A Qualitative Exploration of the Experiences of Adults with Physical Disabilities in Acute Mental Health Services

Jamie Melvin-Freed

A thesis submitted for the Doctorate in Clinical Psychology (D Clin Psych)

School of Health and Social Care

University of Essex

September 2025

Acknowledgements

Thank you to all the participants and consultants who contributed their time and effort to share their experiences with me so openly. Without your voices and strength, this research would not have been possible. I am grateful for your trust in allowing me to articulate your experiences, and I hope that I have done you justice throughout this project.

I would also like to sincerely thank my supervisors, Dr Alison Spencer and Dr Stephen Wood, for believing in and sticking with me throughout the project! Your calm, encouraging support and thoughtful advice were invaluable, particularly through the challenging moments. Alison, I particularly appreciate your support in your dual role as both my thesis supervisor and personal tutor. Your kindness and containment have been a much-appreciated constant during the long journey of doctoral training.

To my partner Joshua, there are not enough words to even begin to express my thanks to you for your support. Throughout all the ups and downs of training, you have somehow managed to bring fun and laughter, even in the times I felt like I couldn't keep going. Thank you for being you. I love and appreciate you more than I can say.

Lastly, but not least, to my family. Thank you to my sister Robyn, though we are separated by distance, you have been close in my mind throughout this journey. Knowing that after finishing training and this project, I get to visit you and my nephew Daniel, has felt like a light at the end of the tunnel. A special thank you to my mum, Maggie, for your belief in me and the values you have instilled in me throughout my life. Your commitment, strength, and compassion have inspired me throughout my training. I would not be who or where I am without you. I am so excited to be reunited with you all soon!

For my dad, I wish you could have been here for this chapter and the many others to come. I carry your memory with me in everything I do. This thesis is dedicated to you.

Abstract

Background: Disabled people are disproportionately affected by inequalities in engaging mental healthcare, including inaccessibility, ableism, and exclusion. Some research has indicated that this may mean that Disabled people do not receive care until the point of mental health crisis, yet specific barriers with acute mental health services (AMHS) may further exclude those most in need. Despite this, research focused on barriers to and facilitators of disability-affirmative AMH care is relatively sparse.

Objective: The present research aimed to explore how Disabled people with physical disabilities (DPPD) experience and navigate AMHS.

Methods: Through purposive sampling, eight DPPD with direct experience of AMHS and four disability advocates with indirect experience were recruited. All participants engaged in semi-structured interviews focused on the experiences of DPPD in navigating AMHS.

Results: Through Reflexive Thematic Analysis, five themes and six subthemes were generated. The five themes were: Barriers to access, inflexibility and exclusion in acute mental health care; Lack of holistic care: integrating physical and mental health; Silencing and epistemic injustice; Discrimination, intersectionality, and identity; and Disability competence and professional avoidance.

Conclusion: AMHS can play a vital role in supporting DPPD experiencing acute mental health (AMH) needs, however interpersonal and structural ableism often means that this care is inadequate, and indeed may cause further harm. Based on these findings, several clinical recommendations can be made for systemic changes within AMHS to improve accessibility, beyond basic service availability, and facilitate more disability-affirmative care for DPPD.

Common and Frequently Used Acronyms

Table 1

Common and Frequently Used Acronyms

Acronym	Phrase or word related to an abbreviation
DPPD	Disabled people with physical disabilities
MHS / MH	Mental health service (s) / mental health
AMHS / AMH	Acute mental health service (s) / acute mental health
MHP	Mental health professional
RTA	Reflexive thematic analysis

Table of Contents

Chapter One: Introduction

Chapter Overview

This first chapter aims to introduce the key frameworks and research literature in which this thesis exists. This includes an outline of the historical, theoretical, clinical, and legal context relevant to disability studies, Disabled people's mental health – with particular attention given to acute mental health settings/services (AMHS; e.g. crisis teams, inpatient units, 136 suites, etc.). Finally, this chapter concludes by presenting a rationale for the systematic literature review presented in the proceeding chapter. Taken together, the introduction and systematic review aim to justify the current research's aims which centre on the experiences of Disabled people with physical disabilities (DPPD) within UK AMHS.

Understanding Disability

Definition

In the United Kingdom, the Disabled population is growing, comprising approximately 22% of the population (Department for Work and Pensions, 2022). There is no consistent approach to defining disability (Nario-Redmond, 2020), as the Disabled population is highly heterogeneous (Annamma et al., 2013), with notable differences in experiences across impairment type, severity, co-occurring impairment, psychosocial factors, and multiple marginalisation. For example, physical disability alone may be congenital or acquired, static or progressive, visible or invisible. For the purposes of the present research, physical disability refers to chronic illnesses or long-term medical conditions, mobility or sensory impairments, or self-identification with the label 'physical disability' (Conner et al., 2023).

Notably, some people, although accepting of their impairments, prefer not to be labelled as 'disabled' (Retief & Letsosa, 2018), perhaps due to the sociocultural devaluing of disability (Banas et al., 2019). Despite this, labels have often been externally imposed by those in positions of power (e.g. medical professionals, institutions, the state; Shakespeare, 2013). Therefore, it is important to understand the frameworks which have shaped how disability is conceptualised and responded to within healthcare services and society more broadly.

Models of Disability

Medical Model. Historically, the structures of the NHS, including mental health services (MHS), have largely drawn on the medical model of disability (Barnes et al., 2022; Beresford, 2002). This frames disability as a defect or failure of the body (Olkin, 1999; Retief & Letsosa, 2018). Through this, Disabled people are conceptualised as inherently abnormal and pitiable (Carlson, 2009). As such, the medical model has also been termed the 'personal tragedy' model (Thomas & Woods, 2003), in which Disabled people are perceived as inferior to non-disabled people (Johnstone, 2012), subsequently disregarding the social and environmental factors that may interact with impairment (Kasser & Lytle, 2005) and impact Disabled people's lives as a whole (Woods, & Thomas 2003).

This fundamentally negative framing of disability has significant consequences for healthcare, which often centre on attempts to prevent, rehabilitate, or cure disability (Carlson, 2009; Oliver, 1992). This places an expectation upon Disabled people to adopt the 'sick role' (Oliver, 1992; Parsons, 1951), however, as many impairments are not amenable to 'cures', Disabled people are labelled as non-compliant or uncooperative patients (Pfeiffer, 2003; Retief & Letsosa, 2018). In contrast, health care professionals are positioned as the primary decision-makers and experts (Thomas & Woods, 2003). Whilst clinical training and knowledge can be beneficial (e.g. offering pathways for responsibility; Barnes et al., 2022), this power imbalance has historically enabled abuses of power, particularly against Disabled people (Retief & Letsosa, 2018).

In the present, power imbalances continue to manifest in coercive mental health care practices, for example, involuntary admissions, restraint, and non-consensual treatment (Beresford, 2002). Moreover, it has been argued that the medical model underpins the structural and financial separation of various health services and organisations on the basis of diagnosis and treatment (Wade & Halligan, 2017). Within inpatient MHS, clinicians have acknowledged the continued structural dominance of and dependency on the medical model, which obscures relevant psychosocial factors (Barnes et al., 2022). Subsequently, a desire for more person-centred, integrated, and multidisciplinary MHS has been reported, indicating emerging shifts in institutional culture (Barnes et al., 2022).

Social Model. In response to the harms and disempowerment Disabled people experienced under the medical model, the Social Model of Disability (Union of the Physically Impaired Against Segregation (UPIAS), 1976) was developed by those with lived experience. This model distinguishes physical impairment from disability, in that people are disabled by an inaccessible society, designed around a non-disabled 'normate' (Hamraie, 2017), rather than the perceived limitations of their own bodies (Oliver, 2013). Subsequently, the model suggests that disadvantages are constructed by structural inaccessibility and ableism at the societal, political, and cultural level (Jóhannsdóttir et al., 2022; Oliver, 1981; 2013). However, critics argue that this framing risks overlooking the often painful lived experiences of impairment (Retief & Letsosa, 2018) as well as the individual emotional experience of oppression (Thomas, 1999). Thus, a holistic approach to Disability requires consideration of factors at both the individual and social level.

Considering this, the social model could provide a valuable lens for understanding how standard practices within MHS can function as disabling. For example, biased attitudes, inaccessible information, or practices and policies based on 'cures' (Beresford, 2002; Reeve, 2006). As Beresford (2002, p.583) highlights, these standards in practice and policy *"often fit poorly with the actual wants and circumstances of mental health service users".* Instead, application of the social model within mental health care would necessitate that services focus on non-medical support to address barriers to participation arising from ableist social and environmental factors (Beresford, 2002). In consideration of the model's stance, for change to be meaningful, the focus must be at the societal/structural, rather than individual, level (Barnes et al., 2010; Retief & Letsosa, 2018). Practically, this necessitates that Disabled people are empowered to assume control over their own lives and that those who seek to help them should be committed to facilitating this power shift (UPIAS, 1976). Thus, application of the social model to AMHS could enable care that considers the intersectional identities, strength and power of Disabled people (Garland-Thomson, 2017; Gillborn, 2015).

Biopsychosocial Model. The biopsychosocial model (Engel, 1977) attempts to integrate medical and social frameworks by positing that disability and psychological distress arise from the interaction of biological, psychological and social factors (Petasis, 2019). As such, the model may provide a more holistic conceptualisation of disability (Bath et al., 2014) and is widely adopted within the NHS, where it has been used to develop infrastructure, practices, and policies aimed at equity and inclusion for Disabled people (Shakespeare et al., 2017; Van Oudenhove & Cuypers, 2014). Despite this, the practical application of the model has been critiqued, as MHS have continued to approach care individualistically, with limited impact on structural barriers or facilitating systemic change (Pilgrim, 2015; Wade & Halligan, 2017) – a key focus of the social model.

Human Rights/Social Justice Model. The human rights model of disability emphasises the human dignity of Disabled people and provides a theoretical framework for disability policy (Degener, 2017; Retief & Letsosa, 2018). This framework encompasses human civil, political, economic, social, and cultural rights. Additionally, the human rights model argues that disability justice theories should consider Disabled people's pain and suffering (Degener, 2017). This is relevant within the context of AMHS, where, as noted above, Disabled people's suffering may be overlooked (Gibson & O'Connor, 2010) and their rights restricted (Beresford, 2002; Retief & Letsosa, 2018).

The human rights model is highly relevant to mental health policy and services more broadly, particularly as the framework it provides can be used to develop ethical and practical proposals for improving the lives of Disabled people (Degener, 2017). Notably, the human rights model provides a basis for these proposals to meet the diverse needs of Disabled people by recognising various minority and cultural identities. This is evident within lived experience and survivor-led movements in research (e.g. Critical Disability & MAD studies, etc.) and AMHS (e.g. Crisis Houses). Thus, human rights model-led services offer an opportunity for the development of more inclusive, ethical, and empowering care that aligns with the overlapping principles of disability justice (Sins Invalid, 2017) and the UN Convention on the Rights of Persons with Disabilities (UNCRPD; United Nations, 2008). Specifically, this would include services that prioritise: respect and dignity, non-discrimination and intersectionality, and collective access, participation, and liberation.

Critical Disability Perspectives. While the social and human rights models of disability have led to advancements in how disability is understood within a sociopolitical context, critical disability theory extends these frameworks by critically examining how ableism is maintained through structural power, cultural norms, and institutional designs (Hosking, 2008; Meekosha & Shuttleworth, 2009). Indeed, critical disability approaches

critique traditional approaches to disability research as minimising Disabled people's pain and suffering (Mollow, 2017), adopting reductionist understandings of physical disability (Meekosha & Shuttleworth, 2009), and connected to other systems of oppression (e.g. classism, patriarchy, and white supremacy; Hall, 2019).

Through this, critical disability perspectives seek to shift emphasis away from medical model frameworks, which require Disabled people to conform to ableist ideals, towards how dominant systems, including healthcare, construct notions of normalcy, foster rigidity, and respond to issues at the intersection of multiple marginalised identities (Hosking, 2008; Linton, 2005). As such, within mental health settings a critical disability perspective seeks to investigate how ableism is embedded within service designs and operating procedures, and clinical practice. Crucially, critical disability approaches seek to centre lived experience and challenge power hierarchies that position professionals as the sole experts (Hall, 2019). Thus, applying a critical disability lens to an AMHS context enables an examination beyond simply the accessibility of these services to understand how institutional structures, priorities, and knowledge hierarchies contribute to disablism.

Relevance to the present study. Primarily, this research aims to contribute to the existing body of critical disability studies, a radical and reflexive approach that seeks to critique dominant systems and power structures through centring lived experience (Hosking, 2008; Meekosha & Shuttleworth, 2009). Subsequently, this thesis is informed by both the Social (UPIAS, 1976) and Human Rights (Degener, 2017) models of disability through the examination of how AMHS might act as disabling or affirming.

In line with these frameworks, this thesis chooses to use identity-first language, referring to "Disabled people" rather than "people with disabilities". This decision aligns with the social model of disability and the preferences expressed by many activists and academics within the Disability Rights movement (Oliver, 1990). Using identity-first language reflects the present research's critique of the medical model and acknowledges the systemic and societal oppression of Disabled people, as well as their acts of resistance (UPIAS, 1976).

Epistemic Injustice

The theoretical lens of epistemic injustice (Fricker, 2007) is also highly relevant to the study of disability and mental healthcare experiences. Epistemic injustice refers to forms of inequality that occur when individuals are dismissed in their capacity as knowers or holders of knowledge. Specifically, Fricker distinguishes between testimonial and hermeneutical injustice, through which marginalised groups are perceived as less credible, lacking capacity, or are denied equitable access to shared interpretive resources when making sense of their experiences (Carel & Kidd, 2014; Fricker, 2007; Hunt & Blease, 2024). Thus, this concept aligns with critical disability research by centring lived experience and exposing power relations as a means of understanding how Disabled people may be marginalised, particularly in medical systems.

Within mental healthcare, epistemic injustice has been used to understand how service users' accounts may be dismissed, minimised, or misinterpreted through dominant biomedical frameworks (Hultman & Hultman, 2023). Consistent with this, Disabled people accessing these services have reported experiencing both implicit and explicit epistemic injustice, including the legitimacy of their needs being questioned (access, physical and mental health), pathologisation of disability, diagnostic overshadowing, and gaslighting (Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Wang et al., 2024). These injustices may arise and be compounded through ableist assumptions about competence, capacity, and dependence related to both physical disability and mental health. For example, those with disputed or invisible disabilities may be perceived as "phony or fools" (Fitzgerald & Paterson, 1995), and thereby their experiential knowledge is devalued or dismissed (Carel & Kidd, 2014). Similarly, in other healthcare settings, the narratives of patients with co-occurring mental health diagnoses were frequently disbelieved due to implicit assumptions of emotionality, irrationality, or unreliability (Carel & Kidd, 2014). Considering this, there may be an increased likelihood of epistemic injustice occurring within AMHS, where distress can often be conceptualised through diagnostic categories and risk management prioritised.

Disability, Ableism and Mental Health

In comparison to non-disabled people, Disabled adults have been found to have poorer wellbeing and higher levels of anxiety (Office for National Statistics, 2022). This is consistent with other findings that Disabled adults more frequently reported depression, anxiety, stress, emotional distress, reduced access to healthcare, and risk behaviours related to health (Cree et al., 2020; Dawood et al., 2022). Concerningly, a recent qualitative study reported that 55% of Disabled adults who participated disclosed having experienced suicidal ideation within the past two years (Glasgow Disability Alliance (GDA), 2022). Additionally, emotional distress was most frequently reported by those with both cognitive and mobility disabilities, who had unmet health needs related to financial cost, were unemployed, identified as LGBTQ+, and reported adverse health behaviours (e.g., smoking or physical inactivity; Cree et al., 2020; GDA, 2022).

Evidence has shown that Disabled people are at greater risk of experiencing health inequalities (Sakellariou & Rotarou, 2017), which have been theorised to arise from sociocultural and systemic circumstances, including stigma, discrimination, poverty, and social exclusion (Emerson et al., 2012; World Health Organisation (WHO), 2023). These patterns reflect a system of marginalisation identified as ableism (King et al., 2019). Ableism is defined as *"prejudice and discrimination toward individuals simply because they are classified as disabled – regardless of whether their impairments are physical or mental, visible or invisible."* (Nario-Redmond, 2020, p. 6). Research has shown that ableism is a significant factor in understanding the experiences of Disabled people, with complex social, physical, and psychological impacts (Jóhannsdóttir et al., 2022). For example, being subject to ableist microaggressions decreased positive mental health outcomes and increased somatic symptoms (Conner et al., 2023; Kattari, 2020). Similarly, internalised ableism had negative consequences for identity and health (Jóhannsdóttir et al., 2022), including anxiety, depression, social isolation, feelings of powerlessness and inferiority, and problems with body image (David, 2013). This represents a phenomenon termed psycho-emotional disablism (Thomas, 1999), through which sociocultural attitudes and responses towards impairment marginalise Disabled people and cause psychological and emotional harm.

Additionally, not only has ableism been linked to increased psychological distress, but this association was most pronounced amongst those who were labelled with psychological disabilities (Brown & Ciciurkaite, 2022). Furthermore, those with more visible, complex or severe impairments, or intersecting marginalised identities (e.g. associated with race, gender, etc.) were more likely to experience unmet health needs and discrimination (Conner et al., 2023; Kattari, 2020; King et al., 2019; Reeve, 2006; Sakellariou & Rotarou, 2017; Wang et al., 2024). For example, visible disability has been associated with paternalistic ableism, whilst invisible disability is more closely linked to invalidation and disbelief (Fitzgerald & Paterson, 1995; Nario-Redmond et al., 2019). Notably, this compounded discrimination has been argued to create a 'chain of dismissal' which negatively impacts both physical and psychological health (Tinner & Curbelo, 2024). Thus, the importance of accounting for the effects of multiple marginalisation, difference and layered discrimination on the mental health of Disabled people is indicated (Dispenza et al., 2017; Tinner & Curbelo, 2024).

Notably, unmet healthcare needs were found to be particularly problematic in mental healthcare, where cost was a primary barrier to access (e.g. seeing a psychiatrist/psychologist or collecting prescribed medication), even in the context of UK NHS services (Sakellariou & Rotarou, 2017). Given that Disabled people are more likely to be 'economically inactive' (Kirk-Wade et al., 2024), alongside the recent planned cuts to disability-related benefits and ongoing austerity measures in the UK, consideration of cost as a barrier to care is of high importance. Concerningly, research has argued that ableism creates interpersonal and structural barriers for Disabled people across their interactions with MHS (Conner et al., 2023; Wang et al., 2024), which broadly present as physical, attitudinal, transportation, and informational barriers. Subsequently, inaccessibility and exclusion from MHS can be argued to extend beyond ableism, to reflect structural disablism, defined as systems that disadvantage Disabled people and privilege non-disabled people, policies, and sociocultural norms (Lundberg & Chen, 2024). In line with this, it is argued that Disabled people are frequently excluded from services when they cannot conform to the inflexible and ableist expectations centred around non-disabled norms (Hamraie, 2017; Campbell, 2009).

Experiences of Mental Health Services

Research regarding Disabled people's experiences of MHS or treatment is limited (Foley-Nicpon & Lee, 2012), however illustrates concerning findings, including physical and procedural inaccessibility, a lack of reasonable adjustments, and unmet health needs – all of which exacerbated psychological distress (Conner et al., 2023; Chrysikou, 2013; Wang et al., 2024). For example, Disabled people have reported experiences of rights violations, dismissal, distrust, stigma, and delayed support and crisis interventions (GDA, 2022). Repeated experiences of micro-aggressions and discrimination within interactions with MHS and psychological therapies were also reported (Jóhannsdóttir et al., 2021), which was associated with reports of increased anxiety, depression, and pessimism about the world (GDA, 2022).

Similarly, ableism within U.S. MHS was characterised by diagnostic overshadowing, medical gaslighting, a lack of disability competence, inaccessibility, and interpersonal and systemic discrimination (Conner et al., 2023; Wang et al., 2024). Notably, this can impede Disabled people's ability to develop a positive relationship with their identity (Jóhannsdóttir et al., 2021).

In regard to physical disability, research has highlighted compounded marginalisation, a lack of cultural competency, dismissal of identity and disability-related topics, physical and attitudinal barriers, lack of knowledge and willingness to self-educate, and the positive impact of affirmative practice (Conner et al., 2023; Hunt et al., 2006). Subsequently, Disabled people have reported mistrusting and avoiding formal MHS, often relying instead on self-advocacy, family, friends, and third-sector or community organisations for mental health support, even when in mental health crisis (GDA, 2022; Wang et al., 2024). These negative experiences of care may discourage future help-seeking from MHS, known as 'recursivity' (GDA, 2022; Lowther-Payne et al., 2023; Petrin et al., 2020). This not only disadvantages and burdens Disabled people, but can also increase strain on family and other caregivers (WHO, 2023).

The recent COVID-19 pandemic further complicated Disabled people's access to MHS (McBride-Henry et al., 2023). Increased levels of distress and despair were reported in relation to the pandemic and the resulting lockdown (Hall et al., 2022; Sage et al., 2022). This was particularly significant for Disabled people with multiple marginalised identities, including age, ethnic background, and geographical location (LaVela et al., 2022; McBride-Henry et al., 2023). For example, whilst online/virtual services were helpful for some, this also further highlighted inequalities and issues with access (e.g. digital poverty; McBride-Henry et al., 2023). Subsequently, some Disabled people reported feeling they had no route to access psychological support. This aligns with the findings of a UK systematic mapping review, which identified key barriers as Disabled people's 'ability to seek' (e.g. discrimination, stigma) and 'ability to reach' (e.g. service availability) MHS (Lowther-Payne et al., 2023).

Acute Mental Health Services

In the UK, acute mental healthcare is primarily delivered by the NHS, comprising inpatient and community or A&E-based mental health crisis services (Lamb et al., 2019; Johnson et al., 2022). These services aim to provide intensive, typically short-term support to individuals experiencing mental health crises. Specifically, crisis services aim to prevent hospital admission, whilst acute inpatient wards support those requiring close monitoring and risk management. For individuals deemed to be at significant risk towards themselves and/or others, care within these settings occurs under detention through the Mental Health Act (1983, amended 2007). As such, acute mental healthcare is often characterised by stabilisation, risk containment, and rapid discharge (Lamb et al., 2019).

Although these services are reportedly of high importance for service users, carers and professionals, care within these settings is often described as traumatic, coercive, or failing to evidence sustained improvements (Johnson et al., 2022). Inpatient MHS in particular have been associated with limited access to psychological therapies, coercion and compulsory treatment, discrimination, inadequate staffing numbers, and overly restricted care (Staniszewska et al., 2019; Sweeney et al., 2015; Walsh & Boyle, 2009). These concerns are often related to broader systemic pressures, specifically a lack of resources to meet demand (e.g. overcrowding, understaffing, and bed shortages), emphasis on risk management over therapy, the use of restrictive measures, and poor continuity of care (Johnson et al., 2022). As such, several reports have called for necessary improvements in UK crisis care (e.g. Care Quality Commission 2017; Commission on Acute Adult Psychiatric Care, 2016; etc.) Whilst no single model of acute mental healthcare is optimal, flexible systems which prioritise co-production, autonomy, safety, and relational practice have been identified as offering potential for improvements in experience and outcomes (Johnson et al., 2022).

These systemic issues may be further compounded for Disabled people who experience acute mental healthcare. For example, those who experienced inpatient mental healthcare expressed feeling that staff support was biased towards their non-disabled peers and a lack of understanding of their needs, particularly in relation to mental health (Parr, 2019). These experiences had adverse effects on willingness to seek help, risked Disabled people being subject to increased restrictions, and contributed to physical and mental health deterioration (Chrysikou, 2013; Staniszewska et al., 2019; Sweeney et al., 2015). Within crisis services, challenges have been reported in accessing timely and adequate support when experiencing crisis (GDA, 2022; Morris, 2004). Crisis services have been argued to frequently fail to understand the specific needs of Disabled people (Morris, 2004) or recognise the seriousness of their crises (GDA, 2022). In some instances, interventions were reportedly only offered following a suicide attempt, despite prior disclosures of suicidal ideation and repeated help-seeking attempts. Subsequently, many participants reported exacerbated feelings of hopelessness, isolation, and distress. Additionally, Disabled adults reported concerns regarding long waiting times and limited availability of support from crisis services (Morris, 2004). This perhaps reflects a shift away from preventative care in crisis services operating in the context of increased strain (GDA, 2022). Subsequently, the inadequacy of crisis services frequently left Disabled people dependent on community organisations, particularly when statutory services halted during the pandemic (GDA, 2022). In these circumstances, the need for improved services, including options for residential crisis support (Morris, 2004), is clear.

Instead, it is recommended that effective mental health support for Disabled people requires accessible environments, personal assistance, and comprehensive training for MHPs to meet the complex needs of this population (Morris, 2004). This extends recommendations for good practice within the general population accessing inpatient mental healthcare, which was found to be facilitated through strong therapeutic relationships (e.g. characterised by respect, empathy, trust, reliability, helpfulness, and good communication), efforts to counteract negative experiences of coercion (e.g. professional interactions with staff, explanation of the reasons for coercion, clear communication about consent, medication, and use of seclusion, etc.), a physically and socially safe environment (e.g. peer support, regular contact with family and friends, access to outside space and a place of worship, feeling empowered to make decisions), and authentic person-centred care (e.g. shared decision making, sensitivity to protected characteristics and intersectional identities, provision of information about their care/diagnoses and rights, and being seen as an individual; Eldal et al., 2019; Staniszewska et al., 2019).

Physical Health in Mental Health Settings

Disabled people admitted to inpatient mental health settings may be likely to require ongoing physical healthcare, and it is the responsibility of services to provide this to a good standard (General Medical Council, 2001). However, research has evidenced difficulties in understanding and managing physical health conditions within mental healthcare settings. For example, The Royal College of Psychiatrists (2009) has reported that the skills to manage general healthcare may be lacking among psychiatrists, as they have specialised in mental healthcare. Similarly, issues have been found within the routine physical health practices of inpatient services, such as an absence of physical health care planning, a lack of records and documentation, and limited communication with physical health providers (NCEPOD, 2022; Rodgers et al., 2018). Furthermore, diagnostic overshadowing, in which physical symptoms are overlooked or misunderstood (Jones et al., 2008), has been highlighted as a barrier to effective care for those with both physical and mental health needs (Molloy et al., 2023). Considering this, it may be unsurprising that mental healthcare staff have reported lacking confidence and competence in supporting patients with long-term physical health conditions and subsequently have highlighted a need for further training (NCEPOD, 2022).

In comparison, good practice in relation to physical healthcare has been found to be facilitated through organisations having a clear and specific physical health strategy, which emphasised communication with patients and family/carers (NCEPOD, 2022). This included accurate electronic records, sharing information across physical and mental healthcare services, regular physical health reviews, and facilitating regular access to primary care and specialist services (NCEPOD, 2022; RCP, 2009; Welthagen et al., 2004). Notably, healthcare providers should also be aware of health inequalities relating to protected characteristics that are associated with mental and physical health, access, and interactions with health services (RCP, 2009).

Standards and Policies

The UK Equality Act (2010) mandates legal protections from discrimination (direct or indirect), harassment, and victimisation, on the basis of protected characteristics (e.g. age, disability, race, etc.). The act also makes explicit the duty of services to provide reasonable adjustments to facilitate equity and inclusion of Disabled people. Alongside this, The Royal College of Psychiatrists Standards for Inpatient Mental Health Services (Perry et al., 2017) set out the following standards relevant to disability: patients and carers should be treated with compassion, dignity, and respect, including in respect of protective characteristics; information for patients and carers should be available in accessible formats for people with sight/hearing/cognitive difficulties including audio, video, symbolic, pictorial, and signers as necessary; and that the environment should comply with the Equality Act (2010) legislation on disability access including assistive technology and equipment.

Unfortunately, research has suggested that despite legal requirements, reasonably adjusted and person-centred care is not consistently provided (Read et al., 2018), indicating a gap between policy and practice. This may be due to NHS pressures to deliver effective, time-limited, and affordable services in a context where resources are limited (Staniszewska et al., 2014). Consistent with this, it has been argued that NHS policies designed to facilitate equality focus heavily on the availability of services, rather than other aspects of service operation or accessibility, including differences in the resources people have available to them (Sakellariou & Rotarou, 2017).

Disability-Affirmative Approaches

Disability-affirmative practice refers to a therapeutic and systemic approach which recognises disability as a valued aspect of human diversity, rather than a deficit or pathology (Olkin, 2007; 2017). In contrast to traditional medicalised approaches within MHS which may conceptualise difficulties as primarily related to individual deficits, disability-affirmative

approaches in mental healthcare are characterised by an affirming and constructivist stance toward disability. These approaches are designed specifically to avoid over-inflation or under-estimation of the role of disability within Disabled people's lives (Conner et al., 2023; Olkin, 2007; 2017), by advocating for individual experiences to be understood within the broader context of ableism, microaggressions, intersectionality, and disability culture (Olkin, 2007; 2017).

Disability-affirmative approaches necessitate validation of Disabled people's lived experiences and acknowledgement of disability as a social and political identity. This stance necessitates that mental health professionals (MHPs) critically examine their own assumptions, biases, and gaps in disability competence (Olkin, 2007; 2017), and through this develop a reflexive 'affirmative consciousness' that can enhance accessibility and inclusion in therapy (Dispenza et al., 2017; Nash, 2013). Crucially, disability-affirmative therapy (D-AT; Olkin, 2007; 2017) provides a lens which can be integrated within any therapeutic model, and thus, this presents an opportunity for the framework to be applied within AMHS.

Aligned with this, the APA (2022) and GDA (2022) have both published recommendations for improved mental health care for Disabled people. These broadly relate to centring Disabled people's voices; accessibility of services; knowledge and awareness of clinicians; training and education; disability and diversity-affirming language and behaviour; addressing gaps in services; and upholding Disabled people's human rights. Despite this guidance, mental health professionals (MHPs) have often been found to lack disability competence and training, and indeed may not recognise the need for further professional development in this area. As such, this may present a barrier to the integration of D-AT and further the risk of poor outcomes and disengagement from services (Artman & Daniels, 2010; Olkin & Taliaferro, 2006; Wang et al., 2024). However, due to the lack of psychological

research on disability and mental health (Artman & Daniels, 2010), it is unclear if professional standards are being met with AMHS.

Chapter Summary

This chapter has outlined the key historical, theoretical, and legal frameworks, as well as the body of research, in which the study is grounded, particularly focusing on the experiences of Disabled people with physical disabilities (DPPD) in navigating acute mental health services (AMHS). Limited previous research has explored Disabled experiences of mental healthcare and treatment more broadly, and from the perspective of other disability sub-types (Conner et al., 2023). This reflects a lack of data collection or analysis focused on disability within health services (McBride-Henry et al., 2024). Subsequently, a systematic literature review is presented in Chapter 2, with the aim of synthesising the existing literature and identifying gaps in knowledge relating to DPPD's experience of mental healthcare.

Chapter Two: Systematic Literature Review

Chapter Overview

This chapter presents a further exploration of the existing research literature through a detailed systematic review of empirical studies examining experiences of mental healthcare amongst Disabled people with physical disabilities (DPPD). The findings of several research studies selected for review are integrated, evaluated, and analysed. Through this process, gaps within the existing literature are identified and discussed in relation to the rationale and research questions of the present study.

Introduction

Systematic literature reviews are a core component of academic research, offering a structured and rigorous approach to synthesising evidence from the existing research (Booth, 2016). By examining the breadth and depth of relevant literature, systematic reviews facilitate the identification of key themes, highlight gaps in current knowledge, and provide recommendations for future research and clinical practice (Thomas & Harden, 2008; Garside, 2014). This makes them particularly useful within applied disciplines such as clinical psychology, where policy and practice are increasingly informed by lived experience and service-user perspectives (Hannes & Macaitis, 2012).

The present review utilised a qualitative thematic synthesis approach (TS; Thomas & Harden, 2008), as it enables a comprehensive overview of existing empirical work while remaining grounded in participants' lived experiences. TS offers a transparent and systematic approach to coding qualitative data, developing analytical themes, and drawing conclusions grounded in participant narratives. This approach was considered more appropriate than alternative qualitative synthesis methods such as meta-ethnography (Noblit & Hare, 1988), which are more interpretive in nature and primarily used to generate new conceptual models or theoretical frameworks (France et al., 2019).

The initial search identified a published scoping review protocol exploring Disabled adults' experiences of accessing mental health counselling and psychotherapy (Longhurst & Full, 2023). A further search found no evidence that this protocol had been completed, indicating that this area remains under-examined. Subsequently, this protocol was read in full to ensure the novelty of the present review.

Objective

The current review aims to develop a greater understanding of the experiences of DPPD within mental healthcare broadly, specifically focusing on their unmet needs, experiences of discrimination, and recommendations for affirmative practice. It is hoped that this will highlight gaps in mental health care for DPPD, with implications for the development of effective, inclusive, and accessible systems. The following research questions were developed for the present review:

- How do DPPD navigate mental healthcare, and how do these experiences impact their wellbeing?
- What factors present barriers to or enable DPPD's engagement with mental health care?

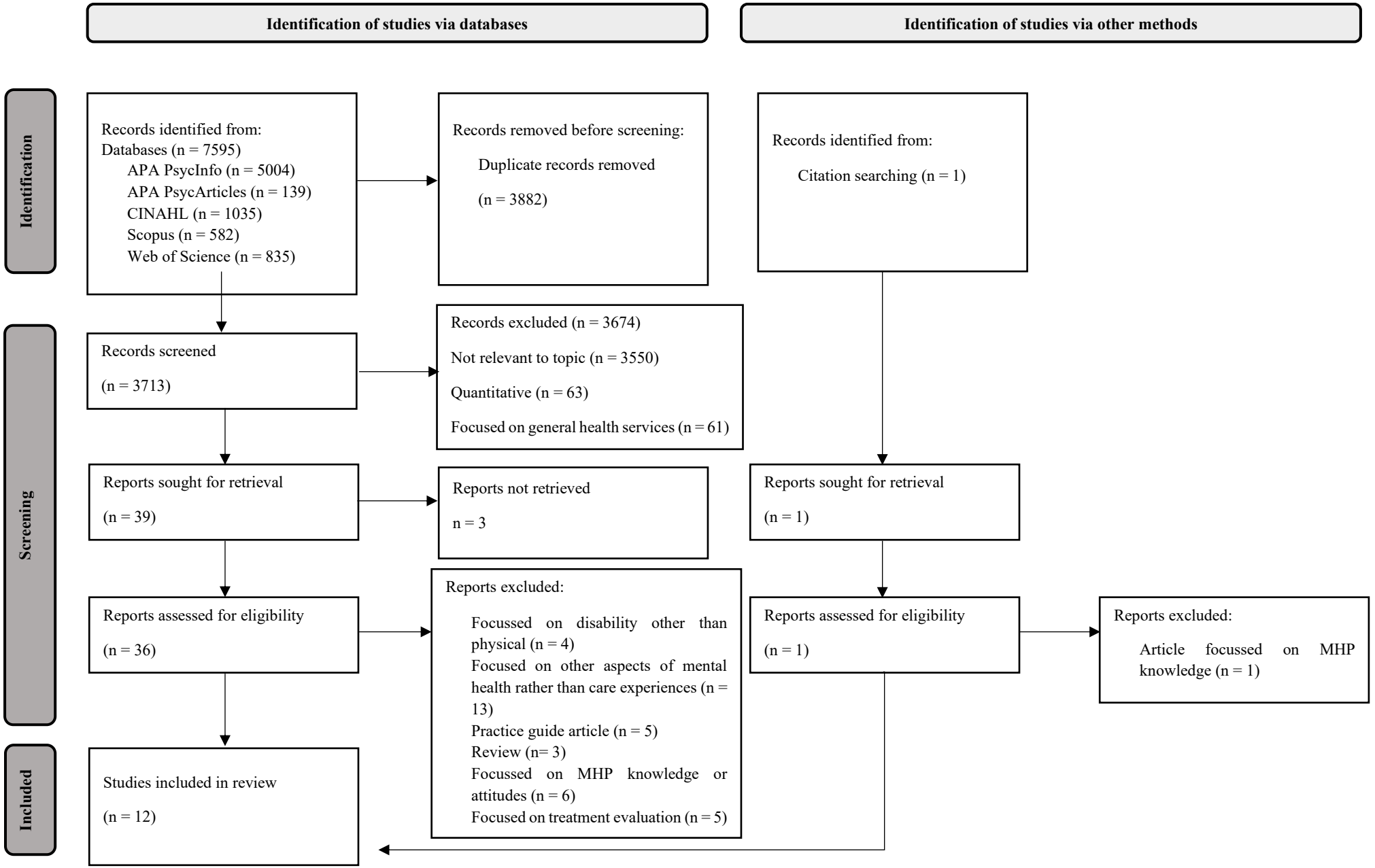
- How do DPPD's experiences of mental health care vary alongside intersecting marginalised identities?
- What recommendations do DPPD and Disability advocates have for improving existing mental health care systems?

Method

A qualitative design was applied within the review, as it was deemed that this would most effectively capture the in-depth and diverse accounts of DPPD's experiences of mental healthcare. Meta-synthesis was conducted using Thomas and Harden's (2008) TS method, as it was designed to facilitate examinations of the effectiveness of current healthcare practices (Barnett-Page & Thomas, 2009), and therefore aligned with the aims of the present review. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009) were followed, and a PRISMA Flow Diagram is presented below (Figure 1).

Figure 1.

PRISMA-Flow-Diagram



Literature Search Strategy

A scoping search of the literature was conducted, including the Cochrane Library and the Centre for Reviews and Dissemination databases. This aimed to identify any existing reviews centred on the selected topic area. Following this, in January 2025, an electronic search was performed of the databases PsycINFO, PsycArticles, CINAHL Ultimate, Web of Science, and Scopus. The strategy involved searching for journal articles using the options 'Title', 'Abstract' and 'Keywords'. Database searches used various related terms associated with concepts significant to the research questions: physical disability, mental healthcare, experiences, access, and ableism. Through further exploration of relevant research and consultation with an academic librarian, additional search terms were identified and included within the search strategy. To facilitate the identification of all relevant literature, search terms were truncated (e.g., disab* = disabled, disability) and Boolean operator functions applied ('AND'/'OR'/'NOT'). The specific search terms used are summarised in Table 2.

Date limitations were set on the database searches to return articles published from 1 January 2010 to January 2025. This limitation was set to focus the review on research relevant to and reflective of current practices within mental healthcare. Furthermore, the date limitation is reflective of the introduction of Disability legislation relevant to mental health service provision, for example, the UK's Equality Act (2010) and the United Nations Convention on the Rights of Persons with Disabilities (2008).

Table 2

Database search strategy
1. disab* OR “chronic* ill*” OR “chronic health” OR “physical* disab*” OR “physical* impair*” OR “mobility impair*” OR blind* OR “visual* impair*” OR “neurological disorder*” OR “musculoskeletal disorder*” OR deaf OR "hard of hearing" OR "hearing impair*" OR ableism OR ableist
2. “mental health service*” OR “psychiatr* service*” OR “mental healthcare” OR “psychiatr* care” OR "mental health treatment” OR “mental health act” OR “psycholog* service*” OR “psycholog* care” OR “psychology* support” OR “psychological therap*” OR “mental health counselling” OR “community mental health” OR “inpatient mental health” OR “inpatient psychiatr*” OR “mental health hospital*” OR “psychiatric hospital*” OR “in-patient mental health” OR “in-patient psychiat*”
3. experience* OR perspective* OR perception* OR attitude* OR opinion* OR view* OR satisfaction OR barriers OR “access to care” OR qualitative OR ethnograph* OR interview* OR narrative* OR theme* OR NVivo OR MaxQDA
4. “development* disab*” OR “learning disab*” OR “cognitive* disab*” OR “intellectual* disab” OR “learning disorder*” OR “autis*” OR “adhd” OR “attention deficit hyperactivity disorder” OR “attention deficit disorder” OR infant* OR child* OR adolescen* OR teen*
5. 1 AND 2 AND 3 AND NOT 4

Selection Criteria for Studies

Eligibility criteria for selecting studies were guided by the SPIDER method (Table 3) against which articles were screened to determine relevance to the present review. Studies including children (<18 years old) and sub-types of disability not classified as relating to physical impairment were excluded (e.g. developmental, intellectual, or neurodiversity), except for psychiatric disability. The term 'psychiatric disability' was not used as an exclusion criterion, given the focus of the review on the intersection between physical and psychiatric disability. Accordingly, articles that included reference to psychiatric disability without physical disability/impairment were excluded. Only qualitative and mixed methods designs, in which qualitative data could be extracted from overall findings, were deemed eligible for inclusion in meta-synthesis. Subsequently, research using quantitative, experimental, and observational methods, as well as review articles, was excluded. Lastly, the present review permitted the inclusion of grey literature (e.g. theses, dissertations, conference papers, etc.) to capture a broader range of perspectives (Mahood et al., 2014) and identify gaps within the existing research literature (Adams et al., 2016).

Notably, whilst designing and conducting the review, the researcher was aware of ongoing debate concerning whether disability research should include Deaf participants (e.g. Scully, 2019). The Social Model of Disability (UPIAS, 1976) recognises that the Deaf and Disabled communities share socio-political experiences of oppression, marginalisation, and injustice (Kenny, 2004). Conversely, others perceive Deaf people as having a unique cultural-linguistic identity, distinct from those who identify as 'hearing' and Disabled (Ladd, 2003). To determine appropriate selection criteria, the researcher considered key disability frameworks, as outlined above, as well as the review's aims and research questions. It can be argued that, whilst Deaf individuals may hold a distinct cultural-linguistic identity, they are likely to experience similar systemic barriers to access and quality mental health care to other Disabled populations, including limited access to MHS and poorer mental health outcomes than the non-disabled hearing population (McDonnall et al., 2017; Rogers et al., 2024; Vernon, 2007). Thus, it was deemed appropriate to include Deaf people's narratives within the review to facilitate a more comprehensive exploration of structural barriers (Scully, 2019).

Table 3

SPIDER-informed Inclusion and Exclusion Criteria

	Inclusion criteria	Exclusion criteria
S: Sample	Physically Disabled adults (>18 years old), Disability advocates, and/or healthcare professionals with experience working with Disabled people.	Disabled children (<18 years old), disabilities not classified as physical (e.g. intellectual, developmental, etc.).
P/I: Phenomenon-of-Interest	Experiences of mental healthcare since 2010.	Experiences of other health services (e.g. primary care, general health services), and experiences of mental health services before 2010.
D: Design	Interview, focus group, questionnaire or survey (where open-ended questions were included).	Experimental, observational, or quantitative design.
E: Evaluation	Experiences, perspectives, perceptions, attitudes, opinions, or views.	Quantitative measures.
R: Research Type	Qualitative or mixed-methods (where the method used to examine the experiences of Disabled adults was qualitative).	Quantitative or review.

Data Extraction and Synthesis

The papers selected for analysis were imported into NVivo Software Version 15. Following this, the three-stage process of thematic synthesis (Thomas & Harden, 2008) was followed: (1) open line-by-line coding of primary findings to identify key concepts and create free codes, (2) organisation of free codes into descriptive themes through examination of similarities and differences, and finally (3) the generation of analytic themes to 'go beyond' the interpretations of the original studies and answer the review questions.

Descriptive information and a summary of each article's key findings were extracted into Table 3, including: lead authors, primary focus of the study, research location, sample description, research and data analysis method, and a summary of main qualitative findings.

Reflexivity

As a non-disabled person, I am mindful that my position as an outsider may limit my understanding of the nuanced experiences of Disabled people. Subsequently, I aimed to approach this review with an awareness of how my privilege influenced my interpretations and assumptions. Accordingly, I discuss my positioning in relation to the review rationale and development of themes.

Whilst conducting the review, I was working as a trainee clinical psychologist within a specialist clinical health psychology setting, which involved direct therapeutic work with Disabled people and people with long-term health conditions, as well as consultation with medical professionals. Before entering this setting, I had previous professional experience working within NHS MHS, both with Disabled and non-disabled individuals, including within secure inpatient and intellectual disability settings. Subsequently, my knowledge and assumptions were likely shaped by the dominant narratives of Disability within healthcare and clinical psychology training curriculum. My individual experiences working directly with Disabled people will also have shaped my understanding, particularly of the accessibility of services and working cross-culturally with Disabled people as a non-Disabled professional. Similarly, my experiences as a relative of Disabled family members mean that I also have personal and relational influences upon my understanding of Disabled people's experiences navigating services. Overall, my experiences are likely to have influenced the way I have engaged with and interpreted the data, including the development and presentation of the review findings.

Results

Search Results

All results from the database searches were exported to the reference management program Zotero. A total of 7595 articles were sourced from database searches. Following this, 3882 duplicates were removed automatically and manually. As discussed above, eligibility criteria for selecting studies were guided by the SPIDER method (Table 3) against which the titles and abstracts of the 3713 remaining articles were screened. Through this process, a total of 3674 articles were excluded, resulting in 39 articles. Of this, one article was unable to be retrieved. 36 articles were read in full, and 24 were excluded for not meeting the inclusion criteria. The reference lists of selected studies were searched, from which one further study was retrieved, but was excluded after being read. Finally, twelve articles were selected for meta-synthesis (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011).

Characteristics of Included Studies

All studies broadly explored the experiences of DPPD receiving mental healthcare or treatment from the perspective of Disabled people, disability advocates, carers, and/or healthcare professionals. Six studies focused on psychological treatments, including psychotherapy and counselling (Braakman & Sterkenburg, 2023; Conner et al., 2023; Dispenza et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Thurston, 2010). The remaining six studies focused on mental healthcare or services more broadly (De Clerck & Willems, 2023; Gerke, 2017; Methley et al., 2017; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). Ten studies used a qualitative methodology and two employed a mixed-methods approach. Methods of data collection included nine studies, which used interviews, two which used surveys, and one which used a focus group. Approaches to data analysis included thematic analysis, consensual qualitative research, content analysis, phenomenological methodology, constant comparative analysis, and grounded theory. Further details on key study characteristics for all 12 papers are presented in Appendix A.

Sample sizes ranged from 7 to 63, and across studies there were 391 participants. This included DPPD with and without direct experience of mental healthcare (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011), health and social care professionals (e.g. psychologists, psychiatrists, psychiatric nurses; physicians; social workers, etc.; Braakman & Sterkenburg, 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Methley et al., 2017), and relatives of Disabled people (Braakman & Sterkenburg, 2023). The Disabled participants in the selected studies reported a range of physical disabilities and/or long-term health conditions, including: blindness or vision loss, deafness or hearing impairment, multiple sclerosis, spina bifida, spinal cord injury, diabetes, Graves' disease, mobility impairment, brain injury, or multiple disabilities. One study (Powers, 2024) also collected data from Disabled people who reported 'psychological/emotional' and 'neurodivergent' disabilities without co-occurring physical disability, however only data collected from participants with physical disabilities was included in the present analysis. Geographical locations of studies included Belgium (1), the Netherlands (1), the UK (2), and the USA (8).

Critical Appraisal of Studies

The twelve studies selected for the present review were critically assessed for quality using the Critical Appraisal Skills Programme qualitative tool (CASP, 2018). The CASP tool comprises nine checklist-style items and one open-ended question to be used in the quality assessment of qualitative research. The CASP qualitative tool does not use a numerical scoring system through which studies can be categorised, instead the tool was used to highlight any limitations of the included studies and support the weighting of synthesis towards articles assessed to be of higher quality (Long et al., 2020). CASP ratings are provided in Appendix B.

One limitation of the included studies relates to the composition and representativeness of the samples. Participants across studies primarily consisted of cisgender women, with few cisgender male participants. Similarly, the samples were largely White and lacking racial and ethnic diversity. Additionally, most samples were recruited from specific geographic regions, potentially making their findings less applicable to broader populations. Two studies included the perspectives of non-disabled healthcare professionals, including one which exclusively sampled professionals (Dispenza et al., 2017). Given the aim of this review to centre the experiences of DPPD, the inclusion of non-disabled participants may reduce the representativeness of the findings and risk the influence of unconscious ableist biases.

The CASP tool also highlighted variability in the extent to which the included studies considered researcher positionality and the researcher-participant relationship. Five studies did not clearly describe how positionality was considered, making it difficult to assess how researcher characteristics may have influenced data collection or analysis (Braakman & Sterkenburg, 2023; DeClerck & Willems, 2023; Methley et al., 2017; Rintell et al., 2012; Zhang-Hampton et al., 2011). This represents a notable limitation, as non-disabled researcher status may have affected interview dynamics and interpretation of narratives (Conner et al., 2023). Similarly, Gerke (2017) described challenges associated with their outsider status in the Deaf community, which may have influenced participant disclosure levels. Despite this, six of the twelve included studies reported procedures to support the reliability of findings (Conner et al., 2023; Dispenza et al., 2017; Gerke, 2017; Powers, 2024; Thurston, 2010; Wang et al., 2024), such as involving multiple researchers in the data analysis process and reaching consensus on emerging themes.

Finally, four studies used thematic analysis as their primary research method (Braakman & Sterkenburg, 2023; De Clerck & Willems, 2023; Powers, 2024 Wang et al., 2024), which, although appropriate for capturing experiential data, can limit the generalisability of findings due to typically small sample sizes and reliance on subjective interpretation Finally, two of the included studies were theses sourced from grey literature (Gerke, 2017; Powers, 2024) and as such have not been subject to peer review, which could potentially limit the methodological rigour of the findings.

Meta-synthesis of Main Findings

The process of free coding produced a total of 181 codes. To organise these codes into descriptive themes, conceptual similarities and differences between free codes were considered. Finally, the descriptive themes were applied to the research questions and aims of the present review to develop four analytic themes: *Exclusion and pathologisation of Disabled experiences; Barriers to mental healthcare are systemic, not individual; Navigating mental healthcare with physical disability; Reimagining mental healthcare as Disability affirmative*. Seven subthemes were also identified. The themes and sub-themes are presented in Table 6.

Table 6

Table of Themes developed from Thematic Synthesis

Analytic Themes	Sub-themes
Exclusion and pathologisation of Disabled people's experiences	
Barriers to mental healthcare are systemic, not individual	Systemic exclusion: physical and procedural inaccessibility
	The consequences of inadequate disability training
	Iatrogenic harm arising from systemic ableism
Navigating mental healthcare with physical disability	Intersectional identities and multiple marginalisation
	The role of professionals' lived experience
Reimagining mental healthcare as Disability affirmative	Embedding disability competence into professional training
	From individual adjustments to systemic inclusion

Theme 1: Exclusion and Pathologisation of Disabled People's Experiences. Across 10 of the 12 studies, DPPD described a tendency for MHS to view disability through a deficit or pathological lens, ignoring broader social, political, and environmental contexts. This included experiences where disability was misinterpreted, dismissed, or pathologised, leading to misdiagnosis, inappropriate treatment, and psychological harm (Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). These findings evidence a fundamental disconnection between mental health care and disability-affirmative practice, primarily the dominance of a medical model framing of disability.

Disability was misinterpreted in two related but opposing ways within mental healthcare (Conner et al., 2023; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024). Some participants reported that the role of disability in their mental health was dismissed or overlooked, resulting in professionals failing to recognise the impact of physical impairments, chronic pain, and systemic barriers on psychological well-being (Conner et al., 2023; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024). Others described the opposite, where disability was assumed to be the sole cause of psychological distress, leading to the neglect of other significant external or contextual factors (Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Wang et al., 2024). Through this, DPPD experienced a 'double-bind' where disability was either erased or overemphasised, meaning that their intersectional experiences were not understood in context. In Powers (2024, p.57), this was described as a failure to meaningfully *"centre the salience of disability-related issues"*, where MHPs either underestimated its relevance or overfocused on it at the expense of other sources of distress. Methley et al. (2017) found that even though healthcare professionals were aware of the potential influence of structural inequalities upon DPPD's mental health, they felt ill-equipped to navigate this in practice. This reflects a broader analytic pattern of the pathologisation of disability, through which DPPD were excluded rather than understood through a holistic and intersectional lens.

Theme 2: Barriers are Systemic, not Individual. All 12 studies evidenced how DPPD encountered practical, attitudinal, and structural barriers to mental healthcare (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). These barriers were not individual but embedded within the design and delivery of MHS. Within this analytical theme, three interrelated sub-themes capturing Disabled people's experiences of systemic barriers within mental healthcare are identified: 1. Systemic exclusion: physical and procedural inaccessibility; 2. The consequences of inadequate disability training; 3. Iatrogenic harm arising from systemic ableism.

Sub-theme: Systemic exclusion: physical and procedural inaccessibility. The notion that Disabled people experience physical and procedural barriers which structurally exclude them from mental healthcare was supported by 11 articles (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011).

Eight studies highlighted that physical and environmental inaccessibility was a major issue, with inaccessible buildings, unsuitable therapy spaces, and geographically distant services limiting DPPD's ability to engage with healthcare (Braakman & Sterkenburg, 2023; Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). Even when reasonable adjustments were available, these were often inconsistently provided (Conner et al., 2023; Wang et al., 2024), reinforcing exclusion and inequity in mental healthcare. Beyond physical inaccessibility, five studies highlighted how rigid policies and procedures created further barriers to DPPD engaging with mental healthcare (Conner et al., 2023; De Clerck & Willems, 2023; Methley et al., 2017; Olkin & Gomez, 2024; Rintell et al., 2012; Wang et al., 2024). This included long waiting lists, inflexible appointment systems, and bureaucratic eligibility criteria. These procedural barriers appear to reinforce the systemic exclusion of DPPD, rather than accommodating their diverse needs. Indeed, Conner et al. (2023, p.994) described physical and procedural inaccessibility as *"harmful"* and *"oppressive"* in the way it acted to reinforce *"overt ableism"*. In summary, these studies evidence Disabled people's systemic exclusion from mental healthcare through physical, procedural, and policy-related barriers.

Subtheme: The consequences of inadequate disability training. Of the 12 studies, 10 illustrated gaps in MHPs' training in disability-related issues (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). Consistently across studies, participants emphasised the need for MHPs to develop both general disability knowledge as well as an understanding of service users' specific conditions, particularly in relation to how this interacts with their mental health and daily lives. For Deaf participants, additional barriers emerged when MHPs also lacked awareness of Deaf culture and language (De Clerck & Willems, 2023; Gerke, 2017). Common amongst both Disabled and Deaf participants were reports of having to educate their MHP themselves to be adequately understood. This was described as an exhausting and frustrating burden that created further barriers to engagement (De Clerck & Willems, 2023; Gerke, 2017; Rintell et al., 2012; Wang et al., 2024).

Beyond knowledge gaps, some MHPs demonstrated a reluctance or unwillingness to educate themselves on disability or make access accommodations (Conner et al., 2023; Gerke, 2017; Methley et al., 2017; Wang et al., 2024). This implicitly communicated that disability was either insignificant, shameful, or unworthy of clinical attention (Conner et al., 2023). Participants described MHPs as having *"unchecked biases"* (Powers, 2024, p. 45) and remaining in the *"zone of unawareness"* (Gerke, 2017, p.50), characterised by an absence of reflexivity and an avoidance of discussing disability. Despite this, there were instances described where MHPs demonstrated curiosity and a willingness to learn about disability. In Conner et al. (2023, p. 993), this is described as *"disability comfort",* in which professionals exhibited openness and ease in working with disability-related issues. It was emphasised that genuine reflexivity, initiative, and ongoing learning were key to reducing the burden of education placed on DPPD. Thus, this supports the notion that MHPs' inadequate training in disability contributed to a sense of 'disability discomfort' leading to an avoidance of disability-related concerns or self-reflection on ableist assumptions.

The absence of disability competence was not solely an individual failing but a systemic issue. MHPs themselves acknowledged gaps in knowledge and expressed a desire for further training (De Clerck & Willems, 2023). However, Olkin and Gomez (2024) highlight that existing clinical training programs largely lack education on disability competency, with minimal focus on the intersections between disability and mental health. As Powers (2024, p.76) described, the lack of disability training represents an *"institutional barrier"* rather than an individual deficit. Zhang-Hampton et al. (2011) argued that MHPs need to become *"disability literate"* to provide competent care, while Conner et al. (2023) highlighted the need for formal disability-competence training, including mind-body interventions tailored to DPPD. These findings suggest that the mental healthcare system reinforces inaccessibility, leaving both MHPs and service users without adequate resources to enable equitable care.

Sub-theme: Iatrogenic harm arising from systemic ableism. Across eight studies (Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011), participants described how MHPs and services reinforced systemic ableism and actively contributed to iatrogenic harm – the harm caused through interactions with healthcare services. This included standard therapeutic approaches that frequently failed to accommodate DPPD's specific physical and psychological needs, leading to inappropriate or harmful interventions (Conner et al., 2023; Olkin & Gomez, 2024; Gerke, 2017; Powers, 2024; Wang et al., 2024). For example, Conner et al. (2023) noted that commonly used interventions could worsen both physical pain and psychological distress.

Another key theme across studies was the systemic dismissal of DPPD's lived experiences and bodily knowledge, which resulted in feelings of invalidation and distress. Participants described MHPs questioning the legitimacy of their access needs or minimising the severity of their physical symptoms (Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Wang et al., 2024). These interactions appear to reinforce existing power imbalances in which non-disabled MHPs' interpretations are privileged and DPPD's expertise is marginalised. Wang et al. (2024, p. 4) conceptualised these interactions as a form of *"gaslighting"* through which DPPD's realities are denied, thereby eroding their sense of self-trust when seeking care.

Beyond invalidation, six studies highlighted prejudicial or patronising attitudes from MHPs (Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Wang et al., 2024; Zhang-Hampton et al., 2011). Conner et al. (2023, p.994) discussed that MHPs were *"not immune"* to these *"negative judgements"* about disability, nor enacting *"harmful practices that reinforced ableism"*. Some participants reported that clinicians displayed both explicit and implicit discomfort in working with DPPD (Conner et al., 2023; Gerke, 2017). For example, some professionals were described as engaging in irrelevant and intrusive questioning about disability that served no therapeutic purpose. Gerke (2017, p. 50) argued this was linked to professionals *"satisfying a personal need"* rather than a genuine interest in providing appropriate care. These interactions contributed to a sense that DPPD were perceived as either too complex to accommodate or ineligible for mental health support.

The effect of these experiences was a loss of confidence in mental healthcare, with participants reporting that negative therapeutic interactions led them to feel physically and psychologically unsafe (Conner et al., 2023; Olkin & Gomez, 2024; Rintell et al., 2012; Wang et al., 2024). Moreover, ableist microaggressions within mental healthcare reinforced existing experiences of internalised and systemic ableism (Conner et al., 2023). For example, both Conner et al. (2023) and Gerke (2017) discussed how the cumulative impact of negative therapeutic interactions and broader sociocultural experiences of ableism led DPPD to anticipate future discrimination within mental healthcare settings. As a consequence of this, participants reported fear, a reluctance to disclose disability-related issues, and intentions to avoid services altogether (Conner et al., 2023; Gerke, 2017).

Theme 3: Navigating mental healthcare with physical disability. Of the 12 studies, 11 described how Disabled participants faced distinct challenges in navigating mental healthcare due to the intersection of their physical and mental health needs (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). This included layered experiences of discrimination, which increased cognitive load and necessitated self-advocacy. The articles also highlighted the nuanced role of MHP's lived experiences with disability, which could both facilitate and create specific barriers to care. This analytic theme is explored through three interrelated sub-themes, which capture Disabled people's experiences of negotiating mental healthcare: 1. Intersectional identities and multiple marginalisation, and 2. The role of professionals' lived experience.

Sub-theme: Intersectional identities and multiple marginalisation. Nine articles supported the notion that DPPD with multiple marginalised identities faced heightened systemic ableism (e.g., disability, gender, race, sexuality), which shaped DPPD's experiences of mental healthcare (Braakman & Sterkenburg, 2023; Conner et al., 2023; Dispenza et al., 2017; Methley et al., 2017; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). Disabled participants in Powers (2024, p. 71) highlighted the *"unique needs"* of service users whose disability identity was *"intertwined"* with other marginalised identities. Several studies identified additional barriers to accessing mental healthcare for DPPD who also experienced racialisation, low levels of education, financial difficulties, chronic pain, mobility impairments, complex medical histories, or un- or under employed (Conner et al., 2023; Wang et al., 2024; Zhang-Hampton et al., 2011). Participants described how complex *"intersectional discrimination"* created an additional emotional and cognitive burden of *"interpreting"* layered experiences of marginalisation within mental healthcare settings (Wang et al., 2024, p.6). Subsequently, this prevented them from bringing their full, *"integrated"* identity to their mental healthcare interactions (Wang et al., 2024, p.6). Thus, multiple marginalisation meant that Disabled participants were effectively excluded from accessing affirmative mental healthcare.

Six papers also explored the role of diverse Disability identities in shaping mental healthcare experiences (Braakman & Sterkenburg, 2023; Conner et al., 2023; Methley et al., 2017; Powers, 2024; Rintell et al., 2012; Thurston, 2010). Key factors included disability type, onset (e.g. developmental, congenital, or acquired), and the individuals' acceptance or denial of their disability (Powers, 2024). For instance, participants in Powers (2024, p. 45) described how the emergence of Disability identity within mental healthcare was influenced by *"the nature and salience of the disability"* in relation to both their mental health and wider lives. For example, participants with acquired disabilities emphasized the importance of MHS addressing transition and loss (Methley et al., 2017; Powers; Thurston, 2010). In Thurston (2010, p.7), participants described sight loss as triggering a *"changed perception of self"* and the formation of a disability identity. Thus, participants in Rintell et al. (2012, p. 607) highlighted the importance of MHPs accepting and validating where service users were in the "*process of adapting"* to Disability. Individualised, disability-competent mental healthcare was described by participants as facilitating a unique opportunity for Disabled service users to explore, understand, and form an affirmative disability identity (Conner et al., 2023; Powers, 2024; Wang et al., 2024). However, participants described that MHPs' assumptions and lack of competence in disability identity development created barriers to engagement (Powers, 2024; Rintell et al., 2012).

Encouragingly, the features of culturally competent and affirmative mental healthcare were discussed in two papers (Dispenza et al., 2017; Powers, 2024). In Dispenza et al. (2017, p. 139), MHPs emphasised the importance of *"competence in intersectionality"* and care that *"intentionally assess[ed] the confluence"* of multiple marginalisation. Participants in this study highlighted that affirmative mental healthcare was facilitated by professionals who demonstrated an awareness of identity development, stigma, institutional power, internalised oppression, and minority stress (Dispenza et al., 2017). Furthermore, culturally competent MHPs were described as possessing an *"affirmative consciousness"* through which they intentionally reflected on unconscious biases to *"critically resist"* ableism and intersectional discrimination. (Dispenza et al., 2017, p.140). Disabled participants in Powers (2024, p. 72) described the positive effects of this approach as facilitating a *"unique relief"* that *"created room for unique needs to be met, disability-related or otherwise".*

Sub-theme: The role of professionals' lived experience. The idea that the MHPs' identity and lived experience with Disability influenced mental healthcare was supported in five studies (Conner et al., 2023; Gerke, 2017; Powers, 2024; Thurston, 2010; Wang et al., 2024). Findings suggested that the MHPs' identity, including their own marginalisation or privilege, could act as either a facilitator or barrier to affirmative care.

In Conner et al (2023, p.985), MHPs' *"self-disclosure of disabilities"* was described by participants as facilitating connection, validation, and safety. Unfortunately, Powers (2024) described how a lack of diverse representation within MHS *"added complexity"* (p.46) and *"created additional burdens"* (p.70) for multiply marginalised DPPD. This aligns with a theme of *"scepticism"* identified by Thurston (2010, p.8), where participants expressed doubts about non-disabled MHPs' ability to understand the lived experience of disability. Similarly, in Gerke (2017, p.54), participants described that assumed shared experiences with a Disabled MHP lessened the burden on service users to educate professionals about disability-related cultural issues. This allowed them to *"proceed at the heart of the issue"* and focus directly on their mental health concerns, rather than first having to establish the MHP's disability competence. Furthermore, participants in Wang et al. (2024, p.6) highlighted that working with a Disabled MHP could facilitate a sense of understanding and *"mitigate"* their lived experiences of systemic *"ableism and sanism"* in MHS.

Despite the potential positive implications of working with Disabled MHPs, participants in three studies indicated that lived experience of disability did not necessarily translate into disability-affirming care (Conner et al., 2023; Powers, 2024; Wang et al., 2024). For example, participants in Wang et al. (2024, p.6) described that despite an assumption of shared experience, being a Disabled MHP did not *"automatically preclude one from enacting systematic forms of ableism".* They related this to the heterogeneity of the Disabled population, arguing that some working MHPs may be relatively *"privilege[d]"* and *"shelter[ed]"* from the harms of systemic ableism (Wang et al., 2024, p.6). Subsequently, both Wang et al. (2024) and Conner et al. (2023) described the potential for Disabled MHPs to inadvertently perpetuate *"internalised ableism"* (Conner et al., 2023, p.992), thereby limiting their ability to fully comprehend *"the various layers of privilege and oppression facing their disabled clients"* (Wang et al., 2024, p.7). Thus, it is reasonable to suggest that where differences between Disabled MHPs and service users are overlooked, this may result in ineffective mental healthcare. For example, over-identification and projection of personal experiences may lead to inappropriate assumptions and recommendations. To address these challenges**,** Conner et al. (2023, p.973) suggest that all MHPs would benefit from adopting a *"disability culture framework"* (Gill, 1995) to facilitate critical self-reflection, cultural competency, and affirmative mental healthcare.

Theme 4: Reimagining mental healthcare as disability affirmative. This final theme reflects a vision present across all 12 studies of how mental healthcare could be transformed from exclusionary to inclusive and affirmative of DPPD (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). Rather than continuing practices which position DPPD as outliers, participants imagined systemic shifts for mental healthcare designed with disability in mind. This theme is explored through two interrelated subthemes: (1) Embedding disability competence into professional training, and (2) Shifting from individual accommodations to systemic inclusion.

Sub-theme: Embedding disability competency into professional training. Across several studies, participants discussed how these shortfalls in MHP disability competence and comfort might be addressed through reforms to education and training (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). As documented above, a lack of competence was identified as a significant barrier to affirmative mental health care.

The necessity of MHP disability training being embedded as a foundational component of clinical training, rather than an optional or tokenistic addition, was emphasised (Dispenza et al., 2017; Gerke, 2017; Olkin & Gomez, 2024; Wang et al., 2024). Several studies argued for the inclusion of a critical understanding of the social model of disability, awareness of systemic ableism, and engagement with Disabled people as experts in their own lives (Conner et al., 2023; Olkin & Gomez, 2024; Wang et al., 2024). Through this, improving disability competence can be seen as multifaceted, involving technical skill development and an attitudinal shift away from impairment-based models to affirmative frameworks that value disability. To further facilitate this, several studies emphasised that training centres should proactively recruit Disabled people to positions within mental healthcare, education/training, and research (Conner et al., 2023; Wang et al., 2024). Through this increased representation, institutionally-held stereotypes and biases about who is positioned as 'expert' may be challenged (Conner et al., 2023; Wang et al., 2024). This could move towards co-producing services that reflect and respect diverse lived experiences.

Several studies recognised the significance of Disability-Affirmative Therapy (D-AT; Olkin, 2007) in challenging impairment-based models and developing inclusive, responsive, and rights-based mental healthcare. As Wang et al. (2024) noted, affirmative practice requires a willingness to unlearn internalised biases and make space for ongoing conversations about disability in therapy. Similarly, MHPs interviewed in Dispenza et al. (2017, p.140) highlighted that embedding disability competency involved evolving an *"affirmative consciousness"* characterised by a willingness to critically examine personal and professional biases, engage in advocacy, and integrate # intersectionality. As Conner et al. (2023) suggest, this requires MHPs to understand *"minority stress"* (p.997) and align their practice with *"disability cultural values"* (p.992), such as interdependence, flexibility, and adaptation. Through this, MHPs may better account for the contextual and sociocultural factors influencing DPPD's distress (Conner et al., 2023), and tailor care to individual needs (Braakman & Sterkenburg, 2023; Powers, 2024; Wang et al., 2024). In this model, both individual and structural influences on distress are approached collaboratively and flexibly.

Sub-theme: Shifting from individual adjustments to systemic inclusion. Five studies highlighted the widespread expectation that DPPD must request individual accommodations, rather than these being embedded as standard in mental healthcare (Conner et al., 2023; Dispenza et al., 2017; Gerke, 2017; Powers, 2024; Wang et al., 2024). This dynamic placed a burden on DPPD to self-advocate, identify and justify their accessibility needs to MHPs/services with limited disability competence. While adjustments were sometimes accommodated, this reactive model led to delays, inconsistency, and additional emotional labour for DPPD. Participants advocate for a shift towards frameworks in which accessibility is co-designed and embedded throughout services. This system-level change reflects a shift from the medical to the social model of disability, which conceptualises exclusion as a result of sociocultural, institutional, and attitudinal barriers. A key aspect of this involves the co-production of the policies, procedures, and physical environments of MHS by DPPD and mental health systems. Through this, accessibility is framed not as a reactive legal requirement, but a proactive practice of accountability. This is reflected in the statements of Braakman and Sterkenburg (2023, p.8) that mental healthcare overall should be proactively *"accessible to all"*, whilst individual MHPs should work collaboratively with service users to *"fine-tune"* care to their specific needs. Powers (2024, p.76) evidenced how this approach proactively "*accommodated"* and *"matched"* DPPD's, thereby reducing barriers and facilitating engagement and trust.

Importantly, structural inclusion counteracts one-size-fits-all models by enabling systems that are capable of responding to diverse needs. This includes physical modifications (e.g., ramp access, quiet rooms) and procedural flexibility (e.g., session length, cancellation policies, communication style). For example, Conner et al. (2023) described that MHPs who were *"mindful"* (p.994), *"willing"* (p.993), and open to finding individual *"creative solutions"* (p.994) contributed to a sense of partnership that may not be present in traditional service models. Furthermore, participants emphasised that structural accessibility must also involve attitudinal and cultural inclusion. As Wang et al. (2024) note, *"accessibility considerations should not be limited"* to environmental modifications alone (p.5), but instead should encompass broader systemic and attitudinal shifts. In line with this, Dispenza et al. (2017, p.141) advocate for an *"affirmative intersectionality"* approach that integrates awareness of multiple marginalisation into access considerations.

Clinical Implications of Findings

This is the first known systematic review to specifically focus on DPPD's experiences of mental healthcare, offering a novel contribution to the literature. The review highlights the pervasive impact of implicit and explicit ableism on DPPD's access to and experiences within MHS. The review suggests that DPPD experience cumulative discrimination and exclusion from mental health systems that are often inflexible and unprepared to accommodate their needs. This marginalisation reflected broad systemic barriers that adversely impacted DPPD's mental and physical wellbeing. These barriers were amplified for DPPD with intersecting marginalised identities who faced layered exclusion and poorer access to affirming care.

Meta-synthesis also highlighted examples of affirmative and inclusive mental health care. While these were less commonly reported, they highlight the potential for MHS to better meet the needs of DPPD through collaborative, identity-affirming, and flexible care. MHPs who acknowledged clients' lived experiences of ableism and adapted their practice to accommodate disability-related needs were seen as facilitating effective care. These findings indicate the need for training and systemic change within services to promote affirmative practice, reduce exclusion, and improve outcomes for DPPD.

Synthesis with Existing Literature and Policy

The findings of the present review align with and extend the existing evidence base outlined in Chapter One by centring the experiences of people with physical disabilities in navigating mental health care. The results also highlight persistent gaps between research, policy, and the lived experiences of DPPD.

Across studies, disability was frequently interpreted through reductive, pathologising and deficit-based frameworks, rather than a social identity shaped by navigating structural barriers and discrimination. This was evident through dismissal, diagnostic overshadowing, and micro-aggressions through which DPPD's marginalisation was exacerbated. This echoes the findings of previous research on ableism in mental healthcare (e.g., Conner et al., 2023; Jóhannsdóttir et al., 2021; Wang et al., 2024) by reflecting the dominance of medicalised conceptualisations of disability in which distress is located within the individual, instead of as an understandable response to systemic exclusion, inaccessibility, and unmet needs.

In contrast, consistent with the social and human rights models of disability, the present thematic synthesis evidences that barriers to mental healthcare are primarily systemic, not a result of individual failings on the part of DPPD, professionals, or specific services. DPPD's access to care was repeatedly constrained by dismissal of lived experience, physical and procedural inaccessibility, inflexibility, and reactive or inconsistent provision of reasonable adjustments. This supports findings that ableism exists within service designs, creating "harmful" and "oppressive" conditions (Conner et al., 2023) which constrain Disabled people's ability to both seek and reach mental health services (Lowther-Payne et al., 2023). Subsequently, despite individual efforts, professionals are ill-equipped to respond to inequalities and ableism is reinforced, leaving DPPD fearful, reluctant or unwilling to seek care (e.g. Wang et al., 2024). These pervasive barriers exist despite the implementation of the (e.g. the UK's Equality Act (2010) or the US' Americans with Disabilities Act, 1990) and professional standards (e.g. APA, 2022; Royal College of Psychiatrists Standards for Inpatient Mental Health, 2017), which mandate the provision of anticipatory reasonable adjustments, accessible environments, and equitable mental healthcare. As such, the persistence of inaccessibility identified within the present systematic review suggests a substantial gap between intention and implementation, in which policy commitments are undermined by service designs that prioritise efficiency and time-limited interventions in the context of limited resource (Staniszewska et al., 2014).

The present review also highlights inadequate training in disability amongst mental health professionals (MHPs) as both a consequence and reproducer of systemic inequality and ableism. Consistent with the existing literature (e.g. Artman & Daniels, 2010; Olkin, 2007), a lack of disability competence, even if inadvertent, contributed not only to exclusion but also to iatrogenic harm due to exacerbated distress, delayed support, and disengagement with services. Subsequently, service structures that fail to account for disability, reinforced mistrust and patterns of recursivity in DPPD's help-seeking. These findings align with critiques of equality policies within UK NHS services, as primarily focused on service availability rather than broader aspects of accessibility and inclusion (Sakellariou & Rotarou, 2017).

In addition, the synthesis extends existing evidence illustrating how marginalisation related to physical disability interacts with other identities, creating distinct challenges to care which thereby compound exclusion. As discussed in Chapter One, the COVID-19 pandemic created distinct circumstances that amplified these inequities, for example, by highlighting both the potential and limitations of alternative approaches to service delivery (McBride-Henry et al., 2023). For example, remote care increased access for some, but reinforced exclusion for those experiencing digital poverty. In regard to identity factors, the present review also highlights the facilitative power involving professionals with lived experience of disability in the provision and design of services, including fostering trust, accessibility, and relational safety. Although individual MHP factors alone could not guarantee affirmative care, systemic inclusion of Disabled professionals has the potential to challenge dominant medical-model assumptions of neutrality and emphasises the importance of lived experience within mental healthcare.

In contrast to the exclusionary practices identified in the existing literature and confirmed within the present review, the findings highlight that disability-affirmative frameworks are possible within mental healthcare. As discussed, whilst current policies tend to emphasise individual reasonable adjustments and service often approach these in a reactive manner which requires DPPD to request equitable care. Instead, the synthesis suggests that meaningful inclusion necessitates a systemic shift towards anticipatory service designs in which disability competence is embedded. Such a shift would seek to address the structural conditions that produce and reinforce exclusion and harm within DPPD's mental healthcare. As such, the findings strongly align with the social and human rights models by evidencing the need for services to move away from the medical model, and instead centre lived experience and conceptualise Disabled people's distress within the context of systemic ableism, marginalisation, and inequity rather than individual pathology (Olkin, 2007; 2017). This also aligns with key recommendations from the American Medical Association (2022) and Glasgow Disability Alliance (2022).

Evaluation and Conclusions of the Systematic Literature Review

Several limitations of the present review were identified. Firstly, the cultural and temporal contexts of the included studies varied, with data drawn from four countries over 15 years. Differences in national policies, health service structures, and cultural beliefs concerning disability and mental health may have influenced the content of the studies. For example, understandings of disability rights, availability of MHS, and social attitudes may differ across time and place. Thus, this may potentially limit the generalisability of the findings. There was also limited exploration within the included studies of how different types and severities of disability influenced mental healthcare experiences. This is relevant as DPPD with visible disabilities may face different forms of discrimination compared to those with invisible disabilities (Ysasi et al., 2018). The findings of the review will also likely have been influenced by the underrepresentation of specific populations in the included studies, primarily the perspectives of Disabled older adults and men. This will perhaps have limited the review's insight into how age, gender identity and related sociocultural factors intersect with disability in mental health contexts. This limits the conclusions that can be drawn about these groups' specific needs or barriers to care.

Methodologically, the review was limited by the search strategy, which was confined to five databases due to time and resource constraints. This may have unintentionally omitted relevant literature. Additionally, only qualitative data was included. While this aligned with the aim of capturing lived experiences, it excluded potentially valuable insights from quantitative research that could have contextualised or extended the findings. For example, Brucker et al. (2023) used a quantitative design to explore LGBT Disabled people's mental health and treatment needs, which found simultaneously high rates of mental health service use and unmet needs among this population. This highlights the complexity of service access and demand, strengthening the argument that DPPD experience systemic barriers to care that may not have been fully captured within the present review. Additionally, a small number of included studies gathered perspectives from clinicians, rather than solely Disabled service users (Braakman & Sterkenburg, 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Methley et al., 2017). Whilst valuable, these accounts may have been shaped by professional or personal biases, including conscious or unconscious ableism.

Future Research

Through this review, several gaps in the literature were identified, highlighting the need for further research to address the complexity of Disabled people's mental healthcare experiences. Firstly, there is a need for research that samples underrepresented populations, particularly cisgender men and older adults. Research situated in a UK context is also underrepresented in the current evidence base. Indeed, of the 12 studies included in this review, only two were UK-based, with a limited focus on NHS MHS. Given specific NHS systems and policies, including ongoing reforms related to equality and accessibility, future UK-based studies are necessary to understand how systemic ableism manifests within MHS and what disability-affirmative care could look like in practice.

Finally, experiences of acute mental health services (AMHS; e.g., inpatient, crisis, and home treatment teams) remain underexplored. The review revealed that many DPPD felt the need to self-advocate in mental health settings, which was significantly more difficult during periods of acute distress. Thus, research is needed to explore how Disabled people navigate mental health crises, including their interactions with AMHS. Additionally, although some studies touched on the misunderstanding of DPPD's physical health needs, none explored how these are managed within mental health settings, particularly inpatient services. This is particularly important, as these contexts may present specific barriers.

Rationale for Present Research

The present study aims to explore how Disabled people with physical disability (DPPD) and/or chronic health conditions experience acute mental health services/settings (AMHS). Additionally, the research aims to provide an insight into how AMHS meet, or fail to meet, the mental health needs of DPPD. A further objective is to explore how DPPD's physical health needs are understood and managed within AMHS. Finally, the research aims to present clinical implications for AMHS, which might facilitate improvements in accessibility, inclusion, and affirmative practice.

Research Questions

The research aimed to explore how DPPD experience AMHS through three questions:

- *How do Disabled people with physical disabilities make sense of their experiences of navigating acute mental health services?*
- *How do acute mental health services meet, or fail to meet, the mental health needs of Disabled people with physical disabilities?*

- *How are the physical health needs of Disabled people with physical disabilities understood and addressed within acute mental health services?*

Chapter Three: Methods

Chapter Overview

This chapter outlines the methodological process of the present research, including a description of the ontological and epistemological positions which underpin the research, as well as a justification for the assumptions and research approach used. Additionally, this chapter aims to provide a transparent reflective account of the lead researcher's professional and personal positioning in relation to the research topic. Following this, the procedure for participant recruitment and conducting interviews is summarised. Finally, the chapter will discuss the ethical issues pertinent to the research.

Philosophical Paradigm

Outlining the philosophical foundations and framework of the research methodology is important to understand how research decisions are influenced and to justify the methodological approach chosen for investigation (Hiller, 2016). The present research is grounded in a qualitative research paradigm that emphasises the importance of aligning epistemological, ontological, and methodological assumptions. A research paradigm encompasses the theoretical assumptions through which knowledge is produced (Howell, 2013). Identifying these foundations facilitates transparency and coherence across the research design (Moon & Blackman, 2014), particularly in work involving marginalised groups where the researcher's positioning can have epistemic and ethical implications (Jacobson & Mustafa, 2019; Willig, 2013).

Aligned with these principles, the present research adopts a relativist ontology and interpretivist epistemology. This is informed by the lead researcher's values and positionality and by the study's overarching aim to explore the subjective experiences of Disabled people with physical disabilities (DPPD) in acute mental health services (AMHS). These foundations are further elaborated below.

Epistemological Positioning and Justification of Methodology

Epistemology can broadly be understood as the theory of knowledge and how knowledge can come to be known (Hiller, 2016), specifically it is concerned with *"the nature, sources, and limits of knowledge"* (Pascale, 2010, p. 4). The present study adopts an interpretivist and contextualist epistemology, which posits that knowledge is constructed through individual, context-bound experiences, shaped by sociocultural and historical influences (Greene et al., 2010; Hiller, 2016). Accordingly, an interpretivist stance views meaning as co-constructed through the interaction between researcher and participant (Schwandt, 2003). An interpretivist approach emphasises that for a phenomenon or experience to be understood, research must focus on the meanings participants construct for or derive from these situations (Pascale, 2010; Schwandt, 2003). This positioning aligns with the study's relativist ontology, in which reality is viewed as subjective and context-dependent (Braun & Clarke, 2013; Ritchie & Lewis, 2003). The focus was therefore not on establishing generalisable truths, but understanding the unique and diverse meanings that participants attributed to their experiences of AMHS (Ritchie & Lewis, 2003; Thomas, 2017).

This stance is particularly important in disability research, as the philosophical lens of the research is argued to have the power *"either to subjugate or to emancipate individual experience"* (Smith-Chandler & Swart, 2014, p.1). This has particular consequences for psychological research, as it is documented Disabled people have frequently been positioned as passive subjects in research that privileges clinical or professional expertise over lived experience (Kitchin, 2000). Furthermore, it is likely that this will have limited the impact of research in providing valid insights and improving the lives of Disabled people (Oliver & Barnes, 2006). Without critical engagement with epistemology, research risks perpetuating ableist knowledge structures and contributing to stigma and misrepresentation (Brown & Ciciurkaite, 2022; Reynolds, 2017). Thus, the research was informed by the social model of disability, critical disability theory, and interpretivism. These approaches challenge epistemic injustice and ableist research paradigms by valuing Disabled participants as knowledge-holders and central contributors to the research process (Inckle et al., 2023; McBride-Henry et al., 2023).

In line with this, the research process aimed to include collaboration and reflexivity. The research aimed to consult Disabled people and disability advocates to provide input to the research process. This consultation aimed to mitigate the risk of privileging researcher or institutional perspectives and strengthen the credibility and relevance of the findings (Woodward & Tzur, 2017). This aligns with the principles of the disability rights movement of "nothing about us without us" or "no participation without representation" (Kichen, 2000; Oliver, 1992), in which Disabled people resist engaging with research that is not representative of their interests or lived experiences (Inckle et al., 2023). Additionally, this is consistent with recommended practice in line with BPS standards on ethical disability-inclusive research (Oates et al., 2021). The lead researcher engaged in ongoing reflexivity, recognising that their own identity – as a non-disabled, white, cisgender woman – inevitably shaped the research process. The researcher's position and self-reflexivity will be discussed later in this chapter. Adopting a critical, interpretivist stance required transparency about this positioning and an explicit rejection of ableist power structures that can be embedded within traditional research paradigms (Hiller, 2016; Sullivan, 2019).

Consideration of Alternative Methodologies

Alternative methodological paradigms, such as realist and positivist approaches, were considered but ultimately rejected as incompatible with the aims and values of the present research. A realist ontology assumes the existence of a single objective reality, while a positivist epistemology seeks to uncover that reality through detached, value-free observation and generalisable measurement (Cohen et al., 2007; Sullivan, 2019). While such paradigms may be appropriate in certain psychological research contexts, they risk marginalising the complex, lived realities of Disabled people by reducing them to variables or diagnostic categories (Reynolds, 2017).

Given that the purpose of the present study was to explore how DPPD make sense of their experiences within AMHS, rather than to test hypotheses or quantify effects, a quantitative positivist approach may have constrained the knowledge that could be generated. It could also have contributed to the epistemic marginalisation of participants by privileging researcher interpretations and "objective" truths over subjective meaning (Oliver & Barnes, 2006).

Instead, a relativist and interpretivist paradigm enabled exploration of multiple perspectives and a disability-affirmative research design. This decision reflects growing recognition within critical disability studies that traditional research methodologies often fail to account for the interpersonal, cultural, and structural dynamics that shape Disabled people's lives (Smith-Chandler & Swart, 2014). Furthermore, experiences of marginalisation can be perpetuated through the application of ableist research designs, which do not involve Disabled people or critically evaluate the epistemological positioning and power dynamics within the study (Brown & Ciciurkaite, 2022; McBride-Henry et al., 2023). Without a critical evaluation of disability and the researcher's positioning, there is a risk that research will actively, yet unwittingly, contribute to ableism and the misrepresentation of Disabled people (Reynolds, 2017).

In consideration of the above, a relativist ontological paradigm was appropriate to the present research design due to the exploratory nature of the research, which aimed to understand the subjective lived experiences of DPPD in how they perceive AMH care. Due to the research aims, in conjunction with the novel and small-scale nature of the study, it was deemed important to acknowledge and explore the multiple truths of DPPD as equally valid. Accordingly, this research aimed to generate insights into participants' experiences in a way that challenged dominant narratives about disability. Through this, the research aimed to produce knowledge in a manner that was more inclusive, epistemically just, and contextually grounded.

Methodology

Consultation

Given the historical exclusion and misrepresentation of Disabled people within research (Oliver, 1992), consultation with individuals with lived experience of disability was an ethical and epistemological priority in this study. As a non-Disabled researcher, and with supervisory input from non-Disabled academics, the inclusion of experts by experience was essential to mitigate the risk of reproducing ableist assumptions or knowledge hierarchies (Fricker, 2007; Reynolds, 2017). This was influenced by the ethos of Participatory Action Research (PAR; Baum et al., 2006; Berghs et al., 2016; INVOLVE, 2012), which promotes collaboration and power-sharing in the research process. PAR seeks to democratise knowledge production and centre participant voices in the development and direction of research. Unfortunately, a fully participatory or co-produced approach was not feasible within the constraints of a time-limited clinical psychology doctoral programme. This may present an avenue for future research. The researcher was critically aware of the limitations of their position as a non-Disabled trainee clinical psychologist, therefore the study sought to engage consultants with lived experience of disability, including both Disabled people and disability advocates, to inform the project. Drawing on PAR principles for inclusive research, the researcher aimed to incorporate consultation throughout the research process, including the development of the research focus, materials, and approach to data analysis.

To incorporate lived expertise into the study, the researcher recruited two disability advocates to provide consultation on the research design and methodology (Mazanderani et al., 2020). These early consultations were also valuable in generating awareness of the project among potential future participants. Consultants were identified through outreach on social media platforms (e.g., Facebook, Instagram, X), via third sector organisations, and the University of Essex's Service User Reference Group. Additionally, in March 2024, a consultation session took place with Healthwatch Essex's Research Ambassador Group. This group included researchers, members of the public with an interest in health research, and lived experience experts. This session provided an opportunity for the researcher to share early ideas and findings from the literature, as well as to discuss the rationale, questions, and proposed design of the current study. Both experts by experience and research ambassador group members offered critical reflections informed by their personal, professional, and academic experiences. Their feedback contributed to refining the research approach and confirmed the relevance of the study focus. In total, three one-hour consultation meetings were held, while the intention was to hold additional sessions, practical constraints and logistical challenges restricted further meetings.

The researcher recognised the possible ethical concerns of asking Disabled people to contribute without appropriate recognition of or reimbursement for their time and expertise. This issue has been identified in the literature as a recurrent form of exploitation, particularly as Disabled individuals and advocacy organisations are frequently called upon to contribute to public sector initiatives without compensation (Beresford, 2013; INVOLVE, 2012). To address this, all consultants and participants were offered financial reimbursement, supported by a research fund from the University of Essex. Funding had been secured to support up to 15 hours of consultation, and although only a portion of this was used for formal sessions, some informal input was also gathered through brief exchanges via email and social media messaging platforms.

Design

Research methodology may be understood as a framework or rationale that guides research design, data collection, and analysis (Giacomini, 2010; Hiller, 2016). Following the ontological and epistemological foundations of the present research, the methodological approach selected as the most appropriate to investigate DPPD's experiences of AMHS was qualitative and phenomenologically informed. A phenomenological approach to research seeks to understand the lived experiences and meanings that emerge as individuals encounter phenomena in the world (Hiller, 2016). As the present research sought to capture and understand the rich accounts of DPPD regarding their experiences and perceptions of AMHS, an interpretive, qualitative, and phenomenological approach was deemed most appropriate.

In consideration of this, and as the experiences of DPPD within AMHS had not previously been explored within the research literature, the approach selected for the present research was Reflexive Thematic Analysis (RTA; Clarke & Braun, 2013; Braun & Clarke, 2021). Reflexive thematic analysis is an approach to developing and interpreting patterns across qualitative data (Braun & Clarke, 2019). This approach is systematic and rigorous, but also accessible and theoretically flexible. Subsequently, RTA is a highly suitable approach to qualitative research exploring under-researched phenomena and the lived experiences of participants (Clarke & Braun, 2013; Braun & Clarke, 2021; Willig, 2013). Furthermore, RTA was chosen over other approaches, such as Interpretive Phenomenological Analysis (IPA; Smith et al., 2009), as it explores how individual experiences are related to wider sociocultural contexts (Braun & Clarke, 2021) and can be applied to a range of sample sizes (Clarke & Braun, 2013). As the present research was exploratory and aimed to involve as many participants as possible, RTA offered greater flexibility than other approaches, including IPA, which utilises small sample sizes (Noon, 2018).

Additionally, RTA requires the researcher to be reflexive by drawing on and critically interrogating their experiences, pre-existing knowledge, and social position (e.g. ethnicity, race, gender, class, ability, etc.; Braun & Clarke, 2019). Through this process, the researcher considers how their background influences how they interpret and make sense of the research.

Participant Inclusion Criteria

The research sought to recruit both DPPD with direct experience of AMHS and disability advocates with indirect experience.

DPPD with direct experience of AMHS were eligible if they met the following inclusion criteria. To participate, they needed to have been in contact with UK adult AMHS (e.g. crisis, home treatment teams, specialist hospital liaison, inpatient, 136 suites, etc.) at least once within the last 10 years. The research also required that participants self-identified as having a physical disability or chronic health condition at the time of their engagement with these services. Additionally, the inclusion criteria specified that participants were not in an acute phase of mental distress at the time of their participation, and thus, could provide informed consent to participate in the research. Other types of disability (e.g. intellectual, neurodivergence, psychological, etc.) in addition to physical disability, were not considered exclusion criteria. This was determined to be appropriate due to the high prevalence of overlapping diagnoses (e.g. Cooper et al., 2015; Khachadourian et al., 2023). Participants were not required to disclose their specific disability or physical health condition.

In relation to disability advocates, the population for the study included individuals who were 18 years old or above; lived in the UK; and had experience advocating for the rights/needs of Disabled people. This included participants who were a) Disabled, b) family members of Disabled people, and/or c) people who worked with Disabled people in a professional or voluntary capacity. Disability advocate participants were not required to have direct lived experience of care within AMHS, however knowledge of these services in some capacity was considered necessary.

Measures

Development of Interview Topic Guide. Two semi-structured interview topic guides were developed: one for DPPD with direct experience of AMHS, and another for disability advocates. Each guide was structured around five broad thematic areas intended to elicit rich, detailed accounts and allow flexibility in how topics were explored. Differences between the two guides reflect the distinct positions of those with direct experience of AMHS and those offering an advocacy perspective. The guides maintained a shared thematic structure to support comparability. The final versions of both interview schedules are included in Appendices C and D.

The topic guides were informed by the research aim and shaped by a review of relevant literature on both Disabled and non-disabled people's experiences of mental health care, with particular attention to acute services. Feedback gathered during the consultation phase of the research helped shape the content and framing of questions to enhance their relevance, sensitivity and accessibility. The researcher made efforts to use clear and accessible language and designed the questions to be open-ended and flexible, allowing participants to shape the direction of the conversation. Subsequently, the order in which topics were covered was not rigidly adhered to and was responsive to each participant. Where responses were brief or unclear, the interviewer used follow-up or clarifying questions to explore participants' perspectives in more depth.

Each guide included open-ended questions and suggested prompts to support further exploration, which aimed to enable participants to share their experiences in their own words. The five overarching topic areas included:

1. Referral and/or admission experiences – including how DPPD accessed services and any barriers encountered;
2. Experiences of care – such as interpersonal, physical, or psychological aspects of care;

3. Integration of physical and mental healthcare – exploring how well participants felt their/DPPD's holistic needs were acknowledged, understood, and met;
4. Discharge and follow-up care – including continuity of care and how transitions were managed;
5. Perspectives on ideal care and service design – allowing space for participants to share their views on how services could be improved or reimagined.

Procedure

Sampling and Recruitment Strategy

A target of 12–15 participants was set, in line with University of Essex guidance for doctoral-level qualitative research. Determining an adequate sample size in qualitative research is complex and debated (Malterud et al., 2016). The concept of "information power" can be used to guide decisions around sample size, which suggests that the amount of data needed is influenced by factors such as the specificity of the sample, the focus of the research aim, the use of theory, the quality of dialogue, and the type of analysis conducted. The present research focused specifically on the experiences of DPPD in AMHS, which is an area with limited existing research. Participants' relevant experiences of this phenomenon and the clearly defined research aim suggest a smaller sample could still find meaningful data (Malterud et al., 2016). Examining the existing qualitative research on similar topics was also used as a means of determining appropriate sample size. For example, a review of the studies included in the literature review (Chapter Two) that used thematic analysis showed that sample sizes ranged from seven (Powers, 2024) to 20 (Wang et al., 2024).

The study was advertised from May 2024 via social media platforms such as Instagram, Facebook, and Twitter, using both the researcher's personal accounts and targeted forums/groups aimed at Disabled people. The initial recruitment strategy focused on identifying DPPD with direct experiences of inpatient mental healthcare. The study advert (see Appendix D) included the researcher's contact details, inviting potential participants to get in touch via email to discuss participation further. Recruitment materials were disseminated via social media (e.g., Instagram, Facebook, X). A dedicated social media presence was created to increase visibility and allow for accessible communication with potential participants.

Purposive sampling (Patton, 2002), in which participants are intentionally selected based on specific characteristics relevant to the research aims, was used to ensure that all participants met the inclusion criteria and had relevant lived or professional experience of the phenomenon under investigation (Rappaport, 1987). Snowball sampling (Parker et al., 2010) was also used, based on the expectation that some participants may be connected with others who also met the criteria.

Despite this approach, recruitment progressed more slowly than hoped. Feedback through supervision and professional networks suggested several potential reasons for this. For example, some individuals may have been denied access to inpatient MHS due to the accessibility barriers that this study sought to explore. Others may have experienced significant iatrogenic harm within services, and indeed potentially from participating in psychological research, and may therefore have understandably felt reluctant to revisit or discuss these experiences in detail.

In response to these recruitment challenges, an amendment to the ethics application was submitted in June and approved in August 2024 to broaden the inclusion criteria. This allowed the recruitment of individuals who had accessed other forms of AMH care (e.g., crisis teams, home treatment teams, Section 136 suites or places of safety, etc.), as well as disability advocates who had indirect or vicarious knowledge of the barriers facing DPPD in these settings. Following this amendment, in addition to the aforementioned online platforms, the study was also advertised through third-sector and voluntary organisations supporting Disabled adults (e.g. Healthwatch, Mind), and an online Disability magazine (Crip Life). Recruitment continued via these channels, as well as through social media and word-of-mouth, until the study closed to new participants. See Appendix E and F for the amended study adverts.

Interested individuals were invited to contact the lead researcher to express interest or ask further questions. They were then provided with a participant information pack (Appendix G) and a written or oral consent form (Appendices H & I). All participants returned the written consent form via email prior to meeting for the interview. A minimum ‘cooling-off’ period of 72 hours was observed between receiving consent and conducting interviews, allowing participants time to reflect and withdraw should they wish.

Following consent and the cooling-off period, participants were sent a short demographic questionnaire (Appendix J) and invited to indicate their availability for an interview. The demographic questions were used to contextualise the qualitative data and included participant age, gender, ethnicity, area of functioning impacted by impairment/disability/health condition, employment status, and year and duration of contact with AMHS (if applicable).

At the point of arranging interviews, participants were invited to share any access needs or adjustments that could help ensure the interview was inclusive and accessible. Informed consent was obtained from all participants in advance of the interview, with several individuals choosing to ask questions or seek clarification before returning the signed consent form. Recruitment was formally closed at the end of January 2025, after 12 interviews had been completed. This decision was made to ensure sufficient time for data analysis and completion of the thesis write-up within the project timeline. Of the 12 participants interviewed, recruitment sources included word of mouth (n = 2), a university-based disability forum (n = 2), third sector or voluntary organisations (n = 3), and social media platforms such as Instagram and Twitter (n = 5). A small number of other individuals expressed initial interest in participating, but either did not respond to follow-up communication or were unable to take part due to scheduling difficulties or other personal commitments.

Data Collection

Data was collected through semi-structured interviews. Individual interviews were offered, instead of group interviews, to facilitate participants' ability to discuss their experiences freely and openly (Morgan, 1997). Interviews were semi-structured, a qualitative approach to data collection which utilises prepared open-ended questions, but with flexibility to explore unplanned topics based upon the interviewees' responses (Karatsareas, 2022). This method supports a deeper understanding of participants' experiences of the phenomena of study, rather than a generalised perspective (Adeoye-Olatunde & Olenik, 2020). Participants who were geographically close enough for the researcher to practically offer a face-to-face interview were given this option, along with video or telephone calls. The rationale for proposing different means of conducting interviews was to ensure the research was accessible to those with differing access needs. Ultimately, one interview was conducted face-to-face, and the remaining 10 were conducted by video call via Microsoft Teams. With participants' consent, interviews were digitally recorded and automatically transcribed using the recording function on Microsoft Teams. Recorded data and interview transcriptions were stored securely on an encrypted Box account provided by the University of Essex. Following transcription, video/audio files were deleted. All identifiable information was excluded from transcription.

Flexible interview duration (e.g. shorter or split interviews) was offered to support access. Interviews were scheduled at times that best suited each individual, with an intended duration of approximately one hour. This timeframe was chosen to balance the need for in-depth and meaningful exploration of experiences with the need to avoid unnecessary burden on participants or the researcher. The actual duration of the interviews ranged from 50 to 90 minutes.

As outlined in the recruitment section, participants were provided with the study information sheet and consent form prior to the interview. Immediately prior to the interview, key aspects of the information sheet were repeated verbally. Particular attention was given to the potential emotional impact of discussing distressing experiences, the limited likelihood of direct personal benefit, available sources of support, the voluntary nature of participation, and the confidentiality of responses (including its boundaries). Participants were invited to ask any final questions before the interview began, and verbal confirmation was sought before commencing the video/audio recording.

As described above, the interviews followed a semi-structured format, allowing for both consistency in key questions and flexibility to follow participants' individual narratives. Questions from the topic guide were used as a framework but were not asked in a fixed order, with follow-up questions responsive to participants' answers. At the end of each interview, participants were encouraged to share anything further they felt was important. They were also asked to confirm they were comfortable with the recording being stopped.

On conclusion of the interview, participants were debriefed and given an opportunity to reflect or raise any concerns. Although no participants appeared visibly distressed during the interviews, sources of support were reiterated as a precaution. Participants were reminded of their right to withdraw their data, within the agreed timeframe and were informed of how to contact the researcher should they wish to do so. Each participant was thanked for their time and contribution. Immediately after the interview, the researcher saved the video/audio recording in a secure, password-protected online cloud storage (Box), where it was stored until transcription could be completed.

Data Analysis

Interview data were analysed using Braun and Clarke's (2006; 2019; 2022) procedures for conducting Reflexive Thematic Analysis (RTA). This approach sets out clear guidelines that involve six steps for qualitative data analysis (Table 7). The process of performing these steps may not be linear, and the researcher may repeat previous steps as necessary throughout the analysis (Campbell et al., 2021). This repetition of stages aims to ensure that the data and emerging themes are rigorously analysed and adequately reflect the meaning of the original data (Braun & Clarke, 2019). An extended period of time was used to complete these phases, to facilitate thorough and in-depth analysis of the data (Connelly & Peltzer, 2016). Throughout this process, the lead researcher also practised reflexivity in reflecting on and considering their own experiences, perspectives, and relationship to the topic, as outlined in the statement of researcher positionality later in the chapter.

Table 7

Six Phases of Reflexive Thematic Analysis (Braun & Clarke, 2006, 2022)

Analysis Steps	Analysis Steps
Phase 1: Familiarisation with the data	Initial reflections were noted by hand following the interviews, including some initial ideas of emerging codes and themes. The interview recordings were listened to, and the automatically generated transcripts were checked and read several times as part of the familiarisation process. Familiarisation was enhanced by annotating each transcript with reflections on initial codes or themes. This process was then repeated for the data set as a whole.
Phase 2: Generating initial codes	In this phase, the process of coding was conducted, characterised by labelling data extracts with descriptive meaning, to generate initial codes. The researcher examined each interview transcript in a systematic manner, coding any extracts of data that appeared pertinent to the research aims. Through this process, both semantic (explicit meaning) and latent (implicit meaning) codes were captured. The codes were added as Microsoft Word comments on the transcripts. An example of a coded transcript is provided in Appendix M). To support thorough data analysis each transcript was reviewed at least twice.

Phase 3: Generating initial themes	The entire data set of codes was then reviewed and organised into more distinct and specific categories. This was achieved through printing and cutting out each code label to physically organise them into initial themes. This process enabled the researcher to explore potential grouping and see all emerging themes simultaneously. Once the initial candidate themes were generated, the researcher further refined them by reviewing the coded data extracts again.
Phase 4: Developing and reviewing themes	At this stage, the initial candidate themes were grouped by perceived connection or shared meanings. This was supported by the researcher returning to and re-reading the coded data extracts and the data set as a whole, to assess the strength of the connection between grouped themes. Through this process, some candidate themes were merged, and some were split into sub-themes, depending on the distinctiveness of meaning. As a result, five superordinate themes and 6 subthemes were developed.

Phase 5: Refining, defining and naming themes	In conjunction with the previous phase, the clarity and distinctiveness of the organising concepts underlying the themes were considered. Following this, the key organising concepts were used in determining names for themes. All participants were offered the opportunity and consented to engage in member checking, specifically respondent validation (Torrence, 2012). This was achieved through sharing an accessible summary of the main research findings (Appendix O) with participants via email and offering an opportunity to provide feedback on how accurately this reflected their experiences. Participants were given the option to provide feedback via email, video or telephone call. Of the 12 participants, three provided feedback on the themes, with two agreeing that the findings aligned with their experiences. One participant provided feedback that the summary did not fully communicate the urgency for systemic change conveyed within the experiences they had shared and offered recommendations for amendments before the results were circulated more widely (e.g. inclusion of exemplar quotes and clinical implications).

Phase 6: Writing the report	The process of writing the present report enabled further interpretation of participant narratives in line with the research aims. Exemplar quotes were selected to illustrate the researcher's analytic narrative and the complex experiences conveyed by participants. These findings are presented in Chapter 4 and then discussed in the context of existing research in Chapter 5. Within this final chapter, the clinical and research implications of the findings are also discussed.

Ethical Considerations

A formal application for ethical approval was submitted to the University of Essex Ethics Committee on the 13th November 2023, and approval was granted on the 15th April 2024 (Appendix K). No participants were approached until ethical approval had been obtained. An amendment was submitted on the 29th June 2024 and approved on the 5th August 2024 (Appendix L). This amendment expanded the study's focus from inpatient MHS to encompass AMHS more broadly, including crisis and home treatment teams. It also enabled the inclusion of disability advocates, in addition to DPPD, with direct experience of AMHS.

Ethical decisions in this study were guided by institutional, relational and accessibility considerations, as it has been argued that conventional ethics procedures often overlook the specific needs and rights of Disabled participants (Inckle et al. 2023). Thus, adaptations were made collaboratively to ensure participants could participate in a way that aligned with their needs.

Informed Consent

Informed consent ensures that participants are provided with sufficient information (e.g. purpose, data storage, right to withdraw, etc.) to enable them to make a free and informed decision to volunteer, decline, or withdraw from the research (Oates et al., 2021). The process for achieving this was outlined above within the procedure section. All participants received an information sheet (Appendix G) outlining the research aims, procedures, potential risks and benefits, voluntary nature of participation, and how their data would be stored and handled. Written consent was obtained from all participants via a consent form (Appendix H), though participants could also provide oral consent via an audio-recorded phone call using a prepared script (Appendix I), which was also made available to accommodate accessibility needs. Additionally, verbal consent was sought at the beginning of each interview to confirm participants' agreement to the audio recording.

Confidentiality and Anonymity

In accordance with BPS guidance (Oates et al., 2021), efforts were made to protect participant confidentiality and anonymise all personal data. Demographic characteristics are reported collectively across the sample to ensure they are not identifiable. Participants were assigned pseudonyms and research ID codes, and any identifiable information within transcripts was redacted. Identifiable data were stored separately from interview recordings and transcripts. All data were held securely as encrypted electronic files on password-protected systems (Box).

Right to Withdraw

Participants were informed that taking part was entirely voluntary and that they retained the right to withdraw at any point prior to data being anonymised and integrated into the wider dataset. It was emphasised that participants did not need to provide a reason for withdrawal.

Risk of Harm

It was recognised that reflecting on experiences of AMHS could elicit emotional distress for participants, particularly when discussing ableism and multiple marginalisation. Prior to each interview, the participant and researcher collaboratively agreed on a plan for how distress would be managed if it arose during the discussion. Participants were also given the option to be accompanied by a chosen support person during the interview (e.g., friend, family member, care assistant, etc.). If a support person was present, the participant and researcher discussed and agreed upon the nature of their involvement beforehand to ensure that the participant remained the central focus of the interview. Of the 12 participants, only one had a supporter present during the interview. Participants were also reminded at the outset of their right to skip questions or end the interview at any time without explanation.

To support accessibility, particularly in consideration of the potential limitations of communicating over video call, the researcher made use of regular pauses and offered participants the option to receive questions via the Microsoft Teams chat function. This gave participants additional time and flexibility to process and respond to questions. A debrief was offered at the end of each interview to allow space for reflection or discussion of any concerns.

The researcher also acknowledged the potential for participants to feel judged or misunderstood when discussing negative experiences of AMHS, particularly given the researcher's position as a non-Disabled trainee psychologist. Basic clinical skills were used to foster an empathetic and non-judgemental tone, while maintaining appropriate researcher boundaries. Consideration was also given to the potential emotional impacts on the researcher arising from hearing distressing accounts, as well as when reflecting on how they themselves implicitly reinforced ableist clinical and/or research practices. The risk of moral injury or vicarious distress was mitigated through regular supervision and the use of a reflective diary.

Critical Appraisal and Researcher Positionality

The following section presents a quality appraisal of the current study alongside a reflexive account of the researcher's positionality and influence within the research process.

Critical Appraisal of the Present Study

Traditional criteria of validity, reliability, and replicability are not appropriate for qualitative research, which is underpinned by distinct epistemological assumptions (Smith, 2024). Instead, this study was evaluated using the qualitative Critical Appraisal Skills Programme (CASP, 2018) criteria, the same framework used in the earlier systematic review. A summary of this appraisal is presented in Table 8, with a more detailed critique of the methodology and research design provided in Chapter Five.

Table 8

Critical Appraisal of the Present Research using the CASP (2018) Tool

Qualitative Appraisal Criteria	Criteria Met? **Key:** ✓= Yes ✗= No ?= Cannot tell	Evidence for meeting the CASP criteria
1. Is there a clear statement of the aims of the research?	✓	The aims and research questions of this study, to explore how Disabled people with physical disabilities (DPPD) experience acute mental health services (AMHS), were clearly stated in Chapter Two.
2. Is a qualitative methodology appropriate?	✓	A qualitative methodology was appropriate for exploring DPPD's and disability advocates' experiences through the use of explorative and open-ended interviews. This approach enabled flexibility during data collection and analysis, supporting the development of nuanced, in-depth accounts of a complex and under-researched topic.
3. Was the research design appropriate to address the aims of the research?	✓	A qualitative design was well-suited to addressing the research aims, given the limited existing literature exploring the specific experiences of DPPD

		in AMHS. Reflexive thematic analysis (RTA) was chosen due to its flexible and transparent approach, which aligned with the key frameworks guiding the study (the social model of disability and critical disability theory). Although limited, consultation with experts by experience also supported the decision to adopt a qualitative design.
4. Was the recruitment strategy appropriate to the aims of the research?	?	Purposive and snowball sampling were used to recruit participants with relevant direct or advocacy experience. Recruitment through third-sector organisations and social media helped build trust in the research/researcher and improve engagement. While NHS recruitment was not pursued due to the time constraints of the DClinPsy programme, this decision may have limited the range of participants and thus perspectives included in the data.
5. Was the data collected in a way that addressed the research issue?	✓	Data was collected through semi-structured interviews, conducted via video call or face-to-face, depending on participant preference. This flexible approach supported accessibility and enabled the participation of participants from across the UK. Interviews followed topic guides developed using the existing literature, with some limited consultation

		input. This aimed to enhance the relevance and clarity of the interview questions for participants. Further details about the data collection process are outlined earlier in this chapter.
6. Has the relationship between the researcher and participants been adequately considered?	✓	The researcher reflected on their position as a non-Disabled trainee clinical psychologist, with consciousness of potential power and lived experiences differences. Reflexivity was embedded throughout the research process through the use of a reflective diary**,** regular supervision, and consultation. The researcher's positionality is explored further in the "Reflexivity and Positionality" section of this thesis (see Chapters 2 and 5 for further reflexive considerations).
7. Have ethical issues been taken into consideration?	✓	Ethical issues were considered throughout the project, as outlined in the "Ethical Considerations" section of this chapter. A full risk assessment was completed and approved by the University Ethics Committee (see Appendices K & L). Key areas of consideration included informed consent, participant wellbeing, and accessibility.

8. Was the data analysis sufficiently rigorous?	✓	The analysis process was iterative and rigorous, as outlined in the results chapter. RTA was conducted following Braun and Clarke's (2006) six-phase process. Coding was inductive and theory-informed. Illustrative exemplar quotes were used to support transparency. Reflexive journaling and supervision supported critical engagement with the data. Reflective member checking was somewhat attempted through sharing a summary of the study's main findings with participants via email and offering the opportunity to provide feedback via a variety of means (e.g. email, video or phone call, etc.). Although only a limited number of participants responded, those who did largely shared that the findings overall were representative of and consistent with their experiences.
9. Is there a clear statement of findings?	✓	A summary of key findings in relation to the research questions is presented at the start of the Discussion chapter, with detailed analysis in Chapter Four.
10. How valuable is this research?	✓	This is the first known qualitative study to explore DPPD's experiences of AMHS in the UK. By primarily centring Disabled people's voices, the

research contributes to an underdeveloped area of literature that is often dominated by non-Disabled perspectives. The findings have important implications for mental health clinician training, service delivery, and policy. In particular, the implications relate to cultivating structural accessibility and disability-affirmative practice into standard mental health care.

Researcher Positionality and Self-Reflexivity

Qualitative research has been critiqued as it has been argued that data and resulting analyses can be impacted by subjectivity and bias (Denzin & Lincoln, 2011). Due to the researcher's involvement in qualitative research, some subjectivity is anticipated, and it can be argued that true objectivity is not possible (Dodgson, 2019; Jootun et al., 2009). Subsequently, credible and trustworthy qualitative research requires researchers to be transparent about their position relative to the phenomenon being studied through a process of reflexivity (Dodgson, 2019; Teh & Lek, 2018). Instead of attempting a false sense of neutrality, reflexivity encourages researchers to be explicit in considering how their positioning may influence the research process as a whole (Berger, 2015; Dodgson, 2019). Reflexivity functions as a methodological and ethical process by encouraging transparency and critical self-awareness in how knowledge is produced. Throughout this project, I engaged in reflexivity through reflective journaling, regular supervision, and ongoing critical engagement with the concepts of power and positionality.

I approached the research as a non-Disabled trainee clinical psychologist, conscious of the power and privilege embedded in my position. Despite my intention to deconstruct and resist systemic ableism within the present research, I have not experienced the lived realities of DPPD either within AMHS or the world more broadly. Nonetheless, my perspective has been shaped by personal and professional experiences aligned with exclusion and systemic injustice. This section aims to build on the self-reflexive statement detailed in Chapter 2, the content of which will not be repeated.

I pursued clinical psychology following significant experiences of distress in childhood, which were connected to bereavement and feeling that my family did not receive the support we needed from health and social care services. This felt connected to both gendered and class-based assumptions, such as the expectation that women should cope quietly with loss, or that our family did not need or would not benefit from professional support. Through these experiences, I developed a strong sense of injustice about who institutions acknowledged, supported, or overlooked. In retrospect, I now link these experiences to my interest in access, equity, and the influence of systemic/societal factors on psychological wellbeing.

Alongside my personal experiences, my awareness of the barriers faced by Disabled people in navigating mental health settings further developed through my professional experiences. Whilst employed within a secure inpatient mental health setting, I encountered a disconnect between physical accessibility and meaningful inclusion. In this context, I noticed a lack of procedural flexibility, adaptation, and uncertainty about how to support Disabled patients. The secure nature of the service also imposed additional barriers for Disabled people, for example, accessibility aids were sometimes perceived as risk items. Subsequently, I noticed that a narrative often emerged that these patients would be better served in more "specialist" services, which often meant being moved further from home and restarting their care journeys. Within my subsequent role in a community learning disability service, I noticed a greater emphasis on reasonable adjustments and procedural flexibility. However, in this setting, issues with physical accessibility were more apparent, for example, service users using mobility aids forced to navigate narrow corridors, heavy doors, and cluttered therapy rooms. Whilst on training placements, I worked with people with a range of disabled identities, who had been impacted by both explicit and implicit ableism (e.g. disbelief about the legitimacy of physical pain). In conjunction with my clinical education, these experiences deepened my understanding of interpersonal and systemic ableism. Through this, I became more attuned to the influence of the medical model in pathologising Disabled people's psychological distress and overlooking systemic factors.

Across my professional roles, I recall feeling ethically conflicted by inaccessibility, but unequipped to mitigate systemically ableist practices. These experiences inspired my interest in disability, access, and epistemic justice. Throughout this research, I was aware of how my experiences, particularly the powerlessness and frustration I felt in inaccessible institutions, might predispose me to focus on accounts of services failing to meet people's needs. With this in mind, I was conscious of remaining open to more positive or affirmative experiences, in an effort to source balanced and nuanced perspectives. Nonetheless, it's important to be clear that I understand issues of ableism in mental healthcare as widespread and reflective of broader sociocultural power structures.

As discussed above, I was transparent with participants about my position as a non-Disabled trainee psychologist, my interest in the topic, as well as my prior work with Disabled people in healthcare settings. I hoped my openness, in conjunction with my professional experience, would support the development of rapport and trust. I also aimed to mitigate power imbalances by integrating reflexivity, participant feedback, offering flexible interview formats, and giving participants some control in how their experiences were represented (e.g. checking in during interviews, inviting reflections on preliminary findings). Nonetheless, I acknowledge the persisting limits of my perspective and the potential for unhelpful responses (conscious or unconscious) when encountering stories of systemic failure in services similar to those I have worked and trained in. For example, defensiveness, complicity, or justification.

Aligned with the reflections of both Disabled and non-disabled disability researchers (e.g. Inckle et al., 2023), I engaged with critiques which question whether non-disabled researchers can conduct truly emancipatory disability research (Branfield, 1998). With this in mind, I felt it was important to actively reflect on my own internalised ableism alongside the dominant norms that shape healthcare and research. Through this, I have aimed to move towards developing a more critically informed "disability consciousness" (Dispenza et al., 2017). I hope this reflexive stance helped reduce any (understandable) participant scepticism or mistrust around my positionality, and instead facilitated rapport, empathy, and mutual respect. Therefore, where any discomfort arose, I tried to frame it as a valuable opportunity to learn, rather than something to avoid.

Dissemination Plan

The findings of this study are intended to be shared with a range of stakeholders. Firstly, all participants were offered and opted to receive an electronic summary of the results upon completion of the research. A concise and accessible summary will be created and distributed to participants as well as the third-sector organisations that expressed an interest during the recruitment process.

To circulate the research within academic and professional contexts, the researcher aims to write up the study for submission to a peer-reviewed journal. One potential option is *Disability & Society*, a critical and multidisciplinary journal focusing on disability rights, policy, and practice. Another option is *Disability and Health,* which focuses on multidisciplinary advancements in knowledge relating to disability and health. These journals align well with the present research. Other publications or magazines aimed at professionals working with Disabled people will also be pursued, such as *The Psychologist*, published by the British Psychological Society. The researcher also hopes to present the findings at relevant academic or professional conferences, such as the *International Conference on Disability and Diversity (ICDD)*.

For further dissemination, the researcher could also develop accessible resources, such as an infographic. This could be shared via online platforms with NHS trusts, local councils, professional groups, and relevant third-sector organisations. Using these mediums could enable the findings to reach both members of the public and professionals who use these resources to inform their practice. Finally, the findings may be relevant at a national-level in informing efforts to improve accessibility and inclusion in MHS. For example, policy bodies such as the UK Government's Disability Unit, the Department of Health and Social Care, or NHS England.

Chapter Four: Results

Chapter Overview

This chapter aims to summarise the results of the study, which identified five superordinate themes and six subordinate themes. First, the demographic characteristics of the sample are presented to contextualise the results and participants' experiences. Following this, the results from the reflexive thematic analysis (RTA) are presented, alongside exemplar quotes extracted from participant transcripts to illustrate each theme.

Sample Characteristics

The sample comprised 12 participants, 11 of whom identified as Disabled, resulting in 15 hours of interview data. Participants ranged in age from 20 to 59, with a mean age of 41.1 years. In regard to gender, the sample was unevenly distributed with eight women, two men, and two non-binary people taking part. Two-thirds of the sample identified as White British, one Asian British, one Black British, one mixed and multiple ethnic groups, and one White Irish. In regard to employment, a third of the sample reported being a student, three as self-employed, three as employed part-time, one as employed full-time, one as a full-time carer, and one as unable to work. Half of the participants reported identifying as heterosexual, three as lesbian, two as asexual, one as gay, and one as pansexual. Participants reported a variety of ways in which they were impacted by their disability and/or health conditions, including mobility, dexterity, concentration, memory, stamina, fatigue, pain, hearing, vision, mental health, speech, sensory issues, social and/or behavioural. Participant demographics are reported in Table 9 below. Participants were not required to disclose the exact nature of their physical disability or chronic health condition; however, some participants chose to provide the following information regarding their health: diabetes, cerebral palsy, Ehler's Danlos syndrome, gene deletion, mild speech impairment, spinal cord injury, endometriosis,

fibromyalgia, ME, arthritis, and nerve damage. Five participants reported they also identified as neurodivergent (autism, dyspraxia, dyslexia) in addition to their physical disability.

Eight participants reported having direct contact with acute mental health services (AMHS) between 2014 and 2024. This included two who had experienced crisis services alone and six who had experienced care in both crisis and inpatient MHS. Four participants were disability advocates with no direct experience of AMHS. Four participants reported contact with AMHS prior to 2010 and consequently were asked to focus on more recent experiences of care during the interview. Participants reported receiving AMH care from NHS (N = 8), private (N = 4), and third-sector (N = 6) organisations. The duration of contact with these services ranged from one day to four years (Mean = 301.75 days, Median = 30 days). Contextual and experiential information is reported in Table 10.

All participants reported not currently experiencing mental health crises, with the most recent contact with a crisis or inpatient MHS occurring in early 2024. All participants have been randomly assigned a pseudonym to protect their anonymity and confidentiality.

Table 9

Demographic Characteristics of Participants

Demographic		Frequency
Gender	Female	8
	Male	2
	Non-binary	2
Ethnicity	Asian or Asian British	1
	Black British	1
	Mixed and Multiple ethnic groups	1
	White British	8
	White Irish	1
Age	18 – 25 years old	2
	26 – 34 years old	2
	35 – 44 years old	3
	45 – 54 years old	2
	55 – 64 years old	3
Sexual Orientation	Asexual	2
	Gay	1
	Heterosexual	6
	Lesbian	3
	Pansexual	1
Employment	Full-time employment	1
	Part-time employment	3
	Full-time carer	1
	Student	4
	Self-employed	3
	Unable to work	1

Area of functioning impacted by disability or chronic health condition(s)		
	Dexterity	4
	Hearing	1
	Learning, understanding or concentrating	7
	Memory	2
	Mental health	8
	Mobility	7
	Pain	7
	Sensory issues	4
	Social or behaviour (e.g. autism and/or attention deficit hyperactivity disorder)	5
	Stamina or breathing, or fatigue	5
	Vision	1
	Other	2
	Mild speech impairment	
	Arthritis	

Note. (N= 12), however sexuality, employment, and area of functioning figures show that participants held multiple identity status.

Table 10

Contextual and Experiential Information

Pseudonym	Accessed inpatient mental health services	Accessed mental health crisis services	Accessed NHS services	Accessed private services	Accessed third-sector services	Disability Advocate (indirect experience)	Year(s) in which contact occurred	Total duration of contact with service(s)
Ash	X	X	X		X		2020	8 days
Hannah	X	X	X	X			2020, 2021	25+ days
Ellie		X	X		X		2018, 2020	35 days, on the second occasion, care was refused by the service
Daniel	X	X	X	X	X		2018, 2019	18 months
Zahra						X		

Sophie						X		
Tom						X		
Riley		X	X	X	X		2023	1 day
Laura	X	X	X	X	X		2014 - 2022	4 years
Emma	X	X	X				2018 - 2024	11 months
Tess	X	X	X		X		2014 - 2022	2 days
Grace						X		

Overview of Findings

The five superordinate and six subordinate themes developed through reflexive thematic analysis are summarised in Table 11. These include: *Barriers to access, inflexibility and exclusion in acute mental health care; Lack of holistic care: integrating physical and mental health; Silencing and epistemic injustice; Disability Competence and professional avoidance; Discrimination, intersectionality, and identity*. A cross-comparison of participants by each of the themes is then presented in Table 12 (Appendix N).

Table 11

Superordinate and subordinate themes

Themes	Sub-themes
Barriers to access, inflexibility and exclusion in acute mental health care	*Physical and procedural inaccessibility and inflexibility* *Access barriers cause iatrogenic harm and protective avoidance of services*
Lack of holistic care: integrating physical and mental health	
Silencing and epistemic injustice	*Devaluing lived experience and self-knowledge* *Self-advocacy and self-silencing*
Discrimination, intersectionality, and identity	*Ableism and attitudinal barriers* *Intersecting and multiple marginalisation*

Disability Competence and professional avoidance

Theme One: Barriers to access, inflexibility and exclusion in acute mental health care

This theme illustrates the barriers Disabled people with physical disabilities (DPPD) encountered whilst navigating access to AMHS. This theme comprises two subthemes. The first, *physical and procedural inaccessibility and inflexibility*, describes the systemic barriers to access Disabled people face in their engagement with AMHS and the missed opportunities to provide collaborative reasonable adjustments. The second, *access barriers cause iatrogenic harm and protective avoidance of services*, explores the impact of experiencing these barriers on DPPD mental and physical health, as well as their willingness to engage with services when experiencing AMH needs.

Sub-theme: Physical and procedural inaccessibility and inflexibility

This first subtheme concentrates on how the design of AMHS often excluded DPPD through both physical (e.g. inaccessible buildings, inadequate facilities, etc.) and procedural (e.g. standardised risk policies, medication procedures, etc.) inaccessibility. Participants described that the presence of these barriers meant services frequently failed to meet their needs, undermined their autonomy, and framed them as problems. These experiences demonstrate evidence of institutional and systemic ableism characterised by a failure to meet

the standards of reasonable adjustments required by law. Participants shared numerous examples of physical inaccessibility within AMHS:

> There was only one because the bath was broken, which obviously meant you had to be a little bit more timed with when you could shower, which, for someone with a disability, isn't always possible. Umm, for me, I have a window to shower, and if I don't do it then it's not gonna happen… obviously, unless I had the support of someone else, but obviously, in hospital, you don't have that option – Hannah

> Getting in there was an absolute nightmare. The access was completely nonstarter really. It's over steps, I had to bring in a ramp of my own and the angle to get down the steps was… I don't think the health and safety inspector would have been terribly impressed. – Tom

Some participants described how inaccessible AMHS could create a sense of entrapment and compound the loss of agency they already experienced in MH crisis. This highlights how inaccessible environments go beyond logistical issues and actively contribute to psychological distress. For example, Ellie described how the design of the crisis service building contributed to her feeling imprisoned and undermined her sense of safety:

> Sometimes they were tiny, tiny rooms and like the one building I went to must have had six heavy fire doors in the corridor to get to the room and helpfully, the woman that I was seeing opened them for me, but I felt very trapped. Like and if I was a non-disabled person and I wanted to leave a room, I could get out and walk out, but I know that I can't do that and when you're adding like six more fire doors, it just like compounds that trappedness. – Ellie

Beyond the physical environment, participants highlighted how standardised processes and procedures used within AMHS failed to accommodate DPPD's needs. They described a myriad of areas in which rigid procedural inaccessibility presented barriers to both physical and mental healthcare. This included experiences of being denied access to their regular medications and self-management tools due to inflexible ward procedures. For example, Ash reported how the medication they brought with them to the inpatient unit was confiscated, despite the services' inability to facilitate a new prescription:

> [they] wouldn't let me take in packets of the meds either, although the last time I brought it in anyway and they took it straight off me, locked it away, and then never went back to it. It will still be "Oh, we're waiting for your medication to come over from the regular hospital". And I'd just say, but you locked it away in that cupboard and I'd be pointing at the cupboard. "No, no, we can't use those". – Ash

Additionally, two of the participants who were wheelchair users also described experiences of their wheelchairs being framed as barriers to accessing AMHS, whilst systemic inaccessibility went unacknowledged:

> Being referred to inpatient services, one. there's normally a wait, a massive wait, and two. because I use a wheelchair, it's finding somewhere that can accommodate the wheelchair – which I bloody hate. So it tends to take a lot longer than it has done for like my friends who don't use a wheelchair or anything other like that… Yeah and you don't get anywhere. You're like, how long's the bed gonna be? And they're like, well, we referred you to here and here and here but they can't accept you because of the wheelchair. And I'm like, OK, great, that makes me feel 10 times better. – Emma

Conversely, participants with invisible disabilities shared experiences of their access needs being dismissed or overlooked entirely. Tess' statements reflect the tension associated

with the perceived visibility of disability, in that invisibility could lead to access needs being side-lined, whilst increased visibility resulted in recognition and adjustment, but risked over-emphasis. This was experienced as particularly problematic in the context of acute psychological distress and treatment by psychiatric medication, which could mean it was challenging for participants to communicate their access needs.

> Accessibility wise, sometimes it would be like they wouldn't even ask. Sometimes it would be ignored, but then other times, particularly for people with visible disabilities, it would be, yeah, put forward. But I guess that's the issue with invisible disabilities, they're not seen, so they aren't seen as important. Yeah, so there's that risk of again, that's like kind of focusing on too much or being overlooked. – Tess

Whilst standard physical environments and procedures in and of themselves were highlighted as problematic, many participants identified a further barrier arising from the inability or unwillingness of services to respond flexibly and adapt to meet their needs. Subsequently, many participants reported that they had been expected to provide their own solutions to inaccessibility to make up for service failings. Ellie reflected on how failures to adapt standard crisis support had made her feel dismissed and, in contrast, acknowledged the flexibility of her private therapist in making reasonable adjustments:

> They’re always quite lost with me on regulations, because of my [cerebral palsy], my speech, and my breathing, I can't do a lot of the breath like calming exercises. And so, my private therapist has like worked hard to find alternatives, whereas they’re like oh you can’t do them, and that was it […] And it goes back to the whole medical model thing, that I'm the problem and it’s not their service. And to be fair, I was left with that feeling, feeling too complex. – Ellie

Unfortunately, Laura described that even where efforts to facilitate reasonable adjustments were made, structural inaccessibility created barriers to adaptation:

> They tried to facilitate moving me downstairs. There were only two rooms for females downstairs at the time, unfortunately one of the ones, the patient in there couldn't be moved out as it would have been the more accessible bathroom for the girl who had the stoma bag […] for her needs, there was definitely absolutely no way that she could be moved out and due to her mental health […] And unfortunately, the other bedroom downstairs, we couldn't fit the shower chair into the bathroom the ensuite was too small. – Laura

Several participants described the necessity of services being flexible, responsive and collaborative to DPPD's lived experiences. This included co-developed, dynamic and evolving care plans that accounted for disability-related needs:

> It was what skills do you need to progress and move on? You know, what do you need? What needs to happen in your life for you to move on? And so do you have to change your job? Do you have to change your friends? Do you need to have a hobby? – Daniel

> Mindfulness and sort of focusing in on my body doesn't work with me because I then feel all the pain that is in my body. And so having the sort of [options] if that doesn't work, these are the things that could work. – Hannah

Participants also described how disability-affirmative practice could be embedded throughout contact with AMHS, from admission to discharge. For example, Hannah described the importance of a holistic intake assessment as an opportunity to not only document access needs, but also to think flexibly about how this could be achieved in the context of standardised procedures:

> The initial kind of conversation that they have with you is what physical health needs do you have? What can we do? Obviously, if some things aren't gonna be allowed, like hot water bottles are a health and safety risk, but what can we do that's different? – Hannah

Significantly, inaccessibility was identified not as an isolated phenomenon, but as a reflection of wider systemic and structural failures to include DPPD across the health and social care system. Sophie's comments emphasise the broader need for services to engage meaningfully with the concept and practical provision of reasonable adjustments to facilitate DPPD to AMHS, rather than perceiving them as optional or troublesome afterthoughts. Sophie's comments took this further, to suggest how a proactive and transparent stance could signal safety even prior to initial contact:

> Have something on your website that says you understand iatrogenic harm, you understand the social model of disability, and that your distress is often caused by others, not your impairment. You know, give more information around what reasonable adjustments are available, are possible, that you are able to have a discussion about it. – Sophie

Sub-theme: Access barriers cause iatrogenic harm and protective avoidance of services

The second subtheme focuses on the consequences of inaccessibility and exclusion within AMHS for DPPD experiencing mental health crises. Participants reported that experiences of exclusion from services contributed to an exacerbation of their existing AMH needs. Subsequently, participants reported losing trust in and avoiding AMHS as a means of protecting themselves from further harm. However, whilst avoidance was described on the one hand as protective, it was also acknowledged that this left DPPD feeling stuck with no avenues for support.

> When I was having the blood test again I was in a crisis, so I was even more upset, and the nurse who was doing it, like, hit me, it wasn't like really hard or anything, but over the back of the head, and she called me a baby. And I thought like I can just imagine someone who is, you know, very deep in a crisis, just experiencing that, that could be the final push. – Tess

Similarly, exclusion from services was identified as compounding the sense of isolation felt whilst admitted to inpatient MHS. For example, participants reported that a lack of local accessible beds often meant they would be geographically displaced from their homes and support networks. These moves were noted to be based on systemic failures to make reasonable adjustments, rather than clinical need for specialist services. Emma illustrated this displacement and the potential emotional consequences for DPPD, through describing both her personal experiences and an encounter with a d/Deaf peer whilst admitted to an inpatient MH service:

> None of the staff spoke sign language. So how are they going to get treatment? I don't know what happened because she was transferred somewhere not in this country. I think they transferred her to somewhere in Europe that did do sign language […] Like I [was transferred nearly 300 miles] because it's the only wheelchair accessible bed they could find and I thought that was bad [...] It just made you even more isolated and lonely than you were before 'cause mental illness in itself is quite isolating. – Emma

Some participants highlighted that inflexible risk procedures could be experienced as punitive and discriminatory. This sense was particularly heightened for DPPD using mobility aids. Wheelchairs, for example, were described as being framed by services as safety risks, rather than essential supports, and subjected to safeguarding procedures to justify their

removal. Emma shared how having her wheelchair removed following incidents of self-harm reduced her agency, increased her vulnerability, and exacerbated her distress:

> What if there's a fire? What if I feel trapped? What if I need the loo? They're like, “we'll get it for you if you need it”. And I'm like, what if that member of staff doesn't get it for me? […] which makes my mental health worse and it's just a bit of a nightmare. – Emma

Additionally, some participants reflected that procedural and physical inaccessibility within AMHS negatively impacted not only their mental health, but their physical health as well. Hannah reported how environmental neglect, lack of reasonable adjustment, and provision of physical healthcare triggered her ME and left her feeling that she needed to fight to have her needs met:

> I have Raynaud's syndrome, it is not disabling for me personally most of the time, but the window was broken in my room, so it couldn't shut. And obviously the bedding they give you is not the thickest, it's not the most warm. And so that was really triggered, like my hands were in so much pain, I couldn't sleep. My joints sort of seized up and that then triggers my ME. So that felt like a lot of a struggle of saying, I know I can't move rooms cause you're full, but is there anything that you can do to sort of make this a little bit easier for me? And they also couldn't get my Raynaud’s medication for me because it wasn't a... their pharmacy didn't usually have it in stock and they had to wait for the main hospital to send it to them or my mum to bring in a full packet that was fully sealed, which I didn't have. So it did feel a little bit like I was fighting an uphill battle with all these things. – Hannah

This illustrates the need for AMHS to be responsive and flexible in the care of DPPD to reduce the iatrogenic harm that heightens the strain on physical and mental health. In the

context of these harmful experiences of inaccessibility and exclusion, the majority of participants with direct experience reported a wish to avoid AMHS in the future. Laura described weighing her mental health needs against the perceived risk of accessing services:

> If I was on crutches and I knew that, I don't know, I couldn't have a shower seat that fitted in the shower because I couldn't stand in the shower at the time. Or you know, if I knew that I wasn't going to be able to live comfortably in you know in a hospital ward. Would I jeopardise my mental health and avoid seeking help because I thought they weren't going to be able to cater for my needs? I think I probably would. – Laura

Laura's statements illustrate how exclusionary service designs created unique pressures and risks for DPPD, which could lead to them risking further deterioration in their mental health. Subsequently, several participants reported avoiding statutory AMHS and accessing alternative mental health supports. Indeed, Ellie reported that her engagement with crisis services created additional mental health needs requiring private psychological support to repair iatrogenic harm:

> I'm still working with the therapist that I had during that time, she was there alongside me throughout all that and I don't think she would ever refer me again either, because we then spent about six months trying to put me back together. They did so much damage – Ellie

This excerpt highlights that protective avoidance of services following exclusion extended beyond the DPPD with direct experience, to those in their wider support.

Theme Two: Lack of holistic care: integrating physical and mental health

This theme concentrates on the separation of physical and mental healthcare within AMHS, specifically how services understood and engaged with physical health needs.

Participants described how their physical health needs were overlooked, misunderstood, or inadequately addressed during AMH care. This lack of integration and artificial separation of physical and mental health were seen as particularly harmful for DPPD, for whom these needs are often deeply connected. Experiences under this theme highlight how fragmentation of services led to deterioration in overall health and contributed to loss of trust in both physical and mental healthcare systems.

Participants described the direct way in which their admission to AMHS worsened both their physical and mental health, particularly due to a lack of access to specialist physical healthcare:

> You had no access to any physical healthcare other than the ward doctor, who was a ward doctor for eating disorders, they dealt with things like anaemia and stuff like that. They didn't deal with complex pain management and stuff like that, which, when you're inpatient so far away, and I was there for almost a year, having no access to any of the like physio and pain management and etcetera, etcetera, etcetera, it makes your physical health worse, which therefore makes your mental health worse, which just makes it all worse. – Emma

Furthermore, Emma's experiences illustrate a broader theme that the compartmentalisation of health services contributed to a vicious cycle of deterioration, particularly for DPPD with complex, rare, or chronic conditions. Similarly, several participants described an absence of communication between physical and MHS, which disrupted ongoing physical healthcare and required DPPD to act as their own care coordinators. This task was reported to be exhausting, especially in the context of AMH needs, for example, Hannah described the experience of navigating her physical healthcare whilst in inpatient MH services:

> The physical health teams, they had a real struggle trying to communicate with any mental health team, whether that was inpatient or outpatient. Umm, because I think one of my doctors needed information about how my mental health medication would impact physical and all of this, and it was a really big struggle trying to get them to talk to each other. – Hannah

The assumption that physical and mental health could be treated separately was repeatedly challenged by participants. For example, Riley described the bidirectional relationship between their physical health, emotional, and cognitive functioning:

> So many things do feedback off each other, like if your mental health is bad, then your physical health is worse, if your physical health is worse then your mental health is, you know, strained. So like for me, if I'm if I'm having a flare-up, then my kind of capacity mentally is a lot lower. And so it takes less to trigger more if that makes sense. – Riley

This further illustrates a failure of services to understand the interrelationship between and practically integrate physical and mental healthcare. This lack of understanding was highlighted to lead to pathologising responses:

> They'd treat like maybe like high blood sugars, which can be caused by stress and illness as though it was me just being difficult […] it was just kind of, I guess, weird at the time. But interesting to me now how it was always blamed on me, whether it was like the type one diabetes on my mental health or me on the type one diabetes. – Tess

Subsequently, this misunderstanding was recognised as harmful and creating missed opportunities to move beyond narrow treatment models, towards more personalised and responsive care. Concerningly, fragmentation of services was emphasised to have potentially

life-threatening consequences for DPPD with complex physical health needs. Tom and Ash described the high risk of an inpatient MH admission due to the lack of provision for essential physical healthcare:

> I did actually ask my daughter whatever would happen if I was admitted to the mental health unit, she said I'd be better off dead [...] She said it would be a death sentence for me because there wouldn't be the backup I need. – Tom

> the very first time I went into a mental health hospital, I'd had an operation a couple of weeks beforehand – I had to have an emergency hysterectomy. So I still had like the dressings on and again they didn't know how to put dressings on they didn't know anything about it. They didn't call anyone from the physical hospital to come over and you know, redress the wounds or anything, they just left it to get infected and everything. And I don't know. I don't understand why there is just such a lack of joined-upness between the physical and mental. – Ash

Furthermore, this highlights how, for some DPPD, physical aspects of health could not be separated from the psychological. In contrast, some participants reported experiences of integrated physical and mental healthcare, which both validated their experiences and provided practical support. Laura described how procedural flexibility in AMHS enabled her physical health needs to be met, which in turn created a sense of safety and reassurance:

> Just knowing those things are there, but also knowing that you're going to be connected with the physical healthcare you need, you know, knowing that you're going to be put in touch with somebody if you need it. If for whatever reason you need to […] You know, being allowed physio bands, you know, the assessment goes 'well, are you are you a ligature risk?' Fortunately, I wasn't, therefore I was allowed physio bands in my room to do my physio […] So it's yeah, it's not just the facilities and the accessibility,

> it's knowing that A, you're going to be put in touch with the right specialist when you need it? And B, are you going to be allowed the right equipment that you need? – Laura

Another key component of affirmative AMH care highlighted by participants involved open, respectful conversations about how physical disability intersected with psychological distress. This was described as validating participants' lived experiences and avoiding pathologising responses, for example, Tom stated, *"Being willing to listen to their physical needs as well as the as well as the mental needs really. It's no separation between mental and physical health needs, because it's a continuum, because we're people".*

Overall, participants expressed a desire for holistic and integrated healthcare systems, able to acknowledge and respond to the needs of the whole person. This challenges the dominant medical model framing of physical and mental health as separable by symptoms and diagnoses.

Theme Three: Silencing and epistemic injustice

This theme captures how DPPD's self-knowledge was disbelieved or silenced within AMHS. This theme comprises two interrelated subthemes. The first, *devaluing lived experience and self-knowledge*, focuses on how DPPD's accounts were overridden by the assumptions of professionals or standardised care, thereby restricting their agency and voices. The second, *self-advocacy and self-silencing*, examines how DPPD were frequently required to advocate for their needs to be recognised and met. This was often described as having significant emotional and cognitive costs.

Sub-theme: Devaluing lived experience and self-knowledge

The first subtheme examines how DPPD's lived experience and self-knowledge were dismissed, disbelieved, or undervalued in AMHS. Participants shared that whilst their perspective was overlooked, the views of professionals and/or services appeared to be assigned more importance. Through this, participants described experiencing harm to both their physical and mental health, as well as their ability to engage in treatment. This delegitimisation of lived experience evidences a clear failure to uphold Disabled people's rights. For example, Daniel described feeling unheard and a sense that his needs were superficially engaged with, whilst service objectives were prioritised:

> I didn't think I was being listened to; I think I was just being placated, if that makes sense. So we're going to medicate you, you're going to be here, and then at some point you're going to leave. And it took a while for me to think, actually somebody is listening, but initially it was all about alright how can we get him out of here quicker? – Daniel

These comments illustrate a lack of collaboration in AMHS, rather than working together to fully understand DPPD's needs. Furthermore, the privileging of standard service procedures over DPPD's needs disempowered participants and overlooked their lived experiences. Some participants reported frustrating experiences of their disability being pathologised or attributed to mental health causes. Emma described that a lack of understanding of the fluctuating nature of health conditions contributed to assumptions that her physical symptoms, in this case, pain, were reflections of her mental state:

> They thought it was all in my head. I wasn't in pain, nothing was wrong with me and it was all my mental health. They took away all my painkillers. They took away basically all my meds and thought that would go well because they were like, yeah, it's going to

> help you realise it's all in your head. And I was like, it's not in my head. I've been diagnosed by a specialist before I got here. You just don't believe me because you're seeing it all through your own eyes and what you want to believe. – Emma

These experiences appear to constitute a form of gaslighting, in which DPPD's bodily knowledge was dismissed and argued to be "all in [their] head". She described that this occurred in spite of her disability being documented by specialist physical health professionals. Emma went on to describe how this impacted her ability to engage in treatment: *"I couldn't attend therapy and I couldn't engage with group therapy or anything like that because I was in too much pain the whole time"*.

For several participants, epistemic injustice in AMHS also put their physical health at risk. Hannah described how intersectional assumptions about her physical and mental health diagnoses contributed to a devaluing of her account of her need for pain management and left her feeling judged:

> It definitely felt like they were assuming I was looking for drugs. I have no history of drug abuse, so I was a little bit confused as to why they were sort of suggesting that. I mean, I understand that not everyone presents the same way, but it did feel a little bit like you can access my notes, I'm happy for you to go and speak to the gynaecologist at the main hospital, and I'm happy for you to speak to my parents because my parents are able to give them the information as well. So it did feel a little bit like I was being judged just […] because I was a mental health patient. – Hannah

Hannah's experiences also echo the statements of Emma documented above, in that she was put in a position of needing to justify her physical health needs and subsequently felt judged and dismissed. These experiences further illustrate the presence of diagnostic overshadowing in DPPD's encounters with AMHS and how this positioned participants to have

to ‘prove’ the legitimacy of their physical health needs. Conversely, other participants reported that assumptions about their disability meant the acuity of their mental health needs was doubted. Ellie described how this increased risk and jeopardised her safety:

> I think my therapist got told at one point by the crisis team that I couldn't take my life because I'm disabled and so it wasn't like a high priority safety concern for them. [...] And like my therapist said because of her disability she kind of has a higher chance of succeeding in that than a non-disabled person would be. […] But they were just taking it on face value and their assumptions. – Ellie

Ellie’s concerning experience highlights an ableist and patronising disbelief in DPPD’s agency and capabilities, which led to a dangerous mis-assessment of risk. Ellie went on to explain how, at the point of mental health crisis, the injustice of this disbelief, assumptions, and denial of care exacerbated psychological distress: *“all my inhibition had gone by then and part of me was like, well I’ll just kill myself and prove something to you”*

These reports underscore the need for collaborative AMHS that centres the voices and rights of DPPD. Aligned with this, several participants described experiences when they had been treated as equal participants in their care, particularly in relation to the management of their physical health:

> It was something that was discussed with [the service manager] and the GP in sort of depth as to you know OK look we need to think about this this you know how we need to manage it. What do you think? And there was a lot of sort of asking your opinion on how you felt things. It wasn't just right we're going to cut this [medication]. – Laura

> [AMHS need to] actually have the people involved that are going through [crisis], that have experienced it, that have come out of it, all of us sitting together around the table

> and sharing that with the professionals. I think that as professionals because they do it day in, day out, they can become tunnel-visioned. – Zahra

Both Laura and Zahra's comments emphasise the importance of services approaching communication in a way that involves DPPD as key stakeholders in decision-making around their care. In particular, Zahra highlighted that involving DPPD and their support networks enabled a more holistic approach to care planning rooted in lived expertise, rather than assumptions. Furthermore, participants recognised that having their perspective listened to and validated also reduced the feelings of self-doubt and internalised stigma caused by earlier epistemic injustice. For example, Tess and Riley described how AMHS, which asked respectful questions and listened to their perspective on the interconnection between their physical and mental health supported them to feel seen:

> So it means that I feel seen rather than having to kind of try and pigeonhole how I'm feeling into the boxes that are expected which makes me feel like I'm censoring myself, which is in itself triggering […] So it's, I hate the phrase, but I haven't found another one that expresses it quite as well, but it makes me feel less crazy. Because it's like, oh, actually, I shared all of this that is new and scary and somebody else was like, yeah, that makes sense. Yeah, just generally it's it just feels less alone. – Riley

> There's nothing wrong with asking them like do you think this is having an impact on your mental health? But then, compare that to either ignoring it completely or pretty much insisting it is having an impact even though you've said it's not. – Tess

Overall, the experiences described under this theme illustrate that with regard to AMH care, self-determination, control, and autonomy are concerns specific to DPPD. Thus, services should value the lived experiences of DPPD as a source of expertise and knowledge necessary to affirmative mental healthcare. Other participants named survivor-led alternatives to statutory

care, such as crisis houses or peer-led support, which were perceived as responding to distress in a more attuned, less medicalised way. Both Ellie and Sophie illustrate how this could work towards redressing the power imbalance between DPPD and non-disabled professionals:

> I really like that ethos and that power dynamic. And I do think there's so much we could gain from, like the survivor community, but it's just silenced and trodden down by these quite paternal professionals that are like, no, no, we know that. […] Yeah, I mean when you're disabled that's even more important, because your whole life is dominated by services and professionals. – Ellie

Sub-theme: Self-advocacy and self-silencing

The second subtheme explores how DPPD navigated and resisted the inaccessibility, epistemic injustice and silencing they encountered in their contact with AMHS. Participants reported that they were frequently positioned to have to advocate for their intersectional needs to be acknowledged and met. Notably, this self-advocacy often occurred in the context of AMH needs in which cognitive and emotional capacities were already strained. Subsequently, the responsibility to justify or fight for their needs could become an additional burden. In response to this dynamic, some participants described resisting by consciously silencing themselves as a means of avoiding further judgment, harm, or disbelief.

Participants consistently described the experience of repeatedly justifying or advocating for their needs in AMH settings. Similarly, other participants described how they were positioned as untrustworthy in their own care, yet were forced to challenge decisions when AMHS failed to adequately meet their needs. For example, Ash described how they advocated for their needs when their medication was confiscated, yet they were blamed for mismanaging their blood sugars and their self-knowledge was dismissed:

> I struggled with the diabetes for decades and I just kind of started to get a handle on things. And then they're just screwing it up and then testing my blood and saying, "oh, your sugar levels are really high". And I'd be thinking, yes, because you haven't given me my meds. You haven't managed to get hold of it, you know. And I'd have like again on my phone a list of my all my diagnosis and they'd be asking me "what does that mean?" – Ash

Ash's experiences also highlighted a contradiction between how the service monitored their physical health but did not support them to manage it, thereby creating a need for them to self-advocate for their needs to be met. The impact of this enforced self-advocacy was described as creating additional burdens for DPPD experiencing AMH needs:

> At such a vulnerable time, I had to advocate again for what I needed. And like it's a weird like juxtaposition where you had like no self-worth, but at the same time you're having to advocate for what you need and I was exhausted by then. – Ellie

Considering this, acknowledgement and meaningful engagement with DPPD's lived narratives was emphasised as important to prevent emotional and cognitive exhaustion. This was argued to require a collaborative understanding of the interplay of physical and mental health, how this may influence engagement with assessment/treatment, and practical adaptations. For example, Hannah reflected how her ability to self-advocate during a mental health act assessment had been compromised by cognitive fatigue (e.g. forgetting words) associated with her health condition, which made it difficult to meaningfully participate, increasing the risk of miscommunication and misrepresentation:

> So I think that was the biggest issue was I was really struggling to keep up with them and I'd get lost on my train of thought and I've been sat there thinking I don't even know what just said to you, which I feel was quite concerning because I could have just said

> something was completely untrue because I've completely mixed my words up and I don't know because I find they don't really reiterate back what you've said. – Hannah

Hannah's comments also highlight the necessity of clear communication, particularly in the context of power imbalances, to centre Disabled rather than institutional voices. In response to these dynamics, participants described ways in which they resisted imposed institutional silencing. For example, Zahra described the impact of AMHS not meaningfully hearing her perspective as an advocate and how this ultimately led them to disengage from services:

> It was like you're wasting my time. You know you're not, you're not even listening to what I'm saying […] So, it is from my own self– that going out and looking for things to make sure that I've got the right things in place rather than someone helping me. – Zahra

These experiences illustrate that epistemic injustice simultaneously triggers yet silences DPPD's attempts to self-advocate. Subsequently, finding themselves caught in this dynamic, participants refused care as a means of resisting. In Zahra's case, she reported that feeling unheard when seeking crisis support for a Disabled family member had triggered a need for self-reliance. This forced self-reliance arising from dismissive interactions with AMHS was also recognised by other participants, but, in contrast, they described it as reinforcing their resilience and personal efforts to reduce their emotional burden:

> That switch kind of flipped. It was really weird because it just went back to being hopeful because I was like, OK, I can try it on my own then and I went back to being hopeful and it did end up working and I think it was probably better for me because I'd been all like trying to rely on people all this time and I didn't have that stress anymore of being disappointed or let down. – Tess

Whilst Tess described an increased sense of resilience arising from her experience of being dismissed, other participants described feeling conflicted between the drive to self-advocate or self-silence as a means of protection. Daniel described this tension and resulting self-silencing when he felt unable to assert his needs in AMHS, which led to further distress:

> You have to either fight your corner or be quiet and quite often I'd just be quiet. […] Then I'll just let them get on with it and you know, let them shout about their concerns and their priorities rather than my own, which sometimes it then means I end up being very unwell. – Daniel

Daniel's reflections illustrate the emotional toll of navigating the dynamic between assertive self-advocacy or withdrawal and self-silencing. Notably, participants explained that the act of self-silencing was a response that had likely been reinforced repeatedly through DPPD's lives, as a means of self-protection in the context of relational power imbalances. Through this, whilst self-silencing could on the one hand be conceptualised as resistance and self-protection, on the other, it likely contributed to an internalised sense of disempowerment and inhibited self-advocacy. Sophie described how encounters with AMHS could reinforce this pattern through undermining DPPD's confidence to assert their needs and encouraging compliance:

> You always have to encourage someone to be honest because they're so used to hiding, hiding their true selves for lots of different reasons and being compliant too. Particularly when you need physical support, you know you're too scared to say anything in case your support leaves or gets violent or aggressive. So definitely I think that that is a big issue, that [Disabled people] are very compliant and so don't speak up, aren't very assertive and don't have a lot of self-esteem, which is all the things you need in those types of situations to challenge services. – Sophie

In particular, Sophie's comments highlight that the experience of epistemic injustice, self-advocacy and self-silencing is not isolated to contact with AMHS, but a repeated experience in DPPD's healthcare more broadly. As Sophie comments, DPPD's experiences of epistemic injustice and dismissal begin early in development, particularly for those with invisible or progressive conditions (e.g. fibromyalgia, EDS), which can discourage them from addressing their psychological needs.

> So there's, you know, something not happening right in services about how they talk about those physical symptoms that then means a lot of Disabled people are even shut down from exploring their mental health. And so like, my job is often to say, you know, even though they the NHS weren't saying in the right way to you, there is a psychological component to how you experience your impairment, your pain. – Sophie

Due to these dynamics and the nature of mental health crises, other participants suggested that carers, advocates, or people in the wider support network could be included to address power imbalances and ensure effective and safe information sharing. Zahra highlighted that including her as an advocate enabled collaborative and person-centred care. Similarly, Grace suggested that where DPPD did not have existing advocates or people they wanted involved in their care, this provision could be embedded in service design, facilitating communication of access needs, trust and safety, and centring DPPD's voices:

> She wasn't pushy, she wasn't, you know, saying, oh, this medication, you know, you have to take it, there was no pressure, […] I think that approach was better because it gave us time to really look into, you know, what steps we'd be taking, what the side effects may be because […] I have to advocate, so I had to make sure that I was doing the right thing right for them, not for myself, not for the professionals, not for anybody else. – Zahra

> having [advocates] just available, kind of like translators, […] so like you enter you're assigned an advocate, you can choose whether or not to use that person. But I guess with the comfort, the knowledge that in a crisis they will actually have your notes, they will actually be able to advocate for you, but also just give your wishes. – Grace

Overall, participants' experiences illustrate the complex tensions between institutional silencing, self-advocacy, and self-protection. Sophie's statements in particular demonstrate how Disabled people's experiences of epistemic injustice are both situational and developmental, both rooted in early experiences and repeated across interactions with health services. This recurring systemic disempowerment created a tension for DPPD in acute distress, either to resist and advocate for themselves, or comply and self-silence.

Theme Four: Discrimination, intersectionality, and identity

This theme explores biases in how DPPD's multi-faceted identities were understood and responded to. This theme comprises two interrelated subthemes. The first, *ableism and attitudinal barriers*, focuses on participants' experiences of both explicit and implicit ableism within AMH settings. The second, *intersecting and multiple marginalisation*, examines how experiences of ableism interacted with discrimination based on other aspects of identity, including gender, age, race and neurodiversity.

Sub-theme: Ableism and attitudinal barriers

This first subtheme examines how ableism manifested both explicitly and implicitly within AMHS. Several participants reported encountering ableist attitudes from professionals within AMH settings. This presented as assumptions about Disabled people's capacity, dependency, or agency. Participants described how this influenced their interactions with services, including how they were treated and whether they were included or excluded, in decisions about their mental healthcare.

Participants highlighted being subject to objectifying, condescending or patronising attitudes. Hannah, for example, reported biases and assumptions around her invisible physical health needs, whereas Emma described experiencing objectification associated with her wheelchair:

> I was trying to stay to my sleep schedule as outside of hospital and that wasn't, I think because for them my schedule seemed ridiculous, that I was sleeping at least 12 hours. That was at the time what I needed for the ME and they didn't see that as healthy, whereas for me I knew I needed that amount of sleep because I was really struggling. – Hannah

> One of my biggest bug bears, people moving my wheelchair because I'm in the way. […] I'm a person, just 'cause I'm in a wheelchair doesn't mean you can just move me. You don't pick up a person and move them unless they're a kid or a baby. – Emma

These comments illustrate appearance-based biases related to the visibility of disability, which contributed to an invalidation of both physical and AMH needs. Emma's experiences also evidence overt ableism, which presented through an infantilising violation of her personal boundaries and bodily autonomy. Similarly, Emma further elaborated on incidents where her mobility and dignity were compromised through oppressive lenses that reduced her to diagnostic labels or viewed mobility aids with suspicion:

> They just seen the words 'wheelchair user'. That's all they see. And I'm like I'm not just a wheelchair user, I'm a person, and they really didn't see that. They saw me as a problem because of the aids and adaptions I use to help me with my life rather than… Like they were all like the wheelchair's awful, […] And I'm like, but it helps me live my life, I love my wheelchair. […], but they always saw it as a barrier rather than a solution. – Emma

These experiences again illustrate explicit ableism in how assistive devices were perceived as problems or representations of limitation, rather than tools to empower DPPD. Emma elaborated that these oppressive attitudes compounded a sense of difference and internalised ableism and shame: *"I'm not different, I'm the same as you or someone down the corridor who's not got a disability, but I use a wheelchair"*.

Patronising attitudes were reflected in imposed minority status and assumptions that DPPD are inherently vulnerable. This created a risk of professionals making decisions for, rather than with, DPPD, particularly in AMHS, in which acute distress also influenced presumptions of capacity. This was evidenced by both Sophie and Grace:

> Disabled people are classed as vulnerable adults and so automatically, as a professional, you supposedly have more say about what you do because they're 'vulnerable'. But obviously, a lot of disabled people don't see themselves as vulnerable and hate it, you know, because they have full capacity. – Sophie

> [AMHS] just fall into this trap that if someone is disabled, they automatically need certain things, and that's not true. Most Disabled people are very capable, but just sometimes need adjustments. But you have to ask them what those adjustments are not assume XY and Z isn't a needed thing. – Grace

In this context, whilst the provision of assumed adjustments was intended as helpful, it also illustrates benevolent ableism through which assumptions about DPPD's needs were imposed rather than arrived at collaboratively.

Stigmatising attitudes were also reported in how reasonable adjustments were perceived, often as burdensome demands or inconveniences. Sophie highlighted that

institutional pressures could influence this framing, indicating both the interpersonal and systemic nature of ableist biases:

> When the staff are stressed themselves and they're underfunded and all of that, I think they see a lot of Disabled people's reasonable adjustments as unreasonable adjustments and they're just being demanding or attention seeking. – Sophie

Sophie's comments highlight how ableist tropes of DPPD as 'difficult patients' were associated with a denial of their legal rights. Ellie illustrated this in her experience of how ableist biases and assumptions about her speech impairment led to dismissal and denial of AMH care:

> I phoned the crisis line for support during the day and I was in quite a bad way and because of my speech impairment, which I'd already requested was flagged up on the notes so it was the first thing they read, despite that the call handlers still said um "I'm not gonna talk to you while you're drunk, ring back when you're sober" and literally put the phone down on me before I had chance to even say like I have cerebral palsy. I never phoned back again and I never would. – Ellie

Notably, this discriminatory misattribution occurred despite clear documentation of Ellie's need for reasonable adjustments. Overall, Sophie reflected that DPPD were subject to dual-discrimination and stigma relating to both disability and mental health, which compounded marginalisation. This included fatalistic and ableist assumptions about the relationship between disability and psychological distress, which subsequently prevented DPPD from seeking care for their mental health:

> There's a massive hurdle to even disclose that you've got mental health, and then when you do disclose it, generally, health professionals either say, well, of course you're

> going to be anxious, depressed or suicidal, because I would be if I was disabled [...] I think their consensus for most disabled clients has been that... you know, either there's this brushing off or they're to blame because they haven't accepted their impairment or they're not trying hard enough, or they're crazy. – Sophie

Sub-theme: Intersecting and multiple marginalisation

This subtheme explores how ableism in AMHS intersected with other marginalised aspects of DPPD's identities, including gender, race, age, body size, and sexuality. Whilst only four of the 12 participants spoke directly to this intersecting marginalisation, their narratives were felt to be qualitatively rich and indicative of broader systemic dynamics worthy of further exploration. Their experiences are suggestive of difficulties in recognising or responding to multiple identities within AMH care, leading to fragmented or inadequate care.

Some participants reflected on the intersection between disability and gender-based discrimination. For example, Hannah described how her endometriosis and associated pain were misunderstood, which subsequently limited her access to necessary physical healthcare:

> I felt like I was being judged for asking for treatment because usually at home I wouldn't need codeine, because obviously I could take my regular medication, but I'd have the hot water bottle, I'd have my tens machine, I'd have a lot of different options, but they weren't available […] also because I didn't have any products with me, like pads or tampons, purely because I wasn't expecting my period. I felt like the nurses were sort of [saying] "Are you actually, you know, you actually on your period?" I felt like I had to prove myself to them – Hannah

These statements highlight how gendered assumptions about menstruation, pain, and women's health conditions led to the dismissal of Hannah's physical health needs. These

experiences are indicative of gendered and disability related medical gaslighting, through which the legitimacy of her symptoms was questioned due to stereotypes about women's health and self-management. Additionally, Ash described experiencing gendered and fatphobic objectification, which resulted in the erasure of their other identities, including their disability:

> When most people look at me, when most cis-het people look at me, they'll see a fat black woman […] And you know the other parts of me, the part of me that's... um that's non-binary, a part of me that's queer, the part of me that is fat. But also, you know that has got disabilities just completely ignored. – Ash

Ash's comments illustrate a reduction of their identity to visible characteristics (e.g. race, body size, perceived gender) and a subsequent overlooking of their full identity. This lack of holistic recognition led to depersonalised and mismatched care. Indeed, Ash added that this focus on their assumed identities led to overshadowing and the adoption of a narrow, pathologising approach to their AMH care. Similarly, another participant spoke about their experience of appearance-based assumptions, though these related to age. Hannah discussed how these assumptions interacted and influenced how her disability was perceived, particularly regarding the legitimacy of her needs:

> There is a lot of bias towards younger people and them having disabilities, like it just doesn't happen or you're making it up, it's not that bad […] I know the older ladies that were there, they would get the treatment they needed because it was assumed, you know, they have arthritis or they have any other form of disability. – Hannah

The interaction of ageism and ableism noted by Hannah indicates that younger DDPD's needs are dismissed, doubted or delegitimised in AMH based on appearance-based assumptions. Whilst this experience was only shared by Hannah, it is a noteworthy reflection that may offer avenues for further exploration.

A further intersection highlighted by participants involved the dual marginalisation of physical disability and neurodiversity. For example, Riley and Daniel reflected on how the interaction of physical discomfort, overstimulating environments and acute distress limited their ability to engage in AMH care:

> I was in a state by the time I spoke to them, and it meant that I was very, because of having to be in, like, the loud noise and everything, because I'm autistic as well. So, like all of that loudness and all of the people and the waiting and the anxiety meant that I was very dissociated and very shut down by the time I got into the appointment. So it was like, so yeah, it wasn't. It definitely did not help my ability to engage at all. – Riley

Similarly, Daniel highlighted that inaccessibility for neurodiversity positioned him to *"just say yes to anything because I didn't understand".* These statements illustrate how a lack of neuroaffirmative practice and recognition of multiple identities created barriers to support and triggered protective responses, including masking and dissociation.

Overall, experiences under this theme illustrated how AMHS appeared overwhelmed by and ill-equipped to work with intersectionality. Participants described feeling that only one aspect of their identity could be responded to at a time, whilst their integrated self was erased or overlooked:

> I think I got also got the impression that I had too many identities. You know you're black and queer and non-binary and disabled and old and without family. You know, it's like, you know, maybe they could handle partially the black part but not all the others. – Ash

Ash's comments reflect how experiences of narrow care and a lack of cultural competence contributed to an internalised sense of being too complex for services. In line with

this, Grace reflected on the services' capacity and the feasibility of providing truly holistic care that integrated all aspects of identity, including Disability:

> Like when you're looking at someone who's disabled, who maybe has gender dysphoria and then has, like, a mental health problem on top of that. What do you tackle first? And then who can tackle it? Is there one service? I guess one professional that could tackle all three? […] So you might have then you know your [mental health] issue dealt with, but not from a disabled and accessible standpoint – Grace

Grace's statements question whether a lack of integrated engagement is attributable to broader systemic failings, rather than isolated instances of exclusion. In particular, these comments align with the experiences shared by Hannah and Ash of fragmented care in which only one aspect of their identity, often the one most visible, was acknowledged, undermining the effectiveness of care. This led to experiences of erasure and a sense that AMHS were not designed with DPPD in mind.

Theme 5: Disability Competence and professional avoidance

This theme explores experiences with AMHS and professionals who lacked knowledge and competency in working with disability and/or long-term conditions. As a result of this training gap, participants described an undermining of trust, increased emotional labour, and a risk of direct harm. The emotional complexity involved in negotiating affirmative and disability-competent care is also illustrated, particularly in relation to the need for responsive and reflexive practice. Several participants reflected on how a lack of knowledge and competence meant that AMH professionals were unable to understand or provide holistic healthcare:

> There's just a lack of training amongst healthcare professionals generally, including mental health workers, about how to work in an empowering way with Disabled people.

> And you know, of course, I think the challenge is the NHS is particularly has a very medical view of disability and so most people's experiences are that any involvement with any health services is actually damaging. – Sophie

These statements illustrate how institutionally embedded gaps in professional competence left AMHS unprepared to support or empower DPPD. As noted by Sophie, participants further elaborated that a lack of knowledge and competence could risk serious physical and psychological harm during contact with AMHS:

> And he said, well, you know, when you're there, it's a very acute life and death matter, and you can't afford to be arguing with the consultant about what his view of spinal injury happens to be compared to the truth. – Tom

> I was kind of made to feel like shame about my diabetes, I'd assume when you're training as a medical professional or in mental health, that would be the first thing you're taught not to make people feel. So […] the training needs to be revamped to stop professionals putting those feelings on people. – Tess

These comments, in conjunction with other participants' accounts, highlight the links between a deficit in disability competence and iatrogenic harm, including internalised ableism and extending to a risk to life. This issue of competence was argued to persist despite the existence of guidance, training, and information, which appeared to be underutilised. Many participants emphasised the availability of a variety of different sources of information:

> If I can open up the search engine and go to the NHS website, which will list all the meds that I put in, and say what they're for, you know other people can do it instead of having to have me, who's had a breakdown, to have to go through every single thing and explain what that is. It was just so distressing. – Ash

Ash's comments highlight that where professional knowledge and curiosity were lacking, they were expected to provide education at a cognitive and emotional cost. This highlights a lack of proactivity amongst professionals to source their own learning and education. In contrast, Emma described how basic professional initiative and willingness to educate themselves validated her lived experience and enabled care:

> I love it when people say, "I've googled your condition, I know everything about it", and I'm like, yes, it's not that hard to Google […] But some hospitals don't seem to have the initiative to go away and Google it, go away and research it and stuff like that. I had one psychiatrist […] who went away and dedicated like a good week to understanding everything about my condition and […] then he was like, I get it, I get what's going on. – Emma

Emma's comments illustrate the power of her psychiatrist's steps to self-educate, which facilitated holistic understanding and strengthened the therapeutic relationship. Additionally, Emma further described that training should be both proactive and responsive, including basic training on disability as well as on-demand education when new needs arose:

> I think just one general training on different disabilities, ambulatory wheelchair users, that they exist, and then just the general outline. […] Like I understand, if you've never had someone in that service before, who's blind or visually impaired, that you've never had training on it before. But I think it's important that if someone was coming in and was visually impaired, then training should be sought for the staff in order to help that person. – Emma

Embedding this model of responsive care was seen to be a way of enabling DPPD's needs to be met. Similarly, participants reflected that training could enable care and improve

competence, not only through increased awareness of physical health conditions, but also by reducing intersectional, unconscious biases and epistemic injustice:

> [training] just builds that relationship with and it builds that level of trust, I think between the patient and the staff. I mean, […] I don't ever remember having to explain to people what I had done, why I was in pain, why I was hunched over. […] I don't recall ever having to explain to anybody. – Laura

Whilst training and disability competence were desired, several participants acknowledged structural and systemic barriers to achieving this, including service demand, professional burnout, and the typically short duration of contact during crisis care. Despite this, other participants reported a lack of perceived organisational barriers to basic training, particularly when a solution-focused approach was taken. As Emma stated, *"It's not that hard to deliver a two-hour session to all your staff in one go […] or even online sessions or whatever they need to train people in different disabilities"*.

In considering Emma's comments, this indicates that barriers to training extended beyond structural barriers, which could be overcome. Some participants discussed professional avoidance and discomfort as a barrier to engaging with and developing competence in working with disability. For example, Ellie described her experience of crisis team professionals psychologically and physically distancing themselves from her care, for example, by avoiding difficult conversations, shifting focus to trivial topics (e.g. her service dog), or refusing AMH care:

> Out of nowhere, the worker that I did get on with went to leave at the end of the visit and said to my dog, my assistance dog, she said "Oh, I'll really miss seeing you. We're not gonna see you again". And I asked her about that and she was like, "oh we're discharging you next week". And like I was no better than when they began, because

> of all the overwhelm that they kind of made worse. And my therapist like contacted them and they said they'd done a risk assessment and I was no longer suicidal, but like they were not letting me talk about suicidal thoughts and I wasn't aware of a risk assessment being done – Ellie

This insensitive communication of Ellie's discharge from AMHS despite her continued need for crisis care illustrates the harm caused by professional avoidance or reluctance to engage with disability. Similarly, Sophie reflected that for non-disabled MHPs, physical disability provoked unique anxieties associated with unconscious fears concerning bodily decline and mortality. Subsequently, unable to contain these feelings of overwhelm, Sophie noted that this could be projected onto DPPD, resulting in psychological distancing, harmful stereotyping, and exclusion from care:

> Disability is the one minority that any of us can end up belonging to. […] unless you, as the professional have done some work around that, your body is going to fail at some point and you're going to die and there's things you can't control, and what happens is you're just projecting that onto that person that disabled client […] then you either get this kind of distancing effect of "I can't deal with that, what you represent to me, so I won't offer you a service" […] or you get the other way of, "I'm gonna try and force my stuff onto you because, you need to be fixed or I need to see you as an inspiration or a 'super-crip'. […] so you get silenced in both ways. – Sophie

Sophie's statements highlight that, through these psychological defences, professionals' emotional comfort was prioritised over DPPD's lived experience and AMH needs. Subsequently, Sophie emphasised that disability affirmative AMH care required professionals to be reflexive and willing to examine their unconscious processes and biases towards disability. For example, through reflective practice, supervision, and continued

professional development. However, others highlighted that training around disability needed to be considered and designed carefully, as this was identified as a potential site for continued transmission of ableist biases:

> When you're trained, you're trained to look out for certain things, but that's become problematic with physical disabilities […], to not make presumptions, not assume that someone needs something just because you know your ten other patients with the same condition require that you know, like you really have to focus in on the individual. – Grace

Through these comments, Grace reinforces the need for training to emphasise individualised over standardised care when working with DPPD. Notably, both personalised care and reflexive practice require professionals to exert emotional labour and a willingness to recognise personal biases. Unfortunately, several participants indicated that there could be both personal and cultural resistance to accountability and learning embedded particularly in NHS institutions:

> They've never had to deal with complex spinal injury, and they literally don't want know what to do. So instead of being sensible and calling a colleague or asking for the carers and patients input, they have hysterics because they're upset and embarrassed and angry. – Tom

> If they're honestly saying I really don't know about it and they're doing it in a genuine way, not just 'cause they're lazy and they can't be bothered to look at something you know, then I'm happy to talk about it. But, yeah, there was no admitting they didn't know about something, but that's something with the NHS anyway, they'll put up a wall of silence rather than admit that anything's wrong. – Ash

These statements illustrate that meaningful inclusion requires authentic openness to adaptation and a willingness to learn from DPPD and their networks. The impact of this on accessibility was captured in Riley's statement: *"they can't know everything about everything, but if they're open to saying, you know, "what would help?", that would make it a lot more accessible".* To counteract resistance and bias, Zahra highlighted the facilitative power of involving lived experience experts, both DPPD and their networks, in the design and delivery of AMH training:

> I think people like myself to be able to be within their teaching, you know, going in, sharing our experiences, our fears, our anxieties and how important communication is, you know, at all levels, you know, because I don't want people to stereotype, I don't want people to have hidden you know, biases […] so that's the sort of thing we can relate back to and work together. – Zahra

Zahra's comments indicate that participatory and collaborative training could enable challenging of stereotypes and implicit bias present in standard institutional training and broader society. Similarly, Ellie's comments illustrate that specific knowledge and expertise in disability, trauma, and long-term conditions enabled power sharing and validation of her lived experience. She described receiving this more affirmative and disability informed care through the third sector or private services, which, whilst not universally accessible, were often perceived as safer, more flexible, and better attuned to participants' needs:

> My private therapist actually specialises in disability and trauma. […] She totally gets all the microaggressions that you get every day and fighting for services. [She] sends me my notes after the session […] if anything is inaccurate, I can email back and say and she'll change it. […] The last thing I had to do, she actually let me write the whole

report and then she, like, added her bit for like strength and signed it and put it on her letterhead. – Ellie

Chapter Five: Discussion

Chapter Overview

This final chapter aims to summarise the findings of the present research and situate them in the context of the existing research literature examining Disabled people's experiences of mental healthcare. The strengths and limitations of the research methodology and design are considered, as well as implications arising for future research, practice, and policy. Lastly, the researcher presents their final self-reflexive reflections with respect to the complete research process.

Summary of findings

The present research explored the experiences of Disabled people with physical disabilities (DPPD) in acute mental health services (AMHS) from the perspective of those with direct and indirect experience. Whilst Disabled people's experiences of MHS have been examined before in both the U.K. (Glasgow Disability Alliance, 2022) and the U.S. (Hunt et al., 2006; Wang et al., 2024), to the researcher's knowledge, this is the first study specifically focusing on this disability group within AMHS (e.g. crisis services, home treatment teams, inpatient).

Using Reflexive Thematic Analysis (RTA; Braun & Clark, 2022), five superordinate themes were developed: barriers to access, inflexibility and exclusion in acute mental health care; lack of holistic care: integrating physical and mental health; silencing and epistemic injustice; discrimination, intersectionality, and identity; and disability competence and professional avoidance.

Barriers to access, inflexibility and exclusion in acute mental health care illustrate DPPD's encounters with inaccessibility and inflexibility within AMHS, and how this effectively excluded them from care. The theme encompasses two sub-themes, the first, physical and procedural inaccessibility and inflexibility, explores the ways in which rigid standardised models of care in AMHS were inaccessible and exclusionary for DPPD. The second subtheme, access barriers cause iatrogenic harm and protective avoidance of services, describes how exclusion caused harm in the domains of both physical and mental health, leading to avoidance of AMHS.

The second theme, lack of holistic care: integrating physical and mental health, explores how AMHS understood and practically provided for DPPD's integrated needs. It describes how the artificial separation of physical and mental health was experienced by participants and how this impacted their mental health and engagement with services.

The theme of silencing and epistemic injustice captures how the lived experiences and truths of DPPD were devalued or dismissed, and the varied responses this elicited. It is comprised of two subthemes, the first of which, devaluing lived experience and self-knowledge, focuses on DPPD's experiences of epistemic injustice and power imbalances within AMHS, whilst the second, the burden of advocacy and self-silencing, examines the emotional and cognitive costs of self-advocacy within systems that devalue DPPD voices and self-silencing as a protective mechanism.

The fourth theme, discrimination, intersectionality, and identity, describes how AMHS understood and integrated the multiple identities of DPPD, including experiences of bias and discrimination. It is divided into two subthemes. The first, ableism and attitudinal barriers, explores how ableism presented both implicitly and explicitly in DPPD's interactions within AMHS. The second, intersecting and multiple marginalisation, illustrates how DPPD with multiple marginalised identities experienced layered intersecting biases and assumptions.

The final theme, disability competence and professional avoidance, explores the dearth of knowledge and experience within AMHS to work with DPPD in an empowering and affirming way. This theme also describes some of the challenges to addressing knowledge gaps, including professional discomfort and avoidance of disability.

Relation of study findings to previous literature

The present research contributes to a developing body of literature broadly exploring Disabled people's experiences of mental healthcare and how these services can most effectively support this population. This section will discuss how the results align with and extend the findings of the existing literature, as well as any areas of difference.

Barriers to access, inflexibility and exclusion in acute mental health care

This theme and both subthemes correspond with existing literature in that they describe how Disabled people frequently have to navigate inaccessibility when accessing mental healthcare, leading to unmet mental health needs and a deepening of psychological distress (Conner et al., 2023; Gerke, 2016; Olkin & Gomez, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). The present study is also consistent with findings regarding Disabled people's access to health services (Sakellariou & Rotarou, 2017). Some of the physical and procedural barriers to access described in the present study have also been identified in the existing literature, such as inaccessible settings, bureaucratic processes, and a lack of reasonable adjustments (Chrysikou, 2013; Conner et al., 2023; Olkin & Gomez, 2024; Gerke, 2016; Powers, 2024; Wang et al., 2024). Consistent with previous research, participants in the present study described that, as a result of barriers to access and inflexibility, their engagement with AMHS created a "*tradeoff*" through which their mental health needs were not fully met (Powers, 2024, p. 76). This also aligns with Wang et al.'s (2024) findings that negotiating reasonable adjustments when accessing mental healthcare was experienced as burdensome and overwhelming, particularly for those with complex MH needs, and caused delays in treatment.

A particular procedural barrier highlighted in the present research involved inflexible risk management processes, which framed assistive devices, particularly mobility aids, as presenting increased risk and restricted access to these items. Whilst there appears to be little research in this specific area, Chrysikou (2013) found that MHPs reported valid fears around the ligature risks presented by universal accessibility devices, such as handrails. Importantly, Chrysikou's research highlights that ignoring either individual patient access issues or service-related concerns (e.g. staffing, safety/security fears, and models of care) is likely to lead to unsuitable facilities requiring reactive modifications, procedures, or rules, which then further compromise access as well as patient and staff wellbeing. In conjunction with the present research, this indicates the need for a shift in how mental healthcare is designed, to ensure that whilst environments are safe, secure, and accessible, they do not place unnecessary or unjustified restrictions on Disabled service users.

Within the second subtheme*, access barriers cause iatrogenic harm and protective avoidance of services*, participants' experiences in the present study resonate with Illich's (1976) concept of iatrogenic harm, defined as the unintended harm caused by healthcare interventions or systems. Similarly, Wang et al. (2014) found that due to structural and interpersonal ableism, as well as a lack of reasonable adjustments, Disabled people mistrusted and avoided formal MHS. The current research conceptualised this avoidance as a protective strategy adopted by DPPD to evade the psychological harm and cognitive demands caused by service contact. Within the general population of mental health service users, non-contact with services was found to be associated with fears of being subject to compulsory treatment, discrimination, and stigma (Sweeney et al., 2015). Notably, some participants in Sweeney et al.'s study also reported serious consequences arising from the conjunction of not being believed and inaccessibility, including exclusion, a reluctance to seek help, as well as physical and mental health deterioration.

Whilst Sweeney's study focused on a general population of mental health service users, these findings may also align with the present study focusing DPPD, particularly to the themes concerning inaccessibility, iatrogenic harm and epistemic injustice. Indeed, it may be reasonable to suggest that the effects found by Sweeney et al. may be magnified for participants in the present study due to factors such as interpersonal and structural ableism. This is concerning, as research has found due to repeated negative experiences of care, Disabled people or people with long-term conditions are more reluctant to seek healthcare and likely to avoid services (Hunter et al., 2013; Shaw et al., 2008). Consistent with the present study, Petrin et al. (2020) found that negative experiences of care led to the choice to seek help becoming a 'cost-benefit' calculation, leading some to self-treat, seek alternative care, or delay seeking care until crises emerged. This pattern, described as 'recursivity' (a feedback loop between past and future help-seeking), was also evident within participant accounts in the current study.

These findings also align with the work of Campbell (2009), who argued that Disabled people are frequently excluded from services when they cannot conform to inflexible and ableist expectations based on non-disabled norms, for example, around communication, presentation, or perceived compliance with treatment. Alongside this, the findings of the current study contribute to the evidence base on structural disablism within health services. Structural disablism is defined as systems that disadvantage Disabled people and privilege non-disabled people, rooted in historical and current institutions, policies, and sociocultural norms (Lundberg & Chen, 2024). Notably, the continued efforts of participants in the present study to persistently navigate AMHS despite these barriers align with the values of disability cultural identity, particularly resilience, humour, and future-orientation (Gill, 1995; Powers, 2024). DPPD's active resistance and resilience were also evident in the strategies they developed to meet their AMH needs where services failed, including independently developing crisis plans and identifying survivor-led services as alternative supports.

Lack of holistic care: Integration of physical and mental health

The second theme extends the findings of the existing literature that MHS have difficulties in understanding and managing physical health conditions (NCEPOD, 2022; Royal College of Psychiatrists, 2009). Indeed, mental health service users in the general population have been found to have poorer physical health outcomes due to barriers linked to stigma, diagnostic overshadowing, and a lack of physical health knowledge and skill in mental health practitioners (Healthcare Commission, 2007; Nash, 2013). Of particular relevance to this theme, participant experiences in the current study closely aligned with the concept of diagnostic overshadowing (Jones et al., 2008), which describes how physical symptoms are misunderstood or minimised within mental health settings. This phenomenon has been widely explored in healthcare services internationally, including a systematic literature review of 24 studies, which identified that service users with both physical and mental health needs were likely to experience their needs being attributed solely to their mental health, leading to delayed and inadequate physical care (Molloy et al., 2023).

In the context of the present research, DPPD were at risk of experiencing dual overshadowing through which their physical symptoms were ascribed to their mental health, and vice versa. This dual overshadowing was further compounded by stigma and stereotypes associated with the visibility, perceived severity, and complexity of participants' disabilities. Similar factors have been associated with diagnostic overshadowing for people with mental health needs accessing physical healthcare, including healthcare provider stigma, inadequate assessment, and lack of training, which were related to premature closure and negative experiences of care (Hallyburton & Allison-Jones, 2023). Consistent with this, other research has evidenced compounded barriers to mental healthcare for Disabled people who experienced chronic pain, mobility impairments, and complex medical histories (Conner et al., 2023; Wang et al., 2024; Zhang-Hampton et al., 2011).

Importantly, the lack of integration between physical and mental health found in the present research was evident not only in individual clinician biases, but rooted in the organisational culture and structural systems of mental health organisations. The findings of existing research indicate that fragmented service models impede effective integrated care, due to poor communication between services, ill-defined responsibilities, a lack of shared electronic systems, and financial barriers (Rodgers et al., 2018). Consistent with this, participants in the present study reported difficulties with the continuity of their physical healthcare and communication between services whilst under AMHS. Subsequently, DPPD in the present study reported direct links between the fragmentation of services and worsening physical and/or mental health outcomes, which created a pressure to advocate for their intersecting needs.

Whilst the current research primarily highlighted persistent failures to integrate care in AMHS, research in other healthcare contexts has evidenced that integration between physical and mental healthcare is possible, can improve outcomes and may mitigate barriers such as gaps in care and fragmentation (Druss et al., 2010; Rodgers et al., 2018). Taken together, this may reflect systemic differences between services and specific challenges for providing care in AMHS. Indeed, through the findings of the current study, AMHS could be argued to reflect Goffman's (1961) concept of the 'total institution' through which institutional structures and power dynamics diminish service users' identities into a single mental health narrative, and thereby neglect their holistic needs. This highlights the need for integration between physical and AMHS, particularly for DPPD, whose physical needs were overlooked, misinterpreted, or deprioritised in the present study (Gibson & O'Connor, 2010).

Silencing and epistemic injustice

The finding of diagnostic overshadowing also intersects with the third theme, which discusses how DPPD were subject to epistemic injustice in AMHS. This corresponds with the existing literature, which has evidenced both implicit and explicit forms of epistemic injustice, including questioning or minimisation the legitimacy of needs (access, physical and mental health), pathologising disability, and gaslighting in psychiatric contexts (Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Wang et al., 2024). Specifically, the results of the current study align with Fricker's (2007) epistemic concepts of testimonial and hermeneutical injustice. Firstly, testimonial injustice describes how Disabled people are perceived as less credible or lacking capacity due to ableist stereotypes and prejudice (Hunt & Blease, 2024; Fricker, 2007). In the current research, testimonial injustice was evident in the experiences of participants' self-knowledge of both their physical and mental health being disbelieved or delegitimised in AMHS, which then impeded their engagement with psychiatric treatment or resulted in disengagement from services altogether. For example, in Hannah and Emma's experiences, their physical health knowledge was rejected, despite documented diagnoses, leading to the withdrawal or denial of pain medication. These examples parallel findings in other healthcare settings in which patient narratives were frequently disbelieved, particularly when co-occurring mental health diagnoses contributed to implicit assumptions of emotionality, irrationality, or unreliability (Carel & Kidd, 2014).

Additionally, testimonial injustice was compounded by hermeneutical injustice (Carel & Kidd, 2014; Fricker, 2007), which describes a lack of shared interpretive resources (e.g. concepts and terms) between marginalised people/groups and those in power to describe social experiences. In the present study, this was evident through incidents of participants' ways of understanding and expressing their experiences not aligning with the dominant biomedical frameworks of AMHS. For example, participants described how their attempts to articulate their experiences were dismissed , as demonstrated in Riley's account of the relationship between their physical symptoms and PTSD. Overall, this reflects a failure of AMHS to value, interpret, and accommodate DPPD's embodied knowledge of their distress. This also links to Carel and Kidd's (2014) extension of the concept of epistemic injustice to include informational prejudice, in which patients' experiential knowledge is systematically devalued and deemed subjective in healthcare settings. This was found to particularly impact those with invisible or disputed conditions. This was evident in the present study as participants described how efforts to articulate their physical health needs, pain, fear, or the impact of inaccessibility were either dismissed, reduced to mental health aetiologies, or framed as non-compliance. Furthermore, the theme of devaluing lived experience and self-knowledge reflects broader systemic dynamics and structural discrimination of DPPD in AMHS, in which their capacity as 'knowers' is marginalised and professional knowledge is privileged. These power imbalances were argued to be further intensified by the looming threat of compulsory treatment, creating a climate of fear in which participants were both surveilled and silenced (Sweeney et al., 2015).

Consequently, participants described losing confidence in the ability of services to understand or engage with their needs, leading to reluctance to seek help or self-silencing either to appear compliant or avoid punitive responses. This was described as as further compounding psychological distress. For example, the present research is also consistent with the concept of epistemic objectification (Dohmen, 2016), which describes how institutional frameworks systemically exclude people's accounts, thereby positioning them as passive recipients of knowledge, rather than experts capable of contributing to the sharing and development of knowledge. Subsequently, the narratives of DPPD were disbelieved or erased, particularly those with invisible conditions who Fitzgerald & Paterson (1995) described may be perceived as "phony or fools".

Despite these dynamics, several participants in the present study described engaging in self-advocacy as a means to assert their knowledge and the validity of their experiences – described in the subtheme *self-advocacy and self-silencing.* For some participants, this facilitated a sense of agency, self-reliance and resilience that has continued to benefit them in coping with emotional distress and disempowering environments. Consistent with this, research has found that self-advocacy may empower some Disabled people with intellectual disabilities, through celebrating resilience, creating identity shifts from passive recipients to actively engaged in care, and building confidence (Goodley, 2005). Although the present study focused on DPPD, similar effects were observed, which can be suggested to have supported participants to effectively navigate fragmented healthcare systems, despite barriers. Nonetheless, other participants described that responding to institutional disbelief came at a psychological cost and exhaustion, particularly during times of AMH need. Similarly, Disabled people with mobility disabilities, as well as people with chronic illnesses, have described feelings of stress, overwhelm, and emotional and cognitive burden associated with self-advocacy (Wilkenfeld & Thomas, 2023; VanPuymbrouck, 2024). These findings emphasise the need for epistemically just practices in AMHS, where DPPD's experiential knowledge is treated as clinically valid and integral to care.

Discrimination, intersectionality, and identity

The dynamics of epistemic injustice are also linked to this theme, which illustrates the presence of intersecting forms of marginalisation within DPPD's encounters with AMHS. Specific to the sub-theme of *ableism and attitudinal barriers*, the present research contributes to growing evidence that interpersonal and systemic ableism are embedded in mental healthcare interactions, training, and service structures (Conner et al., 2023; De Clerck & Willems, 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). In the current study, ableism manifested in various forms within DPPD's interactions with AMHS, for example, assumptions about capacity and stigmatising attitudes towards disability, reasonable adjustments, and assistive devices. Ellie reported how paternalistic disbelief in her agency placed her at increased risk, whilst Emma described experiencing objectification associated with her wheelchair, which reinforced internalised ableism. This echoes dynamics highlighted in both the general and Disabled population receiving inpatient psychiatric care, which were characterised by infantilising or punitive care, and a perception of patients as untrustworthy (Conner et al., 2023; Gerke, 2017; Olkin & Gomez, 2024; Powers, 2024; Sweeney et al., 2015; Wang et al., 2024; Zhang-Hampton et al., 2011). This is consistent with findings of paternalistic ableism as a pervasive form of discrimination, manifesting in benevolence, sympathetic pity, and unsolicited protection (Nario-Redmond et al., 2019). Furthermore, experiences of ableism were found to vary alongside the visibility of disability, with paternalistic ableism associated with visible impairment and invisible conditions more closely linked to invalidation and allegations of fraud. The findings of the present research parallel this finding, for example, overly-protective perceptions of mobility aids as risk items or dismissal of legitimate need for pain medication. Subsequently, participants described disengaging or avoiding AMHS, suggesting that past experiences of cumulative discrimination contribute to the anticipatory impact of ableism and reluctance to disclose disability-related needs (Conner et al., 2023; Gerke, 2016).

These ableist attitudinal barriers were described by participants in both the current research and the existing literature as embedded in the culture of health services, and shaped by wider structural and cultural ableism (Banerjee, 2025; Read et al., 2018). For example, in the present study, Sophie described how reasonable adjustments may be perceived as inconveniences, rather than understood as basic rights. This sentiment was echoed in Read et al's (2018, p. 6) research in one participant's statement of: *"I don't want special. I just want appropriate."* Furthermore, findings in wider healthcare settings have evidenced continued marginalisation and pathologisation of disability, as well as a failure to perceive disability as valuable diversity (Banerjee, 2025). This was reflected in the current study, wherein DPPD's voices and experiences were dismissed or seen through a deficit lens.

In contrast, some participants in the present study highlighted experiences of more affirmative care in which clinicians understood, recognised, and adapted their practice to account for ableist microaggressions. Although limited, reports of disability affirmative care in the present study reflect what Dispenza et al. (2017) described as an 'affirmative consciousness' characterised by clinicians who proactively reflected on unconscious biases as a means to critically resist ableism and enabled holistic needs to be met (Powers, 2024). However, as highlighted in theme five, research has highlighted that MHPs lack disability competence and training to recognise ableism, limiting their ability to address adverse impacts (Wang et al., 2024). This is concerning as ableist microaggressions have been linked to negative mental health outcomes and increased somatic symptoms – as reflected in the present study (Kattari, 2020).

Research has found that discrimination is often complex, intersecting, and difficult to reduce to one identity (Tinner & Curbelo, 2024). The subtheme of intersecting and multiple marginalisation extends the above findings and corresponds with the existing research literature, which has found that Disabled people with multiple marginalised identities experienced intersectional discrimination (Braakman & Sterkenburg, 2023; Conner et al., 2023; Dispenza et al., 2017; Methley et al., 2017; Powers, 2024; Rintell et al., 2012; Thurston, 2010; Wang et al., 2024; Zhang-Hampton et al., 2011). Similarly, for DPPD in the present study, ableism was frequently compounded by other forms of discrimination based on race, gender, and age. This aligns with Crenshaw's (1989) concept of intersectionality, which describes how systems of oppression interact and create interlocking discrimination. For example, in this study, Ash described experiences of their integrated identity being overlooked, whilst Hannah recognised intersecting gender and age-based assumptions about her disability. Through the lens of intersectionality, DPPD's experiences are not understood as a monolith, but instead are shaped by identity-related factors, leading to layered discrimination or disregard for experiences specific to culture or gender (Crenshaw, 1989). Consistent with these findings, research has found intersecting discrimination in healthcare between Disability and gender (King et al., 2019; Nakkeeran & Nakkeeran, 2018), LGBTQ+ status (Kempapidis et al., 2024), age (Lu et al., 2022), and race (Holliman et al., 2023). Through examining layered discrimination, Tinner and Curbelo (2024) developed the chain of dismissal theory, which suggests the denial of symptoms occurs at multiple levels, including stereotypes related to age, gender, mental health status, or disability, thereby compounding discrimination and worsening both psychological and physical health outcomes. This was reflected in DPPD's experiences in the present study, specifically being perceived as "too complex" and ultimately excluded from AMHS.

Additionally, these experiences reflect broader patterns of services reinforcing internalised ableism, masking of holistic identities, feelings of alienation, and psychological distress (Merit, 2025). Dispenza et al. (2017) highlighted the need for competence in intersectionality, including an understanding of the impact of multiple marginalisation. However, DPPD in the present study expressed scepticism about the feasibility of truly holistic and integrated care within fragmented and structurally ableist systems. Notably, participant concerns arose despite the existence of multiple policy frameworks explicitly designed to promote diversity, equity, inclusion, and accessibility (e.g. Equality Act, 2010; NHS Long Term Plan, 2019; United Nations Convention on the Rights of Persons with Disabilities, 2006). For example, the NHS Long Term Plan (2019) promises to deliver personalised care and tackle healthcare inequalities. This disconnect between policy and practice may reflect institutional failures to meaningfully implement lived experience frameworks, disability research, and anti-discrimination guidelines. Subsequently, this may reflect 'symbolic compliance' (Van-Erp et al., 2020) or 'lazy intersectionality' (Watermeyer and Swartz, 2022), which describes superficial engagement with intersecting oppressions without translation into structural or cultural change.

Disability competence and professional avoidance

Many of the issues discussed above can be traced to challenges captured in the above theme, which highlights both individual and systemic gaps in AMH clinicians' and services' knowledge of affirming care for DPPD. This aligns with the existing literature, which has identified a lack of disability knowledge, awareness, and comfort as barriers to affirmative mental healthcare (Braakman & Sterkenburg, 2023; Conner et al., 2023; De Clerck & Willems, 2023; Dispenza et al., 2017; Gerke, 2017; Methley et al., 2017; Olkin & Gomez, 2024; Powers, 2024; Rintell et al., 2012; Wang et al., 2024; Zhang-Hampton et al., 2011). Similarly, participants in the present study reported that clinicians' lack of knowledge in supporting co-occurring mental and physical health needs could lead to physical and psychological harm for DPPD, including reinforcing internalised ableism. This is supported by findings that basic disability training is lacking amongst psychologist and psychotherapists (Artman & Daniels, 2010), and indeed many clinicians are unaware of the need for additional training (Olkin & Taliaferro, 2006), and subsequently increases Disabled people's risk of poor treatment outcomes, disengagement, and reluctance to engage in psychological treatment (Olkin, 2002). In conjunction with the findings of the present study, this indicates a need for systemic change in the training curriculum of MHPs.

Furthermore, some participants recognised that barriers to improving knowledge within AMHS extended beyond issues in practically integrating disability competence into clinician training. Indeed, individual clinician factors were identified as relating to the application of existing guidance, proactive information seeking, and unconscious processes. As Sophie reflected, professionals' unresolved conflicts regarding mortality and bodily decline may unconsciously influence their interactions with DPPD, and therefore, good practice requires awareness and reflection. Consistent with this, the existing literature recognised MHPs presented both explicit and implicit discomfort or reluctance to work with Disabled people, leading to assumptions that Disability inherently indicated complexity or unsuitability for psychiatric treatment (Conner et al., 2023; Gerke, 2017). This evidences a lack of 'critical awareness' of personal biases and deficits in knowledge or competency (Artman & Daniels, 2010; Balcazar et al., 2009). Thus, the present study aligns with calls for increased education within professional mental health training in disability-specific knowledge, humility, comfort, and cultural competence (Artman & Daniels, 2010; Conner et al., 2023; Olkin & Pledger, 2003).

Of concern, disentangling professional disability discomfort has been argued to be challenging as it requires clinicians to think reflexively about their practice, attitudes, skills, and need for education (Nash et al., 2022). This may be difficult to achieve due to systemic obstacles to learning within MHS and professional training. For example, some participants in the present study identified that a "wall of silence" and a lack of accountability could contribute to a resistance to acknowledging gaps in knowledge and learning. These systemic factors were argued by Dhanani et al. (2022) to stem from structural power dynamics and inadequate application of disability rights, which contributed to fear and protective silencing for Disabled patients. Subsequently, they posit that intersectional ableism impacts all stages of clinician training (Dhanani et al., 2022). This indicates that improving disability competence amongst healthcare professionals, including those working within AMHS, requires examining and deconstructing training programmes as these may act as mechanisms which transmit and reinforce ableist knowledge, assumptions, and practices. For example, in the present study, participants highlighted the pervasiveness of the deficit-based medical model of disability within AMHS, which reduced participants' identities and led to inadequate care. Indeed, in the current study, Grace reflected that clinicians may be "over trained" in deficit-based approaches, which she suggested reinforced ableist assumptions and distanced them from more personalised and affirmative practice. Furthermore, this may be reflective of what Pope (2018) terms persistent 'organisational dysfunction' within the NHS, characterised by defensiveness, dishonesty, suppression of voice, silence, fear, and resistance to 'knowing'. Conversely, they argued that the NHS should redefine its identity as an organisation to one that listens, learns, respects, and is honest in service of both patients and staff.

The approach suggested by Pope (2018) is consistent with research that disability affirmative mental healthcare can be enabled by increased awareness of identity factors, diagnostic overshadowing, stigma, systemic/structural power dynamics, internalised oppression, and minority stress (Dispenza et al., 2017; Nash, 2013). Although limited in the present study, a small number of participants reported experiences of AMH care that aligned with affirmative practice, including professionals with knowledge of ableism, microaggressions, an understanding of disability identity, and who proactively sought information about their disability. These experiences are consistent with the principles of Disability-Affirmative Therapy (D-AT; Olkin, 2007), a person-centred approach to integrating disability into psychological formulation and intervention without minimising or overemphasising its role. D-AT identifies nine key dimensions of experiences with disability and the importance of clinicians embracing a collaborative and affirmative stance towards Disabled people's lived experiences. Furthermore, Olkin's approach underscores the importance of common humanity and strengths-based conceptualisations of disability grounded in disability knowledge and advocacy (Olkin, 2007; Powers, 2024). Experiences of affirmative care in the present research support this, for example, several participants highlighted how services would benefit from learning from the experiences, creativity, and wisdom of Disabled people. In consideration of the experiences of participants, the D-AT approach can be seen as antithetical to the pervasive deficit-based medical model of disability currently adopted within NHS AMHS. Notably, D-AT is not a specific therapeutic modality, but instead a lens developed to be integrated within existing treatment frameworks and approaches (Olkin, 2007), and thus could be applied to enrich existing practices within AMHS.

Critical evaluation of the research

To the researcher's knowledge, the present study is the first to specifically examine Disabled People with Physical Disabilities' (DPPD) experiences in acute mental health services (AMHS), extending existing research focusing more broadly on mental healthcare or interventions (e.g. counselling). Consistent with the literature, the findings overall indicate that participants encountered structural and interpersonal ableism when accessing care which impacted both their physical and psychological wellbeing. However, the findings also demonstrated some variability between experiences associated with intersectionality as well as some reported experiences of affirmative AMH care. This may reflect individual differences between participants reflective of the wider Disabled population, which is highly heterogeneous, for example due to complex interactions between impairment type, severity, social factors, and intersectional dynamics (Annamma et al., 2013; Shakespeare, 2006). Subsequently, when interpreting the findings consideration must be given to the strengths and limitations of the study overall. Nonetheless, through applying the research findings to a UK context several recommendations are proposed for AMH care to better meet the needs of DPPD.

Recruitment constraints

Although, the study reached the lower end of the targeted number of participants, recruitment was found to be one of the more challenging parts of the research. Initially, the research had aimed to recruit only DPPD with direct experience of AMH services, however due to difficulties with recruitment, the inclusion criteria were widened to include Disability Advocates with indirect experiences of services. As discussed in the methods chapter, there is debate concerning what constitutes sufficient sample sizes in qualitative research (Malterud et al., 2016). Through the application of Malterud et al's criteria for information power, the narrow research aims and quality of the interview dialogue indicates that the sample size was adequate for the research. Specifically, participant interviews provided detailed accounts of the experiences of DPPD in AMH care from both the perspectives of those with direct experiences and disability advocates with indirect experiences.

The researcher considered many factors which may have influenced recruitment, including the choice not to pursue recruitment through the NHS, due to feasibility and time constraints, and to instead advertise online through social media, circulation to disability organisations, and word of mouth. Arguably, recruiting through the NHS may have facilitated the participation of DPPD, recently engaged with services and/or involved in advocacy through patient representation initiatives. However, recruiting and retaining Disabled people for health research is a commonly recognised challenge with several barriers to participation. Banas et al. (2019) identified the most common and entrenched barriers as the structure of the research endeavour, accessibility, and scepticism about research. Applying these barriers to the present study, it is reasonable to suggest that the recruitment processes employed may have limited the accessibility of the research, for example, text-heavy information sheets and consent forms may have disadvantaged those with visual impairments or co-occurring difficulties with reading (Banas et al., 2019). Of note, the researcher made efforts to ensure that all documents, including the recruitment poster, emails and social media posts, included written descriptions to enable the use of screen readers and/or text-to-speech programmes. Despite this, as recruitment was primarily facilitated online, this may have inadvertently excluded Disabled people experiencing digital poverty, as Disabled people have been found to have less access to technology due to economic barriers (Banas et al., 2019; Davidson et al., 2012). Moreover, the present research required participants to self-identify as a Disabled person with a physical disability. This was intended to be inclusive, due to the heterogeneity of the Disabled population and subsequent difficulties in defining inclusion criteria. This aligns with the work of Ellard-Gray et al. (2015) on recruiting 'hard to reach' populations, who advocate for flexible and inclusive sampling strategies (e.g. expanding inclusion criteria). However, this may have deterred potential participants who, due to the sociocultural devaluing of disability, may have been reluctant to identify in this way (Banas et al., 2019).

Data collection methods were also highlighted by Banas et al. (2019) as potentially creating barriers due to the time and energy commitment required for participation. Subsequently, Disabled people may not perceive participation in academic research as a priority, particularly if it does not directly relate to or address their presenting concerns (Kitchin, 2000). Additionally, many Disabled people already expend a significant amount of time and effort organising services, attending to their health/health care, and advocating for themselves in the context of interpersonal, structural, and societal barriers (Hammel et al., 2015; Iezzoni, 2011). Therefore, cognitive and emotional fatigue may have presented a barrier to participation.

In relation to the structure of and scepticism about the research, the researcher considered how their status as a non-disabled academic and clinician-in-training influenced the study design and the willingness of DPPD to participate. Mistrust and power imbalances are particularly relevant in this context, as Disabled people are frequently called upon as participants by non-disabled researchers, but are likely disenfranchised when research findings are inaccessible or are not disseminated to relevant communities/bodies to facilitate meaningful change (Banas et al., 2019; Kitchin, 2000). Furthermore, the legacies of historic and contemporary power differentials between non-disabled researchers and Disabled people may have meant that potential participants perceived the present research as placing them at risk of medicalisation, scrutiny, surveillance, and being "mined" for information (Banas et al., 2019; Shakespeare, 2013). As discussed in the methods section and below, the researcher attempted to adopt aspects of a participatory action framework within the limitations of doctoral clinical psychology training, attempts to recruit Disabled consultants to the research were met with little uptake. It is also worth noting that the researcher took steps to reduce power imbalances, such as compensating participants for their contributions as well as giving participants and disability organisations the option to receive an accessible summary of findings, following the completion of the research.

Overall, the majority of barriers to recruitment and limited solutions to address these challenges were rooted in time and resource constraints associated with conducting research as part of a professional doctoral programme. In consideration of the above, it is possible that the present research overrepresented the experiences of DPPD who were 'more accessible' in that they had greater capacity to participate, perhaps due to greater support, knowledge of their disability, assertiveness, or access to resources (Becker et al., 2004; Kroll, 2011). This is a commonly identified problem in disability research (Banas et al., 2019). Furthermore, it is possible that those with particularly poor experiences of NHS services may have been more motivated to participate as a means of having their voice heard.

Consequently, the recruitment criteria were expanded to include disability advocates without direct experience of AMH services. Whilst this broadened the data collected, the researcher noted that advocates' accounts often focused more on systemic and structural factors (Beresford, 2002), rather than personal interactions. Additionally, some participants identifying as advocates also occupied roles as family members and carers of Disabled people. Thus, their narratives often incorporated themes related to caregiving experiences, which, whilst connected to the lives of Disabled people, also reflected carer concerns that may differ in focus from those with direct, lived experience. This may reflect what Alcoff (1991) discussed as *"the problem of speaking for others",* as, even though well-intentioned, carers/advocates experiential position may differ from Disabled people, as they can often occupy a position of greater social, institutional or communicative power than the people they support. This can lead to a risk of Disabled people's experiences being overshadowed or misrepresented, thereby inadvertently reinforcing marginalisation and silencing in disability research. Notably, within the present research, out of the four disability advocates participating, only one identified as non-disabled, meaning that the majority of advocates, despite lacking direct experience of AMHS, had lived experience of disability. Whilst this shared identity is not necessarily equivalent to shared experiences of marginalisation within AMHS, and could risk distinct experiences being erased (e.g. through deprioritisation or sanism), the inclusion of Disabled advocates may provide empathy and a shared understanding of systemic ableism not lived by non-disabled participants.

Sample considerations

Despite the above concerns regarding recruitment and sample size, the present study had some strengths in the characteristics of participants in relation to the wider population of Disabled people. According to the UK Disability Statistics Research Briefing (Kirk-Wade et al., 2024), the prevalence of disability for working age adults is 23%, with women representing a larger proportion of Disabled people than men. This is largely consistent with the present sample, in which the mean age equalled 41 years, with 60% identifying as female and 16% as male. Additionally, through offering remote interviews, the research was able to recruit participants from across the UK, who had experienced a variety of acute services (e.g. inpatient, crisis, home treatment team, place of safety, etc.). There was also a mix of physical impairments, chronic health conditions, LGBTQ+ identities, and length of contact with services in the sample.

In spite of these strengths, there were also limitations concerning the demographics of the sample, in that all but three participants identified as White British or Irish. When standardised for age, the Disability Statistics has found that the prevalence of Disability is approximately 36% for Bangladeshi, 32% Pakistani, 30% for mixed and multiple ethnic groups, 28% White, and 26% Black. Considering this, Disabled people and advocates from racialised backgrounds were underrepresented in the current research. This reflects a commonly occurring problem within Western research, with a variety of barriers to increasing participation amongst racialised groups, such as the legacies of historically racist and oppressive academic practices resulting in a lack of trust (Tuhiwai-Smith, 2012). Additionally, it is possible that Disabled people from racialised backgrounds faced compounded barriers to participation in academic research through the intersection of both systemic racism and ableism (Annamma et al., 2012). It is unclear if any further factors contributed to this underrepresentation, other than those discussed above.

Additionally, information about employment status was collected as a proxy for socioeconomic status, as research has evidenced financial barriers to health services for Disabled people (Sakellariou & Rotarou, 2017). Of the Disabled participants with direct experience, four reported they were students, three were in some form of employment, and one was unable to work. According to Kirk-Wade et al. (2024), Disabled people were more likely to be 'economically inactive', meaning they are not in work and not able to work, compared to non-Disabled people, with rates of 43.1% and 15.4% respectively. Considering this, the present sample was underrepresentative of Disabled people who are out of work. This may be significant as Disabled people who are unable to work may be more significantly impacted by their physical impairment or health condition, and therefore may be likely to experience additional or compounded barriers to accessing services (Morris, 2001; Shakespeare, 2013). Furthermore, Disabled people unable to work are more likely to be receiving disability-related benefits (e.g. Personal Independence Payments or Employment Support and Allowance). Given the recent government cuts to these benefits as well as negative media and political rhetoric about claimants (Garthwaite, 2011; Ryan, 2020), this is potentially relevant as Disabled people reliant on these financial supports may experience increased economic strain alongside exposure to ableist discrimination and stigma.

Notably, a third of Disabled participants reported that they were students studying at a degree level or higher. Whilst this may align with recent findings of a rise in Disabled people accessing higher education (Kirk-Wade et al., 2024), these participants may not be wholly representative of the wider Disabled population. As, through exposure to academia, these participants may have held more positive views and willingness to contribute to the research, than other DPPD who, due to aforementioned research practices and power imbalances, may have been reluctant to participate (Banas et al., 2019).

In retrospect, it may have been useful for the researcher to dedicate more time to building relationships with Disability organisations and groups to promote the research, encourage participation (particularly amongst those experiencing multiple marginalisation), and address any potential concerns (Banas et al., 2019). Moreover, this may have highlighted any additional barriers to participation that the researcher was not aware of, thereby enabling these to be addressed more fully. Even so, attempts were made to contact a variety of organisations across the country via email to promote collaboration in developing the project as well as participation, which unfortunately was met by a very low response rate. In consideration of this, following up by telephone or visiting organisations, especially those local to the researcher, in person, may have provided an opportunity to build relationships with organisations and discuss the research. However, as the research was primarily undertaken by a sole researcher, this would have been time-consuming and not feasible in the context of a clinical psychology training programme.

Participatory action research

As discussed in the methods chapter, the researcher initially hoped to incorporate elements of participatory action research (PAR) throughout the study. However, in retrospect, it is acknowledged that perhaps sufficient effort was not dedicated to applying this in practice, particularly in the development of the research design and interview schedule. This is potentially significant as, without active inclusion of Disabled people's perspectives in the research design, relevant topic areas and perspectives may have been excluded (Banas et al., 2019).

Despite this, attempts were made to consult with Disabled people and members of the research community during the development and recruitment stages of the research, resulting in the revision of the research advertisement and widening of the participant inclusion criteria (e.g. widening to AMHS more broadly and including disability advocates). Nonetheless, implementing a more fully PAR approach may have supported and improved recruitment by enabling the researcher to build stronger relationships and trust with Disabled communities, and thus potentially mitigating some of the aforementioned barriers to participation (Banas et al., 2019).

Significantly, as discrimination and structural barriers within academic research continue to limit Disabled people's access to active roles in shaping, conducting, or leading research (Kitchin, 2000; Puyalto et al., 2016), engaging more meaningfully with PAR principles may have helped to address power imbalances between the non-disabled researcher and Disabled participants. For example, reducing the risk that DPPD's experiences would be inadvertently misunderstood or misinterpreted through unconscious processes or ableist assumptions (Stone & Priestley, 1996). The involvement of Disabled research consultants could also have supported by more in-depth reflections on research findings and write-up, through examination of the raw data and analysis (Wigginton & Setchell, 2016).

Unfortunately, as the researcher undertook the study as part of a professional doctorate programme, time constraints limited the feasibility of truly participatory research**.** With adequate time and funding, future studies could address this limitation, for example, by employing Disabled researchers, stakeholders, or a steering group (Nind & Vinha, 2014). This approach would not only promote more representative and equitable research but could also enhance the validity, dissemination, and impact of research findings (Nind, 2017). With this in mind, it may also be important to consider that assumptions of knowledge simply due to identity as a member of the Disabled community may also be problematic and based in erroneous assumptions of homogeneity (Sheldon, 2017). Instead, Disabled researchers can provide a critical lens through which dominant academic conceptualisations of disability may be deconstructed (Sheldon, 2017).

Role of the researcher and self-reflexivity

The research was positioned from a relativist, interpretivist, and contextualist perspective in acknowledgement that narratives were co-constructed within the interaction of participants and the researcher, and shaped by sociocultural and historical contexts (Greene et al., 2010; Hiller, 2016; Schwandt, 2003). In consideration of the principles of participatory and emancipatory research paradigms in disability research, the present research committed to openness, transparency, and a critically reflexive stance through which potentially negative representations of participants could be challenged (Kitchin, 2000; Wigginton & Setchell, 2016). Such approaches are particularly significant given the social and political context of disability research, which has historically and continues to be dominated by non-disabled academics, and is often rooted in medicalised, disempowering narratives. Subsequently, it has been argued that often disability research fails to acknowledge the expertise of Disabled people, overlooks issues of importance to them, and is ineffective in creating meaningful change in their lives (Kitchin, 2000; Oliver, 1992). This section therefore presents a first-person written exploration of the researcher's critical self-reflexivity and the influence that this had upon the study.

The researcher as an outsider

As a non-Disabled trainee clinical psychologist, I regularly considered my outsider position in the context of understanding and representing Disabled people's experiences. As I do not have lived experience of physical disability nor the interpersonal and systemic ableism that participants described, I was mindful of not claiming to 'know' these experiences (Gair, 2012). My dual role as an NHS trainee psychologist and academic carried a great deal of institutional power, particularly as these structures have historically and to large degree continue to marginalise Disabled voices (Oliver, 1992; Shakespeare, 2006). Therefore, the ethical tensions arising throughout the research process are considered, particularly concerning how I engaged with, represented, and interpreted the experiences of Disabled participants.

I was mindful of the risk of conducting research that objectified or dehumanised participants, through ignoring the narratives of participants and privileging my own (Stone & Priestly, 1996). To negotiate this, I approached interviews with openness, attempted to listen more than lead discussions, and was transparent about my outsider status (Wigginton & Setchell, 2016). These efforts were further supported through aspects of the research design intended to increase participant power and control, for example the use of flexible recruitment strategies (e.g. accepting participant self-definition as 'Disabled'), open-ended and semi-structured interviews, and seeking involvement in the interpretation of the data (e.g. participant feedback requests; see Appendix O for descriptive summary of research findings). However, I remain conscious that reflexivity alone cannot negate the power imbalance embedded in the researcher-participant relationship (Wigginton & Setchell, 2016), and indeed there are limits to what can be done to *"alter the social relations of research production"* (Stone & Priestly, 1996, p.16) and minimise potential negative aspects of research. This was evident in feedback received by one of the participants on the research findings summary that the information was "too vague" and not explicit enough in its call for change. I reflected that this had perhaps arisen through my focus on the process of synthesising a large amount of data into a more concise and accessible document, and subsequent oversight of the importance of explicit action-orientation in disability research (Kitchin, 2000). Thus, the participant feedback was an important reminder that my efforts towards transparency and collaboration, did not equate to shared experience.

Inevitably, my position as an outsider also influenced both data collection and interpretation. Whilst I hoped that my status as a researcher-clinician and explicit openness to both positive and negative experiences might help participants feel less judged and freer to critique mental health systems, I'm also conscious that it may have inhibited the depth of information shared or created additional labour for Disabled participants to explain experiential knowledge I lacked (Dwyer & Buckle, 2009; Kitchin, 2000). In particular, I was concerned about the risk of misinterpreting participant narratives during data analysis and at times experienced anxiety about enacting epistemic injustice (Fricker, 2007). Nonetheless, I was aware that attempts to deny my personal/professional power through assigning myself the role of 'naïve outsider' risked avoiding responsibility and accountability (Dwyer & Buckle, 2009). As Wigginton & Setchell (2016) argue in their research on stigma, simply proclaiming outsider status does not provide a shield against critique or an excuse to disengage from the lived experiences of research participants. Indeed, identifying myself as an 'outsider' necessitates greater critique and accountability (Dwyer & Buckle, 2009; Wigginton & Setchell; 2016). This is particularly relevant given my role as a soon-to-be qualified psychologist within the same systems critiqued in this research, as I cannot and should not remove myself from the institutions critiqued within the research. Therefore, I have tried to navigate this research with ongoing critical reflexivity, through the use of supervision, a reflective diary, and engagement with disability justice literature.

Notably, as Gair (2012) and Dwyer & Buckle (2009) discuss, the insider/outsider dichotomy can be overly simplistic and overlook the complexity of researcher identity. Indeed, Dwyer and Buckle (2009) reflect on the possibility of outsider researchers occupying a third position or 'the space in between' through qualitative research that necessitates immersion in the literature, reflexivity, and relational engagement with participants. Nonetheless, I am aware that my interpretations are shaped by my position and thus any claim to 'accurately represent' participants is open to critique.

Critical self-reflexivity

Initially, I had hoped for the research to be informed by participatory action principles, specifically involving Disabled people as stakeholders and consultants throughout the project. I felt this was ethically important given that psychological research has historically positioned Disabled people as passive subjects, rather than experts by experience (Kitchin, 2000; Oliver, 1992). Although I am disappointed that this was not fully possible within the constraints of doctoral training, I have tried to approach the research reflexively, with a view to representing participants' experiences accurately and meaningfully.

This project has taught me a great deal about both disability and the research process. Prior to beginning the doctorate, my experience was largely limited to quantitative service evaluations and questionnaires online. In particular, I feel I have developed my skills in research interviewing and qualitative data analysis. Within my interviews, I frequently felt conflicted in my dual identity as a clinician-researcher. I often noticed a draw to validate, empathise, or respond to participants' distress. This perhaps felt particularly heightened by my position as a non-disabled person and professional working within the same systems that had excluded and harmed many of the participants. In retrospect, I recognise some of this as stemming from anxiety about reinforcing epistemic injustice or ableist research practices. Although it has been argued that when conducting research with marginalised populations, a gentle, warm, and empathetic tone is important to convey curiosity and respect (Gair, 2012; Wigginton & Setchell, 2016). Subsequently, my leaning towards this style of communication could be considered ethical and intended to facilitate both participant safety and comfort in discussing potentially difficult experiences relevant to the research.

I was also acutely aware of how my position, power, and lack of lived experience may have influenced data collection and analysis. During analysis, I often found myself hesitant, for example, coding items multiple times to avoid imposing my own interpretations on participant narratives. This perhaps reflected something of my own anxiety, as I have frequently felt preoccupied with concerns about "saying the wrong thing" or being perceived as an imposter throughout doctoral training more broadly. This, alongside my inexperience as a researcher and positionality, may have led to missed opportunities for deeper exploration or questioning during the data collection phase (Dwyer & Buckle, 2009).

My personal and professional experiences also inevitably informed my approach to the research. As discussed in my self-reflexive statements in Chapters Two and Three, I have Disabled family members, and have previously worked within both community and inpatient mental health settings. These experiences were close in my mind throughout the research. Much of what participants shared resonated with me, particularly concerning inaccessible physical environments, experiences of the medical model, and professionals anxious about the prospect of working with Disabled people. During the interviewing process, I noticed that I was often anticipating that participants would have had negative experiences of services, particularly considering my knowledge of inpatient settings. I also consistently felt provoked by accounts of Disabled people's self-knowledge being dismissed or problematised. This felt unjust and brought to mind past experiences of my own distress being unseen and unheard by those who were positioned to help. I am aware that my identification may have risked assuming similarity and overlooking difference (Dwyer & Buckle, 2009). However, these dynamics may also be reflective of empathetic listening, connection, and immersion in participants' felt narratives (Gair, 2012). I have strived to utilise supervision and reflexivity to explore these dynamics and minimise their influence on the data.

Whilst undertaking the final phases of the research, I continued to work clinically within a clinical health psychology service. Of note, this involved working directly with Disabled people, people with long-term conditions, and medical professionals. Undertaking this role underscored the clinical implications of the research. I have noticed myself becoming more frustrated with inaccessibility, inflexibility, and unconscious bias within the systems in which I work. I have also felt more intentionally aware of my own unconscious biases, as well as the importance of validating lived experience. For example, when beginning the placement, I felt tentative about discussing prognosis and end-of-life concerns with service users, perhaps due to wanting to avoid exacerbating distress as well as my own discomfort with death. Through the process of both the placement and research project, I now recognise that this may have represented unconscious ableism through inadvertently signalling these were not valid topics of discussion within therapy or that discussing them could harm, rather than help the service user. This thereby risked centring my non-disabled perspective and comfort over Disabled service users' valid concerns about mortality. Subsequently, I have noticed an increased openness, commitment and willingness sit with my discomfort around end of life concerns, which has facilitated greater depth and meaning in my therapeutic work. Furthermore, as this placement coincided with the writing of my results and discussion sections, my clinical experiences likely influenced my decision to select narratives that I found particularly ethically and emotionally challenging.

I have consistently felt deeply moved by participants' stories of strength and determination in the face of systemic injustice. I was also encouraged to hear stories of affirmative practice, as this confirmed that improved care is possible even if currently limited. Although these experiences were less common within my data set, I have aimed to capture them fairly within the results. Deeply engaging with participants' experiences and disability literature has further strengthened my intention to pursue dissemination of the research findings (Kitchin, 2000). Overall, I hope that this project contributes to efforts to develop meaningfully accessible, equitable, and affirming approaches to mental health care.

Clinical Implications

The impact of ableism within UK MHS and treatment appears to present a gap in existing research (Hollomotz et al., 2025). Indeed, this is an increasingly relevant and urgent area for research and clinical attention. Ongoing socio-political events, including austerity and planned cuts to disability-related benefits, are likely to heighten financial strain, psychological distress, and increase the need for MHS amongst Disabled people. Despite this, research, including the present study, suggests that many Disabled people are discouraged from mental health care due to previous negative experiences of structural and interpersonal ableism (GDA, 2022; Lowther-Payne et al., 2023; Wang et al., 2024).

This study provides a novel contribution to the literature by exploring how Disabled people with physical disabilities (DPPD) make sense of their experiences within acute mental health services (AMHS). The findings highlight how DPPD's accounts of their lives and needs were overlooked or misinterpreted within the interpersonally and structurally ableist systems of AMHS. These insights are relevant for AMHS, clinicians, charities (e.g. disability and crisis support), and governmental organisations working to improve equity, inclusion, and responsivity in acute mental health care.

To enhance accessibility and impact, the following clinical implications are presented in bullet point format (Ledin & Machin, 2015):

- *Embed a broader definition of access to AMHS*. In the present study, participants encountered barriers to accessing services, including physical inaccessibility, procedural inflexibility and interpersonal ableism. These barriers were described as being misattributed by services to participants' disability or their assistive devices, rather than viewed in the context of systemic and structural disablism. This is consistent with critiques of contemporary NHS policies, which have been argued to centre on the availability of services, rather than relational or holistic measures of access (Powell & Exworthy, 2003). Petrin et al (2020) criticise traditional means of measuring access through service availability and utilisation alone as overly simplistic and failing to reflect the lived experiences of marginalised groups. Using the candidacy framework, they argue that Disabled people face additional considerations when seeking healthcare, including previous encounters and interactions with services, and expectations of care outcomes. In conjunction with the barriers to access highlighted in the present study, this indicates that a broader conceptualisation of access, which accounts for attitudinal, structural and procedural barriers, is necessary. Consistent with this, Levesque et al. (2013) identify five dimensions of access: approachability, acceptability, availability, affordability, and appropriateness.
- *Recognise inaccessibility as causing iatrogenic harm and ensure AMHS fully meet legal accessibility standards.* The Equality Act (2010) requires healthcare providers, including AMHS, to make reasonable adjustments to ensure DPPD are not adversely impacted by discrimination or disadvantage when accessing care. However, the findings of both the present study and more broadly across UK health services (Read et

al., 2018) suggest that reasonably adjusted and person-centred care is not consistently provided, despite legal requirements. Instead, research suggests that services often adopt a 'retrofitting' approach, which reflects what Hamraie (2017) termed the "normate template" in which default institutional designs centre around an able-bodied norm. Dolmage (2017), in their writing on academic institutions, argues that such attempts to address inequity and inaccessibility, through 'temporary additions', may inadvertently reinforce ableism and exclusion by singling out and positioning Disabled people as 'charity cases' or 'villains' – a sentiment that was echoed by participants in the present study. Therefore, it is essential that services ensure access is proactively considered as well as responsive to DPPD's emerging needs.

- *Integrate physical health care within AMHS*. Participants in the present study demonstrated that fragmentation between physical and AMHS led to 'dual overshadowing' for DPPD, which worsened overall health outcomes. As discussed in the introduction chapter, good physical healthcare practice within mental health settings emphasises having a clear and specific physical health strategy, inclusion of patients and family/carers, accurate electronic records, knowledge of health inequalities, sharing information, regular physical health reviews, and regular access to primary care and specialist services (NCEPOD, 2022; RCP, 2009; Welthagen et al., 2004). Whilst integrated models of care have demonstrated mixed outcomes, there is evidence of improved mental health quality of life and reduced psychiatric admissions amongst people with serious mental illness (Rodgers et al., 2018). Notably, the application of this approach specifically for DPPD in AMHS has not yet been piloted, thus is an area for further clinical exploration.
- *Review standardised risk and safety procedures in AMHS.* The present study highlighted that standard risk protocols within AMHS are inflexible and may

disproportionally exclude DPPD (e.g. restriction of mobility aids). Whilst Chrysikou (2013) identified valid tensions between safety and accessibility, they also argue that focusing solely on either inclusion or safety risks creating environments that are neither suitable nor safe. AMHS should develop more accessible and responsive risk procedures that ensure efforts to achieve safety do not unfairly exclude or disempower DPPD. Co-production with DPPD and their networks could be a potential route to ensuring that risk minimisation does not lead to further exclusion.

- *Education of future clinicians.* Given that engagement in mental health treatment may be more likely amongst the Disabled population, clinicians should be prepared and skilled in working with disability (Conner et al., 2023). As Powers (2024, p. 89) emphasised, whether professionals are *"aware or not, they are likely working with people with disabilities and need to be equipped and skilled to handle this work".* Participants in the current study described exclusionary and sometimes harmful practices stemmed from a lack of clinician knowledge, unconscious bias, or discomfort with disability. These experiences highlighted a need for routine training for all AMH professionals in disability studies, disablism, microaggressions, stigma, epistemic injustice, and intersectionality. Given that disability can trigger unconscious processes, ongoing opportunities for supervision and reflective practice are also vital, to promote openness to continuous learning, recognition and unlearning of internalised ableism (Conner et al., 2023; Hunt et al., 2006). This could involve co-production with Disabled experts-by-experience to develop and integrate a framework for disability competence within training curricula and MHS (Powers, 2024; Wang et al., 2024).
- *Embed Disability-affirmative and justice-informed approaches within AHMS.* Instances of affirmative practice in the present study evidence that this approach is possible and improves DPPD's experiences of care. However, the experiences of

participants also highlight that the provision of affirming care is inconsistent and often dependent on individual clinicians. Adopting principles of Disability-Affirmative Therapy (D-AT; Olkin, 2007) and disability justice (Sins Invalid, 2016) is necessary, as an alternative to the medicalised and deficit-based models currently deeply embedded in mental healthcare (Barnes et al., 2022; Beresford, 2002), including AMHS. These approaches could facilitate an understanding of disability as a form of human diversity (Andrews, 2020), and, as identified by participants in the present study, counter epistemic injustice, enable an understanding of intersectionality, and facilitate more equitable services**.**

- *Prioritise co-production with Disabled people.* Continuing efforts should be made to engage DPPD with lived experience and advocates in co-production to develop more inclusive and disability-affirmative AMHS. Furthermore, co-production should focus on involving those with more severe impairments or who are socially isolated, to avoid reinforcing exclusion in service design. Importantly, participants in the present study described self-advocacy as necessary but exhausting. Therefore, AMHS must move beyond tokenism and not rely on Disabled people to "do the work" of improving systems. In conjunction with staff training, co-production efforts may also counter epistemic injustice by centring DPPD's self-knowledge and expertise.

Future Research

Further research on Disabled people's experiences of UK MHS is necessary, particularly as disability remains an under-examined identity in mental health care research (Foley-Nicpon & Lee, 2012). As discussed above, the present study was limited in relation to time, recruitment constraints, and unsuccessful attempts to employ principles of participatory action research.

Due to the aforementioned recruitment challenges, the participant inclusion criteria for the present research was widened to include both DPPD with direct experiences of AMHS and disability advocates without direct contact with services. Whilst this decision enhanced the breadth of the data, sample and time constraints meant that direct and vicarious experiences of services were not formally compared. Future research could explore how advocates accounts may differ from or parallel the perspectives of DPPD with lived experience. Given that non-disabled advocates often play a significant role in amplifying the voices of Disabled people, but can also risk speaking for them (thereby obscuring Disabled voices), research critically examining this dynamic is warranted with particular consideration of the principles of the disability justice movement of "nothing about us without us" (Inckle, 2023).

To strengthen validity and authenticity, future research should also centre the voices of Disabled people, for example by employing emancipatory and participatory action epistemologies to drive the research design (Kitchin, 2000). This would align with the broader aims of critical disability studies and disability justice by recognising lived experience as a valued source of expertise (Sins Invalid, 2016).

Further research is also necessary to collect a more demographically representative sample of Disabled people in relation to race, socioeconomic status, and severity of impairment. It has been argued that previous research has explored race and disability as parallel, rather than intersecting, oppressions thereby masking unique and compounding discrimination (Frederick & Shifrer, 2019). The effect of multiple marginalisation upon experiences of ableism and exclusion within MHS should be explored through an intersectional lens, particularly given the findings of intersectional marginalisation (Conner et al., 2023; Wang et al., 2024). Efforts to recruit from this sub-section of the Disabled population may benefit from gaining NHS ethical approval (which was not pursued in the current study) to

recruit directly from services and patient advocate groups. However, it should be noted that participants in the present research described actively avoiding services as a form of protection against iatrogenic harm. Thus, individuals with negative experiences of services may be challenging to recruit through NHS channels. Therefore, research should also consider working directly with third sector disability organisations and snowball sampling to promote inclusion of those who have disengaged from formal services due to systemic ableism (e.g. Wang et al., 2024). Moreover, the finding of protective avoidance due to anticipated harm could be explored in future. For example, exploring the long-term impact of avoidance through a longitudinal lens, including how this influences Disabled people's coping strategies, resilience, thresholds for help-seeking, and use of alternative sources of support (e.g. private sector, family, etc.).

Research exploring clinician knowledge and attitudes towards disability within UK MHS more broadly is also necessitated. This could shed light on gaps in disability competence, prevalence of microagressions and unconscious biases, and the impact of ableist assumptions on care (e.g. diagnosis, treatment plans, and therapeutic alliance; Hunt et al., 2006). Given that the present research findings align with the principles of D-AT (Olkin, 2007) and disability justice frameworks (Sins Invalid, 2016), further studies could explore the practical application of these approaches within NHS AMHS and the impact of this on DPPD's experiences of care (e.g. piloting D-AT informed care plans). Furthermore, the training of clinicians in these approaches may also offer opportunities to evaluate the outcomes of D-AT informed training including changes in professional attitudes, accessibility, and satisfaction with care. This may be of particular interest within inpatient or acute settings more broadly, as power imbalances and restrictive risk procedures are likely to be heightened in these contexts. Given that the medical model is deeply embedded within these systems, understanding how affirming and rights-based care can be implemented is of high importance.

Finally, participants in this study identified cultural and systemic barriers to institutional accountability. Future research should also seek to explore how NHS mental health systems resist or enable disability rights. This is particularly relevant given the policy-practice gaps highlighted within the present and wider research (Read et al., 2018), which indicate that sustainable disability reform within mental health services is vital.

Conclusion

Overall, the present research provides a novel contribution to the growing literature focused on Disabled people's experiences of mental health services. By centring lived experience, the research hopes to add to the growing body of critical disability studies which seek to challenge the medicalised and deficit-based approaches entrenched within mental health care. In particular, to the researcher's knowledge this is the first study to explore DPPD's experiences of AMHS in a UK context. Using Reflexive Thematic Analysis, five themes were generated and six subthemes focussing on how DPPD experienced and engaged in AMH care, the barriers they encountered, affirmative practice and their acts of resistance. Based on these findings, recommendations are made for future research, practice, and policy. Crucially, the research argues that meaningful inclusion of Disabled people in AMHS must extend beyond compliance with legal accessibility standards and individual clinician competence. Indeed, a fundamental change is necessitated in MHS structures and how they value the knowledge of Disabled people. Most of all, this research aims not only to critique current practices but to inspire collective action towards more accessible, equitable, and affirming mental health care.

References

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., & Summerbell, C. (2016). Searching and synthesising 'grey literature' and 'grey information' in public health: critical reflections on three case studies. *Systematic Reviews, 5,* 1-11. https://doi.org/10.1186/s13643-016-0337-y

Adeoye-Olatunde, O. A., & Olenik, N. L. (2021). Research and scholarly methods: Semi-structured interviews. *Journal of the American College of Clinical Pharmacy*, *4*(10), 1358-1367. https://doi.org/10.1002/jac5.1441

Alcoff, L. (1991). The problem of speaking for others. *Cultural Critique*, 20, 5-32. https://doi.org/10.2307/1354221

Andrews, E. E. (2020). *Disability as Diversity: Developing Cultural Competence*. Oxford University Press.

Annamma, S. A., Connor, D., & Ferri, B. (2013). Dis/ability critical race studies (DisCrit): Theorizing at the intersections of race and dis/ability. *Race Ethnicity and Education*, *16*(1), 1-31. https://doi.org/10.1080/13613324.2012.730511

Artman, L. K., & Daniels, J. A. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. *Professional Psychology: Research and Practice*, *41*(5), 442. https://doi.org/10.1037/a0020864

Balcazar, F. E., Suarez-Balcazar, Y., & Taylor-Ritzler, T. (2009). Cultural competence: Development of a conceptual framework. *Disability and Rehabilitation*, *31*(14), 1153-1160. https://doi.org/10.1080/09638280902773752

Banas, J. R., Magasi, S., The, K., & Victorson, D. E. (2019). Recruiting and retaining people with disabilities for qualitative health research: Challenges and solutions. *Qualitative Health Research*, *29*(7), 1056-1064. https://doi.org/10.1177/1049732319833361

Banerjee, A. T. (2025). Legacies of ableism and the pursuit of disability justice in medicine. *The Lancet*, *405*(10480), 690-691. https://doi.org/10.1016/S0140-6736(25)00349-6

Barnes, C., Mercer, G. & Shakespeare, T. (2010) 'The social model of disability', in A. Giddens & P. Sutton (eds.), *Sociology: Introductory Readings*, (3), 161–166. Polity Press, Cambridge.

Barnes, G. L., Haghiran, M. Z., & Tracy, D. K. (2022). Contemporary perceptions and meanings of 'the medical model' amongst NHS mental health inpatient clinicians. *International Journal of Mental Health Nursing*, *31*(3), 567-575. https://doi.org/10.1111/inm.12972

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC Medical Research Methodology, 9*, 1-11. https://doi.org/10.1186/1471-2288-9-59

Bath, B., Trask, C., McCrosky, J., & Lawson, J. (2014). A Biopsychosocial Profile of Adult Canadians with and without Chronic Back Disorders: A Population-Based Analysis of the 2009-2010 Canadian Community Health Surveys. *BioMed Research International*, *2014*(1), 919621. https://doi.org/10.1155/2014/919621

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854. https://doi.org/10.1136/jech.2004.028662

Becker, H., Roberts, G., Morrison, J., & Silver, J. (2004). Recruiting people with disabilities as research participants: Challenges and strategies to address them. *Mental Retardation*, *42*(6), 471-475. https://doi.org/10.1352/0047-6765(2004)42%3C471:RPWDAR%3E2.0.CO;2

Beresford, P. (2002). Thinking about 'mental health': Towards a social model. *Journal of Mental Health*, *11*(6), 581-584. https://doi.org/10.1080/09638230020023921

Beresford, P. (2002). User involvement in research and evaluation: liberation or regulation? *Social Policy and Society*, *1*(2), 95-105. https://doi.org/10.1017/S1474746402000222

Beresford, P. (2013). *Beyond the usual suspects: Towards inclusive user involvement*. Shaping Our Lives and Joseph Rowntree Foundation. Sourced from: https://www.shapingourlives.org.uk/resources/our-resources/beyond-the-usual-suspects

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Berghs, M. (2017). *Emancipatory Engagement and Co-production: Disability Research for Activism*. SAGE Publications Limited.

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: a structured methodological review. *Systematic Reviews*, *5*, 1-23. https://doi.org/10.1186/s13643-016-0249-x

Braakman, J., & Sterkenburg, P. S. (2023). Needed adaptations in psychological treatments for people with vision impairment: A Delphi study, including clients, relatives, and professionals. *Frontiers in Psychology*, *14*. 1028084. https://doi.org/10.3389/fpsyg.2023.1028084

Branfield, F. (1998). What Are You Doing Here? “Non-disabled” people and the disability movement: A response to Robert F. Drake. *Disability & Society*, *13*(1), 143–144. https://doi.org/10.1080/09687599826966

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi-org.uniessexlib.idm.oclc.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. SAGE.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. Qualitative *Research in Sport, Exercise, and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37-47. https://doi-org.uniessexlib.idm.oclc.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, *9*(1), 3. http://dx.doi.org/10.1037/qup0000196

Brown, R. L., & Ciciurkaite, G. (2022). Disability, ableism, and mental health. In: *Marta Elliott (ed.), Research Handbook on Society and Mental Health, 12, 201-217.* Edward Elgar Publishing.

Brucker, D. L., Surfus, C., & Henly, M. (2023). Mental health experiences in 2021 for adults with disabilities who are lesbian, gay, bisexual, or transgender. Rehabilitation Psychology, 68(4), 374. https://psycnet.apa.org/doi/10.1037/rep0000511

Campbell, F. (2009). *Contours of ableism: The Production of Disability and Abledness*. Springer.

Campbell, K. A., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., ... & Jack, S. M. (2021). Reflexive thematic analysis for applied qualitative health research. *The Qualitative Report*, *26*(6), 2011-2028. https://doi.org/10.46743/2160-3715/2021.5010

Care Quality Commission. (2017). *The State of Care in Mental Health Services 2014– 17* [Internet]. Available from: https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: a philosophial analysis. *Medicine, Health Care and Philosophy*, *17*(4), 529-540. https://doi.org/10.1007/s11019-014-9560-2

Carlson, L. (2009). *The Faces of Intellectual Disability: Philosophical Reflections*. Indiana University Press.

Chrysikou, E. (2013). Accessibility for mental healthcare. *Facilities*, *31*(9/10), 418-426. https://doi.org/10.1108/02632771311324972

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, *26*(2), 120-123. Sourced from: https://uwe-repository.worktribe.com/index.php/preview/937606/Teaching%20thematic%20analysis%20Research%20Repository%20version.pdf

Cohen, L., Manion, L., & Morrison, K. (2007). Experiments, quasi-experiments, single-case research and meta-analysis. In *Research methods in Education*, *6,* 276–309. Routledge.

Connelly, L. M., & Peltzer, J. N. (2016). Underdeveloped themes in qualitative research: Relationship with interviews and analysis. *Clinical Nurse Specialist*, *30*(1), 52-57. https://doi.org/10.1097/nur.0000000000000173

Conner, K. J., Acosta, V. M., Nouri, R., Tyler von Wrangel, M., Gramillo, E., & Conner, A. (2023). Psychotherapy Experiences of U.S. Adults With Physical Disabilities: Recommendations for Affirmative Practice. *Counseling Psychologist*, *51*(7), 970–1004. https://doi.org/10.1177/00110000231186824

Cooper, S. A., McLean, G., Guthrie, B., McConnachie, A., Mercer, S., Sullivan, F., & Morrison, J. (2015). Multiple physical and mental health comorbidity in adults with intellectual disabilities: population-based cross-sectional analysis. *BMC Family Practice*, *16*, 110. https://doi.org/10.1186/s12875-015-0329-3

General Medical Council, (2001). Medical research: the role and responsibilities of doctors. *Bulletin of Medical Ethics*, (166), 18-24. Retrieved from: http://hdl.handle.net/10822/944349

Cree, R. A., Okoro, C. A., Zack, M. M., & Carbone, E. (2020). Frequent mental distress among adults, by disability status, disability type, and selected characteristics—United States, 2018. *Morbidity and Mortality Weekly Report, 69*(36), 1238. https://doi.org/10.15585/mmwr.mm6936a2

Crenshaw, Kimberlé. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine. University of Chicago Legal Forum 1989, 139–168.

Crisp, N., Smith, G., & Nicholson, K. (2016). Old problems, new solutions—improving acute psychiatric care for adults in England (The Commission on Acute Adult Psychiatric Care). *London: Royal College of Psychiatrists*. Available from: http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf

Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist. [online] Retrieved from: https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf. Accessed: 11/02/2025

David, E. J. R. (Ed.). (2013). *Internalized oppression: The psychology of marginalized groups*. Springer Publishing Company.

Davidson, C. M., Santorelli, M. J., & Kamber, T. (2012). Broadband Adoption| Toward an Inclusive Measure of Broadband Adoption. *International Journal of Communication*, *6*, 21. Retrieved from: https://ijoc.org/index.php/ijoc/article/view/1807

Dawood, R., Sunderalingam, D., & Ranieri, V. (2022, May). A public health crisis is a disability rights crisis: Health inequality and ableism in the pandemic. In *Clinical Psychology Forum, 353*, 11. Retrieved from: A public health crisis is a disability rights crisis (researchgate.net)

De Clerck, G. A. M., & Willems, R. A. (2023). Structural stigma in mental health care for deaf and hard of hearing people: the perspectives of care users and caregivers. *Tijdschrift Voor Psychiatrie*, *65*(3), 205-210. Retrieved from: https://www.tijdschriftvoorpsychiatrie.nl/en/artikelen/article/50-13134_Structureel-stigma-in-ggz-voor-doven-en-slechthorenden-perspectief-van-clienten-en-zorgverleners

Degener, T. (2017, February). A new human rights model of disability. In *The United Nations Convention on the rights of Persons with Disabilities: A Commentary*, 41-59. Springer International Publishing. https://doi.org/10.1007/978-3-319-43790-3_2

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage Handbook of Qualitative Research*. Sage.

Department for Work and Pensions. (2023). Family Resources Survey: Financial year 2021 to 2022. Retrieved from: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2021-to-2022

Dhanani, Z., Huynh, N., Tan, L., Kottakota, H., Lee, R., & Poullos, P. (2022). Deconstructing ableism in health care settings through case-based learning. *MedEdPORTAL*, *18*, 11253. https://doi.org/10.15766/mep_2374-8265.11253

Dispenza, F., Varney, M., & Golubovic, N. (2017). Counseling and Psychological Practices With Sexual and Gender Minority Persons Living With Chronic Illnesses/Disabilities (CID). *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 137–142. Scopus. https://doi.org/10.1037/sgd0000212

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Dohmen, J. (2016). A little of her language": epistemic injustice and mental disability. *Res Philosophica*, *93*(4), 669-691. https://doi.org/10.11612/resphil.1475

Dolmage, J. T. (2017). *Academic ableism: Disability and Higher Education* (p. 244). University of Michigan Press.

Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. *American Journal of Psychiatry*, *167*(2), 151-159. https://doi.org/10.1176/appi.ajp.2009.09050691

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Eldal, K., Natvik, E., Veseth, M., Davidson, L., Skjølberg, Å., Gytri, D., & Moltu, C. (2019). Being recognised as a whole person: A qualitative study of inpatient experience in mental health. *Issues in Mental Health Nursing*, *40*(2), 88-96. https://doi.org/10.1080/01612840.2018.1524532

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods*, *14*(5). https://doi.org/10.1177/1609406915621420

Emerson, E., Llewellyn, G., Honey, A., & Kariuki, M. (2012). Lower well-being of young Australian adults with self-reported disability reflects their poorer living conditions rather than health issues. *Australian and New Zealand journal of Public Health*, *36*(2), 176-182. https://doi.org/10.1111/j.1753-6405.2011.00810.x

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129-136. https://doi.org/10.1126/science.847460

Equality Act 2010. Retrieved from:https://www.legislation.gov.uk/ukpga/2010/15/contents (Accessed 28 January 2025)

Foley-Nicpon, M., & Lee, S. (2012). Disability research in counseling psychology journals: A 20-year content analysis. *Journal of Counseling Psychology*, *59*(3), 392. https://doi.org/10.1037/a0028743

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A., ... & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology*, *19*, 1-18. https://doi.org/10.1186/s12874-019-0670-7

Frederick, A., & Shifrer, D. (2019). Race and disability: From analogy to intersectionality. *Sociology of Race and Ethnicity*, *5*(2), 200-214. https://doi.org/10.1177/2332649218783480

Gair, S. (2012). Feeling their stories: Contemplating empathy, insider/outsider positionings, and enriching qualitative research. *Qualitative Health Research*, *22*(1), 134-143. https://doi.org/10.1177/1049732311420580

Garland-Thomson, R. (2017). Disability bioethics: From theory to practice. *Kennedy Institute of Ethics Journal*, *27*(2), 323-339. https://doi.org/10.1353/ken.2017.0020

Garside, R. (2014). Should we appraise the quality of qualitative research reports for systematic reviews, and if so, how? Innovation: *The European Journal of Social Science Research, 27*(1), 67-79. https://doi.org/10.1080/13511610.2013.777270

Garthwaite, K. (2016). Stigma, shame and 'people like us': an ethnographic study of foodbank use in the UK. *Journal of Poverty and Social Justice*, *24*(3), 277-289. https://doi.org/10.1332/175982716X14721954314922

Gerke, A. C. (2016). *A phenomenological examination of disability, microaggressions, and the experiences of deaf adults in mental health services*. Alliant International University. Retrieved from: https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2016-53065-055&site=ehost-live&scope=site&authtype=sso&custid=s9814295

Giacomini, M. (2010). Theory matters in qualitative health research. *The SAGE handbook of Qualitative Methods in Health Research*, 125-156. SAGE.

Gibson, J., & O'Connor, R. (2010). Access to healthcare for disabled people: a systematic review. *Social care and Neurodisability*, *1*(3), 21-31. https://doi.org/10.5042/scn.2010.0599

Gill, C. J. (1995). A psychological view of disability culture. *Disability Studies Quarterly, 15*(4), 16–19. Retrieved from: https://www.independentliving.org/docs3/gill1995.html

Gillborn, D. (2015). Intersectionality, critical race theory, and the primacy of racism: Race, class, gender, and disability in education. *Qualitative Inquiry*, *21*(3), 277-287. https://doi.org/10.1177/1077800414557827

Glasgow Disability Alliance & Gribben, A. (2022). Disabled people's Mental Health Matters. Retrieved from: https://gda.scot/resources/disabled-peoples-mental-health-matters/ on 27 June 2023.

Goffman, E. (2017). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Routledge.

Goodley, D. (2005). Empowerment, self-advocacy and resilience. *Journal of Intellectual Disabilities*, *9*(4), 333-343. https://doi.org/10.1177/1744629505059267

Greene, J. A., Torney-Purta, J., & Azevedo, R. (2010). Empirical evidence regarding relations among a model of epistemic and ontological cognition, academic performance, and educational level. *Journal of Educational Psychology*, *102*(1), 234. https://psycnet.apa.org/doi/10.1037/a0017998

Hall, M. C. (2019). Critical Disability Theory. *Stanford Encyclopedia of Philosophy* (Monday 23rd September 2019). Sourced from: https://plato.stanford.edu/ENTRIES/disability-critical/

Hall, K. A., Deusdad, B., D'Hers Del Pozo, M., & Martínez-Hernáez, Á. (2022). How did people with functional disability experience the first COVID-19 lockdown? A thematic analysis of youtube comments. *International Journal of Environmental Research and Public Health*, *19*(17), 10550. https://doi.org/10.3390/ijerph191710550

Hallyburton, A., & Allison-Jones, L. (2023). Mental health bias in physical care: an integrative review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *30*(4), 649-662. https://doi.org/10.1111/jpm.12911

Hammel, J., Magasi, S., Heinemann, A., Gray, D. B., Stark, S., Kisala, P., ... & Hahn, E. A. (2015). Environmental barriers and supports to everyday participation: A qualitative insider perspective from people with disabilities. *Archives of Physical Medicine and Rehabilitation*, *96*(4), 578-588. https://doi.org/10.1016/j.apmr.2014.12.008

Hamraie, A. (2017). Designing collective access: A feminist disability theory of universal design. In *Disability, Space, Architecture: A Reader*, 78-297. Routledge.

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: update on a review of published papers. *Qualitative Research*, *12*(4), 402-442. https://doi.org/10.1177/1468794111432992

Healthcare Commission. (2008). *Making Healthcare Safer for Patients: Annual Report 2007/2008*. Healthcare Commission. Retrieved from: https://www.gov.uk/government/publications/healthcare-commission-annual-report-2007-to-2008

Hiller, J. (2016). Epistemological foundations of objectivist and interpretivist research. *Books and Book Chapters by University of Dayton Faculty.* 53. Retrieved from: https://ecommons.udayton.edu/books/53

Holliman, B., Stransky, M., Dieujuste, N., & Morris, M. (2023). Disability doesn't discriminate: health inequities at the intersection of race and disability. *Frontiers in Rehabilitation Sciences*, *4*, 1075775. https://doi.org/10.3389/fresc.2023.1075775

Hollomotz, A., Priestley, M., Andre, D., Lavery, B., & Hadi, F. (2025). The Lived Experience of Disabled People in the UK: A Review of Evidence. Report. Cabinet Office, London, UK. Retrieved from: https://www.gov.uk/government/publications/the-lived-experience-of-disabled-people-in-the-uk-a-review-of-evidence/the-lived-experience-of-disabled-people-in-the-uk-a-review-of-evidence

Hosking, D. L. (2008). Critical disability theory. In *A paper presented at the 4th Biennial Disability Studies Conference at Lancaster University, UK*, *14*(5), 736. Retrieved from: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.lancaster.ac.uk%2Ffass%2Fevents%2Fdisabilityconference_archive%2F2008%2Fpapers%2Fhosking2008.doc&wdOrigin=BROWSELINK

Howell, K. (2013). *An Introduction to the Philosophy of Methodology*. Los Angeles, CA: Sage.

Hultman, L., & Hultman, M. (2023). “Believe me, only I know how I feel.” An autoethnographic account of experiences of epistemic injustice in mental health care. *Frontiers in psychiatry*, *14*, 1058422. https://doi.org/10.3389/fpsyt.2023.1058422

Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development*, *84*(2), 163-173. https://doi.org/10.1002/j.1556-6678.2006.tb00392.x

Hunt, J., & Blease, C. (2024). Epistemic injustice, healthcare disparities and the missing pipeline: reflections on the exclusion of disabled scholars from health research. *Journal of Medical Ethics*. https://doi.org/10.1136/jme-2023-109837

Hunter, C., Chew-Graham, C., Langer, S., Stenhoff, A., Drinkwater, J., Guthrie, E., & Salmon, P. (2013). A qualitative study of patient choices in using emergency health care for long-term conditions: the importance of candidacy and recursivity. *Patient Education and Counseling*, *93*(2), 335-341. https://doi.org/10.1016/j.pec.2013.06.001

Iezzoni, L. I. (2011). Eliminating health and health care disparities among the growing population of people with disabilities. *Health Affairs*, *30*(10), 1947-1954. https://doi.org/10.1377/hlthaff.2011.0613

Inckle, K., Brighton, J., & Sparkes, A. (2023). Who is ' us' in 'nothing about us without us'? Rethinking the politics of disability research. *Disability Studies Quarterly*, *42*(3-4), 1-23. https://doi.org/10.18061/dsq.v42i3-4.7947

Sins Invalid (2017). Skin, tooth, and bone–the basis of movement is our people: a disability justice primer. *Reproductive Health Matters*, *25*(50), 149-150. https://doi.org/10.1080/09688080.2017.1335999

Jacobson, D., & Mustafa, N. (2019). Social identity map: A reflexivity tool for practicing explicit positionality in critical qualitative research. *International Journal of Qualitative Methods*, *18*, https://doi.org/10.1177/1609406919870075

Jóhannsdóttir, Á., Egilson, S. T., & Gibson, B. E. (2021). What's shame got to do with it? The importance of affect in critical disability studies. *Disability & Society*, *36*(3), 342-357. https://doi.org/10.1080/09687599.2020.1751076

Jóhannsdóttir, Á., Egilson, S. Þ., & Haraldsdóttir, F. (2022). Implications of internalised ableism for the health and wellbeing of disabled young people. *Sociology of Health & Illness*, *44*(2), 360-376. https://doi.org/10.1111/1467-9566.13425

Johnson, S., Dalton-Locke, C., Baker, J., Hanlon, C., Salisbury, T. T., Fossey, M., ... & Lloyd-Evans, B. (2022). Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care. *World Psychiatry*, *21*(2), 220-236. https://doi.org/10.1002/wps.20962

Johnstone, D. (2012). *An Introduction to Disability Studies*. Routledge.

Jones, S., Howard, L., & Thornicroft, G. (2008). 'Diagnostic overshadowing': worse physical health care for people with mental illness. A*cta Psychiatrica Scandinavica*, *118*(3), 169-171. https://psycnet.apa.org/doi/10.1111/j.1600-0447.2008.01211.x

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-47. https://doi.org/10.7748/ns2009.02.23.23.42.c6800

Karatsareas, P. (2022). Semi-Structured Interviews. Cambridge University Press.

Kasser, S. L., & Lytle, R. K. (2005). *Inclusive Physical Activity: A Lifetime of Opportunities*. Human Kinetics.

Kattari, S. K., Ingarfield, L., Hanna, M., McQueen, J., & Ross, K. (2020). Uncovering issues of ableism in social work education: A disability needs assessment. *Social Work Education*, *39*(5), 599-616. https://doi.org/10.1080/02615479.2019.1699526

Kempapidis, T., Heinze, N., Green, A. K., & Gomes, R. S. (2023). Queer and disabled: Exploring the experiences of people who identify as LGBT and live with disabilities. *Disabilities*, *4*(1), 41-63. https://doi.org/10.3390/disabilities4010004

Kenny, M. (2004*). The Politics of Identity: Liberal Political Theory and the Dilemmas of Difference*. Cambridge: Polity.

Khachadourian, V., Mahjani, B., Sandin, S., Kolevzon, A., Buxbaum, J. D., Reichenberg, A., & Janecka, M. (2023). Comorbidities in autism spectrum disorder and their etiologies. *Translational Psychiatry*, *13*(1), 71. https://doi.org/10.1038/s41398-023-02374-w

King, T. L., Shields, M., Shakespeare, T., Milner, A., & Kavanagh, A. (2019). An intersectional approach to understandings of mental health inequalities among men with disability. *SSM-Population Health*, *9*, 100464. https://doi.org/10.1016/j.ssmph.2019.100464

Kirk-Wade, E., McCulloch, A., & O'Neill, D. (2024). *UK disability statistics: Prevalence and life experiences* (Research Briefing No. CBP-9602). House of Commons Library. Retrieved from: https://commonslibrary.parliament.uk/research-briefings/cbp-9602/

Kitchin, R. (2000). The Researched Opinions on Research: Disabled people and disability research. *Disability & Society*, *15*(1), 25–47. https://doi.org/10.1080/09687590025757

Kroll, T. (2011). Designing mixed methods studies in health-related research with people with disabilities. *International Journal of Multiple Research Approaches*, *5*(1), 64-75. https://doi.org/10.5172/mra.2011.5.1.64

Ladd, P. (2003). *Understanding Deaf Culture: In Search of Deafhood. In Understanding Deaf Culture*. Multilingual Matters.

Lamb, D., Davidson, M., Lloyd-Evans, B., Johnson, S., Heinkel, S., Steare, T., ... & Osborn, D. (2019). Adult mental health provision in England: a national survey of acute day units. *BMC Health Services Research*, *19*(1), 866. https://doi.org/10.1186/s12913-019-4687-8

LaVela, S. L., Wu, J., Nevedal, A. L., Harris, A. H., Frayne, S. M., Arnow, K. D., ... & Eisenberg, D. (2022). The impact of the COVID-19 pandemic on individuals living with spinal cord injury: A qualitative study. *Rehabilitation Psychology*. https://psycnet.apa.org/doi/10.1037/rep0000469

Ledin, P., & Machin, D. (2015). How lists, bullet points and tables recontextualize social practice: A multimodal study of management language in Swedish universities. *Critical Discourse Studies, 12*(4), 463-481. https://doi.org/10.1080/17405904.2015.103955

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Linton S. What Is Disability Studies? *PMLA/Publications of the Modern Language Association of America*. 2005;120(2):518-522. doi:10.1632/S0030812900167823

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Longhurst, P., & Full, W. (2023). Disabled people's perceptions and experiences of accessing and receiving counselling and psychotherapy: a scoping review protocol. *BMJ Open*, *13*(6), e069204. https://doi.org/10.1136/bmjopen-2022-069204

Lowther-Payne, H. J., Ushakova, A., Beckwith, A., Liberty, C., Edge, R., & Lobban, F. (2023). Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review. *BMC Health Services Research*, *23*(1), 1042. https://doi.org/10.17605/OSF.IO/RQ5U7

Lu, P., Kong, D., Shelley, M., & Davitt, J. K. (2022). Intersectional discrimination attributions and health outcomes among American older adults: A latent class analysis. *The International Journal of Aging and Human Development*, *95*(3), 267-285. https://doi.org/10.1177/00914150211066560

Lundberg, D. J., & Chen, J. A. (2024). Structural ableism in public health and healthcare: a definition and conceptual framework. *The Lancet Regional Health–Americas*, *30*. https://doi.org/10.1016/j.lana.2023.100650

Mahood, Q., Van Eerd, D., & Irvin, E. (2014). Searching for grey literature for systematic reviews: challenges and benefits. *Research Synthesis Methods, 5*(3), 221-234. https://doi.org/10.1002/jrsm.1106

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Mazanderani, F., Noorani, T., Dudhwala, F., & Kamwendo, Z. T. (2020). Knowledge, evidence, expertise? The epistemics of experience in contemporary healthcare. *Evidence & Policy*, *16*(2), 267-284. https://doi.org/10.1332/174426420X15808912561112

McBride-Henry, K., Nazari Orakani, S., Good, G., Roguski, M., & Officer, T. N. (2023). Disabled people's experiences accessing healthcare services during the COVID-19 pandemic: a scoping review. *BMC Health Services Research*, *23*(1), 346. https://doi.org/10.1186/s12913-023-09336-4

McDonnall, M. C., Crudden, A., LeJeune, B. J., & Steverson, A. C. (2017). Availability of mental health services for individuals who are deaf or deaf-blind. *Journal of Social Work in Disability & Rehabilitation, 16*(1), 1-13. https://doi.org/10.1080/1536710X.2017.1260515

Meekosha, H., & Shuttleworth, R. (2009). What's so 'critical' about critical disability studies?. *Australian Journal of Human Rights*, *15*(1), 47-75. https://doi.org/10.1080/1323238X.2009.11910861

Merit, J. (2025). The Experiences of Internalized Ableism of Seven Transgender Autistic Adults. In *Proceedings of the International Conference on Gender Studies and Sexuality, 2*(1), 61-70. https://doi.org/10.33422/icgss.v2i1.913

Methley, A. M., Chew-Graham, C. A., Cheraghi-Sohi, S., & Campbell, S. M. (2017). A qualitative study of patient and professional perspectives of healthcare services for multiple sclerosis: Implications for service development and policy. *Health & Social Care in the Community*, *25*(3), 848–857. psyh. https://doi.org/10.1111/hsc.12369

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Bmj*, 339. https://doi.org/10.1136/bmj.b2535

Mollow, A. (2017). Disability studies. *A companion to critical and cultural theory*, 339-356. https://doi.org/10.1002/9781118472262.ch21

Molloy, R., Brand, G., Munro, I., & Pope, N. (2023). Seeing the complete picture: a systematic review of mental health consumer and health professional experiences of diagnostic overshadowing. *Journal of Clinical Nursing*, *32*(9-10), 1662-1673. https://doi.org/10.1111/jocn.16151

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167-1177. https://doi.org/10.1111/cobi.12326

Morris, J. (2001). Impairment and disability: Constructing an ethics of care that promotes human rights. *Hypatia*, *16*(4), 1-16. https://doi.org/10.1111/j.1527-2001.2001.tb00750.x

Morris, J., (2004). People with physical impairments and mental health support needs: A critical review of the literature, Joseph Rowntree Foundation. United Kingdom. Retrieved from https://policycommons.net/artifacts/1886185/people-with-physical-impairments-and-mental-health-support-needs/2635500/ on 03 Jul 2023.

Nakkeeran, N., & Nakkeeran, B. (2018). Disability, mental health, sexual orientation and gender identity: understanding health inequity through experience and difference. *Health Research Policy and Systems*, *16*(1), 97. https://doi.org/10.1186/s12961-018-0366-1

Nario-Redmond, M. R. (2020). Ableism: The causes and consequences of disability prejudice. Wiley Blackwell. https://doi.org/10.1002/9781119142140

Nario-Redmond, M. R., Kemerling, A. A., & Silverman, A. (2019). Hostile, benevolent, and ambivalent ableism: Contemporary manifestations. *Journal of Social Issues*, *75*(3), 726-756. https://doi.org/10.1111/josi.12337

Nash, M. (2013). Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. *Mental Health Practice*, *17*(4). https://doi.org/10.7748/mhp2013.12.17.4.22.e862

Nash, R., Conner, B., Fellows, K., Clemmensen, B., Gullickson, R., & Goldrup, S. (2022). Barriers in medical education: A scoping review of common themes for medical students with disabilities. *Discover Education*, *1*(1), 4. https://doi.org/10.1007/s44217-022-00003-0

National Confidential Enquiry into Patient Outcome and Death (2022, May 12). 'A Picture of Health?' A review of the quality of physical healthcare provided to working age and older adult patients admitted to a mental health inpatient setting. London. Retrieved from: https://www.ncepod.org.uk/2022phmh.html

NHS England & NHS Improvement. (2019). *The NHS Long Term Plan*. https://webarchive.nationalarchives.gov.uk/ukgwa/20230418155402/https:/www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Nind, M. (2017). The practical wisdom of inclusive research. *Qualitative Research*, *17*(3), 278-288. https://doi.org/10.1177/1468794117708123

Nind, M., & Vinha, H. (2014). Doing research inclusively: Bridges to multiple possibilities in inclusive research. *British Journal of Learning Disabilities*, *42*(2), 102-109. https://doi.org/10.1111/bld.12013

Noblit, G. W., & Hare, R. D. (1988). *Meta-Ethnography: Synthesizing Qualitative Studies*. SAGE.

Noon, E. J. (2018). Interpretive phenomenological analysis: An appropriate methodology for educational research. *Journal of Perspectives in Applied Academic Practice*, *6*(1). https://doi.org/10.14297/jpaap.v6i1.304

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., ... & Wainwright, T. (2021). BPS code of human research ethics. British Psychological Society. https://doi.org/10.53841/bpsrep.2021.inf180

Office for National Statistics. (2022). Outcomes for Disabled people in the UK: 2021. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/outcomesfordisabledpeopleintheuk/2021#:~:text=Disabled%20people%20aged%2016%20to%2064%20years%20had%20poorer%20ratings,(year%20ending%20June%202021).

Oliver, M. (1981). A new model of the social work role in relation to disability. *The Handicapped Person: A New Perspective for Social Workers*, 19-32. RADAR, London.

Oliver, M. (1990). The politics of disablement—New social movements. In *The politics of disablement*, 112-131. London: Macmillan Education UK.

Oliver, M. (1992). Changing the Social Relations of Research Production? *Disability, Handicap & Society*, *7*(2), 101–114. https://doi.org/10.1080/02674649266780141

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, *28*(7), 1024-1026. https://doi.org/10.1080/09687599.2013.818773

Oliver, M., and Barnes, C. (2006). Disability politics and the disability movement in Britain: Where did it all go wrong? *Leeds University Disability Studies Archive.* Retrieved from*:* https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Barnes-Coalition-disability-politics-paper.pdf.

Olkin, R. (1999). The personal, professional and political when clients have disabilities. *Women & Therapy*, *22*(2), 87-103. https://doi.org/10.1300/J015v22n02_07

Olkin, R. (2002). Could you hold the door for me? Including disability in diversity. *Cultural Diversity and Ethnic Minority Psychology*, *8*(2), 130. https://doi.org/10.1037/1099-9809.8.2.130

Olkin, R. (2007). Disability-Affirmative Therapy and Case Formulation: A Template for Understanding Disability in A Clinical Context. *Counseling & Human Development*, *39*(8). Retrieved from: https://www.proquest.com/openview/103024811a47cbfce6e360b77ef0b34b/1?pq-origsite=gscholar&cbl=48224

Olkin, R. (2017). *Disability-affirmative therapy: A case formulation template for clients with disabilities*. Oxford University Press.

Olkin, R., & Gomez, M. (2024). Experiences of physically disabled and blind people in psychotherapy: Lessons for CBT therapists. *The Behavior Therapist*, *47*(1), 8–21. Retrieved from: https://psycnet.apa.org/record/2024-51625-003

Olkin, R., & Pledger, C. (2003). Can disability studies and psychology join hands? *American Psychologist*, *58*(4), 296. http://dx.doi.org/10.1037/0003-066X.58.4.296

Olkin, R., & Taliaferro, G. (2006). Evidence-based practices have ignored people with disabilities. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions,* 353–359. Washington, DC: American Psychological Association.

Parker, C., Scott, S., and Geddes, A. (2019) Snowball Sampling. SAGE Research Methods Foundations. Retrieved from: http://methods.sagepub.com/foundations/snowball-sampling

Parr, J. (2019). Inpatient Experience. *Counties Manukau Health Inpatient Experience Report*, *3*, 1. Retrieved from: https://www.countiesmanukau.health.nz/assets/About-CMH/attachments/Inpatient-experience-report-implicit-bias.pdf

Parsons, T. (1951). Illness and the role of the physician: a sociological perspective. *American Journal of Orthopsychiatry*, *21*(3), 452. https://psycnet.apa.org/doi/10.1111/j.1939-0025.1951.tb00003.x

Pascale, C. M. (2010). *Cartographies of Knowledge: Exploring Qualitative Epistemologies*. Sage Publications.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261-283. https://doi-org.uniessexlib.idm.oclc.org/10.1177/1473325002001003636

Perry, J., Palmer, L., Thompson, P., Worrall, A., & Chaplin, R. (2017). Standards for inpatient mental health services. *Royal College of Psychiatrists*. Retrieved from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/rcpsych-core-standards-inpatient-mental-health-services.pdf?sfvrsn=2d474631_2

Petasis, A. (2019). Discrepancies of the medical, social and biopsychosocial models of disability; a comprehensive theoretical framework. *The International Journal of Business Management and Technology*, *3*(4), 42-54. https://doi.org/10.5281/zenodo.7655939

Pétrin, J., Finlayson, M., Donnelly, C., & McColl, M. A. (2021). Healthcare access experiences of persons with MS explored through the Candidacy Framework. *Health & Social Care in the Community*, *29*(3), 789-799. https://doi.org/10.1111/hsc.13320

Pfeiffer, D. (2003). Disability studies and the disability perspective. *Disability Studies Quarterly*, *23*(1). https://doi.org/10.18061/dsq.v23i1.406

Pilgrim, D. (2015). The biopsychosocial model in health research: Its strengths and limitations for critical realists. *Journal of Critical Realism*, *14*(2), 164-180. https://doi.org/10.1179/1572513814Y.0000000007

Pope, R. (2019). Organizational Silence in the NHS:'Hear no, See no, Speak no'. *Journal of Change Management*, *19*(1), 45-66. https://doi.org/10.1080/14697017.2018.1513055

Powell, M., & Exworthy, M. (2003). Equal access to health care and the British National Health Service. *Policy Studies*, *24*(1), 51-64. https://doi.org/10.1080/01442870308038

Powers, D. (2024). *Disability as Diversity: Exploring the Psychotherapy Experiences of People With Disabilities* (Doctoral dissertation, University of Georgia). Retrieved from: https://www.proquest.com/openview/ad0faa124cadfe1897d6f7c2c241210d/1?cbl=18750&diss=y&pq-origsite=gscholar

Puyalto, C., Pallisera, M., Fullana, J., & Vilà, M. (2016). Doing research together: A study on the views of advisors with intellectual disabilities and non-disabled researchers collaborating in research. *Journal of Applied Research in Intellectual Disabilities*, *29*(2), 146-159. https://doi.org/10.1111/jar.12165

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology*, *15*(2), 121-148. https://doi.org/10.1007/BF00919275

Read, S., Heslop, P., Turner, S., Mason-Angelow, V., Tilbury, N., Miles, C., & Hatton, C. (2018). Disabled people's experiences of accessing reasonable adjustments in hospitals: a qualitative study. *BMC Health Services Research*, *18*(1), 931. https://doi.org/10.1186/s12913-018-3757-7

Reeve D. (2006) Towards a psychology of disability: the emotional effects of living in a disabling society. In: Goodley D, Lawthom R, (eds). *Disability and Psychology: Critical Introductions and Reflections,* 94-107. London: Palgrave. https://doi.org/10.1007/978-1-137-12098-4_7

Retief, M., & Letšosa, R. (2018). Models of disability: A brief overview. *HTS Teologiese Studies/Theological Studies*, *74*(1). https://doi.org/10.4102/hts.v74i1.4738

Reynolds, J. M. (2017). "I'd rather be dead than disabled"—the ableist conflation and the meanings of disability. *Review of Communication*, *17*(3), 149-163. https://doi.org/10.1080/15358593.2017.1331255

Rintell, D., Frankel, D., Minden, S., & Glanz, B. (2012). Patients' perspectives on quality of mental healthcare for people with MS. *General Hospital Psychiatry*, *34*(6), 604–610. https://doi.org/10.1016/j.genhosppsych.2012.04.001

Ritchie, J., Spencer, L., & O'Connor, W. (2003). Carrying out qualitative analysis. In *Qualitative Research (Ed.), Practice: A Guide for Social Science Students and Researchers*. London: Sage.

Rodgers, M., Dalton, J., Harden, M., Street, A., Parker, G., & Eastwood, A. (2018). Integrated care to address the physical health needs of people with severe mental illness: a mapping review of the recent evidence on barriers, facilitators and evaluations. *International Journal of Integrated Care*, *18*(1), 9. https://doi.org/10.5334/ijic.2605

Rogers, K. D., Rowlandson, A., Harkness, J., Shields, G., & Young, A. (2024). Health outcomes in Deaf signing populations: A systematic review. *Plos one, 19*(4), e0298479. https://doi.org/10.1371/journal.pone.0298479

Royal College of Psychiatrists (2009). Physical health in mental health: Final report of a scoping group. Retrieved from: https://www.ucl.ac.uk/core-study/sites/core-study/files/18physical_mental.pdf

Ryan, F. (2020). *Crippled: Austerity and the Demonization of Disabled People*. Verso Books.

Sage, R., Standley, K., & Ipsen, C. (2022). "Everything is a Mess. I'm Just Trying to Survive It.": Impacts of COVID-19 on Personal Assistance Services. *Journal of Healthcare for the Poor and Underserved*, *33*(4), 1844-1864. https://doi.org/10.1353/hpu.2022.0141

Sakellariou, D., & Rotarou, E. S. (2017). Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data. *BMJ Open*, *7*(8), e016614. https://doi.org/10.1136/bmjopen-2017-016614

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In Denzin, N. and Lincoln, Y (Eds.), *The Landscape of Qualitative Research: Theories and Issues*, 292-331. Thousand Oaks, CA: Sage.

Scully, J. L. (2019). Deaf identities in disability studies. In *Routledge Handbook of Disability Studies*, 145-157. Routledge.

Shakespeare, T. (2006). *Disability Rights and Wrongs*. Routledge.

Shakespeare, T. (2013). *Disability Rights and Wrongs Revisited*. Routledge.

Shakespeare, T., Watson, N., & Alghaib, O. A. (2017). Blaming the victim, all over again: Waddell and Aylward's biopsychosocial (BPS) model of disability. *Critical Social Policy*, *37*(1), 22-41. https://doi.org/10.1177/0261018316649120

Shaw, C., Brittain, K., Tansey, R., & Williams, K. (2008). How people decide to seek health care: a qualitative study. *International Journal of Nursing Studies*, *45*(10), 1516-1524. https://doi.org/10.1016/j.ijnurstu.2007.11.005

Sheldon, J. (2017). Problematizing Reflexivity, Validity, and Disclosure: Research by People with Disabilities About Disability. *The Qualitative Report*, *22*(4), 984-1000. https://doi.org/10.46743/2160-3715/2017.2713

Smith, J. A. (2024). *Qualitative Psychology: A Practical Guide to Research Methods*. Sage Publications.

Smith, J.A., Flowers, P. and Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method, and Research*. London: Sage.

Smith-Chandler, N., & Swart, E. (2014). In their own voices: Methodological considerations in narrative disability research. *Qualitative Health Research*, *24*(3), 420-430. https://doi-org.uniessexlib.idm.oclc.org/10.1177/1049732314523841

Staniszewska, S., Boardman, F., Gunn, L., Roberts, J., Clay, D., Seers, K., ... & O'Flynn, N. (2014). The Warwick Patient Experiences Framework: patient-based evidence in clinical guidelines. *International Journal for Quality in Healthcare*, *26*(2), 151-157. https://doi.org/10.1093/intqhc/mzu003

Staniszewska, S., Mockford, C., Chadburn, G., Fenton, S. J., Bhui, K., Larkin, M., ... & Weich, S. (2019). Experiences of in-patient mental health services: systematic review. *The British Journal of Psychiatry*, *214*(6), 329-338. https://doi.org/10.1192/bjp.2019.22

Stone, E., & Priestley, M. (1996). Parasites, pawns and partners: Disability research and the role of non-disabled researchers. *British Journal of Sociology*, 699-716. https://doi.org/10.2307/591081

Sullivan, C. (2019). 8. Using discursive methods to research the quality of working lives. In *Handbook of Research Methods on the Quality of Working Lives*, 109-123. Edward Elgar Publishing.

Sweeney, A., Gillard, S., Wykes, T., & Rose, D. (2015). The role of fear in mental health service users' experiences: a qualitative exploration. *Social Psychiatry and Psychiatric Epidemiology*, *50*(7), 1079-1087. https://doi.org/10.1007/s00127-015-1028-z

Teh, Y. Y., & Lek, E. (2018). Culture and reflexivity: Systemic journeys with a British Chinese family. *Journal of Family Therapy*, *40*(4), 520-536. https://doi.org/10.1111/1467-6427.12205

Thomas, C. (1999). *Female forms: Experiencing and Understanding Disability*. Open University Press.

Thomas, C. (2017). *Sociologies of Disability and Illness: Contested Ideas in Disability Studies and Medical Sociology*. Bloomsbury Publishing.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 1-10. https://doi.org/10.1186/1471-2288-8-45

Thurston, M. (2010). An inquiry into the emotional impact of sight loss and the counselling experiences and needs of blind and partially sighted people. *Counselling & Psychotherapy Research*, *10*(1), 3–12. https://doi.org/10.1080/14733140903492139

Tinner, L., & Alonso Curbelo, A. (2024). Intersectional discrimination and mental health inequalities: a qualitative study of young women's experiences in Scotland. *International Journal for Equity in Health*, *23*(1), 45. https://doi.org/10.1016/j.ssmqr.2025.100534

Tinner, L., Curbelo, A. A., & Gillespie, K. (2025). 'You've got to fight, every time': how women with a chronic illness or disability navigate intersectional discrimination within healthcare. *Epidemiol Community Health, 79.* https://doi.org/10.1136/jech-2025-SSMabstracts.5

Union of the Physically Impaired Against Segregation (1976). Fundamental principles of disability. Retrieved from: https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-fundamental-principles.pdf.

United Nations Department of Economic and Social Affairs (2008). *The UN Convention on the Rights of Persons with Disabilities.* New York: UN DESA. Retrieved from http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

Van Erp, J., Wallenburg, I., & Bal, R. (2020). Performance regulation in a networked healthcare system: from cosmetic to institutionalized compliance. *Public Administration*, *98*(1), 46-61. https://doi.org/10.1111/padm.12518

Van Oudenhove, L., & Cuypers, S. (2014). The relevance of the philosophical 'mind–body problem'for the status of psychosomatic medicine: A conceptual analysis of the biopsychosocial model. *Medicine, Health Care and Philosophy*, *17*(2), 201-213. https://doi.org/10.1186/1747-5341-5-2

VanPuymbrouck, L., & Magasi, S. (2024). Confronting Barriers to Equitable Care: A Qualitative Analysis of Factors That Inform People with Mobility Disabilities' Decisions to Self-Advocate in the Context of Healthcare. *Health & Social Care in the Community*, *2024*(1), 9975084. https://doi.org/10.1155/2024/9975084

Vernon, M. (2007). Mental health services for people who are deaf. *American Annals of the Deaf, 152*(4), 374-381. https://doi.org/10.1353/aad.2008.0005

Wade, D. T., & Halligan, P. W. (2017). The biopsychosocial model of illness: a model whose time has come. *Clinical Rehabilitation*, *31*(8), 995-1004. https://doi.org/10.1177/0269215517709890

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues in Mental Health Nursing*, *30*(1), 31-38. https://doi.org/10.1080/01612840802500733

Wang, K., Ostrove, J. M., Manning III, R. B., Fodero, S., Ash, S. L., Whang, J., ... & Lowe, S. R. (2024). Ableism in mental healthcare settings: A qualitative study among US adults with disabilities. *SSM-Qualitative Research in Health*, *6*, 100498. https://doi.org/10.1016/j.ssmqr.2024.100498

Watermeyer, B., & Swartz, L. (2023). Disability and the problem of lazy intersectionality. *Disability & Society*, *38*(2), 362-366. https://doi.org/10.1080/09687599.2022.2130177

Welthagen, E., Talbot, S., Harrison, O., & Phelan, M. (2004). Providing a primary care service for psychiatric in-patients. *Psychiatric Bulletin*, *28*(5), 167-170. https://doi.org/10.1192/pb.28.5.167

Wigginton, B., & Setchell, J. (2016). Researching stigma as an outsider: Considerations for qualitative outsider research. *Qualitative Research in Psychology*, *13*(3), 246-263. https://doi.org/10.1080/14780887.2016.1183065

Wilkenfeld, D. A., & Hagan Thomas, T. (2023). What are we asking patients to do? A critical ethical review of the limits of patient self-advocacy in the oncology setting. *The New Bioethics*, *29*(2), 181-190. https://doi.org/10.1080/20502877.2022.2143742

Willig, C. (2013). *Introducing Qualitative Research In Psychology*. McGraw-Hill Education (UK).

Woods, H., & Thomas, D. (2003). *Working with people with learning disabilities: Theory and practice*. Jessica Kingsley Publishers.

Woodward, J., & Tzur, R. (2017). Final commentary to the cross-disciplinary thematic special series: Special education and mathematics education. *Learning Disability Quarterly*, *40*(3), 146-151. https://doi.org/10.1177/0731948717690117

World Health Organisation (WHO; 2023). Disability Fact Sheet. WHO. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/disability-and-health https://iris.who.int/bitstream/handle/10665/70670/WHO_NMH_VIP_11.01_eng.pdf?sequence=1

Ysasi, N., Becton, A., & Chen, R. (2018). Stigmatizing Effects of Visible Versus Invisible Disabilities. *Journal of Disability Studies, 4*(1), 22-29. Retrieved from http://www.pubs.iscience.in/journal/index.php/jds/article/view/779

Appendices

Appendix A – Systematic Review Study Characteristics

Table 4

Characteristics of Included Studies (n = 12)

Author/year	Focus of study	Location	Sample description	Method and data analysis	Key qualitative findings
Braakman & Sterkenburg (2023)	Needed adaptations in psychological treatments for people with vision impairment: A Delphi study, including clients, relatives, and professionals	Netherlands	37 experts, including health and social care professionals, people with a visual impairment, and relatives of people with a visual impairment.	Qualitative Delphi study using semi-structured interviews followed by an online survey. Reflexive thematic analysis.	Seven factors were identified as significant to the mental healthcare of people with a visual impairment: the visual impairment, environment, stressors, emotions, the professional's role and attitude, treatment setting, and accessibility of materials. Individual factors concerning the experience of visual impairment (e.g. severity) should inform reasonable adjustments.

Conner et al. (2023)	Experiences of people with physical disabilities in psychotherapy	USA	24 Disabled people who had engaged in at least one session of psychotherapy	Semi-structured interviews analysed through a consensual qualitative research approach.	Four superordinate themes were developed, including: positive therapeutic interventions and interactions, negative therapeutic interventions and interactions, in/accessibility of services, and suggestions for improving mental health services.

De Clerck & Willems (2023)	Structural stigma in mental healthcare for the deaf and hard of hearing: perspective of clients and caregivers	Belgium	9 deaf and hard of hearing individuals and 9 healthcare professionals.	Semi-structured interviews, analysed through thematic analysis.	Six themes were developed, divided into three themes arising from interviews with deaf and HOH participants and three from healthcare professionals, including: experiences of stigma around deafness in the life course; experiences of stigma in mental healthcare and inadequacy of care; need for culturally sensitive and language-appropriate tailor-made care; high intention and confidence to provide accessible care; little knowledge about and work experience with deaf clients and caregivers; empathy with Deaf perspectives and reflections on accessible care.

Dispenza et al. (2017)	Counselling and Psychological Practices with Sexual and Gender Minority Persons Living with Chronic Illnesses/Disabilities (CID)	USA	63 MHPs	Online survey comprised of descriptive and open-ended questions. Data was analysed using qualitative content analysis.	Four themes were described as important within the mental healthcare of Disabled and chronically ill people: competence in intersectionality, affirmative consciousness, social justice practice, and ethical values.
Gerke (2017)	A phenomenological examination of disability, microaggressions, and the experiences of deaf adults in mental health services	USA	7 people self-identified as deaf or hard of hearing	Unstructured interviews analysed using a phenomenological methodology.	A total of five clusters with themes including: experiences with or without mental health services; barriers deaf clients encounter when seeking mental health services; factors to consider when Deaf clients enter counselling; what has or can be done to address these barriers; and interactions between interviewer and participant.

Methley et al. (2017)	Experiences of mental health support for people with multiple sclerosis (MS) and healthcare professionals	UK	24 people with MS, 13 practice nurses, 12 general practitioners, and 9 MS specialist nurses	Semi-structured interviews analysed using constant comparative analysis	Four themes were identified: candidates for care, management choices, defining roles, and permeability and responsiveness.
Olkin & Gomez (2024)	Experiences of Physically Disabled and Blind People in Psychotherapy: Lessons for CBT Therapists	USA	62 adults who self-identified as either physically disabled, blind, low vision, or a combination of these.	Mixed methods online survey. Qualitative data analysed using a phenomenological theory approach	Responses to an open-ended question about worst experiences in psychotherapy related to: disability, feeling misunderstood the therapist not knowing about disability, prejudiced or inappropriate interactions, and encountering a barrier.

Powers (2024)	Exploring Disabled people's experiences of psychotherapy	USA	7 Disabled people who had engaged in psychotherapy	Semi-structured interviews analysed through reflexive thematic analysis.	Five superordinate themes were developed, including: multifaceted experience of living with a disability; affirming and supportive therapy; interpersonal invalidation and marginalization; salient social identities; and environmental and institutional imprint.
Rintell et al. (2012)	People with MS' experiences of receiving mental healthcare	USA	54 people with MS	Focus groups with data analysed using grounded theory.	Eight categories were developed: identification of need; connecting with a provider; integration of behavioural healthcare; physical barriers to care; financial barriers to care; provider characteristics; mental healthcare at MS centres; and other approaches to mental healthcare.

Thurston (2010)	Exploring the counselling experiences of blind and partially sighted people	UK	18 blind or partially sighted people	Mixed methods including semi-structured interviews. Data analysed using grounded theory.	Four main categories were identified: making the transition to blindness; counselling perceptions and experiences; suggestions for improving services; and the effect of the researcher's visual impairment on data collection.
Wang et al. (2024)	Exploring how ableism impacts the perceived effectiveness and relevance of mental health services	USA	20 Disabled people who were engaged in mental health services	Semi-structured interviews analysed through reflexive thematic analysis	Six themes were developed relating to participants' experiences of ableism in mental healthcare, including: misplaced assumptions about the impact of disability on mental health; medical trauma and gaslighting; interpersonal ableism; lack of disability knowledge, accessibility challenges; and systematic ableism.

Zhang-Hampton et al. (2011)	Exploring the needs and experiences of women with neurological disorders in accessing health services (psychological and social domains of health)	USA	23 women with neurological disorders (MS, spina bifida, spinal cord injuries)	Semi-structured interviews analysed through content analysis.	Five superordinate themes were developed, including: a need for psychological and social services; the lack of the expertise about disability among mental health service providers; the lack of choices for selecting psychological services among participants; seeking informal support as the major strategy in coping with psychological problems; and inaccessible environments.

Appendix B - Quality Appraisal of Review Studies

Table 5

Quality Appraisal of Review Studies using Critical Appraisal Skills Programme (CASP) qualitative tool

Appraisal Criteria	Braakman & Sterkenburg (2023)	Conner et al. (2023)	De Clerck & Willems (2023)	Dispenza et al. (2017)	Gerke (2017)	Methley et al. (2017)	Olkin & Gomez (2024)	Powers (2024)	Rintell et al. (2012)	Thurston (2010)	Wang et al. (2024)	Zhang-Hampton et al. (2011)
1. Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Is a qualitative methodology appropriate?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

3. Was the research design appropriate to address the aims of the research?	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓
4. Was the recruitment strategy appropriate to the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

5. Was the data collected in a way that addressed the research issue?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Has the relationship between researcher and participants been adequately considered?	✗	✓	✗	✓	✓	✗	?	✓	✗	✓	✓	✗	
7. Have ethical issues been	✓	✓	✓	✓	✓	**?**	✓	✓	✓	✓	✓	✓	

taken into consideration?													
8. Was the data analysis sufficiently rigorous?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Is there a clear statement of findings?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10. How valuable is the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note. Key: ✓= yes; ✗ = no; **?** = can't tell.

Appendix C – Interview Topic Guide: Direct Experience

People with Physical Disabilities' Experiences of Acute Mental Health Services

Interview Topic Guide: Disabled people with direct experience

Thank you for participating in this interview. Your experiences of crisis and inpatient mental health settings are valuable, and I would like to ask you some questions to understand them better. This includes your personal experiences as well as any observations you may have made about others' experiences during your/their contact with these health services.

Referral and Admission

1. Please describe your experiences of being referred to crisis / inpatient mental health services.

Suggested Prompts

- How well do you feel your physical disability and needs were considered during the referral/admission process?
- Can you give me specific examples of situations or interactions that stood out to you during this time?
- How were your access needs or reasonable adjustments met during your referral or admission?

Experiences in Inpatient Mental Health Services:

2. Please describe your experiences during your contact with crisis / inpatient mental health services.

Suggested Prompts

- Can you share any specific situations or interactions that stood out to you during your care?
- How did you feel about the overall accessibility and inclusivity of the service/ward environment?
- How did you feel about the support and treatment you received for your mental health?
- What aspects of the care were especially helpful or unhelpful in supporting your mental health?
- Did you feel that your mental health needs were adequately addressed?
- How did the actions or attitudes of others (e.g. staff, other patients, the service as a whole) impact your experience? How, if at all, do you feel this related to your physical disability?
- How well did you feel services/staff listened to you?
- How important is it for acute mental health services to acknowledge and address the unique challenges faced by individuals with physical disabilities?

3. How well were your disability-related needs met during your contact with crisis services / admission to inpatient mental health services?

Suggested Prompts

- Were there any challenges or barriers you encountered to care? How, if at all, did you feel this related to your physical disability?

- Were your access needs or reasonable adjustments identified and acted on?
- In what ways did the service show an understanding (or lack of understanding) of your physical disability?
- Did the care you receive demonstrate an awareness and understanding of your specific needs as a person with a physical disability?
- Tell me about how the physical healthcare you received outside of inpatient services was continued during your contact with crisis services / admission (e.g. were you able to attend regular appointments, receive medications/treatments, etc.).
- Did you feel your physical health and mental health were considered together, or separately?

Follow-up Care after Discharge:

4. Could you tell me about your experiences of care after being discharged from crisis / inpatient mental health services?

Suggested Prompts

- How did the support you received after discharge compare to your expectations?
- Were there any aspects of the follow-up care that you found particularly helpful or unhelpful?

- Are there any gaps or areas for improvement in the transition from crisis / inpatient to community care that you identified, particularly as a person with a physical disability?
- Describe any changes you would have made to your care following discharge from crisis / inpatient services.
- What improvements would you suggest to enhance the continuity of mental healthcare for individuals with physical disabilities?

5. Describe your ideal mental health crisis and/or inpatient care.

Suggested Prompts

- What accommodations or adjustments would need to be made for you to experience care that meets your needs?
- How do you envision an ideal environment for individuals with physical disabilities receiving crisis / inpatient mental health care?
- What, if anything, would have made a difference in supporting your needs and recovery (both mental and physical)?
- What resources or forms of support do you believe are essential for individuals with physical disabilities in acute mental health settings?
- How could the accessibility and inclusivity of acute mental health services be improved for people with physical disabilities?

Closing:

Thank you for sharing your experiences and insights.

- Is there anything else you would like to add or discuss that we haven't covered?
- Do you have any feedback on the interview process or any final thoughts you'd like to share?

Appendix D – Interview Topic Guide: Indirect Experience

People with Physical Disabilities' Experiences of Acute Mental Health Services

Interview Topic Guide: Disability advocates with indirect experience

Thank you for taking part in this interview. Your interest in, and/or experiences related to, crisis and inpatient mental health settings are highly valuable. I'd like to ask you some questions to better understand your perspective. This includes any advocacy, professional, or personal insights you may have. You may also share any observations you've made about how Disabled people with physical disabilities experience these services.

Referral and Admission

1. From your perspective, how might a Disabled person with physical disabilities experience referral to, or admission into, inpatient or crisis mental health services?

Suggested Prompts

- How can crisis / inpatient mental health services best meet the needs of disabled people during referral and admission?
- What can crisis / inpatient mental health services do to meet the needs of people with physical disabilities during the referral and admission process?

Experiences in Inpatient Mental Health Services:

2. Based on your advocacy experiences, how might Disabled people with physical disabilities experience contact with crisis / inpatient mental health services? (including any barriers to or facilitators of care)

Suggested Prompts

- What challenges or barriers may people with physical disabilities encounter to care in crisis/inpatient mental health settings?
- How can care in these settings demonstrate an awareness and understanding of the specific needs of people with physical disabilities?
- How well are Disabled people's physical healthcare needs typically managed alongside mental healthcare in these settings (e.g. access to treatments, appointments, medications)?
- What do crisis/inpatient mental health services need to do to ensure there is continuity of physical healthcare for people with disabilities?
- How well do crisis/inpatient services consider and treat both the mental and physical health needs of people with physical disabilities?
- How can the rights of people with physical disabilities be upheld in crisis and inpatient mental health services?

Follow-up Care after Discharge:

3. What are your views on the follow-up care Disabled people with physical disabilities receive after discharge from crisis or inpatient mental health services?

Suggested Prompts

- What expectations would you have of crisis / inpatient mental health services in relation to the support they offer people with physical disabilities following discharge?
- What aspects of follow-up care following contact with these services could be particularly helpful or unhelpful?
- Are there any gaps or areas for improvement you perceive in the transition from crisis / inpatient to community care for disabled people with physical disabilities?
- What improvements would you suggest to enhance the continuity of mental healthcare for individuals with physical disabilities discharged from crisis / inpatient services?
- Describe any changes you would make to people with physical disabilities' care following discharge from crisis / inpatient services.

4. From your perspective, what would ideal crisis and/or inpatient mental health care look like for people with physical disabilities?

Suggested Prompts

- What accommodations or adjustments would need to be made for people with physical disabilities to experience care that meets their needs?
- How do you envision an ideal environment for individuals with physical disabilities receiving crisis / inpatient mental health care?

- What, if anything, would make a difference in supporting disabled people with physical disabilities' needs and recovery from acute mental health needs?
- What would an ideal environment for disabled people with physical disabilities experiencing acute mental health needs look like?
- What resources or forms of support do you believe are essential for individuals with physical disabilities in crisis / inpatient mental health settings?
- How could the accessibility and inclusivity of crisis / inpatient mental health services be improved for people with physical disabilities?

Closing:

Thank you for sharing your experiences and insights.

- Is there anything else you would like to add or discuss that we haven't covered?
- Do you have any feedback on the interview process or any final thoughts you'd like to share?

Appendix D – Recruitment Advertisement Poster

PARTICIPANTS WANTED

University of Essex

Do you identify as having a physical disability or impairment?

Would you like to participate in research impacting your community?

We are seeking to explore and understand the experiences of people with physical disabilities or impairment who have experienced care within inpatient mental health services.

To take part in this project, you must:

- **Be aged 18 or over.**
- **Have experienced care within UK inpatient mental health services within the past 10 years.**
- **Self-identify as having a physical disability or impairment at the time of your admission to inpatient mental health services.**
- **Not currently be experiencing a mental health crisis or receiving care in inpatient services.**

What is involved in taking part?

- **An interview that will take approximately 60 minutes. This can take place by phone or Microsoft Teams.**
- **The interview will be recorded and transcribed.**
- **We will ask you for some demographic information, but your participation will be anonymous.**
- **No identifiable information will be included in the recording, transcript or final report.**

Interested in taking part?

For further information or to take part, please contact the Lead Researcher who will send you a detailed Information Sheet and Consent Form. There will also be an opportunity to talk through any questions or concerns if you have any.

Lead Researcher: Jamie Melvin-Freed, Trainee Clinical Psychologist.

jm22257@essex.ac.uk.

This project is supervised by Dr Alison Spencer (Clinical Psychologist) & Dr Stephen Wood (Lecturer)

This project has been reviewed by the University of Essex Ethics Committee and has received a favourable ethical opinion (ETH2324-0075)

Appendix E – Amended Recruitment Adverts

PARTICIPANTS WANTED

University of Essex

We are seeking to explore the experiences of people with physical disabilities who have received care from UK crisis or inpatient mental health services.

To take part, you must:

- Identify as having a physical disability or chronic health condition.
- Be aged 18 or over.
- Have experienced care within mental health crisis or inpatient mental health services and / or have an interest in advocating for Disabled People's mental health.
- Not be experiencing a mental health crisis or receiving care in inpatient services.

What is involved in taking part?

- An audio recorded interview that will take around 60 minutes. This can take place by phone or Microsoft Teams.
- We will ask for some demographic information.
- No identifiable information will be included in the recording, transcript or final report.

Interested in taking part?

For more information, any questions, or to take part, please contact the Lead Researcher, Jamie Melvin-Freed, Trainee Clinical Psychologist.

jm22257@essex.ac.uk.

This project is supervised by Dr Alison Spencer (Clinical Psychologist) & Dr Stephen Wood (Lecturer)

SCAN QR CODE TO EMAIL NOW

This project has been reviewed by the University of Essex Ethics Committee and has received a favourable ethical opinion (ETH2324-0075)

PARTICIPANTS WANTED

University of Essex

We are seeking to explore the experiences of people with physical disabilities who have received care from crisis or inpatient mental health services.

To take part, you must:

- Identify as having a physical disability or chronic health condition.
- Be aged 18 or over.
- Have experienced care within mental health crisis or inpatient mental health services and / or have an interest in advocating for Disabled People's mental health.
- Not be experiencing a mental health crisis or receiving care in inpatient services.

What is involved?

- An audio recorded interview that will take around 60 minutes. This can take place by phone or Microsoft Teams.
- We will ask you for some demographic information, but your participation will be anonymous.
- No identifiable information will be included in the recording, transcript or final report.

Interested in taking part?

For more information, any questions, or to take part, please contact the Lead Researcher, Jamie Melvin-Freed, Trainee Clinical Psychologist.

jm22257@essex.ac.uk.

This project is supervised by Dr Alison Spencer (Clinical Psychologist) & Dr Stephen Wood (Lecturer)

This project has been reviewed by the University of Essex Ethics Committee and has received a favourable ethical opinion (ETH2324-0075)

Appendix F – Screen-reader Recruitment Advert

(alt text: Research recruitment poster with beige background and bold text. Title text is presented in a pink font, whilst content is presented in black text. Text is divided into sections through text boxes with a dashed border line shown in pink. In the top right corner, the logo for the University of Essex is shown, which has a white background, dark purple text, and, to the left of the text, a pattern of two purple and three orange squares. At the bottom left of the poster is an illustration of a group of people, who are all smiling. On the left-hand side is a white man with shoulder length blonde hair, a dark orange top with a light orange stripe across the middle, light yellow trousers, and dark orange shoes. He is waving his right hand. Next to him is a woman with long brown hair, a white long-sleeved top, and a pink skirt and shoes. She is stood on her left leg, which is a blue above the knee prosthesis, with her right leg kicked out behind her. She is high fiving a man to her left who is sitting in a blue wheelchair, he is white and has short brown hair. He is wearing an orange jacket, yellow top, blue trousers, and brown lace up shoes. There is a black gender-neutral person holding the push handles of his wheelchair. They have blue hair, thick black eyebrows, a purple jacket, light blue top, blue trousers, and dark blue shoes. Behind them is a black woman with long brown hair, she is wearing a long green dress, a pink cross body bag, and green heeled shoes. There is a man stood next to her on the left, with his arm around her shoulder. He has spiky short brown hair and a beard. He is wearing a yellow collared shirt and rose-pink trousers. To the left of him there is a white woman with ginger hair, wearing a rose pink, long and flowy dress. In front of her is a tanned gender-neutral person, they have short brown hair which is pulled into a tight bun at the back of their head. They are wearing dark glasses, a green jumper with two yellow stripes on each arm, dark blue trousers, and green lace up shoes. They are holding a black cane and a red dog lead. In front of them is a yellow Labrador, wearing a red harness lead. The dog is walking to the right.)

PARTICIPANTS WANTED

We are seeking to explore the experiences of people with physical disabilities who have received care from UK crisis or inpatient mental health services.

To take part, you must:

- Either: identify as having a physical disability or chronic health condition, or have experience advocating for Disabled people.

- Be aged 18 or over.
- Have experienced care within mental health crisis or inpatient mental health services and / or have an interest in advocating for Disabled People's mental health.
- Not be experiencing a mental health crisis or receiving care in inpatient services.

What is involved in taking part?

- An audio-recorded interview that will take around 60 minutes.
- This can take place by phone or Microsoft Teams.
- We will ask for some demographic information.
- No identifiable information will be included in the recording, transcript or final report.

Interested in taking part?

For more information, any questions, or to take part, please contact the Lead Researcher, Jamie Melvin-Freed, Trainee Clinical Psychologist at jm22257@essex.ac.uk.

This project is supervised by Dr Alison Spencer (Clinical Psychologist) & Dr Stephen Wood (Lecturer)

This project has been reviewed by the University of Essex Ethics Committee and has received a favourable ethical opinion (ETH2324-0075)

Appendix G – Participant Information Sheet

University of Essex

Participant Information Sheet

A Qualitative Exploration of Disabled Adults with Physical Disabilities Experiences of Acute Mental Health Services

Invitation

My name is Jamie Melvin-Freed and I am a Trainee Clinical Psychologist in the Department of Health and Social Care at the University of Essex. I would like to invite you to take part in a research project. Before you decide whether or not to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

Understanding the lived realities of Disabled people accessing mental health services is of high importance, particularly in the context of health inequalities, ableism, and the recent COVID-19 pandemic. Yet, there is limited research into how Disabled people experience care within both community and inpatient mental health services, particularly those who identify as having a physical disability or impairment. The existing literature, which focuses on disability overall (e.g. physical, intellectual, mental health, and neurodivergence), reports concerning findings relating to mental health services. This includes Disabled people expressing experiences of their human rights not being upheld or disregarded; not being heard, believed, or taken seriously and feeling dismissed; delayed support and crisis interventions; difficulties in transitioning between child and adult services; distrust of services; fear of stigma about accessing mental health services; and concern about policies and procedures that undermined disability rights (Glasgow Disability Alliance, 2022). Reports also describe repeated experiences of micro-aggressions and discrimination within interactions with mental health services, which compounded emotional distress and mental health difficulties,

As the experiences of Disabled people receiving care from crisis or inpatient mental health services have received little exploration within the research literature, it is unclear whether national standards of practice (e.g. National Institute for Health and Care Excellence (NICE), The Equality Act (2010), The Accessible Information Standard (2016), Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2017), etc.) are being met in practice and if there are any barriers to care that aligns with these principles. Subsequently, this research aims to explore the experiences of adults with physical disabilities who have received support from acute mental health services (e.g. crisis and/or inpatient) in the United Kingdom. In particular, the aims of the research are to understand:

- How do Disabled adults with physical disabilities make sense of their experiences within mental health crisis and/or inpatient mental health services?
- How well do mental health crisis and/or inpatient services meet the mental health needs of Disabled adults with physical disabilities?
- To what extent are the physical health needs of Disabled adults with physical disabilities addressed within crisis and/or inpatient mental health services?

This research will collect data using semi-structured interviews with people who self-identify as Disabled with a physical disability and/or disability advocates. Topic areas will include experiences of acute mental health care, access, barriers to care, and good practice. It is anticipated that the duration of the interview will be between 45 – 60 minutes. Data will be

analysed using thematic analysis, which is an approach to encode qualitative data and developing common themes across participant experiences.

This research project is being completed to fulfil the requirements for qualification in the Doctorate of Clinical Psychology at the University of Essex.

Why have I been invited to participate?

You have been invited to participate in this study as you:

- Either: identify as having a physical disability or chronic health condition, or have experience in advocating for Disabled people's mental health.
- Are aged 18 or over.
- Have recently experienced care within acute mental health services (e.g. crisis or inpatient) **and** / or have an interest in advocating for Disabled People's mental health.
- Are not currently experiencing a mental health crisis or receiving care in inpatient services.

The research aims to interview 12 – 15 participants.

Do I have to take part?

It is up to you to decide whether or not you wish to take part in this research. If you do decide to take part, you will be asked to provide written or oral consent. You are free to withdraw at any time, without giving a reason.

Should you wish to withdraw from the study, please contact Jamie Melvin-Freed email on jm22257@essex.ac.uk, so that any information you have provided for the purposes of the study can be removed from the records.

What will happen to me if I take part?

The research will collect data using semi-structured interviews with Jamie Melvin-Freed. Prior to the interview, an appointment will be arranged you to complete this. Interviews can be conducted face-to-face, online through Microsoft Teams, or via telephone, depending on your needs. It is anticipated that the duration of the interview will be between 45 – 60 minutes. Following the completion of the interview, your data will be pseudonymised, this that any information which could be used to identify you is replaced with a name/value which does not allow you to be directly identified. All information will be password-protected and securely stored on the University's electronic system, Box. It is proposed that the interviews are audio or video recorded to support accurate data collection and transcription. Please note, that if a recording is made through Microsoft Teams this will capture both audio and video information. Following transcription, all recordings will be deleted. Pseudonymised information will be permanently deleted following the completion of the project in September 2025.

What are the possible disadvantages and risks of taking part?

Potential disadvantages of participating in the research are considered as follows:

- **Emotional**: Talking about experiences within acute mental health services can be emotionally difficult. Should this impact you or you feel distressed in any way, you are free to withdraw or stop the interview at any time. All participants will also be provided with debrief information following participation, which will include contact details for talking therapy services.

- **Time:** It is anticipated that there will be a time cost involved in participating in interviews which are estimated to take between 45 – 60 minutes to complete.

What are the possible benefits of taking part?

This research aims to explore how Disabled people with physical disabilities or impairment experience care within acute mental health services. It is undertaken with the goal of drawing attention to the voices of Disabled people, which historically have been absent from research literature. Through taking part in this research, you will be helping to inform and further develop practice through highlighting barriers to care and good practice. You will also be able to share your views on an issue that you care about, which could be personally meaningful and rewarding. It is hoped that your contributions will make a positive difference to those receiving care within acute mental health services in the future. Results of the research will be shared with you if you choose to participate and receive feedback.

Will I be compensated or reimbursed for taking part?

Your participation in this study is voluntary. Should you choose to participate in an interview, you will be compensated with a £15 amazon voucher in return for your time. Please note that you will need to provide your email address to the researcher in order to receive this.

What information will be collected?

The primary goal of the research is to collect information on Disabled people's experiences of mental health crisis and/or inpatient mental health services, including issues of access, barriers to care, and good practice. Additional information will also be collected on your age, gender, ethnicity, as well as the year and duration of contact with acute mental health services. This information will be pseudonymised, which means that data will not be identifiable to any individual but will be linked to a unique identifier.

Relevant contact details will also be requested to facilitate interviews and provide feedback once the study has been completed (e.g. phone number or email address). This information will be password protected and stored securely on Box to protect your identifiable data. This information will be stored separately from the research data.

Will my information be kept confidential?

Your confidentiality will be safeguarded within legal limitations during and after the research. Your data will be kept securely at all times, using encrypted devices. Microsoft Teams is also compliant with Data Protection legislation. All audio and/or video recordings of interviews and resulting transcripts will be password-protected and securely stored on the University's electronic system, Box. This will avoid the risk of data being lost through theft or confiscation and automatic back-ups will be undertaken. Audio and/or video recordings will be deleted following transcription. It is recommended that data should be retained for a period of at least ten years after the completion of the project. All electronic data will be deleted following this.

Your data will be accessible to the primary researcher, Jamie Melvin-Freed, and both university supervisors of the research, Dr Alison Spencer and Dr Stephen Wood.

What is the legal basis for using the data and who is the Data Controller?

Should you wish to participate in this research, you will provide written consent to this effect. The GDPR states that consent must be freely given, specific, informed and unambiguous –

University of Essex

given by a statement or a clear affirmative action. The Data Controller will be the University of Essex and the contact will be University Information Assurance Manager (dpo@essex.ac.uk).

What should I do if I want to take part?

If you wish to opt in to the research project, please contact Jamie Melvin-Freed (jm22257@essex.ac.uk). The deadline for recruitment is November 2024.

What will happen to the results of the study?

Your data will be accessible to the primary researcher, Jamie Melvin-Freed, and both university supervisors of the research, Dr Alison Spencer and Dr Stephen Wood. The results of the research will be available to you automatically following the completion of the project, should you choose to participate and opt in to receive feedback. The results will also be submitted in document form, as a thesis, to the University of Essex to fulfil the requirements for qualification in the Doctorate of Clinical Psychology at the University of Essex. It is anticipated that results may also be published as a journal article or used as a conference paper or presentation. At the point of publishing to the public domain all results will be anonymised and will not be identifiable.

Who has reviewed the study?

This research project has been reviewed and approved by the University of Essex ethics committee. The ethics reference is ETH2324-0075.

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the lead researcher of the project, Jamie Melvin-Freed, using the contact details below. If you are still concerned, think your complaint has not been addressed to your satisfaction, or feel that you cannot approach the principal investigator, please contact the Departmental Director of Research for the School of Health and Social Care, Professor Camille Cronin (camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Integrity Manager, Dr Mantalena Sotiriadou (e-mail ms21994@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Names of the Investigators

Jamie Melvin-Freed (Lead Researcher; Trainee Clinical Psychologist) – jm22257@essex.ac.uk

Dr Alison Spencer (Research Supervisor; Clinical Psychologist, School of Health & Social Care, University of Essex) - as16018@essex.ac.uk

Dr Stephen Wood (Research Supervisor; Lecturer, School of Health & Social Care, University of Essex) - scwood@essex.ac.uk

Appendix H – Participant Consent Form

University of Essex

Consent Form

Title of the Project: A Qualitative Exploration of Disabled Adults with Physical Disabilities Experiences of Acute Mental Health Services

Service Evaluation Team: Jamie Melvin-Freed (Lead Researcher; Trainee Clinical Psychologist), Dr Alison Spencer (Research Supervisor; Clinical Psychologist, School of Health & Social Care, University of Essex), & Dr Stephen Wood (School of Health & Social Care).

Please initial box

1. I confirm that I have read and understand the Information Sheet dated 07/06/2024 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand I can retract any information I provide up to the time it is anonymised and interpreted. I understand that any data collected up to the point of my withdrawal will be destroyed. ☐
3. I understand that, due to the nature of the research, experiences of care within inpatient mental health settings will be discussed, which can be emotionally distressing. With this in mind, I confirm that I would like to participate in the project. ☐
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐
5. I understand that my fully anonymised data will be used for submission of an assignment for the requirements of the Doctorate in Clinical Psychology, and potentially within research publications. ☐
6. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
7. I give permission for the audio and/or video recording of interviews for the purposes of creating de-identified (pseudonymised) transcripts. ☐

University of Essex

8. I agree to take part in the above study. ☐

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix I – Script for Oral Consent

University of Essex

Oral Consent Script

Title of the Project: A Qualitative Exploration of Disabled Adults with Physical Disabilities Experiences of Acute Mental Health Services

Research Team: Jamie Melvin-Freed (Lead Researcher; Trainee Clinical Psychologist), Dr Alison Spencer (Research Supervisor; Clinical Psychologist, School of Health & Social Care, University of Essex), & Dr Stephen Wood (Research Supervisor, School of Health & Social Care).

Introduction (*): Hello [again], my name is Jamie. I'm currently doing my doctorate training in clinical psychology at the University of Essex within the School of Health and Social Care. I would like to invite you to take part in a research study. As explained in the information sheet I sent/gave you, I am researching how adults with physical disabilities have experienced mental health crisis and inpatient mental health services in the United Kingdom. The research aims to understand:

- How do Disabled adults with physical disabilities make sense of their experiences within mental health crisis and/or inpatient mental health services?
- How well do mental health crisis and/or inpatient services meet the mental health needs of Disabled adults with physical disabilities?
- To what extent are the physical health needs of Disabled adults with physical disabilities addressed within crisis and/or inpatient mental health services?

Before you participate, I'd like to gain your consent to be involved in the research. Is it ok with you if I record your responses to this?

- Record response:

First, have you had an opportunity to read and consider the information sheet, and/or ask any questions you have about participating in the research?

- Record response:

The information you provide during the interview will be used within my thesis to fulfil the requirements of the Doctorate in Clinical Psychology, and potentially within research publications. It is also possible that the data collected from you will be used to support other research in the future, and may be shared anonymously with other researchers. Do you understand and agree to this?

- Record response:

The information you provide will be pseudonymised and confidential, which means your name and any identifiable details will **not** be used in my thesis or any resulting publication. You can retract any information you provide up to the time it is anonymised and interpreted. Do you understand and agree to this?

- Record response:

The information you provide will be securely stored and only accessed by members of the research team directly involved in the project. Do you understand and agree to this?

- Record response:

University of Essex

The study will involve an interview which may be conducted in person, over the telephone or on Microsoft Teams, depending on your needs. How would you like to participate? Is it ok for me to audio/video record the interview? This is only to help me write notes/transcribe afterward. I will then delete the recording. Please note, that if a recording is made through Microsoft Teams this will capture both audio and video information.

- Record response:

During the interview, if any questions make you feel uncomfortable, you do not have to answer them. Please let me know and we can move on to a different question. Your participation in the study is voluntary and you are free to ask me any questions you have throughout, to take a break, or to withdraw at any time without giving a reason. Any data you have provided up to the point of your withdrawal will be deleted. Do you understand and agree to this?

- Record response:

As part of the interview, you will be asked about your experiences of care from mental health crisis and/or inpatient mental health settings. This may involve a discussion of difficult experiences which could understandably elicit emotional distress. With this in mind, would you like to continue?

- Record response:

If that's all clear and alright with you, are you happy to take part in the study? If so, we will arrange a time and day that is convenient for you, at least 3 days after today to give you time to change your mind or ask any further questions. The interview should take approximately 45 minutes to one hour.

- Record response:

I would also like your permission to keep your contact details so that I can re-contact you following the completion of the research, to give you feedback on the findings. Would this be ok?

- Record response:

Do you have any questions?

- Record response:

Post-interview

Thank you so much for your answers. To confirm, are you happy for me to use the information you provided for my thesis with the terms outlined before? I'm also happy to go through them again.

[interviewee reconfirms/asks for details of the study or how data will be used to be repeated]

Participant Name	Date	Verbal Agreement? (Yes/No)
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix J – Participant Demographic Information Sheet

University of Essex

A Qualitative Exploration of Disabled Adults with Physical Disabilities Experiences of Acute Mental Health Services

Demographic Information Form

The following questions are asked to enable comparisons of anonymous responses across individuals and groups in order to understand the different experiences of people with different identities. We believe it is important to ask about these intersecting identities to contribute to our understanding of the perceptions and experiences of individuals from different backgrounds.

1. What is your age? _____
2. What best describes how you self-identify?
   - Female
   - Male
   - Non-Binary
   - Prefer to describe: _____
   - Prefer not to share
3. What best describes your race/ethnicity?
   - Asian and Asian British
   - Black, African, Caribbean or Black British
   - Gypsy, Roma or Traveller
   - Mixed and Multiple ethnic groups
   - White
   - Prefer to describe: _____
   - Prefer not to share
4. Which of the following best describes your sexual orientation?
   - Heterosexual or Straight
   - Gay or Lesbian
   - Bisexual
   - Pansexual
   - Asexual
   - Prefer to describe: _____
   - Prefer not to share
   - Prefer not to share
5. Which of the following best describes your current employment status?
   - Full-time employment
   - Self-employed
   - Part-time employment
   - Unemployed (looking for work)
   - Unemployed (not looking for work)
   - Student
   - Unable to work
   - Other, please describe: _____

University of Essex

- Prefer not to share

6. Do you identify as a Disabled person or as having a chronic health condition?
   - Yes
   - No

7. Do any of your conditions or illnesses affect you in any of the following areas? *(Please select all that apply)*
   - Vision (for example, blindness or partial sight)
   - Hearing (for example, deafness or partial hearing)
   - Mobility (for example, walking short distances or climbing stairs)
   - Dexterity (for example, lifting and carrying objects, using a keyboard)
   - Learning, understanding or concentrating
   - Memory
   - Mental health
   - Breathing
   - Socially or behaviourally (for example associated with autism spectrum disorder and/or attention deficit hyperactivity disorder)
   - Pain
   - Fatigue and stamina
   - Sensory issues
   - Other, please describe: _____
   - Prefer not to share

8. If you were in contact with UK mental health crisis services, were they provided by the NHS, or third sector / voluntary organisations?
   - NHS
   - Third sector / voluntary (e.g. Samaritans, Mind, helplines, etc.)
   - Other, please specify: _____
   - I have not had direct contact with these services.

9. If you received care within UK inpatient mental health services were they provided by the NHS or private services?
   - NHS
   - Private
   - Other, please specify: _____
   - I have not had direct contact with these services

10. If you received care from UK crisis / inpatient services, what year were you in contact with these services?
    _____

11. If you received care from UK crisis / inpatient services, what was the duration of your care under this service / admission?
    _____

Appendix K - Confirmation of Ethical Approval

University of Essex

15/04/2024

Miss Jamie Melvin-Freed

Health and Social Care

University of Essex

Dear Jamie,

Ethics Committee Decision

Application: ETH2324-0075

I am pleased to inform you that the research proposal entitled "A Qualitative Exploration of Physically Disabled Adults Experiences of Inpatient Mental Health Services " has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

REO Research Governance Team

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

T 01206 873333

Appendix L – Confirmation of Ethical Approval Following Amendments

University of Essex

05/08/2024

Miss Jamie Melvin-Freed

Health and Social Care

University of Essex

Dear Jamie,

Ethics Committee Decision

Application: ETH2324-1983

I am pleased to inform you that the research proposal entitled "A Qualitative Exploration of Physically Disabled Adults Experiences of Inpatient Mental Health Services " has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

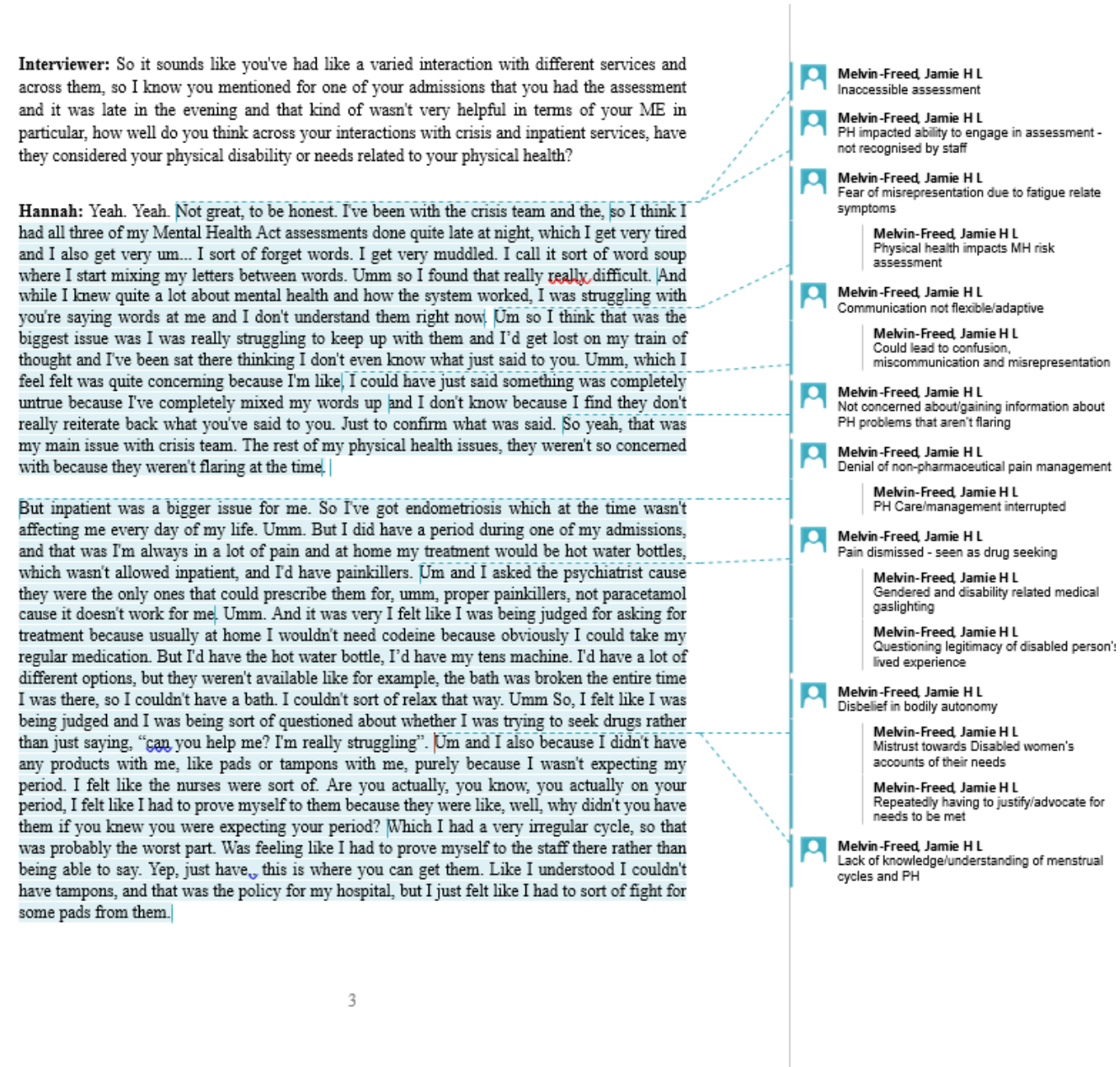
REO Research Governance team

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

T 01206 873333

www.essex.ac.uk
@Uni_of_Essex /uniofessex /uniofessex

Appendix M – Example Transcript with Initial Codes



Interviewer: So it sounds like you've had like a varied interaction with different services and across them, so I know you mentioned for one of your admissions that you had the assessment and it was late in the evening and that kind of wasn't very helpful in terms of your ME in particular, how well do you think across your interactions with crisis and inpatient services, have they considered your physical disability or needs related to your physical health?

Hannah: Yeah. Yeah. Not great, to be honest. I've been with the crisis team and the, so I think I had all three of my Mental Health Act assessments done quite late at night, which I get very tired and I also get very um... I sort of forget words. I get very muddled. I call it sort of word soup where I start mixing my letters between words. Umm so I found that really really difficult. And while I knew quite a lot about mental health and how the system worked, I was struggling with you're saying words at me and I don't understand them right now. Um so I think that was the biggest issue was I was really struggling to keep up with them and I'd get lost on my train of thought and I've been sat there thinking I don't even know what just said to you. Umm, which I feel felt was quite concerning because I'm like, I could have just said something was completely untrue because I've completely mixed my words up and I don't know because I find they don't really reiterate back what you've said to you. Just to confirm what was said. So yeah, that was my main issue with crisis team. The rest of my physical health issues, they weren't so concerned with because they weren't flaring at the time.

But inpatient was a bigger issue for me. So I've got endometriosis which at the time wasn't affecting me every day of my life. Umm. But I did have a period during one of my admissions, and that was I'm always in a lot of pain and at home my treatment would be hot water bottles, which wasn't allowed inpatient, and I'd have painkillers. Um and I asked the psychiatrist cause they were the only ones that could prescribe them for, umm, proper painkillers, not paracetamol cause it doesn't work for me. Umm. And it was very I felt like I was being judged for asking for treatment because usually at home I wouldn't need codeine because obviously I could take my regular medication. But I'd have the hot water bottle, I'd have my tens machine. I'd have a lot of different options, but they weren't available like for example, the bath was broken the entire time I was there, so I couldn't have a bath. I couldn't sort of relax that way. Umm So, I felt like I was being judged and I was being sort of questioned about whether I was trying to seek drugs rather than just saying, "can you help me? I'm really struggling". Um and I also because I didn't have any products with me, like pads or tampons with me, purely because I wasn't expecting my period. I felt like the nurses were sort of. Are you actually, you know, you actually on your period, I felt like I had to prove myself to them because they were like, well, why didn't you have them if you knew you were expecting your period? Which I had a very irregular cycle, so that was probably the worst part. Was feeling like I had to prove myself to the staff there rather than being able to say. Yep, just have, this is where you can get them. Like I understood I couldn't have tampons, and that was the policy for my hospital, but I just felt like I had to sort of fight for some pads from them.

3

Melvin-Freed, Jamie H L
Inaccessible assessment

Melvin-Freed, Jamie H L
PH impacted ability to engage in assessment - not recognised by staff

Melvin-Freed, Jamie H L
Fear of misrepresentation due to fatigue relate symptoms

Melvin-Freed, Jamie H L
Physical health impacts MH risk assessment

Melvin-Freed, Jamie H L
Communication not flexible/adaptive

Melvin-Freed, Jamie H L
Could lead to confusion, miscommunication and misrepresentation

Melvin-Freed, Jamie H L
Not concerned about/gaining information about PH problems that aren't flaring

Melvin-Freed, Jamie H L
Denial of non-pharmaceutical pain management

Melvin-Freed, Jamie H L
PH Care/management interrupted

Melvin-Freed, Jamie H L
Pain dismissed - seen as drug seeking

Melvin-Freed, Jamie H L
Gendered and disability related medical gaslighting

Melvin-Freed, Jamie H L
Questioning legitimacy of disabled person's lived experience

Melvin-Freed, Jamie H L
Disbelief in bodily autonomy

Melvin-Freed, Jamie H L
Mistrust towards Disabled women's accounts of their needs

Melvin-Freed, Jamie H L
Repeatedly having to justify/advocate for needs to be met

Melvin-Freed, Jamie H L
Lack of knowledge/understanding of menstrual cycles and PH

Appendix N – Cross Comparison of participants by themes

Table 12

Cross comparison of participants by superordinate themes

Themes	**Participant Pseudonym**											
	Ash	Hannah	Ellie	Daniel	Zahra	Sophie	Tom	Riley	Laura	Emma	Tess	Grace
Theme 1	X	X	X	X		X	X	X	X	X	X	X
Theme 2	X	X	X		X		X	X	X	X	X	
Theme 3		X	X	X	X	X	X	X	X	X	X	X
Theme 4	X			X	X	X			X	X		X
Theme 5	X	X	X	X		X	X	X		X	X	X

Appendix O - Participant Summary of Findings Sheet

Summary of Findings: Disabled People's Experiences of Acute Mental Healthcare

Thank you again for sharing your time and experiences with me. This summary shares key findings from 12 interviews with Disabled people who have accessed acute mental health services and Disability Advocates. I have grouped these experiences into five main themes reflecting the main issues that affected people's care, safety, and overall wellbeing in acute mental health settings.

I would love to hear from you if these findings reflect your experience and what you think needs to change.

Theme 1: Barriers to Access, Inflexibility, and Exclusion

Many services were not designed to meet Disabled people's needs. Common problems included:

- Buildings and bathrooms that were not accessible.
- Restrictions on mobility aids and access to medication.
- Lack of support with personal care or daily tasks.
- Inflexible rules and procedures that didn't adjust for individual needs.

These barriers often led Disabled people to experience harm within services. Some participants felt dehumanised or traumatised through their contact with acute mental healthcare. Others avoided seeking help because they feared more harm or did not think services could meet their needs, especially during mental health crisis.

Some participants shared more affirming experiences of care within services that were open to listening to people's needs and offered flexible/creative solutions. Participants appreciated being acknowledged as a whole person, in which both disability and mental health were understood as interconnected parts of their lived experiences. Some participants reported that leaving NHS services and accessing alternatives (e.g. third sector or private services) enabled them to access inclusive care, including trauma-informed and disability-affirmative practices.

Theme 2: Lack of integrated physical and mental healthcare

Participants often described poor coordination of physical and mental health care, leading to their needs being overlooked or poorly managed in acute settings. Experiences under this theme included:

- Staff lacking knowledge and experience in supporting complex physical needs.
- Poor communication between physical and mental health teams.
- Mental and physical health were treated as separate issues.

Some positive experiences occurred when services worked together, acknowledged the integration of physical and mental health needs, listened to Disabled people's lived expertise, and ensured respectful communication. For example, several participants highlighted experiences where clinicians genuinely asked about physical health issues in the context of acute mental health care and validated their lived experiences.

Theme 3: Silencing and Epistemic Injustice

This theme describes how Disabled people's lived expertise and self-knowledge was often ignored or dismissed by acute mental health services. Epistemic injustice describes when people aren't believed, listened to, or taken seriously because of power imbalances (e.g. between clinicians and service users) and assumptions about aspects of their identity (e.g. disability, race, gender, or class). Key issues included:

- Not being believed about symptoms or needs.
- Sometimes being labelled as “care-seeking” or “drug-seeking.”
- Being treated as less capable due to ableist assumptions.
- Having to advocate for when experiencing acute mental health needs adding to stress/fatigue.
- Sometimes staying quiet or not disclosing information to avoid harm or judgement.

When professionals actively listened to and respected Disabled people's lived experiences, it made participants feel more understood, less isolated, and more positive about their care.

Theme 4: Disability Competence and Professional Avoidance

Many participants felt professionals lacked the necessary understanding of how disability, chronic illness, and mental health interacted. This caused misunderstandings, emotional harm, and sometimes risk to life. Key issues included:

- People often had to explain their conditions repeatedly, even during mental health crises.
- Some clinicians avoided engaging meaningfully with Disabled people because they due to discomfort or a lack of knowledge about disability.

Positive experiences occurred when professionals took time to listen, asked respectful questions, and demonstrated a willingness to learn (e.g. co-creating care plans). This approach to acute mental health care empowered Disabled people and ensured their agency was respected. Several participants suggested that training should be led by Disabled people and their networks.

Theme 5: Discrimination, Intersectionality, and Identity

Some participants shared how ableism in acute mental health settings often combined with other forms of discrimination based on race, gender, or age. Key findings include:

- Ableist assumptions about disability, often led to infantilisation or dismissal.
- Reasonable adjustments were often seen as optional or burdens, rather than necessities.
- Disability and mental health stigma caused people to hide their needs.
- Intersectional discrimination based in biases about race, gender, age, and disability compounded the difficulties people faced.
- Acute mental health services sometimes struggled to address all parts of Disabled people’s identities.

Participants described how services that recognised and respected their multi-layered identities provided more meaningful care. Participants suggested that acute mental health services should be more transparent (e.g. explicitly acknowledging efforts to address ableism), so Disabled people could feel safe and informed before engaging with the system.

We’d Love Your Feedback!

You can share your feedback in any way that works best for you.

Please let us know:

- Do these findings reflect your experience?
- Is anything missing or unclear?
- Are there any other thoughts or reflections you would like to share?