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Social Determinants, Structural Inequities, and Comprehensive Care Strategies in Mental Health for At-Risk Populations

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Abstract

Mental health is a fundamental dimension of overall health and social well-being; however, its distribution remains profoundly unequal due to structural social determinants that disproportionately affect at-risk populations. This study aimed to analyze how social vulnerabilities influence mental health outcomes in at-risk groups and to identify comprehensive and integrated care strategies capable of reducing mental health inequities. A narrative literature review was conducted using the PubMed, SciELO, and LILACS databases, combining controlled descriptors and free-text terms in Portuguese, English, and Spanish. Studies published within the last five years were included if they addressed mental health outcomes among socially vulnerable populations and examined community-based or integrated care strategies; editorials, opinion papers, duplicates, and studies lacking methodological rigor were excluded. The findings indicate that socioeconomic deprivation, discrimination, violence, housing instability, and unemployment are strongly associated with higher prevalence of depression, anxiety, trauma-related disorders, and substance misuse. The concept of cumulative risk emerged as central, demonstrating how overlapping vulnerabilities intensify psychological distress over time. Persistent systemic barriers, including economic and geographic obstacles, service fragmentation, institutional stigma, insufficient professional training, and policy discontinuities, continue to limit effective and sustained access to care. The review highlights that community-based services, primary care integration, intersectoral policies, trauma-informed practices, culturally responsive interventions, psychosocial rehabilitation, peer support, and digital health strategies are promising approaches for reducing inequities. Evidence suggests that integrated, person-centered, and rights-based models are more effective in addressing the structural roots of mental suffering. Reducing mental health inequities therefore requires sustained public investment, intersectoral coordination, and structural transformation grounded in social justice principles.

Keywords: Mental health; Social vulnerability; At-risk groups; Social determinants of health; Mental health inequities; Comprehensive care; Integrated care; Community-based mental health; Public health.

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Introduction

Mental health has increasingly been recognized as a fundamental component of overall health and social well-being, yet its distribution across populations remains profoundly unequal. Social determinants such as poverty, unemployment, gender inequality, racism, and exposure to violence significantly shape patterns of psychological distress and access to care (da Silva et al., 2025; Soares & Silva, 2025). In contexts marked by structural inequities, mental suffering is not merely an individual condition but a socially produced phenomenon, reflecting broader socioeconomic and political dynamics (Cedraz et al., 2025). These structural factors disproportionately affect at-risk groups, intensifying vulnerability to depression, anxiety, trauma-related disorders, and substance use.

In addition to the influence of social determinants, limitations within health systems further exacerbate mental health inequities. Despite advances associated with community-based care and psychiatric reform, barriers such as service fragmentation, insufficient funding, institutional stigma, and regional disparities continue to restrict access and continuity of care (Ribeiro et al., 2022; Krefer & Oliveira, 2025). High rates of psychiatric hospitalization and readmission in certain regions reveal persistent weaknesses in preventive and community-based approaches (Melo et al., 2022; Gomes et al., 2025). These challenges indicate that expanding services alone is insufficient without structural integration and intersectoral coordination.

In this context, the present study aims to analyze how social vulnerabilities influence mental health outcomes in at-risk groups and to identify comprehensive and integrated care strategies capable of reducing mental health inequities. By examining recent scientific evidence, this work seeks to contribute to the understanding of the relationship between structural determinants and mental health and to highlight pathways for strengthening equitable, person-centered, and rights-based care models.

Methodology

This study is a narrative literature review, a methodological approach that allows the collection, analysis, and synthesis of scientific evidence on a specific topic. This strategy enables the integration of studies with different designs and methodological approaches, promoting a comprehensive, critical, and contextualized understanding of mental health in at-risk groups, particularly in relation to social vulnerabilities and comprehensive care strategies.

The review focuses on identifying the main social determinants that increase mental health vulnerability, examining their impact on different at-risk populations, and analyzing integrated and community-based care strategies aimed at prevention, intervention, and psychosocial rehabilitation.

The guiding question of this review was: How do social vulnerabilities influence mental health outcomes in at-risk groups, and what comprehensive care strategies can effectively address these challenges?

The literature search was conducted in the PubMed, SciELO, and LILACS databases, selected due to their relevance in the fields of public health, mental health, social determinants of health, and health policies. These databases provide broad national and international coverage of studies addressing mental health disparities, vulnerable populations, access to care, psychosocial interventions, and health system responses.

Controlled descriptors and free-text terms were used in Portuguese, English, and Spanish, combined using the Boolean operators AND and OR. The main search terms included “mental health,” “at-risk groups,” “vulnerable populations,” “social vulnerability,” “social determinants of health,” “health inequities,” “psychosocial care,” “comprehensive care,” “integrated care,” “community-based mental health,” and “public health.”

Studies published in the last five years were included if they addressed mental health outcomes among socially vulnerable populations, such as low-income communities, racial and ethnic minorities, migrants and refugees, homeless individuals, adolescents exposed to violence, and other marginalized groups. Both national and international studies were considered, provided they contributed to understanding the relationship between social vulnerability and mental health, as well as the development and implementation of comprehensive and intersectoral care strategies.

Excluded from the review were duplicate studies, editorials, letters to the editor, opinion papers, experience reports without methodological rigor, and publications that did not directly address mental health in the context of social vulnerability or that lacked relevance to comprehensive and integrated care approaches.

The analysis of the selected studies was conducted systematically, considering thematic relevance, methodological consistency, and contribution to understanding mental health disparities among at-risk populations. Data synthesis allowed the identification of recurring thematic categories, such as structural determinants of vulnerability, barriers to access and continuity of care, stigma and discrimination, intersectoral and community-based interventions, and innovative strategies for strengthening equitable, person-centered, and rights-based mental health care.

Results and Discussion

This section presents and critically analyzes the findings identified in the literature review, organized according to the central themes that emerged from the analysis. The discussion explores how social vulnerabilities shape mental health outcomes in at-risk populations, examines structural barriers that limit access and continuity of care, and evaluates comprehensive and integrated strategies aimed at reducing mental health inequities. By articulating empirical evidence with theoretical perspectives, this section seeks to respond directly to the guiding research question and to assess whether current care models are capable of addressing the complex and cumulative nature of social vulnerability in mental health.

Social Determinants and Structural Vulnerabilities Affecting Mental Health in At-Risk Groups

The literature consistently demonstrates that social determinants such as poverty, financial insecurity, unemployment, and informal labor conditions play a central role in shaping mental health outcomes among at-risk populations. Chronic exposure to economic instability increases psychological distress, limits access to health services, and reduces protective social resources. Studies conducted within the Brazilian primary care context show that users assisted by the Family Health Strategy (FHS) often present significant socioeconomic vulnerability, which is directly associated with higher prevalence of depressive and anxiety symptoms (de Lima Júnior et al., 2022).

Furthermore, research highlights that financial insecurity not only exacerbates emotional suffering but also restricts continuity of

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care, reinforcing cycles of exclusion and mental illness (de Moura Sousa et al., 2026).

Beyond economic deprivation, structural inequality and social exclusion emerge as persistent determinants of psychological distress. Vulnerable communities frequently experience limited access to education, housing, healthcare, and social protection policies, resulting in cumulative disadvantages over time. An interdisciplinary analysis of public policies emphasizes that insufficient or fragmented social interventions tend to intensify mental health disparities rather than mitigate them (da Silva et al., 2025).

Similarly, populations living in contexts of structural vulnerability face substantial obstacles in seeking comprehensive healthcare, often encountering institutional neglect and bureaucratic barriers (da Maia et al., 2025). These structural conditions contribute to a chronic state of psychosocial stress, increasing the likelihood of depression, generalized anxiety, and trauma-related disorders.

Racism, discrimination, and stigma further compound mental health inequities, particularly among racial minorities, migrants, and socially marginalized groups. Discriminatory practices, whether institutional or interpersonal, produce persistent psychological harm, reinforcing feelings of inferiority, social isolation, and hopelessness. In primary care settings, mental health professionals report challenges in addressing the psychosocial dimensions of discrimination due to limited interdisciplinary integration and insufficient training (Almeida et al., 2022).

Moreover, Cedraz et al. (2025) emphasize that psychological care within vulnerable contexts must recognize the social production of suffering, moving beyond an exclusively biomedical perspective to incorporate social justice and rights-based approaches. This reinforces the need to understand mental health not merely as an individual condition, but as a phenomenon deeply embedded in power relations and structural inequalities.

Exposure to violence, urban, domestic, and institutional, also represents a significant predictor of adverse mental health outcomes. Individuals exposed to chronic violence are more likely to develop post-traumatic stress symptoms, substance use disorders, and severe anxiety conditions. Mental health services operating in high-vulnerability territories frequently report increased demand related to trauma and substance misuse (El Jundi et al., 2025).

Additionally, children and adolescents living in violent environments demonstrate early manifestations of emotional and behavioral disorders, underscoring the importance of early detection and comprehensive intervention within primary care (de Sousa Vieira et al., 2025).

Forced migration, displacement, and homelessness intensify these risks, as they are often accompanied by social disintegration, loss of support networks, and exposure to precarious living conditions (da Maia et al., 2025).

Importantly, the reviewed literature highlights the concept of **cumulative risk**, whereby overlapping vulnerabilities, such as poverty, racial discrimination, unemployment, and exposure to violence, interact synergistically, producing more severe and persistent mental health outcomes. Rather than acting in isolation, these determinants accumulate across the life course, amplifying psychological distress and reducing resilience. This dynamic is particularly evident in socially marginalized communities assisted by primary healthcare services, where socioeconomic hardship, limited educational opportunities, and restricted access to social protection converge (de Lima Júnior et al., 2022; de Moura Sousa et al., 2026).

The intersectionality of gender, race, class, and age further intensifies vulnerability, as women, Black populations, and young individuals in deprived contexts tend to experience disproportionate mental health burdens (Cedraz et al., 2025).

Overall, the evidence indicates that social vulnerabilities significantly influence mental health outcomes by creating chronic stress environments, restricting access to protective resources, and perpetuating structural inequities. Depression, anxiety disorders, trauma-related conditions, and problematic substance use are consistently associated with contexts of socioeconomic deprivation, discrimination, and violence. Addressing these outcomes requires recognition of the social production of mental suffering and the implementation of integrated, equity-oriented public policies capable of interrupting the cycle of cumulative disadvantage (da Silva et al., 2025).

Thus, social determinants and structural vulnerabilities are not peripheral factors but central mechanisms through which mental health inequities are produced and maintained in at-risk populations (Almeida et al., 2022).

Barriers to Access, Continuity, and Quality of Mental Health Care

Although social determinants significantly shape mental health outcomes, the persistence of unmet needs among at-risk groups cannot be explained solely by socioeconomic vulnerability. Structural barriers within health systems themselves contribute decisively to the exclusion and discontinuity of care. Economic barriers remain central, particularly in contexts where indirect costs, such as transportation, absence from informal work, or medication expenses, limit access to services. Even within publicly funded systems, resource allocation is uneven, resulting in disparities in service availability across regions (Weber & Silva, 2025). Geographic barriers further intensify inequities, especially in rural and peripheral urban areas, where specialized mental health services are scarce and referral systems are fragile.

Beyond issues of access, the fragmentation of services undermines continuity and integrality of care. Despite the principles of the Brazilian Psychiatric Reform, gaps persist between primary care, psychosocial care centers (CAPS), hospital services, and social assistance networks (Ribeiro et al., 2022). Policy reformulations over the past decade have altered the balance between community-based care and hospital-centered approaches, producing inconsistencies in service organization and outcomes (Krefer & Oliveira, 2025).

Data on psychiatric hospitalizations reveal fluctuations and, in some regions, persistent reliance on inpatient care, suggesting limitations in community support networks (Melo et al., 2022; Gomes et al., 2025). These trends indicate that the availability of services does not necessarily translate into coordinated, person-centered care.

Institutional stigma and the persistence of predominantly biomedical models also restrict effective assistance. In many contexts, mental suffering is still addressed primarily through symptom control and pharmacological management, with insufficient integration of psychosocial and community-based

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approaches (Pezzotti & Silva, 2025).

This model often neglects the broader social dimensions of distress, particularly among individuals experiencing poverty, substance use disorders, or homelessness. In CAPS AD settings, for example, social workers report structural limitations that hinder interdisciplinary collaboration and comprehensive interventions (Nascimento, 2025). Furthermore, debates surrounding involuntary hospitalization reflect tensions between rights-based care and coercive practices, raising ethical and legal concerns about autonomy and protection (Schulman, 2025; Weber & da Silva, 2024).

The shortage of adequately trained professionals and the precarization of public systems further compromise care quality. Mental health teams frequently operate under conditions of work overload, insufficient infrastructure, and limited continuing education opportunities. Nursing strategies and interdisciplinary initiatives have shown potential in addressing social vulnerability within primary care settings, yet these efforts remain constrained by systemic limitations (Oliveira et al., 2025).

The broader context of social inequality, particularly gendered divisions of labor and the disproportionate burden of care placed on women, has intensified psychological distress, especially in the post-pandemic period (Matos & Albuquerque, 2023; Soares & Silva, 2025). These structural inequities are mirrored in service demand, yet policy responses often fail to address the root causes of distress.

Importantly, access to services does not equate to effective or sustained care. High rates of psychiatric readmissions and complications related to substance abuse illustrate gaps in continuity and community follow-up (Santana et al., 2022; Pereira, 2023). Rehospitalization patterns suggest that crisis-oriented interventions frequently replace preventive and rehabilitative strategies. Moreover, insufficient public investment and policy discontinuities weaken the capacity of mental health networks to function cohesively (Weber & Silva, 2025). The unequal distribution of resources across territories reinforces cycles of exclusion, disproportionately affecting socially marginalized populations.

In this context, barriers to access, continuity, and quality of care reveal a deeper structural issue: the mismatch between the complex social production of mental suffering and the limited institutional responses available. Overcoming these challenges requires not only expanding service availability but also strengthening intersectoral coordination, ensuring equitable resource distribution, and adopting culturally sensitive, rights-based approaches that recognize the intersectionality of gender, race, class, and territory. Without structural transformation, vulnerable groups will continue to experience symbolic inclusion in policy discourse while remaining effectively underserved in practice.

Comprehensive and Integrated Care Strategies for Reducing Mental Health Inequities

Community-based mental health services are consistently identified as central strategies for reducing inequities in access and outcomes. The Brazilian Psychiatric Reform emphasizes territorial and community care as alternatives to asylum-based models (Ribeiro et al., 2022). However, policy shifts and funding instabilities have challenged their consolidation (Krefer & Oliveira, 2025). Strengthening community networks is therefore essential to address socially produced mental suffering.

The integration of primary care within mental health strategies enhances early detection and continuity of care. The Family Health Strategy has demonstrated potential in identifying psychosocial vulnerabilities and promoting comprehensive follow-up (Almeida et al., 2022; de Sousa Vieira et al., 2025). Nevertheless, integration remains uneven across territories due to workforce limitations and structural constraints (Oliveira et al., 2025). Expanding collaborative care models is crucial to improving equity.

Intersectoral policies linking health, education, and social assistance are also fundamental. Mental health inequities are deeply rooted in poverty, unemployment, and social exclusion, requiring coordinated responses beyond the health sector (da Silva et al., 2025; de Moura Sousa et al., 2026). Evidence indicates that fragmented interventions fail to disrupt cycles of vulnerability (da Maia et al., 2025). Effective intersectoral articulation strengthens prevention and social protection mechanisms.

Trauma-informed care has gained prominence in contexts marked by violence and chronic adversity. Exposure to urban and domestic violence is strongly associated with trauma-related disorders and substance misuse (El Jundi et al., 2025; Santana et al., 2022). Incorporating trauma-sensitive approaches within CAPS and primary care services promotes safer and more responsive environments. Such models acknowledge the cumulative impact of structural violence on mental health.

Culturally responsive interventions are particularly relevant for marginalized populations affected by racism, gender inequality, and stigma. Studies highlight the need to recognize intersectional vulnerabilities when designing mental health actions (Cedraz et al., 2025; Soares & Silva, 2025). Person-centered approaches must address social identity dimensions alongside clinical needs. This perspective reinforces equity and human rights principles within care delivery (Weber & da Silva, 2024).

Psychosocial rehabilitation and peer-support programs further contribute to social reintegration and autonomy. High readmission rates reveal the insufficiency of crisis-focused interventions without sustained community support (Pereira, 2023; Gomes et al., 2025). Strengthening community bonds and user participation reduces institutional dependency. These strategies align with the principle of comprehensive, rights-based mental health care (Pezzotti & Silva, 2025).

Digital mental health strategies have emerged as complementary tools for underserved populations. Telehealth and digital platforms can expand access in geographically isolated regions, although disparities in digital literacy and infrastructure persist (Weber & Silva, 2025). When integrated with primary care and community services, digital tools may enhance monitoring and continuity. However, they must not replace territorial and relational care models.

Ultimately, reducing mental health inequities requires sustainable public policies grounded in prevention, promotion, and social justice. Evidence suggests that integrated, community-oriented systems produce more consistent outcomes than hospital-centered approaches (Melo et al., 2022; Krefer & Oliveira, 2025). A human right–based framework strengthens autonomy and dignity in care provision (Schulman, 2025). Comprehensive integration across sectors remains the most promising pathway to addressing the structural roots of mental health disparities.

Conclusion

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This study aimed to analyze how social vulnerabilities influence mental health outcomes in at-risk groups and to identify comprehensive care strategies capable of addressing these challenges. Based on the reviewed literature, the objective was achieved, as the findings clearly demonstrate that mental health inequities are deeply rooted in structural determinants such as poverty, unemployment, violence, discrimination, and social exclusion. These factors operate cumulatively and intersectionally, intensifying the prevalence of depression, anxiety, trauma-related disorders, and problematic substance use among socially marginalized populations.

The analysis also revealed that, despite the existence of mental health services, significant barriers persist in access, continuity, and quality of care. Economic and geographic obstacles, service fragmentation, institutional stigma, insufficient professional training, and inconsistencies in public policies contribute to the ongoing exclusion of vulnerable groups. Importantly, the findings reinforce that access alone does not guarantee effective care. Structural weaknesses within health systems, combined with broader social inequalities, limit the transformative potential of mental health policies when not supported by sustainable investment and intersectoral coordination.

Finally, the evidence indicates that comprehensive, integrated, and rights-based approaches offer the most promising pathway for reducing mental health inequities. Community-based services, primary care integration, intersectoral policies, trauma-informed practices, culturally responsive interventions, psychosocial rehabilitation, peer support, and digital strategies demonstrate positive impacts when implemented cohesively. Strengthening these models requires political commitment, equitable resource distribution, and recognition of the social production of mental suffering. Addressing mental health in at-risk groups therefore demands not only clinical interventions but structural transformation grounded in social justice and human rights principles.

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