

# “I don't care about my mental health because I have a physical disability”: A qualitative study on the mental healthcare-seeking behaviours of people with disabilities in Bangladesh

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## ARTICLE INFO

### Keywords:

Mental health  
Public health  
Care seeking behaviour  
Disability  
Bangladesh

## ABSTRACT

In Bangladesh, people living with disabilities are one of the most vulnerable groups, as they receive little or no assistance. They face numerous challenges regarding financial, social, and access to basic education and healthcare, which contribute to experiences of distress and mental health issues. However, there is limited research on the mental health needs of people with disabilities and the accessibility of mental health services in Bangladesh. This qualitative study addresses this gap by examining the mental healthcare-seeking behaviours of people with disabilities and challenges in care-seeking pathways and recommendations for devising an inclusive system in existing mental health services through key informant interviews and focus group discussions with 55 participants from four stakeholder groups. Findings highlight that limited mental health, literacy, stigma, and financial and logistical challenges, such as inaccessible transportation and distant facilities, hinder access to care. System-level barriers, including a lack of specialists and inadequate community-based services, further exacerbate the issue. Stakeholders recommended strengthening social support systems by providing disability identity cards, allowances, and access to inclusive education and employment opportunities. They also emphasized the need for awareness campaigns, better transportation options, and training for healthcare workers. Policymakers are urged to design culturally relevant needs-based interventions to improve mental healthcare pathways for people with disabilities while promoting multisectoral collaboration.

## 1. Introduction

Worldwide, over 1 billion people live with some form of disability, and 80% of these people with disabilities live in low and middle-income countries (LMICs) (Saran et al., 2020). In Bangladesh, it is estimated that over 1.8 million people live with a disability and are one of the most vulnerable groups as they receive little or no assistance (Thompson, 2020). Physical (loss or impairment of upper or lower limbs, motor coordination) and sensory (visual and hearing impairment) disabilities are the most common types of disabilities that contribute to around 3% of the total population in the Bangladeshi community (Noorman Abdullah, 2022; Shawkat Ara Shakoor et al., 2022).

Evidence from LMICs suggests that people with disabilities face many challenges in terms of economy, social support, community involvement, and access to basic education and healthcare services (Banda-Chalwe et al., 2014). Consequently, such difficulties cause distress and affect the overall well-being of this populace (Honey et al., 2011; Tough et al., 2017a). Studies support, in comparison with persons without any disabilities, people with disabilities are more vulnerable to developing mental health conditions such as loneliness, anxiety, depression, post-traumatic stress disorder (PTSD), and social phobia (Bruffaerts et al., 2012; Emerson et al., 2021; Fellingner et al., 2005; Honey et al., 2011; Kavanagh et al., 2016; Milner et al., 2014; van der Aa et al., 2015). If these conditions remain unaddressed, they can lead to

*Abbreviations:* CDD, Center for Disability in Development; FGD, Focus group discussion; KII, Key informant interviews; LMIC, Low and middle-income countries; NIMH, National Mental Health Institute; NGOs, Non-governmental organisations; OPDs, organisations of people with disabilities; WHO, World Health Organisation.

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<https://doi.org/10.1016/j.actpsy.2024.104624>

Received 8 July 2024; Received in revised form 27 October 2024; Accepted 27 November 2024

Available online 2 December 2024

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the occurrence of complex and severe mental illnesses, short- and long-term psychosocial impairments, and poor quality of life (Sareen et al., 2007). Additionally, most individuals with disabilities are more likely to experience adverse life experiences such as bullying, social exclusion, and abuse in childhood, which eventually contribute to developing mental health conditions (Balogh et al., 2001; Tobias & Mukhopadhyay, 2017). They frequently encounter negative attitudes, lack of compassion, and stigma at the family level in adulthood. Thus, all these factors negatively influence their healthcare-seeking behaviour, while historically, their physical and mental healthcare needs are seldom addressed (Baart & Taaka, 2017).

Before the COVID-19 pandemic, multiple studies reported a high burden of mental health conditions among the different population groups in Bangladesh; consequently, the situation was exacerbated further due to additional pandemic-inflicted factors (Hossain et al., 2019; Islam et al., 2020; Islam et al., 2021; Rafi et al., 2019). However, the mental healthcare system of Bangladesh is insufficient, as there are only 270 psychiatrists and 543 psychologists for the population of 174 million. Moreover, the public services are limited to 69 mental health hospital outpatient units in government tertiary level facilities, one specialised institute based in the capital city Dhaka (National Mental Health Institute-NIMH), and Pabna Mental Health Hospital (500 beds) located in a northern district of Bangladesh (Koly et al., 2022). As a result, the percentage of the overall treatment gap is 92.3% in Bangladesh. Regarding people with disabilities, the treatment gap might be even higher; nevertheless, it is still unknown due to a lack of available evidence. Therefore, the unaddressed mental healthcare needs of people with disabilities can make them more vulnerable to a double burden of health conditions and impact their overall functional capacity.

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) includes mental health within its broader disability rights framework, acknowledging that disabilities include long-term mental impairments, in addition to physical, intellectual, and sensory impairments (Article 1). Moreover, UNCRPD declarations also appeal to the countries to emphasise the right of people with disabilities to the highest attainable standard of health for them, including mental health services, and emphasise the importance of providing health services without discrimination, ensuring accessibility, and respecting human dignity. There is a paucity of research on mental healthcare-seeking behaviour, and how accessible and inclusive mental health services are for them in Bangladesh. To achieve Sustainable Development Goal 3, *ensure healthy lives, and promote wellbeing for all at all ages* (Izutsu et al., 2015), it is a pre-requisite to explore their perspective about their mental health needs, particularly as they represent a large percentage of the population with increased risk factors. Since most of the population is totally or partially dependent on their family members, exploring their emotional needs is also important for ensuring the quality of life of this population and their caregivers (Rohwerder, 2018; Yamaoka et al., 2016). Moreover, it is crucial to generate baseline evidence about care-seeking behaviours to develop community-based inclusive mental health interventions and safeguard human rights for his population. Therefore, this study assessed the mental healthcare-seeking behaviours of people with physical disabilities from the perspective of multiple levels of stakeholders in Bangladesh. In addition, this study also compiled the challenges in accessing mental health care services and recommendations for devising an inclusive system for people with disabilities in existing mental health services in Bangladesh.

## 2. Materials and methods

### 2.1. Study setting

According to the recent National Survey on People with Disabilities (NSPD) 2021, 2.80% of people in Bangladesh have at least one disability, and 1.19% have a physical disability, accounting for the highest percentage. The survey reported that of the total population

with disability, 3.29% are males and 2.34% are females. The majority of the population lives in rural areas. Only 57.43% of the population with a disability has internet access. Only 18.47% of people with disabilities use assistive devices as per their needs. Only 27.21% are employed.

Regarding healthcare seeking, 61.65% received general healthcare, mainly from private facilities (71.60%). About 7.14% of the population have at least one functional difficulty, meaning they experience difficulties seeing, hearing, walking, self-care, communication, and remembering. There is no prior data about the pattern of mental healthcare seeking among people with disabilities in Bangladesh. Regarding the country's mental health system, affordable services are severely lacking, as is the availability of suitably qualified mental healthcare professionals (Koly, Saba, Rao, et al., 2024). These factors, combined with social and cultural factors, such as mental health stigma, constitute major factors that hinder the tendency of mental healthcare-seeking of the Bangladeshi population (Nuri et al., 2018). It has been reported in a recent study conducted in Bangladesh that 11% of individuals have a disability but that there are no community-based mental health services offered to them (Koly et al., 2023).

### 2.2. Study design

We adopted a qualitative descriptive approach to understanding the experiences of people with disabilities regarding their mental health needs, care-seeking behaviour, and related factors from different levels of stakeholders (Colorafi & Evans, 2016). Semi-structured interviews provided a degree of freedom for the stakeholders to share their viewpoints and highlight their perspectives on research (Horton et al., 2004). We conducted 13 key informant interviews (KII) and four focus group discussions (FGDs) among 55 stakeholders who were people with physical disabilities, caregivers, healthcare providers (occupational therapists, community-level healthcare providers, mental health professionals), and disability activists (representatives of organisations of people with disabilities- OPDs, national and international non-governmental organisations- NGOs). KIIs were conducted to collect information from a wide range of participants who have first-hand knowledge about the community or study matter, can share their experiences and understandings of the study matter, and can provide possible recommendations (Milena et al., 2008). FGDs were implied to collect views, perceptions, and notions of a selected group of people, thus generating valuable information in group dynamics (Milena et al., 2008).

### 2.3. Participants

We used a purposive and snowball sampling technique to recruit study participants. These sampling techniques are well-established and widely used in qualitative research. We selected both techniques since the former helps to gather information from the individuals who have deeper insights about the research questions (Sharp, 2003). The latter supported identifying participants referred by the other participants with similar experiences (Sharp, 2003). These non-probability sampling techniques help select study subjects that satisfy the objectives of the study based on the researcher's conviction (Obilor, 2023). Although there were chances of selection and network biases, we tried to mitigate those by recruiting people from diverse backgrounds and settings and using multiple organisational referrals (Etikan, 2016). Participants were selected with the help of the lead author's existing collaboration with the Centre for Disability in Development (CDD). CDD is a non-profit organisation working in partnership with a network of over 350 organisations both nationally and internationally to develop an inclusive society for people with a disability. While recruiting participants with physical disabilities, the inclusion criteria were: (a) being adults (18–64 years) with any form of physical disability, (b) having the ability to communicate in Bangla, (c) willingness to participate, and d) having the capacity to understand the research and consent for themselves. People

with disabilities and their caregivers were affiliated with CDD's listed beneficiary OPDs of three major cities of Bangladesh (Dhaka, Chattogram, and Sylhet) (Table 1). Healthcare providers were recruited with the help of different organisational staff members of CDD. The group of healthcare providers consisted of members such as occupational therapists affiliated with Chittagong-based OPDs, community-level healthcare providers affiliated with Sylhet-based OPDs and mental health professionals affiliated with CDD (Table 2). Disability activists were recruited from the lead author's existing networks based at CDD, CBM Bangladesh and the WHO (Table 2).

2.4. Data collection

The participant recruitment of this study started on 24th August 2022 and ended on 4th October 2022. Data were collected face-to-face by three research team members (KNK, JS, SI) with graduate degrees in global mental health, public health, and nutrition, respectively. Face-to-face data collection allows synchronised communication and understanding of in-situ social cues (Opdenakker, 2006). KNK and JS contacted the eligible participants, who were healthcare providers and disability activists. During initial communication through telephone calls, KNK and JS introduced themselves to the participants, informed them about the study objective, and invited them to participate. Those who agreed to participate were sent an email about the study information, consent forms, and leads about interview guidelines. The interviews were scheduled at a time convenient to the participants.

For conducting FGDs, people with disabilities and caregivers were approached by the CDD field workers. On specific dates, they were asked to visit their affiliated disability-specific community clubs near their household areas, such as Mirpur, Khilgaon (Dhaka); Bashkhali, and Rangunia (Chittagong) and Kulaura (Sylhet). The participants who agreed to participate attended the club meetings and participated in the FGDs. These FGDs were conducted by JS and KNK. Other team members collected field notes.

Five separate semi-structured interview guides (Supplementary 1) were developed by taking the different models of disability, such as medical, social, and human rights models, into account by reviewing related literature for conducting FGDs and KIIs (Degener, 2017; Hogan,

**Table 1**  
Sociodemographic characteristics of the focus group among people with disabilities and the selected caregivers (n = 38).

	Focus groups with people with disabilities (n = 19)	Focus groups with caregivers (n = 19)
Age (years)		
18–35	9	3
36–50	6	7
51–65	4	9
Gender		
Male	8	7
Female	11	12
Area		
Dhaka	6	5
Chattogram	6	8
Sylhet	7	6
Type of impairment		
Upper and lower limb impairment	4	0
Lower limb impairment	13	0
Low vision	2	0
Identification	FGD-1 FGD-2 FGD-3	FGD-CG1 FGD-CG2 FGD-CG3

**Table 2**  
Categories of service providers and their identification (n = 17).

Key informant categories	Work experience (range of years)	Area	Type of organisation	Identification
Occupational therapists (n = 3)	4–7 years	Chittagong	Public healthcare facility	OT-01-KII OT-02-KII OT-03-KII
Community-level healthcare providers (CHCP) (n = 1)	8 years	Sylhet	Public healthcare facility	CHCP-01-KII
Mental health service providers (n = 4)	5–10 years	Dhaka	Private facility	MHS-01-KII MHS-02-KII MHS-03-KII MHS-04-KII
Representatives of National OPD (n = 4)	3–14 years	Dhaka	Community level organisation	OPD-01-KII OPD-02-KII OPD-03-KII OPD-04-KII
Representatives from National NGOs (n = 2)	10–15 years	Dhaka	Non-profit organisation	NGO-01-KII NGO-02-KII
Representatives from international NGOs	10–12 years	Dhaka	International Non-profit organisation	INGO-01-KII INGO-02-KII INGO-03-KII

2019; Oliver et al., 2012; Reber et al., 2022; Teunissen et al., 2014). FGD guides explored the understanding of mental health, awareness about the available mental healthcare services, attitudes and stigma towards mental health, experiences in accessing services, perceived barriers in seeking care, opportunities, and recommendations for designing community-based mental health programs among people with disabilities and their caregivers. In terms of the other stakeholders, current disability care in Bangladesh, the situation of mental health support available for people with disabilities, understanding of the importance of community-based mental health programs, community-level perception about disability and mental health, barriers to seeking mental healthcare, opportunities, and recommendations for designing community-based inclusive mental health program for people with disabilities were explored. On average, Interviews took 30–40 min, and FGDs took 80–90 min. The research team members recorded and transcribed all the interviews and discussions for analysis. Transcripts were quality-checked by the KNK and JS.

2.5. Data analysis

We used the six-phased thematic analysis methods by Braun and Clarke to analyse the Bengali data transcripts since this is familiar for analysing and understanding the pattern of qualitative data (Braun et al., 2022). One of the major strengths of using thematic analysis is that, it helps to derive data from interviews in a bottom-up manner, which means researchers were introduced to the new topics when they conducted interviews and used those topics to construct new questions in the subsequent interviews. Firstly, the research team familiarized with the data by iteratively reading the transcripts and noting initial understandings about the data. JS and KNK reviewed the data and initially remarked on preliminary codes. Secondly, SI and ZN (both had prior experience in qualitative analysis) coded the transcripts independently and organized data relevant to each code in a systematic way. Afterwards, three team members (JS, SI, and ZN) individually organised potential themes and subthemes based on their ideas and understanding of the data. For triangulation, the research team members attended multiple meetings (n = 4) when the lead author discussed the themes identified by each author. Importantly, themes were not discussed among the authors before this point to ensure the robustness and reliability of data.

The lead author (KNK) reviewed the situation with a wider research team as a general consensus and harmonised it by solving the conflicts. While analysing the data, it was apparent that the authors' understandings were comparable, offering strong testimony of data analysis being reliable. Inductive thematic saturation with a robust explanation of data was reached when no new codes emerged for each theme from transcripts (Saunders et al., 2018). Moreover, we continued recruiting participants for each group until no new information emerged from the KIIs and FGDs, and this process also helped the study's sample size, thus ensuring methodological rigour (Marshall et al., 2013). Finally, important findings and quotes were translated into English and were quality-checked for accuracy. Pseudo-names and identifications were used to present the findings from the stakeholders. Moreover, all the research team members discussed, appraised, and approved the presented quotations and contextual text. Also, the team ensured the accurate reporting and interpretation of data. The study adhered to the consolidated reporting criteria for qualitative studies (COREQ; Supplementary 2) (Tong et al., 2007).

### 3. Result

Three main themes were generated from transcript analysis and coding (Fig. 1). The themes are 1) Prevalence of mental health conditions among people with disabilities, 2) Barriers to utilising mental health services of people with disabilities, and 3) Proposed solutions to improve access to mental health services.

#### 3.1. Theme 1: Prevalence of mental health conditions among people with disabilities

##### 3.1.1. Common mental health symptoms

Most people with disabilities expressed poor mental health symptoms such as sadness, hopelessness, sleep difficulties, and low interest in daily life activities. With similar observations, caregivers added that most of their near ones with disabilities tend to express anger and emotional outbursts from time to time.

*My lower limbs are paralysed, so I cannot function like others. At times, this is so upsetting for me that I can't eat and properly sleep. However, I always try to keep myself positive, but it becomes impossible when I think about my physical limitations. – Mohammed-PWD-FGD1*

One of the caregivers added,

*My son is a person with a physical and mental disability. Most of the time, he feels downhearted and unable to go around and play like most children. He gets aggressive when we cannot get him the things he wants. Gradually, his anger issues became unmanageable and violent. - FGD-CG2*

Other stakeholders, such as disability activists, occupational therapists, and mental health service providers, agreed that people with disabilities are highly vulnerable to poor mental health symptoms such as extreme mood changes, hopelessness, and stress. Moreover, some added that most fail to cope with daily life challenges and develop low self-esteem, which can get more complicated, such as suicidal behaviour.

*Those with physical disabilities always feel stressed as they cannot participate actively in daily activities like normal people. Moreover, they experience different challenges regarding fundamental rights, which eventually dishearten them. All these issues cause them to lose interest in living at some point. - OT-02-KII*

##### 3.1.2. Perceived reasons for mental health issues

When participants were asked about the causes of mental health problems among people with disabilities, the majority concurred that physical impairment was the main contributing factor. They stated that having a disability limited their capacity to participate in daily life activities and caused them to feel isolated.

*It is incredibly challenging for me to move to places as I can't work properly. I am dependent on others for my basic needs and activities. This is demotivating for me as I cannot support anybody. How can I be well mentally? – Sharmin-PWD-FGD2*

Caregivers expressed a similar viewpoint; their family members with disabilities are mostly at home and avoid social, cultural, and religious occasions. Due to less functional ability and limited socialisation, they are prone to feel loneliness and sadness.

*My daughter has extremely low vision. She remains silent and alone most of the time. She does not go anywhere else. If we force her to socialise, she gets angry. - FGD-CG-01*

Other stakeholders, such as disability activists from OPDs and occupational therapists, indicated that people with disabilities experienced different types of discrimination, which negatively impacted their mental health. Stakeholders pointed out that these populations

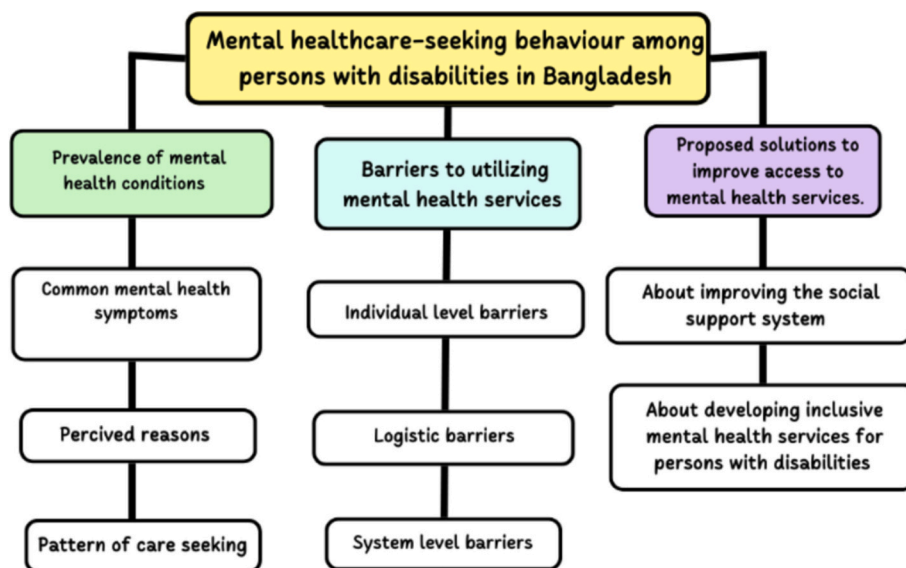


Fig. 1. Thematic analysis of the findings

encounter various levels of unfair treatment in societal, educational, and professional settings. Additionally, most families are conservative about introducing their family members who have disabilities to society. Moreover, families tend to provide less basic support to them in comparison to their siblings without disabilities.

*In our experience, most people with disabilities discovered that their parents treat them differently. Their mental health is impacted since they do not receive the same attention as their other siblings. Sometimes, they may even be locked in the room to prevent them from socializing in family-oriented programs. -OPD-02-KII*

On the other hand, some stakeholders perceived that discrimination at educational institutions was an early life factor that triggered poor mental health symptoms among those with disabilities. Teachers are less inclusive toward children with disabilities as they perceive they would not be able to learn like other students in the class. Moreover, some caregivers shared that students with physical limitations were frequently bullied by their classmates. These kinds of negative behaviour from classmates and teachers compel most people with disabilities to lose interest in studying.

*My daughter's classmates used to make fun of her continuously. Even one of her teachers thought that keeping her in class would hamper the learning process of other students. Experiencing such behaviour, my daughter felt humiliated and eventually stopped attending school. -FGD-CG1*

Mental health professionals agreed and claimed that factors such as negligence, abuse, discrimination, and failure to achieve fundamental rights were the major reasons for reducing the quality of life among people with disabilities.

*People with disabilities belong to the disadvantaged population, as their basic needs are often ignored. They cannot access all the social support and experience constant negligence in their family or community. Stigmas and superstitions bi-directionally affect their opportunity to participate and contribute to different social roles. All these reduce their self-confidence and make them psychologically vulnerable. -MHS-02-KII*

### 3.1.3. Pattern of mental healthcare-seeking behaviour

When participants were asked about their healthcare-seeking behaviour, the majority of caregivers and people with disabilities mentioned that they receive healthcare services from their nearby community clinics, which do not provide any support regarding mental health. As one disability activist described:

*In our society, a person with a disability commonly is from a low socio-economic background. So, their first point of access to health services is usually community clinics. However, these facilities are not equipped with any psychosocial services. INGO-03-KII*

On the other hand, some caregivers indicated that since there are no appropriate community-based services, they must travel far from home to visit public facilities based in the capital city of Dhaka (Dhaka Medical College or the National Institute of Mental Health (NIMH)). In addition, study participants said that while they might access healthcare facilities for their physical health, they never disclosed their mental health difficulties with healthcare providers.

*I have never seen a doctor for any mental health issues, as I do not know what this is about. So, I always try to keep the pain inside me. -Aziz-PWD-FGD-1*

Some stakeholders from disability activist groups and healthcare providers added that people with disabilities and their caregivers often visit traditional healers when experiencing mental health difficulties. Other participants with disabilities mentioned that whenever they felt sad and had sleeping difficulties, they bought medicines from the

nearest pharmacies.

*I am always worried about what will happen in the future. So, I usually buy a sedative from the nearest pharmacy when I feel any tension or headache. After taking that medicine, I try to have a sleep, to keep mind tension free. -Rahim-PWD-FGD-1*

The inclination to seek informal care from traditional healers is rooted in the religious beliefs of the communities. Stakeholders reported that communities in rural regions attributed struggles to various superstitions and connected their poor mental health conditions to supernatural causes, such as the presence of spirits. Furthermore, the lack of knowledge and low trust in formal treatment leads to inadequate treatment, as some participants believe that their conditions cannot be medically cured but require traditional methods like exorcism.

*In the rural regions, there's a prevalent trend of seeking medical treatment from Kabiraj (traditional healers). People have superstitions that their conditions cannot be cured by medicine. They believe mental health conditions can only be managed by traditional healers or shamans. They follow religious practices and travel to different places, seeking a solution. In reality, they do not understand that they have a mental health condition that can be treated or cured by formal treatments. Everyone claims that their afflictions are due to possession by ghosts or demons. CHCP-01-KII*

### 3.2. Theme 2: Barriers to utilising mental health services of people with disabilities

When stakeholders were invited to share their opinions about the perceived barriers to utilising mental healthcare services among people with disabilities, three dimensions were identified, including (i) individual-level barriers, (ii) logistical barriers, and (iii) system-level barriers. These are presented in more detail in the subsequent sections.

#### 3.2.1. Individual-level barriers to access mental healthcare services

**3.2.1.1. Knowledge about mental health symptoms.** Regarding individual-level barriers, a lack of mental health literacy for people with disabilities and their caregivers was identified by stakeholders as a major barrier to mental health care-seeking. Often, people with disabilities were not aware of the importance of taking care of their mental health. Moreover, many people were unable to recognize poor mental health symptoms. According to them, sadness is “karo sathe kotha na bola” (Not talking to someone), loneliness is “eka eka boshe thaka” (Sitting alone), and aggressive behaviour is “Jed dekhano” (being stubborn) were the only symptoms of mental health conditions. Most people with disabilities and their family members had a limited understanding of available mental healthcare services in Bangladesh.

*I don't know what mental health is. I have never taken any services regarding this issue. When I get upset, I usually take a sleeping pill from a pharmacy, nothing more than that- Maksuda-PWD-FGD1.*

Similarly, disability activists stated,

*Most of the people with disabilities are unaware of the information that mental well-being and physical well-being are related. They don't even care or give any importance to their mental well-being.-OPD-04-KII*

When people with disabilities were asked about their mental health, they described numerous distressing experiences, such as lack of mobility leading to unemployment, constant physical discomfort, economic insecurity, dependency on caregivers, and social exclusion. Moreover, the mental strain caused by the presence of discrimination by denying them access to public services such as transportation, healthcare, education, and job-related facilities also reinforces societal stigmas and restricts the independence of individuals with disabilities. The



feeling of being inferior is often triggered by negative attitudes of family members, neighbours, or employers. Some other people with disability perceive their physical health as more important than their mental health. These reasons justify their poor mental health literacy and care-seeking behaviour.

*I don't care about my mental health because I am physically disabled. Even if I try to walk, I start to sweat. My physical limitations don't let me do any work properly. – Abdul-PWD-FGD3*

**3.2.1.2. Financial barriers.** Financial issues were recognised as another major obstacle to availing mental healthcare services. Stakeholders stated that most people with a disability could not afford available healthcare services due to their economic dependency on their family members. Furthermore, they perceived the cost of psychological counselling and medicines would be an added burden for them as most of them are unemployed. As one participant with disabilities described:

*One of the main challenges we face while seeking health care is that the facilities do not give us any medicine for free. If doctors prescribe any medicine, we have to buy it with our own money. If I seek mental health, who would pay for my medicines and counselling sessions? Already me and my family are struggling to afford daily commodities. – Saiful-PWD-FGD3*

According to a mental health service provider:

*Although there is availability of free medicine in some of the facilities, most of the people with disabilities do not seek care due to financial constraints.*

-MHS-02-KII

**3.2.1.3. Lack of support from family.** Regarding family support, stakeholders stated that people with disabilities are dependent on their family members for daily life activities and financial matters. These sometimes make it difficult for them to avail themselves of or continue the treatment.

*I need to continue my treatment to improve my health condition, for which I need my family support. However, as they do not know about the importance of mental health care, sometimes they procrastinate in assisting financially. After a great deal of thought, I decided not to pursue any further treatment. I am fine with my condition, so there is no need to give a burden to my family. – Mahmuda-PWD-FGD2*

**3.2.1.4. Social and cultural barriers.** Social and cultural barriers such as stigma negatively affect accessing mental health services for people with disabilities. Our study participants described how social stigma associated with disability and mental health could serve to doubly disadvantage people with disabilities experiencing mental health difficulties and, therefore, act as a significant barrier to seeking mental health care. The fear of being labelled, judged, or detested by society for having disabilities amplifies the reluctance to acknowledge and address mental health issues within the disabled community. Consequently, individuals facing this dual challenge may endure silently, coping with their mental health struggles in isolation, devoid of the necessary support and interventions that could alleviate their suffering.

*First, disability, and then there is a mental health issue; no one is more helpless than the person who is dealing with both of these...I already face negligence and exclusion due to my disability; if I disclose my mental health difficulties, then they will label me as 'mad' and will throw stones at me. – Syed-PWD-FGD3*

Disability activists and caregivers further described how social stigma and myths around mental health and disability, such as it being God's punishment or the result of supernatural possession, reduce

people's interest in seeking mental healthcare.

*Most of our beneficiaries do not know about the importance of mental health. Instead, they label the people with mental health problems as mad in the community. Even people with severe mental health problems are excluded from the family due to their negligence.— CHCP-01-KII.*

*We are already secluded from society for having a child with special needs, which restricts us from getting the proper information about health care services. This is the reason we do not seek timely health care - FGD-CG-3*

On the other hand, some people with disabilities claimed that the likelihood of facing negligence and maltreatment from healthcare professionals eventually decreases their intention of mental healthcare seeking.

*I have experienced bad behaviour from the healthcare professionals due to my disability. They pay less attention to what we say. How can we seek mental health support from them if they don't listen to us? We may go there to treat our depression and but will return being more depressed. – Hasan- PWD-FGD1*

### 3.2.2. Logistical barriers

Participants expressed their concerns regarding the distance needed to travel to access appropriate mental healthcare facilities. Travelling long distances to access mental healthcare was not feasible for people with disabilities. Since the majority of these facilities were concentrated in urban areas such as Dhaka (the capital city) or Chittagong and based in tertiary care facilities (medical colleges or specialised institutes), these services were not accessible for people with disabilities.

*There is no hospital or clinic nearby with a mental health service facility; we need to go to Chittagong Medical College and Hospital. However, it is a hassle, as Chittagong is far from our home. If we want to go there, we need to a vehicle which involves cost and most often is not disability friendly. - FGD-CG2*

Coupled with issues to physical distance, participants raised concerns about the non-favourable situation of existing short and long-distance transportation facilities for people with disabilities. Participants mentioned that almost none of the available transportation options have disability-friendly features necessary for people with disabilities.

*People with physical disabilities often do not get accessible environments, especially accessible transportation. For their movement from one place to another, the means of transportation are not proper in our country, and the infrastructure is not there. -NGO-01-KII*

Pointing out their different needs, one participant with a disability mentioned:

*I am a handicapped person; like other people, I cannot travel by bus. I need an auto-rickshaw to go outside, but these vehicles are costly. I cannot afford to visit multiple times for my treatment. - Karim-PWD-FGD1*

Even when people with disabilities are ready to bear the extra cost of transportation, they are often denied access to public transport. People with disabilities and stakeholders argued that these actions are influenced by superstition and the stigma associated with people with disabilities.

*If I stand and signal to the bus, they won't take me because I am disabled. I can't get in fast. Also, many people are not willing to sit beside me because of stigma and superstition. I must pay double the fare. We hardly earn anything; how can we spend so much on transportation before spending it on treatment? - Nur-PWD-FGD1*

While discussing issues to do with transport and physical mobility, some stakeholders also raised concerns about the impact that these

logistical barriers pose on caregivers' ability to support a person with a disability. For example, the absence of locally available services and transportation can serve to exacerbate the challenges experienced by caregivers in trying to ensure that their relatives with disabilities receive appropriate care and support. The indirect healthcare cost related to these issues also negatively influences the mental healthcare seeking of people with disabilities, who tend to rely on family caregivers to attend healthcare appointments.

*People with disabilities are mostly dependent on their parents. Their parents are often mostly day labourers; if they spend one day with the child, they cannot earn that day. So, when they decide to seek care, they have to think about both the direct and indirect costs of seeking mental healthcare. For example, they have to pay for medical treatment and transportation. -INGO-02-KII*

### 3.2.3. System level barriers

**3.2.3.1. Attitudes of healthcare service providers.** The majority of the stakeholders indicated the unsupportive behaviour of healthcare providers as a barrier to accessing mental healthcare services. They added that most doctors provide very minimum time during the consultation. They show low empathy and willingness to listen to the problems of people with disabilities. Echoing a similar aspect, one of the caregivers shared:

*Doctors do not have five minutes for my child. Even in large hospitals, we face the same situation; they don't want to give time to a disabled child. Doctors do not give any priority to our child's problems. - FGD-CG2*

Some participants with disabilities and their caregivers described long waiting times to receive healthcare services and that healthcare providers are often not considerate of their needs. Such a situation is often stressful for the care seeker.

*I don't go to visit doctors much now. If I go, I must wait in queue with a serial, like everyone else. Saima-PWD-FGD2*

*Standing there for a long time and then getting the visiting doctor's serial. Sometimes, it happens, like when I am about to go to the doctor's room [after standing in the queue for a long time], he becomes impatient and doesn't want to go to the doctor's room. Then, I lost three hours of my time and not been able to seek help from a doctor for my child. - FGD-CG3*

Some of the participants reported the inadequate number of mental health service providers, which reduces the availability of the services, and there is a perceived absence of mental health service providers at district and local level hospitals in peripheral areas. Moreover, the dearth of female mental health service providers also acts as a challenge for female people with disabilities.

*There are no psychiatrists in local or district hospitals, but specialists for mental health illness should be present in all sectors of the health system, not only for patients with a disability but also for everyone. -NGO-02-KII*

*I think when disabled people like us go for mental healthcare service, we face obstacles like- there is lack of female specialists to understand our problems which any male doctor cannot understand. -Jhorna-PWD-FGD2*

**3.2.3.2. Infrastructural barriers.** Infrastructural barriers have emerged as another key system-level barrier. Stakeholders mentioned that the infrastructures of available mental health facilities are not favourable and inclusive for people with disabilities.

*A few days ago, I visited Pabna Mental Hospital (the premier mental healthcare facility) in the country and came to know that they are not admitting any person with disabilities because the infrastructure of that*

*hospital is not built for disabled people. So, there is no specialized facility for this population. - OPD-04-KII*

Stakeholders also mentioned that many government health facilities do not have an inclusive arrangement for people with disabilities, which significantly hinders access and service seeking. Furthermore, the lack of a dedicated and inclusive queuing system for people with disabilities is another key infrastructural barrier, and participants with disabilities and their caregivers described having to stand in long queues to seek healthcare services.

*Many government medical facilities do not have ramps or lifts for going to the doctors' rooms. A wheelchair person or someone like me with a crutch won't be able to go up the stairs, I mean, they did not make it friendly - OPD 01 KII*

### 3.3. Theme 3: proposed solutions to improve rehabilitation, logistical supports, and mental health services

When all the stakeholders were asked to share their opinion on overcoming the barriers of health-seeking behaviour of the person with disabilities, stakeholders mentioned some recommendations which were categorised into two aspects: (1) Improving the social support system and (2) Developing inclusive mental health services for people with disabilities.

#### 3.3.1. Improving the social support system

People with disabilities and their caregivers expressed anxieties about the future. Sharing distress, participants with disabilities stated that they needed social safety support services such as disability identity cards and ration support to lead their lives peacefully. Moreover, they added identity cards and disability allowances that would ensure food security and help them access, including mental health services, at a reduced cost.

*The caregiver in the family wonders about what will happen to their disabled child if he or she dies. Who will take care of him? If he gets the Suborno citizen card, he will have an economic advantage; someone will take care of him, even if it's in exchange for that money. -OT-03-KII.*

However, acquiring these disability identity cards is a lengthy process requiring much paperwork. Participants mentioned needing assistance on multiple occasions during the application process. One stakeholder highlighted that corruption is a barrier to obtaining these cards, as representatives responsible for issuing them may distribute them among their relatives instead of ensuring equitable distribution.

*These cards are given to the area representatives to distribute; however, they provide them to their family members first. If there are any left, they give them to other individuals with disabilities in their community. They are called disability identity cards, but people with disabilities do not receive them. - FGD- CG1*

Additionally, there is an existing monthly allowance from the government through the Suborno citizen card (social safety net); most people with disabilities and their caregivers feel that that allowance is severely inadequate in recent price hikes.

*A small amount of assistance comes from the government; one cannot survive without that. Some people don't have a home, and they cannot even pay the rent of the housing ... combining the government's help, and whatever one manages by himself, they eat one meal and starve the next to survive. - FGD-CG3*

Caregivers also highlighted the importance of providing assisted accommodation, for example, group homes, wheelchair accessibility, ramps, grab bars, wider doorways, and modified transportation. Both stakeholders expected government-level attention to providing such

specialized facilities. Reflecting on his situation, a caregiver of a person with a disability stated:

*I have different kinds of tensions. I have a daughter; what will happen to her? She's ill, and cannot speak. What will happen if I die? I wish there were hostels or care homes for people like my daughter. -FGD-CG2*

Disability activists and family carers called for more government-led initiatives to ensure that people with disabilities received equitable access to education and employment opportunities, enabling economic independence. Caregivers also felt that the government should take proper steps to ensure inclusive education, employment, and income-generating opportunities for people with disabilities, enabling their economic independence.

*People with disabilities should get an equal chance to complete their education to participate in social development activities. Also, policymakers should come forward to ensure job opportunities or economic rehabilitation so that they can sustain their livelihood by working and be safe from mental distress due to unemployment. -OPD-02-KII*

In addition, caregivers felt that people with disabilities should be offered more opportunities to receive vocational training to get skilled in different vocational activities.

*If the girls are trained in something for 2-3 months and then provided with jobs, then it would be beneficial for them, and they would not have any problems. - Anisul-PWD-FGD1*

Some stakeholders also highlighted the potential benefits of providing tailored recreational and leisure opportunities for people with disabilities as a means to alleviate experiences of isolation and stressful life experiences and improve mental health.

*My point is that there should be a place of recreation only for them where they can play, maybe once a week or once a month. So that they can play according to their wish or as they like. -FGD-CG1*

### 3.3.2. Developing inclusive mental health services for people with disabilities

Participants emphasised the necessity of increasing mental health and disability-related awareness. They recommended utilising mass media, tele, and digital services as major platforms for ensuring mass awareness.

*If a lot of talks are held on TV about it, radio messages are broadcast, and leaflets are distributed, then awareness will quickly rise among people. If people are aware, they will want service, and by wanting service, demand is created, and the market will be able to provide supply. It can be like this: people can sit on every alternative day or two days a week, and telehealth activities can also be strengthened. I think, in these places, if we do more work, it can be done. NGOs can also collaborate with the government because I don't prefer scattered interventions as their sustainability is very low. - NGO-01-KII*

One of the caregivers suggested opting for digital services, such as informational texts to mobile phones, to raise awareness. On the other hand, some stakeholders suggested focusing on specific target groups for arranging community-based awareness programs regarding mental health issues and available services.

*What is mental health? It is unknown to people; they also do not know where they would get the treatment. We need various interventional programs, which can be school-based, community-based, or slum-based, which would target community people as well as people with disabilities. -OPD-02-KII*

However, some other stakeholders emphasised counselling to raise

awareness among the caregivers as people with disabilities often rely on their caregivers for assistance to access and seek healthcare services. Some are also informed about arranging self-care-related sessions to cope with the burden of caregiving. According to one of the mental health service providers:

*It's not like disabled people are not willing to go to these places; in reality, it's not possible for them to go there alone, and their families don't know where to get the services. So, their caregivers should be counselled more so that they properly know where to go to get services and also take care of their emotional wellbeing. -MHS-02-KII*

In terms of mental health services, participants suggested increasing the availability of community-based mental health services. They added that such services should be readily available and accessible.:

*Mental health services are very inadequate in Chittagong. But if it were available, people would not have suffered so much. People could get this service very easily. -OT-01-KII*

Stakeholders pointed out that affordable and inclusive transportation services are one of the key prerequisites for increasing accessibility of mental health services, along with the increased availability of affordable medicines. Some recommended that government or NGOs introduce disabled-friendly transportation, e.g., buses or special vehicles, so they can easily visit health centres and seek health care services.

*If the government or any organisation stands beside us and does something to establish a system of transportation, then it will be of great help to us; we won't be facing this issue of lack of inclusive transportation. -Karim- PWD-FGD1*

Indicating various disability-specific needs, some stakeholders claimed proper training for mental healthcare professionals and other care providers to attend to people with different disabilities.

*I am a visually impaired person; I may suffer from mental health problems and may need to be hospitalized. Similarly, a person with a disability can have a mental illness and need to be hospitalised. So, the service providers should know how the services should be for people with different disabilities and build infrastructure accordingly. -OPD-04-KII*

Multisectoral collaboration was identified as a key recommendation for improving access to mental health services for people living with disabilities in Bangladesh. Participants suggest ways in which local and national governments and NGOs should work collaboratively to ensure the availability of mental health and disability-related support services. Moreover, they insisted on engaging people with lived experience while developing intervention programs. They also emphasised mobilising the existing healthcare resources such as community healthcare workers through training who would significantly increase awareness, reduce stigma, and ensure basic mental health support services and referrals.

*We must think about making the service available by mobilising the existing resources. In that case, it can be a joint venture, which is always good if the government and NGOs can do something collaboratively. For example, what do we have at our doorstep? Community Clinic. If we can teach the CHCPs in these community clinics about basic mental health literacy...so when people go to a community clinic, then they will get a kind of basic counselling [from there], or if the CHCP knows that these are the symptoms of mental health disorder, then CHCP can give further advice of referral. It can be a very good option to take the service to the doorstep of people weekly. It's [for] community people, including disabled people. -NGO-01-KII.*

Some stakeholders also desired the presence of mental healthcare professionals at primary and secondary healthcare facilities such as upazila health complexes and district-level general hospitals.

*It would have been great if a psychiatrist could visit the upazila health complex or district health complex one day per week, or a psychologist*



could visit every alternative day so that people could seek needed services.  
–NGO-02-KII

Overall, participants, including individuals with disabilities and their caregivers, voiced concerns about future support and stressed the importance of government attention to providing specialised facilities. Moreover, the need for government initiatives to ensure equitable access to education, employment, and vocational training was also highlighted. Multisectoral collaboration and mobilisation of existing healthcare resources were seen as crucial for improving mental health services for people with disabilities in Bangladesh.

#### 4. Discussion

Worldwide, around 1.3 billion people live with some form of disability and their mental needs are seldom addressed. Studies from different country settings have previously explored the pattern of mental healthcare-seeking among diverse populations such as women, gender-diverse populations, immigrants etc.; however, very few have explored such behaviours among people with disabilities (Amri & Bemak, 2013; Dutta et al., 2022; Hasan et al., 2021a, 2021b; Hossain et al., 2014; Islam & Biswas, 2015; McNair & Bush, 2016; Odufuwa et al., 2022). To the authors' best knowledge, this qualitative study is the first to investigate the mental healthcare-seeking behaviours of people with physical disabilities in Bangladesh from the perspective of multiple stakeholders, including people with disabilities.

Our findings highlighted the types of mental health symptoms and yielded valuable insights into the causes contributing to these symptoms experienced by individuals with disabilities. Stakeholders linked a range of mental health symptoms to limited participation, mirroring findings from low-income settings like Ghana and Nigeria, where experiences of unemployment, marital issues, education barriers, and financial struggles exacerbate mental health risks for people with disabilities (Hackett et al., 2020; Hosain et al., 2002; Jackson et al., 2019; Jorm, 2000; Kurawa, 2010; Tarvainen, 2021; Turner & Turner, 2004). Our findings also support other research that describes how limited opportunities to participate in household and social activities cause distress and reduced self-confidence among people with disabilities (Tough et al., 2017b). Under the UNCRPD, these challenges indicate a violation of the following four articles – the right to work and employment, respect for home and the family, right to education, and right to an adequate standard of living and social protection. Furthermore, aligning with our findings, other studies have reported how familial challenges such as dependency on caregivers, inadequate parental support, and social exclusion worsen mental health outcomes aggravated by mistreatment and discrimination in social, educational, and organisational contexts (Jackson et al., 2019). To enhance the mental health and well-being of individuals with disabilities, more comprehensive research is needed to identify their specific mental health needs.

Stakeholders in this study illustrated the pattern of mental health care seeking of people with disabilities. The findings indicated different individual-level, cultural, and contextual factors that directly and indirectly, influence the decision-making of mental healthcare seeking. Individual-level factors such as low mental health literacy often dictate the care-seeking pattern, resulting in seeking services from unqualified medical professionals and the use of unlicensed sedatives for unidentified psychosomatic conditions from local medicine shops (Koly et al., 2022; Nuri et al., 2018). Mental health literacy indicates understanding the psychological conditions and opinions contributing to their identification, management, or prevention (Jorm, 2000). This aspect is demonstrated in a recent nationwide survey in Bangladesh that reported that 62.2 % of the population, including people with disabilities, seek mental health-related support from informal resources (Health, N. I. o. M., 2019). In another study, pharmacy owners, village quacks (Kobiraj), and spiritual healers were identified as the most common resources sought by 81 % of the disabled population in Bangladesh. (Hosain &

Chatterjee, 1998; Nuri et al., 2018). On the contrary, our findings also indicate that impediments, such as stigma and misconception, also bring detrimental impacts on mental healthcare decision-making for individuals with disabilities. Correspondingly, another Bangladeshi study reported that parents of children with disabilities believe that autism and other psychological problems stem from malevolent spirits, leading them to seek assistance from non-specialist practitioners (Hussain & Raihan, 2022). Even in the young demographic of LMICs, such as Vietnam, Jordan, Iran, India, Papua New Guinea, Nigeria, and China, there exists a notable prevalence of stigma, misinformation, and confusion regarding mental illnesses (Callan et al., 1983; Dardas et al., 2017; Dogra et al., 2012; Essau et al., 2013; Sharma et al., 2017; Yamaguchi et al., 2014). These misconceptions often involve attributing mental illnesses to spiritual, religious, and ethereal factors, which suggests a deficiency in mental health literacy within these populations (Callan et al., 1983; Dardas et al., 2017; Dogra et al., 2012; Essau et al., 2013; Sharma et al., 2017; Yamaguchi et al., 2014). Moreover, insufficient knowledge and understanding of mental health might heighten the probability of individuals avoiding or postponing treatment (Henderson et al., 2013), potentially leading to negative trajectories in accessing appropriate care (Clement et al., 2015). Socio-cultural manifestation of stigma, religious attitudes toward mental illness, misinformation and confusion regarding mental illnesses, and ease of obtaining, reaching, and affording informal services interplay with the individual factors level factors, thus causing underutilisation of mental health services in Bangladesh and similar developing settings (Callan et al., 1983; Dardas et al., 2017; Dogra et al., 2012; Esan et al., 2019; Essau et al., 2013; Sharma et al., 2017; Yamaguchi et al., 2014).

To address the individual level and cultural factors influencing care seeking aspect, community-based approaches such as mental health-related workshops incorporating active involvement and interaction with individuals who have lived experience to enhance public consciousness, establishing community-based or satellite mental health facilities, conducting capacity-building activities for traditional healers and local pharmacy owners, and utilising educational approaches across various platforms are necessary to increase care seeking. Moreover, it is essential to promote de-stigmatising language nationwide through the integration of mental health awareness into the workplace, educational, and other organisational settings, using mass media and telecommunications services. As such, propositions were found thriving in neighbouring countries in enhancing the utilisation of adequate mental health care and mitigate the treatment gap (Shah et al., 2020). Further investigation is required to comprehensively assess the characteristics of mental health literacy and examine the connections between knowledge, beliefs, and attitudes in diverse cultural contexts (Renwick et al., 2022).

The decision-making of availing healthcare for people with disabilities also depends on the affordability and accessibility of the treatment. Additionally, secondary aspects related to availing healthcare, such as dependency on caregivers, favourable transport options, added cost, proximity, and disability-friendly features at facilities also play a pivotal role. The absence of such amenities was found to reduce the interest in care-seeking among people with disabilities from similar developing settings such as Pakistan, Afghanistan, Ghana, Nigeria, South Africa, and Uganda (Ahmad, 2013; Gething et al., 2012; Mulumba et al., 2014; Naidoo & Ennion, 2019; Senghor et al., 2017). Additionally, healthcare infrastructural challenges such as restricted availability of ramps, escalators, rails, and tiny entrances; low number of professionals, unsupportive behaviour of the healthcare professionals, and long waiting hours in queues resulted from the lack of a specialised and all-encompassing queuing system also negatively influence support seeking attitude of people with impairments (Magnusson et al., 2022). All these barriers breach the right to equitable and accessible healthcare services, as underpinned by the UNCRPD, and were a common experience for people with disabilities in Bangladesh, as reported by the stakeholders. For example, the Bangladeshi government is duty bound to

ensure that the right of this population, declared by UNCRPD, to have the highest attainable standard of health without discrimination; however, the concentration of services in major urban areas such as Dhaka heightens the challenges to ensure mental healthcare in many stages. The disparities continue to expand as study participants stated about the unavailability of mental healthcare at primary care facilities, the low ratio of psychiatrists, the scarcity of female care providers for females with physical impairments, and low consultation times (Hasan et al., 2021a, 2021b; Soltani et al., 2019; Sultana, 2010). A systematic review reported that Bangladesh had the lowest recorded consultation time of 48 s among primary care physicians from 67 countries (Irving et al., 2017).

Furthermore, adding to these challenges, reaching and navigating any healthcare facility is challenging for people with disabilities as they need personal assistants, have out-of-pocket expenditures on transportation, are often denied onboard into the transportation, or are overlooked by the local transport system (Acheampong et al., 2022). All these barriers interact, causing low adherence to treatment, delay, loss of follow-up, and difficulty choosing informal care providers (Dassah et al., 2018; Hussain & Raihan, 2022). Therefore, it is crucial to enhance the provision of mental health services in Bangladesh by integrating them into primary care and secondary care settings, eventually reducing economic and distance-related challenges. Additionally, establishing a social safety net tailored explicitly for those with disabilities will facilitate their access to mental health care services at a reduced or affordable cost. Increasing disability-friendly transportation, ensuring equity in public transport options, and building ramps and specialized facilities for easy navigation in reaching healthcare facilities could also be feasible options (König et al., 2021).

The limited provision and efficacy of mental health support provide obstacles to equitable accessibility, hence demanding comprehensive reforms to promote inclusion and eliminate impediments for those with disabilities. To surmount these issues, it is imperative to train community healthcare workers and doctors as non-specialist psychosocial support providers to provide basic mental health support services such as screening symptoms, counselling, management, empathetic communication, and appropriate referrals (Hartzler et al., 2018; Koly et al., 2022). Moreover, evidence supports that introducing peer support services could be feasible for ensuring basic psycho-social support for people with disabilities in Bangladesh (Koly, Saba, Christopher, et al., 2024). In addition, specialised support assistants at healthcare facilities and the introduction of online telecare services can streamline the process, diminish obstacles, and enhance the accessibility of crucial services. Healthcare centres must prioritise inclusion by providing disability-specialised supplies to reduce waiting times. This may entail several steps, including removing exclusive stair installations at entrances, providing adequately broad doorways to accommodate wheelchairs, and the construction of handrails close to toilets and bathtubs (Moro et al., 2022). Another potential strategy for enhancing service delivery and promoting inclusivity could be establishing a designated line specifically intended to accommodate people with disabilities.

To reduce the vulnerability of mental health conditions of people with disabilities, stakeholders emphasised the requirement for a social safety net and governmental support services such as inclusive education, employment, and income-generating opportunities that foster social inclusion and security. Furthermore, the facilitation of rehabilitation and vocational training, the delivery of affordable and effective healthcare services, the distribution of disability identification cards, the allocation of disability benefits, and the provision of ration assistance possess the capacity to alleviate ambiguity and offer individuals with disabilities a more stable and assured future (Dangal et al., 2020; Nevala et al., 2015; Nuri et al., 2012). Also, such facilities would empower individuals with disabilities regarding self-development and financial independence. Furthermore, implementing awareness campaigns and educational programs could serve as effective strategies to tackle the issues of discrimination and neglect within

society and families.

Stakeholders in our study highlighted barriers on multiple levels, such as attitudinal barriers encompassing stigma, prejudice, and discrimination; environmental barriers, ranging from a dearth of family support to architectural obstacles, societal attitudes, and limited inclusion; and systemic barriers, including inequitable service provision and institutional practices, that further impede full participation and access for individuals with disabilities. Interestingly, the statements of the stakeholders about these different barriers to care seeking represent different models of disability. Attitudinal barriers and the requirement of familial support for better functionality and quality of life scream the aspect of the medical model of disability coined by psychiatrist Dr. Szasz, in the mid-1950s (Hogan, 2019). The medical model of disability mentions one's disability to be the sole reason for not being able to access services, utilising opportunities and stresses the importance of curing the disability conditions (Hogan, 2019). The rest of the barriers indicated by the stakeholders aligned with the social model of disability, theorised by Mike Oliver, which was introduced during the disability rights movement in the early 1970s (Oliver et al., 2012). This model condemns society for operating these obstacles against persons with disabilities that eventually introduce exclusion, discrimination, and violation of rights (Hogan, 2019). The recommendations concluded by the stakeholders are also guided by these models and draw the way forward for the inclusion of the human rights model of disability by UNCRPD (Degener, 2017). A study conducted in Bangladesh reported that the government of Bangladesh, apart from recognising and regulating the UNCRPD, has implemented several legislations, ordinances, and policies intending to safeguard the rights, equal treatment and access to services (Nuri et al., 2020). This includes provisions for auxiliary aids and services, disability incentives, and educational benefits that support our stakeholders' suggestions (Nuri et al., 2020). However, ensuring all the rights is still challenging as Bangladesh lacks a formalised distribution mechanism for financial support and assistive equipment, along with limited financial incentives for students with disabilities in the education system (Al Imam et al., 2022; Thompson, 2020). To effectively address this issue, it is imperative that the government increases the allocation of funds and enhances transparency.

Further suggestions for enhancing the accessibility, affordability, and efficacy of mental health care for those with disabilities involve implementing a comprehensive strategy comprising multiple components. To ensure that people with disabilities have access to mental health treatments, governments and non-governmental organisations (NGOs) can fund the provision of accessible modes of transportation such as buses and modified automobiles. To enhance accessibility, the inclusion of mental healthcare professionals within every level of healthcare establishments was encouraged. Additionally, there is a prerequisite for proper training for mental healthcare professionals and other care providers to attend to people with different disabilities. Healthcare providers must undergo comprehensive training covering aspects such as human rights awareness, effective counselling techniques, adherence to professional codes of conduct, and the application of gender-sensitive approaches when engaging with marginalised and vulnerable health service users since the UNCRPD emphasises the need for such equitable health service and rehabilitation opportunities for persons with disabilities. In Bangladesh, despite endorsing the convention, entrenched stigmas surrounding gender and mental health hinder its full implementation. A shift from curative to preventive healthcare is essential for a more comprehensive approach.

Additionally, there is a critical need to increase funding for social safety net programs, as only 0.42 % of the total budget is allocated to support persons with disabilities, limiting the impact of direct benefits such as disability allowances and education stipends. Policymakers should increase designated funding within the country's Ministry of Health budget to recruit and train the workforce to integrate them into diverse healthcare establishments (Bruckner et al., 2011). In general, the findings of our study are consistent with existing literature and offer a

comprehensive understanding of various facets of mental healthcare for people with disabilities in Bangladesh.

## 5. Strength and limitations

This study included multiple level stakeholders to have insights regarding the present situation of our country regarding mental health conditions among people with disabilities and their caregivers. One of the main constraints of our study is data collection explored the factors influencing mental health-seeking behaviour only from three particular regions of Bangladesh. In addition, for participants with significant hearing impairment and autism, in-depth interviews could not be possible due to communication via sign barriers; instead, interviews with the primary caregiver were carried out, which is likely to have provided another point of view. Further policy and system-level research is required to obtain an enhanced awareness of the barriers that prevent people with disabilities and their caregivers from accessing mental healthcare services.

## 6. Conclusion

Our research demonstrates the knowledge and challenges of people with disabilities to access mental healthcare. Negative perception toward people with a disability has a direct connection with the customs and values of a community while seeking services. Therefore, the formulation and execution of inclusive education, employment opportunities, multisectoral collaboration, and awareness programs are crucial to improving their health outcomes. There is a pressing need for right-based holistic interventions that involve training healthcare workers, disseminating medical information, and implementing cost-effective rehabilitation programmes. Additionally, increasing government support and improving funding distribution mechanisms are crucial steps toward addressing disability rights violations effectively. All these aspects should remain a top concern for the government policymakers of Bangladesh.

## Author's credentials

**Jobaida Saba**, MSPH, BSc in Public Health and Informatics: She is an early career researcher and has been a research assistant at icddr,b during the study.

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## CRedit authorship contribution statement

**Jobaida Saba**: Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Zinnatun Nessa**: Writing – original draft, Formal analysis. **Shahida Islam**: Writing – original draft, Formal analysis. **Alex Kaley**: Writing – review & editing, Supervision. **Kamrun Nahar Koly**: Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

## Consent to participate

Participants gave informed consent that findings could be published anonymously.

## Ethics approval

This study protocol (PR 22079) was reviewed and approved by the Institutional Review Board (IRB) of the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr, b). The anonymity and privacy of the participants were well maintained. We maintained ethical guidelines for research with disabilities of NDA (National Disability Authority) based in Ireland and CRPD. The participants were informed about the study objectives, and we obtained verbal and written consent forms. The participants were provided full independence to stop their interviews and discussions and asked for their permission to audio record. We shared a brochure regarding Bangladesh's governmental mental health services and provided the transport cost to the participants (people with disabilities and caregivers). Participants were informed about the voluntary nature of participation. Participants were assured of preserving the anonymity and confidentiality of the subjects.

## Funding statement

The authors are thankful to Centre for Disability in Development (CDD) and Christian Blind Mission (CBM) Global for the financial support for implementing this project of icddr,b.

## Declaration of competing interest

The authors declare that they have no competing interest in the publication of this research output.

## Acknowledgements

The authors are grateful to all respondents who participated in this study. The authors are thankful to Trisha Mallick for supporting them in project-related work. Icddr, b is thankful to CDD and CBM Global for their support in implementing the project. Icddr, b, b is also grateful to the Governments of Bangladesh and Canada for providing core/unrestricted support.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.actpsy.2024.104624>.

## Data availability

The qualitative data used and/or analysed during the current study are highly confidential.

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