribhuvan University, Saraswati Multiple Campus, Lekhnath Marg, Thamel,

Kathmandu, Nepal. He can be reached at

maharjanmanilraj@gmail.com

ORCID: 0009-0003-6437-962X

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ABSTRACT

Mental health is integral to overall well-being. Approximately 16% of the global population experiences disability, facing higher rates of mental health challenges exacerbated by social determinants such as income disparity, social exclusion, and limited access to education and healthcare. The essay explores these determinants in relation to People with Disabilities (PWDs), highlighting the inadequate mental health services available for this group. Social and cultural stigmas surrounding mental health issues further complicate the situation, leading to discrimination and decreased access to necessary services. The social model of disability underlines that disability results more from structural barriers than individual impairments, suggesting that mental health professionals and policymakers should address these systemic issues. The paper advocates for developing inclusive, accessible mental health resources that consider the unique experiences of PWDs while integrating their voices into policymaking processes. Drawing from personal experience as a PWD and mental health counselor, the author expresses a commitment to improving mental health services for PWDs in Nepal, emphasizing the need for collaboration with government and organizations representing individuals with disabilities. By recognizing and addressing the social determinants affecting PWDs' mental health, the goal is to foster an equitable support system that improves mental well-being and life outcomes for this marginalized group.

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Introduction:

Mental health (MH) is featured as one of the important components of health and well-being, as highlighted in the World Health Organization's (WHO) constitution. The WHO (2022) defines mental health as "a state

of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community." According to an estimate by WHO (2022), about 16% of the world population lives with some form of

disability, and this vulnerable subgroup faces mental health challenges at a higher rate than their non-disabled counterparts (Emerson et al., 2009); this vulnerability increases due to various social factors (Emerson et al., 2009; Honey et al., 2011), including employment status (Milner et al., 2014), financial hardships, and lack of social support (Gannon & Nolan, 2004).

These interconnected issues of mental health and disability capture my attention due to my personal experiences as a person living with vision impairment and my previous work as a mental health counsellor. Unlike the many initiatives to promote the MH status of vulnerable population subgroups like women, children, LGBTQI+, and senior citizens, I observed very limited MH services designated for meeting PWDs' specific challenges and support structures to emphasize social determinants that influence the overall spectrum of their mental well-being.

WHO (2008), in its commission report, has defined these social determinants of health as the “conditions in which people are born, grow, live, work, and age” and claims these determinants to be influenced by the multilevel distribution of money, power, and resources. Needless to say, it becomes quite eminent to consider the social determinants of mental health among PWDs because it is the level of social support and influences of sociocultural factors that determine how empowered and independent someone living with disability feels and actually is.

Against this backdrop, this essay will critically examine three different social determinants, namely income and employment disparity, social exclusion and stigma, and access to education and health services, which have a crucial role to play in shaping the mental health of PWDs; will then highlight a theoretical lens to promote the mental health of PWDs using the social model of disability for health professionals and policymakers; and will conclude by providing a critical reflection on the topic with highlights on my personal aspirations of contributing to the field of mental health of PWDs.

Methodology

As a reflective piece, this essay employs a critical narrative style of presenting ideas, integrates scholarly literature to construct and support the main theme, makes use of the theoretical framework of the social model of disability to support the position, and utilises personal reflections to reiterate the necessity of more comprehensive policy and practice initiatives. The selection of three specific social factors—“income and employment disparity, social exclusion and stigma, and access to education and health services” among several other social determinants as highlighted in WHO’s (2008) list makes more sense for this essay because it is the attainment of basic determinants like good health, education, and employment opportunities as well as the positive social environment where we live that ensures the successful attainment of other determining factors for good health and quality of life. For people with disabilities, who face additional

layers of inaccessibility, injustice, and insufficiency compared to their non-disabled peers, achieving all these social determinants is crucial for improving their overall health and particularly their mental health.

Disparity in Income and Employment

The difference in income and access to employment opportunities can be considered as one of the important social determinants of mental health because fewer employment opportunities mean less income, and little income means more unmet basic and social needs. Poor income means poor access to nutritious food and a healthy lifestyle, which also acts as a push agent to unhealthy practices like alcohol and substance use (Messias et al., 2011). This lack of healthy life options and more exposure to unhealthy practices increase the risk of contracting MH issues.

Low household income and unemployment not only act as risk factors for MH breakdowns but also act as major obstacles in the treatment process because someone with low income who is struggling to meet the basic needs of the family can hardly afford the medicines and psychometric assessments as prescribed by the psychiatrists. Though psychiatric consultation may be free in several countries, especially at the government-owned facilities, the psychotropic medicines generally cost more because it is generally expected to use such medicines for a long period of time to prevent symptom relapse. Moreover, the charges for counselling

and psychotherapy sessions as well as the psychometric assessments are also mostly higher than the psychiatric consultations, be it in developed or developing nations, which then hinder someone with low income or who is unemployed from seeking treatment facilities. This condition applies to all individuals, irrespective of their physical abilities.

However, People with Disabilities (PWDs), who typically lack employment opportunities and work in low-wage jobs (Milner et al., 2014), are particularly vulnerable to the vicious cycle of low income and poor mental health. Unlike their non-disabled peers, most of the PWDs are living on the social benefits from their national governments, and the amount they receive is barely enough to cover their basic living, let alone the coverage of counseling and psychotherapy sessions, a situation that is gloomier in developing nations.

Social exclusion and stigma

Both exclusionary and stigmatizing mindsets and behaviors are quite rampant in our world towards people living with MH disorders, which can be considered another important social determinant. Firstly, there are stigmas around mental disorders that view these conditions as incurable and people experiencing them as dangerous and antisocial. There are other religious and cultural practices where the traditional healers, shamans, and religious preachers, unlike the trained psychiatrists and psychologists, are heavily involved

in treating patients with mental disorders, labelling such illnesses as demonic possession and curses from the almighty.

Some even trivialize the symptoms of mental health illness, as most of the symptoms of mental illness, which are of a neurotic nature, cannot be observed in behaviors, thereby labelling these people as attention-seekers and troublemakers. Consequently, people hesitate to reach out to the MH service providers during the early stages of their illness and talk about their conditions in hush tones within their close circles, which ultimately leads to further exasperation of their condition. Even for those who choose to speak up about their condition, they are treated as different beings in their immediate groups and communities. They are either excessively patronized or completely ignored.

Occasionally, these people are even subjected to discriminatory practices like name-calling and attaching humiliating tags, shunning them from social events, limiting their access to jobs and education, and so on. Now, when PWDs are brought into this equation, they are further subjugated and double marginalized, first for their disability and next for having MH disorders.

Among all the above stigmas and discriminatory practices, PWDs face additional hardships because of their disability and their functional limitation, which can easily lead to their social exclusion, low self-esteem, sense of helplessness,

worthlessness, and hopelessness (Honey et al., 2011). The discrimination they face for having a disability can be a cause of developing MH disorders, whereas the discriminatory practices against MH illness can further prevent them from opening up about their condition to the MH service-providers.

Access to education and health services

Proper access to education and health services serves as an important social determinant of mental health because those with poor access to education and health facilities are usually found to be living with poor mental health outcomes (Compton & Shim, 2015). When people are poorly educated, they lack knowledge about the hazards, risks, and protective factors of MH disorders and, above all, cannot make informed decisions when struck by the psychosocial illness.

Poor access to or absence of education even hinders the capacity of people to be self-aware that they or their near ones are having the symptoms of even the common mental health conditions like depression and anxiety and fail to pay immediate medical attention. Next, the poor access to health services, which is mostly the case in regional areas and even in urban areas due to socioeconomic constraints, will make the situation worse for the survivors of MH conditions and their family members.

These vulnerable people will have their symptoms worsen because they cannot meet the psychiatrists and counsellors on time,

would have to keep using the medicines without tapering their suitable dose, could even have to give up the medicine when the symptoms are fairly getting better, and would have to face the relapse of the symptoms. PWDs are found to be more cut off from education and health services when compared to their non-disabled peers (Reichard et al., 2011; Mithen et al., 2015), and this deprived access has the potential to submerge their MH conditions.

This vulnerable population group is mostly under the care and custodianship of their caretakers and family members, for whom the observable physical health challenges of PWDs usually become the problems to allocate limited resources and attention. Their emotional sufferings often become worse because of their own lack of awareness about the risk factors and symptomology of different MH conditions, as well as their poor access to health service providers and promotional materials owing to their disabilities.

Social Model of Disability and Mental Health of PWDs

The social determinants that shape the mental health of PWDs echo quite closely with the approach highlighted in the social model of disability, a term first coined by Mike Oliver in 1983, which immediately gained prominence in response to the rigid medical model of disability (Oliver, 2018). This paradigm shift in viewing disability makes a clear distinction between impairment and disability, where the former is individual and

private, while the latter is more structural and public (Oliver, 2018), meaning impairment is a product of medical condition, whereas disability is a social product created because of biases and hindrances rampant in the society we live in towards PWDs.

This more humanistic model of disability projects that PWDs are limited in their capabilities and in their daily living mostly because of the barriers they face, which include inaccessible physical infrastructures, fewer opportunities for higher education, poor health outcomes, higher unemployment rates and lower participation in the labor market, negative social attitudes, stigmas and stereotypical thinking, demeaning media representation, and the list goes on, as elucidated by the Australian Federation of Disability Organizations (n.d.).

Considering the core argument of the social model of disability, the mental health status of PWDs also owes more weight to the unequal social conditions in which PWDs live and function rather than the biological risk factors. The genetic predisposition, neurochemical imbalances, and other organic factors undoubtedly play their role in developing early symptoms of mental disorders, which holds true for all populations regardless of their physical abilities, but the symptoms could get worse quite rapidly among PWDs because they are further subjugated due to their disability.

To consider one easy example here, the mental health promotional materials are mostly available in print or in audio/video format,

but someone with impaired vision using Braille or someone with hearing impairment using Auslan and video captions cannot have access to those health promotional materials at all, and their condition can worsen as they fail to recognize their problems as the actual problem. This is just one example of how a disability can hinder someone's ability to access mental health services, not due to their unwillingness or incapacity, but due to the strong communication barrier our society has established between individuals with and without disabilities.

Putting theory into practice, mental health workers and policymakers who either work directly in the field or indirectly by designing policies and mental health promotional strategies should adopt the proposition made by the social model of disability. They should be able to see PWDs with mental health conditions not as another individual with MH conditions, but with distinct sociocultural risk factors that have led to the onset of those conditions or served as the precipitating and maintaining factors for those conditions. As already pointed out in the social determinants section, these health workers and policymakers should focus on the educational gap, health inequities, higher unemployment, and lower workplace participation rates to make their practice and policy more disability- friendly and to make sure that they are not just addressing the causes of mental health disorders but are also addressing the causes of the causes so that the results can be more sustainable and durable.

For example, it is undoubtedly essential to

address the disability- specific barriers when designing and disseminating mental health promotional materials; however, it is equally important to ensure that the promotional content is suitable for uneducated persons with disabilities (PWDs), for individuals living with intellectual disabilities who may find complex messaging and medical terminology confusing, and to determine whether the proposed program is affordable for unemployed PWDs who have limited access to social benefits. In addition, as the motto "Nothing about us, without us" from the United Nations' (2004) observance of International Day of Disabled Persons proclaims, it is also important to include the voices of PWDs and have them on board while designing policies for their MH promotion and designing interventions for their psychosocial wellbeing.

The social model of disability, with its emphasis on inclusivity, plays a crucial role by advocating for the establishment of a fair social environment that allows individuals with varying abilities to coexist and function. Goering (2015) observes in her article that MH workers and policymakers must listen compassionately to the unique struggles and challenges of PWDs, maintaining their fullest respect, and encourages them to think creatively about opportunities for "inclusion, accessibility, and accommodation" to successfully integrate the social model of disability into their practice.

Discussion

Despite being a comprehensive and humane way of looking at the condition of people

with disabilities, the social model of disability still faces substantial challenges while being implemented, particularly in developing nations like Nepal, where there is a constraint in financial resources and where other problems take precedence over focusing on mental health. The government's spending on 'social benefits for people with disabilities in the first place is considerably lower than what is spent in developed nations, and the first priority is to mitigate hunger and poverty among this vulnerable population. Moreover, the limited human resources and subjective know-how also stifle the holistic implementation of the initiatives as prescribed in the social model, which is where the medical model of disability offers a quick fix and shortcut to the practicing health personnel and policymakers. The medical model itself is not something that is to be blamed solely for incomplete adherence to the social model of disability while focusing on the mental health status of people with disabilities; however, this model attributes mental health conditions to a purely medical condition, thereby limiting the role different social determinants have towards the development and maintenance of such conditions. As a result, the social model of disability remains merely a promising concept on paper, while its actual implementation appears to be a disappointing reality.

Critical Reflection

The issue of the mental health of PWDs holds special pertinence to me, first because I am myself a PWD and a survivor of an MH condition, and second because I

am currently in this profession of mental health and psychosocial support (MHPSS). As a survivor, I witnessed firsthand the incompleteness of the medical approach, where my treating psychiatrist mostly focused on my observable physiological changes and emotional turmoil but failed to understand the intersections between my MH condition and my physical disability and paid little attention to the social realities from which my condition had sprung.

I eventually overcame my depressive symptoms, but I always felt a sense of incompleteness, believing that I would not have experienced such a decline in my mental health if I had found a "disability-informed" mental health professional in time, someone competent enough to recognize that my unemployment, the lack of accessible counselling support for individuals with disabilities, social stigmas surrounding mental health disorders, and the stereotypical expectations placed on high-achieving persons with disabilities collectively contributed to my struggles.

Learning from my own survivor story, I always make sure that I pay equal attention to the social sides of my clients, just like I pay attention to their biological and psychological elements, in my current professional role as an MH counsellor. I haven't had a lot of counselling experiences with someone living with disabilities during my practice of more than three years, which I presume is not because they experience less psychological stress, but because of different social factors that hinder someone with a disability from

accessing MH services.

Therefore, I am unwaveringly committed to working in the mental health field for persons with disabilities (PWDs) in Nepal after graduating from Australia, which includes designing accessible materials for promoting mental health services, advocating for and implementing the social model of service delivery, and collaborating with government stakeholders and Disabled People Organizations (DPOs) to conduct further research on this topic and improve data quality to facilitate more impactful decisions in the future.

Conclusion

In conclusion, the intersection of mental health (MH) and disability highlights significant social determinants that disproportionately affect People with Disabilities (PWDs). The World Health Organization acknowledges the crucial role of mental health in overall well-being and emphasizes the unique challenges faced by PWDs, who often encounter higher rates of mental health challenges

due to factors like income disparity, social exclusion, and limited access to education and health services. These obstacles not only exacerbate existing mental health issues but also impede treatment access, particularly as many PWDs rely on limited social benefits to meet their basic needs.

The stigma surrounding mental health can further alienate these individuals, compounding their vulnerability. Utilizing the social model of disability, which shifts focus from medical impairments to structural barriers, can enhance understanding and support for PWDs. As a mental health professional and a PWD myself, I recognize the necessity of integrating the voices of PWDs into mental health policy and practice. I envision developing inclusive, accessible materials and engaging with stakeholders to strengthen support systems and research. My commitment to addressing these social determinants reflects a dedicated effort to improve the mental health landscape for PWDs, ultimately fostering an equitable environment where all individuals can thrive.

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