

How can we promote disability inclusion?

Background

Loneliness and social isolation are key determinants of health and wellbeing. However, individuals and communities are heterogeneously impacted (Umberson & Donnelly, [2023](#)) – with some people facing a greater burden of isolation due to a variety of factors, including stigma, discrimination, exclusion, violence, and accessibility barriers (Barjakova et al., [2023](#); Dahlberg et al., [2022](#)). In particular, people living with disabilities face significant challenges to social participation and inclusion (Rimmerman, [2013](#); Scheer et al., [2003](#)). As such, it is important to understand the social health needs of this population.

Purpose

The purpose of this evidence brief is to understand how to promote inclusion of people living with disabilities. In doing so, we recognize that people with disabilities are a diverse community and that there is no one-size-fits all solution to meeting their social health needs. Indeed, in conceptualizing disability, we recognize that while people living with disabilities experience a wide range of physical and mental impairments—including difficulties hearing, seeing, speaking, learning, remembering, and processing emotions (Statistics Canada, [2017](#))—the fundamental source of their disability arises primarily from ableism, external barriers, and lack of accessibility (e.g., stigma, discrimination, lack of accommodation), not their particular physical attributes or characteristics (Ontario Human rights Commission, [2016](#); World Health Organization, [2011](#)).

Evidence from Existing Studies

The existing evidence suggests that people with disabilities face higher rates of loneliness and isolation and lower levels of social support than people without disabilities (Emerson et al., [2021](#); Strautins & McDiarmid, [2023](#); Alexandra et al., [2018](#); Gooding et al., [2017](#); Macdonald et al., [2017](#); Korporaal et al., [2008](#)). For example, Gilmore & Cuskelly ([2014](#)) report that as many as half of people with an intellectual disability are chronically lonely, compared to 15-30% of the general population. In particular, worse social health among people with disability has been linked to lower economic participation, lesser familial support, lesser access to environmental assets (e.g., transportation, accommodating physical venues, healthcare and rehabilitation services), and greater stigma or discrimination (Gómez-Zúñiga, [2023](#); Emerson et al., [2021](#); Repke & Ipsen, [2020](#); Wormald et al., [2019](#); Warner & Adams, [2016](#); Fiorati & Elui, [2015](#); Werner et al., [2015](#); Gilmore & Cuskelly, [2014](#); Casas, [2007](#); Baldwin & Marcus, [2006](#); Rokach et al., [2006](#)). Contributing to the burden of loneliness and isolation, adults with disability have been observed to be excluded from the social networks of people without disabilities – with the majority of their social contact coming from family, support staff, and other people with disabilities (Harrison et al., [2021](#)). That said, support from these groups has been observed to

be of critical importance in reducing the burden of loneliness among people with disabilities (Warner & Adams, [2016](#); Kumaran, [2011](#); Russell, [2009](#)).

In addition to an elevated risk for loneliness and isolation, specific forms of impairment have been linked to particular social health challenges that if not addressed can lead to loneliness and isolation (Olsen et al., [2018](#)). These conditions include visual, auditory, and speech impairments that may make social interaction more difficult (Bott & Saunders, [2021](#); Harithasan et al., [2020](#); Suen et al., [2020](#); Shukla et al., [2020](#); Brunet et al., [2019](#); Sung et al., [2016](#); Most, [2007](#); Jacobs et al., [2005](#); Verstraten et al., [2005](#); Hart et al., [2004](#); Holmen et al., [1994](#); Barron et al., [1994](#); Knutson & Lansing, [1990](#); Christian et al., [1989](#)) – particularly in the absence of appropriate corrective technologies or actions (Mira & Vivian, [2017](#); Weinstein et al., [2016](#); Foley & Ferri, [2012](#); Chen, [1994](#)). As well, difficulties with cognition, memory, or emotion regulation can also make it difficult for individuals to maintain relationships (Burholt et al., [2017](#); Meltzer et al., [2013](#); Holmen et al., [2000](#)). Finally, mobility difficulties can also make it harder for individuals to engage in social interactions by reducing opportunities for social participation through transportation and other accessibility barriers (Satariano et al., [2016](#); Mellor & Edelman, [1988](#)).

To address these barriers, tailored interventions are needed that support independence, self-efficacy, and general wellbeing for people with disabilities (Solomon et al., [2019](#)), address specific impairments (GSen & Prybutok, [2019](#); Elisha et al., [2006](#)), or help reduce the barriers they face. Among such interventions, studies have observed that it is effective to promote economic inclusion (e.g., through employment and housing) and access to other forms of participation (Grogan et al., [2019](#); Repke & Ipsen, [2020](#); McVilly et al., [2006](#)). Additionally, it is important to go above and beyond facilitating mere inclusion, but also foster a sense of belonging and fulfillment by engaging people with disabilities in diverse and fulfilling activities such as sports, arts, volunteerism, and cultural activities (Grandisson et al., [2019](#); Jeanes et al., [2018](#); van den Berg et al., [2016](#); Bigby & Wiesel, [2011](#); Hall, [2010](#)). In these ways, efforts to address loneliness among people with disabilities have mirrored those undertaken in the general population by focusing on improving social skills, enhancing social support, facilitating social interaction, and improving cognitive processes (Gómez-Zúñiga, [2023](#)). However, such efforts require adaptation to the specific population (or individual) being worked with, and efforts must be taken to not treat impairments as the source of disabilities (Koller & Stoddart, [2021](#)). In adapting interventions, studies suggest that it is beneficial to empower people living with disabilities – who are not only aware of their needs but also have capacity to identify a wide range of solutions to the barriers they face to meeting these needs (Ipsen & Repke, [2022](#); Robinson & Idle, [2022](#); Amado et al., [2013](#); Overmars-Marx, [2012](#); Hernandez et al., [2010](#); Milner & Kelly, [2007](#); Abbott & Mcconkey, [2006](#)). As well, communities should champion the interests of people with disabilities so that the burden of finding inclusion is not unfairly distributed (Fuhimoto et al., [2013](#)).

Highlighting the importance and urgency of addressing poor social health among people with disabilities, research has shown that loneliness and isolation contribute to worse health, frailty, and decline – including among people with disabilities (Banks & Polack, [2019](#)). For example, loneliness is linked to the onset of new mental health problems (Mann et al., [2021](#), Erzen & Cikrikci, [2018](#)). Given these effects, it is important to stop the cyclical feedback loop between physical impairments and social outcomes in order to co-produce health and inclusion.



Analyses from The Canadian Alliance for Social Connection and Health

Using data from the 2021 Canadian Social Connection Survey, we examined the relationship between UCLA loneliness scale scores and demographic factors (i.e., age, gender, ethnicity, household income, and disability status). The analysis revealed that higher loneliness was associated with age ($F(1, 2384) = 10.953, p = .0009$), gender ($F(2, 2384) = 14.334, p < .0001$), household income ($F(25, 2384) = 2.216, p = .0005$), and disability ($F(1, 2384) = 67.408, p < .0001$). In comparing the effects, that of disability on loneliness was pronounced even in comparison to these other demographic factors.

Expanding on this analysis, we next used data from the 2022 and 2023 Canadian Social Connection Survey and examined levels of Emotional and Social Loneliness across types of disability. Types of disability included intellectual disability ($n = 103$); learning disability ($n = 327$); Asperger's, autism, or other neurodiversity spectrum conditions ($n = 406$); mental health disabilities, including depression ($n = 1,318$); survivors of the psychiatric system ($n = 214$); blindness, low vision, or other visual impairments ($n = 215$); communication disabilities, including the use of augmentative or alternative communication systems ($n = 108$); chronic pain ($n = 1,074$); chronic illness ($n = 821$); and deafness or difficulty hearing ($n = 341$). Additionally, we included 1,772 participants who reported having none of these conditions. The results from these analyses suggested that there are considerable variations in both types of loneliness across disability types. As well, the relative effects of disability on each type of loneliness differed. For example, individuals with intellectual and learning disabilities had relatively higher emotional loneliness scores compared to individuals with other disabilities, but lower social loneliness scores. Across all groups, people without disabilities had the lowest levels of emotional and social loneliness.

Figure 1. Emotional Loneliness, by Disability Type

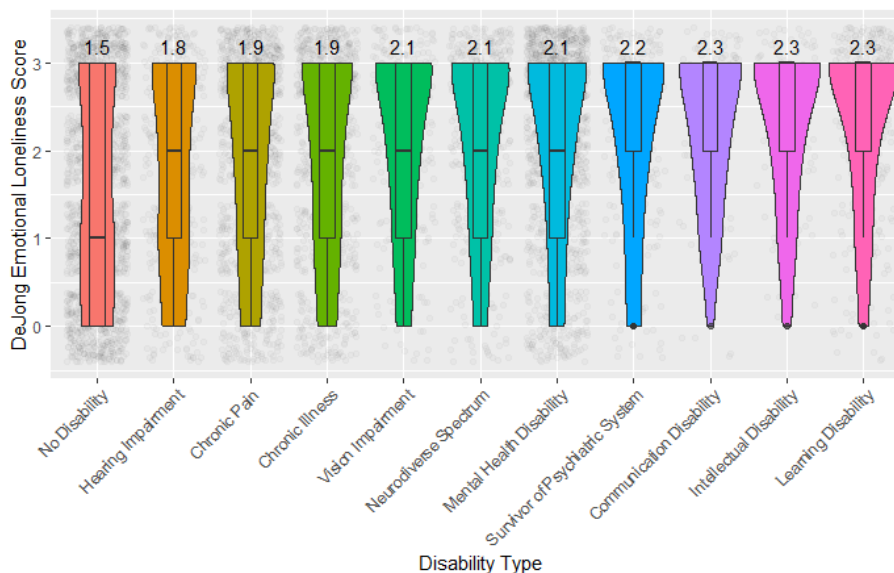
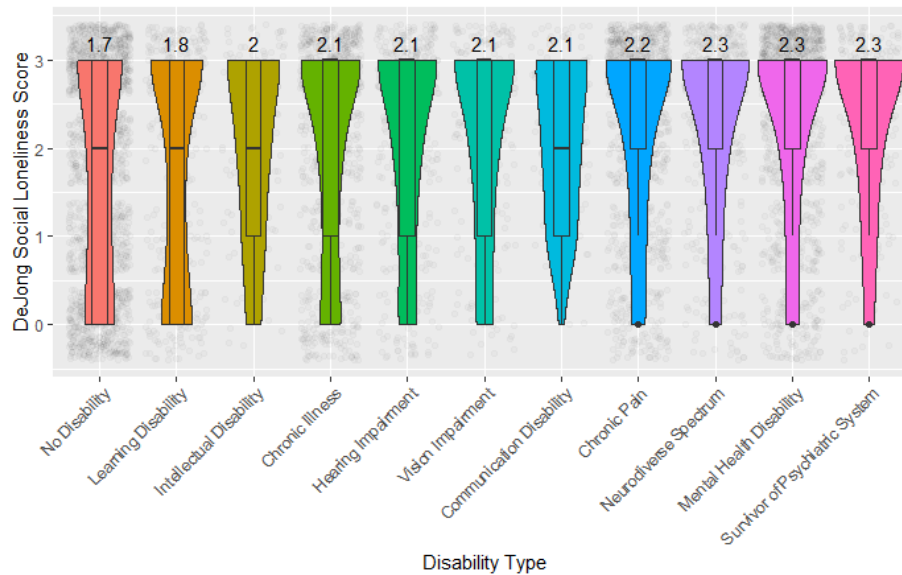


Figure 1. Social Loneliness, by Disability Type



Next, in a subset of 582 participants, we asked about self-reported barriers to social participation and compared individuals who reported a disability to those who did not. These analyses showed that across the majority of barriers to social participation were more common among people with disabilities and chief among these was lack of financial resources, mental health and stress related barriers, and challenges with transportation or accessibility.

Table 1. Barriers to Social Connection Reported by People with and Without Disabilities.

	Disability N (%)	No Disability N (%)	p-value
I cannot afford to go out with people	96 (29.6)	22 (8.5)	<0.001
I am too depressed	76 (23.5)	15 (5.8)	<0.001
It is too expensive to spend time with other people	68 (21.0)	15 (5.8)	<0.001
It's hard to get around (e.g., transportation issues)	65 (20.1)	14 (5.4)	<0.001
I am too anxious	75 (23.1)	23 (8.9)	<0.001
I am too tired	102 (31.5)	47 (18.2)	<0.001
I am too stressed	70 (21.6)	24 (9.3)	<0.001
I don't have people to hang out with	68 (21.0)	23 (8.9)	<0.001
I have social anxiety	87 (26.9)	39 (15.1)	0.001
I am embarrassed about the place I live	56 (17.3)	16 (6.2)	<0.001
I am too tired to meet people	61 (18.8)	20 (7.8)	<0.001
Nobody invites me to do things	63 (19.4)	23 (8.9)	0.001
I'm afraid people won't like me	71 (21.9)	30 (11.6)	0.002
I feel alienated by other people	55 (17.0)	22 (8.5)	0.004
I'm afraid people will think I'm unattractive	47 (14.5)	16 (6.2)	0.002
I don't want to go meet people alone	61 (18.8)	28 (10.9)	0.011
People live too far away	101 (31.2)	61 (23.6)	0.055
My living space is too small to have people over	46 (14.2)	19 (7.4)	0.014
I'm afraid of rejection	48 (14.8)	23 (8.9)	0.042
There is nothing to go and do in my community	60 (18.5)	33 (12.8)	0.078
I am worried about COVID-19	92 (28.4)	69 (26.7)	0.727
There is a language barrier between me and others	27 (8.3)	22 (8.5)	1.00
I am too busy	39 (12.0)	51 (19.8)	0.014



Discussion

Based on the evidence reviewed and analyses of data from the Canadian Social Connection Survey, it is clear that physical and mental impairments have significant impact on social health and that these impacts are quite strong in the context of other demographic and identity-related factors.

In considering how to address these disparities, it is important to recognize that social exclusion of people with disabilities arises from a complex interaction of factors, including stigma, discrimination, accessibility barriers, and the diverse nature of disabilities themselves. In understanding the relative effects of these factors, the evidence reviewed highlights external barriers to social participation as critical determinants of social wellbeing. As such, the built, natural, and social environments must be made to be accessible in order to meet the needs of people with disabilities.

In considering how to best improve environments, it's important to recognize and consider the diverse impairments that people with disabilities experience. As noted from the outset, we recognize that there is no one-size-fits all solution. Meaningful engagement of individuals and communities is needed to identify appropriate accommodations, which may include assistive technologies, enhanced supports, and other forms of structural intervention. As well, interventions must address the many different environments in which people living with disabilities seek connections. This includes supporting workplace and economic inclusion, appropriate housing supports, and opportunities to engage civically and culturally through sport, the arts, and through other leisure activities.

Conclusion

Considering the literature reviewed and our secondary data analyses, we recommend policies and practices that empower people with disabilities to find inclusion and wellbeing. Such efforts must be undertaken in consultation with affected communities and be tailored to their unique needs and the specific barriers they experience.

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