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Barriers to accessing free or low cost talking therapies for disabled people in Gloucestershire

A report by
Inclusion Gloucestershire
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Contents

Executive Summary

In our Big Survey 2022 (Inclusion Gloucestershire 2022), many disabled people reported barriers to accessing appropriate or accessible support for lower level mental health concerns. Our Big Survey, along with other research identifies that disabled people are disproportionately impacted by poor mental health and wellbeing (Longhurst & Full, 2023, Chinn et al., 2014; Baou et al., 2023). This research study was conducted to look further into the barriers that disabled people in Gloucestershire face in accessing talking therapies that are either free or low cost.

This was a co-produced, emancipatory research study conducted by disabled people with lived experience of accessing talking therapy services. Semi structured interviews were conducted with 14 disabled people aged over 18 who had accessed or attempted to access talking therapy support in Gloucestershire within the past 5 years.

The findings identify the barriers participants experienced under the following three themes:

'Providing reasonable adjustments',

This reveals how not receiving or being offered reasonable adjustments can create a barrier for accessing therapy and getting the most benefit from it, due to lack of understanding and accessibility. Key examples of this include:

- Not being asked about reasonable adjustments
- Lack of physical access for wheelchair users
- Being refused reasonable adjustments
- Refusal to provide different methods of delivering therapy (group/face to face etc) or different types of therapy
- Therapists not experienced or qualified to work with someone with their disability
- Being refused a service due to an (inactive) serious mental illness

‘Treating disability as important in therapy’

This looks at how disability was often not addressed, was forgotten about or not given any significance during therapy despite participants foregrounding their diagnosis and the relevance it has in their lives. Key examples of this include:

- Very little or no time spent talking about their disability/reasonable adjustments
- Not sharing disability or reasonable adjustment information with people taking over their therapy
- Therapists forgetting someone had a disability
- Presumptions/limiting beliefs or unrealistic expectations of patients

‘The impact of living with a disability’ explores ways in which day-to-day living with a disability can impact on the likelihood of being able to do certain things, health is constantly fluctuating, and many of these factors may impact whether someone is able to attend a therapy session. Key examples of this include:

- Being penalised or treated as untrustworthy for not being able to attend sessions due to fluctuating conditions
- Being refused therapy due to a lack of stability in their life because of being reliant on carers
- Inability to accommodate transport barriers
- Having a low income meaning that even income related/low cost therapy is unaffordable

On the basis of these findings, the following **recommendations** are made for talking therapy service providers and commissioners:

1. Have a positive and ‘can do’ attitude to providing reasonable adjustments. Let the patient know you want to be able to provide a service that meets their needs.

2. Ask patients about their need for reasonable adjustments before the first appointment and again at the assessment stage. They may be needed in order to attend the first appointment, don’t presume that it is as easy for them to attend appointments like non-disabled people.

3. Assessment processes should include a collaborative exploration around reasonable adjustments with the patient. Don’t rely on the disabled person to always tell you everything you need to know. It would be important

to let patients know what might be expected of them in therapy so they can explain what reasonable adjustments they need to make the most of it e.g. there will be a workbook you need to complete at home, is that something you need support to do? Do you have support? Do you mind the person supporting you knowing about what you write in the workbook as it could be personal?

4. Avoid simply asking patients ‘do you need reasonable adjustments?’. Not everyone is familiar with the term. Ask questions about specific things, for example; are there likely to be any disability or health related reasons that you cannot attend every session? What can we do to make the room/talking therapy sessions accessible for you? If I have to give you any written information, how can I make it accessible/understandable for you?
5. Ensure reasonable adjustments are recorded and shared with anyone providing the service, as a priority. Treat them as a necessary part of providing a service to disabled people, rather than an add on or a preference.
6. Ensure that alternative ways of delivering therapy are possible such as online, in groups, face to face.
7. Do not include appointments missed due to disability or health related reasons in ‘three strikes and you’re out’ rules.
8. Complete a risk assessment with the patient if there is a valid reason to believe there may be a risk in delivering

face to face therapy. Ensure that controls are put in place to minimise any risk that is identified. Don’t refuse to provide a service on the basis of a diagnosis.

9. Ensure there is clarity within services about being able to provide talking therapies to people with a diagnosis of a serious mental illness who are seeking help with lower lever mental health concerns. Can they receive a service if the condition is controlled? Is specialist training really needed for the therapist?
10. Provide clarity to patients about whether a serious mental illness will prevent them from accessing talking therapies and why.
11. Provide clear, accessible information on websites and other promotional material about how your service is accessible to disabled people. This will make them feel reassured about the service they can receive and that they will be welcomed. Information could include; what skills do therapists have to work with people with certain conditions e.g. Autism? What is the physical accessibility of your building like? Will you have conversations about their reasonable adjustments? Will you accommodate their need to rearrange sessions due to disability/health related reasons? Etc
12. Ensure you have options for receiving a referral e.g. phone, paper, email. Only being able to accept referrals one way, such as the website, will mean that this will not be accessible to a number of disabled people. Don’t presume they will have someone to do it for them.

13. Provide information about your service, referral forms and workbooks in alternative formats, for example audio versions and Easy Read.

14. Improve understanding and confidence in providing a service to disabled people. This should include awareness of conditions including Autism, neurodiversity, Dissociative Identity Disorder and ‘invisible’ conditions, disability equality, limiting and ableist beliefs, reasonable adjustments, The Equality Act 2010, trauma and disability and the impact of living with a disability on an individual’s life, mental health and wellbeing. Disabled people themselves are the best source of this information and any training should be user-led by Experts by Experience.

15. Consider changing the language used to describe when disabled individuals cannot complete part of the therapy due to reasonable adjustments not being provided. ‘Not engaging’ places blame with the disabled person.

16. Ensure that flexibility is provided as a reasonable adjustment to disabled patients in order to fit in with a condition or life which is not predictable or controllable.

17. Consider the ability to provide transport bursaries for those who can only use power wheelchair accessible taxis to access your service.

18. Ask disabled patients about the impact of travel barriers on their ability to attend and engage with therapy and provide reasonable adjustments to accommodate this. This could include appointments coinciding with transport availability, options for closer venues or online appointments if transport provides too many challenges.

19. Use a straightforward way to prove eligibility for discounted or low cost therapy. This will relieve some of the administrative burden that disabled people repeatedly face.

20. Commissioners to consider the ability to provide a greater range of options for free talking therapies that are accessible to all disabled people.

21. Commissioners to work with services to improve their accessibility to disabled people in the ways covered in this report, in order to minimise the likelihood of there being no suitable, accessible service for them.

1 Introduction

Talking therapies are a type of treatment that involve talking about your feelings and thoughts with a trained professional, either a counsellor or therapist (NHS, 2025) and are for anyone who is going through a difficult time or who has some mental health problems that they want help with. Talking therapies have been recognised as effective treatment for many mental health problems and having access to these therapies at the right time can be extremely beneficial to the individual and detrimental to those who do not (Mind, 2013).

Disabled people have a greater chance of developing mental health problems and are more likely to experience poor mental health and wellbeing compared to non-disabled people (Longhurst & Full, 2023). This has been particularly identified amongst autistic people and people with learning disabilities (Chinn et al., 2014; Baou et al., 2023). People with physical disabilities have been found to face emotional challenges occurring from healthcare factors, stigmatisation and lack of social inclusion (Mental Health Foundation, 2021).

People who are disabled face many health inequalities in their everyday life, including stigma and discrimination, employment, living conditions and less access to community activities; all of these factors can impact on both physical and mental health (WHO, 2023). Coinciding with this they are also likely to face more inequalities when accessing health services, due to there being a lack of knowledge, negative attitudes, inaccessible facilities and lack of information, particularly with therapies and counselling. It is widely recognised that disabled people face barriers to accessing healthcare, with issues including transportation, waiting times and cost of services (Sakellariou & Rotarou, 2017) and whilst there is recognition that there is a problem with accessing mental health support across all disabilities, this is predominantly documented for people with learning disabilities (Ee et al., 2021).

The need for this study arose as a result of Inclusion Gloucestershire's previous research from October 2022, looking into the main concerns and worries of disabled people in Gloucestershire (Inclusion Gloucestershire, 2022). It was identified that many respondents were concerned about accessing support for their mental health and wellbeing. A recurring theme was that the amount of worries and pressures that they faced as disabled people had an impact on their mental health. The key relevant findings found that 57% of respondents reported having a mental health condition either as their primary disability or in addition to their primary disability, and 54% were concerned about accessing support for their mental health and wellbeing. Throughout the study, respondents reported a preference for one-to-one talking therapy over other types of mental health and wellbeing support. However, for some, there were significant barriers to accessing primary and secondary mental health support or felt that there was a complete lack of relevant and appropriate services to meet their needs. These findings highlight the need for further research as this community have increased likelihood of poor mental health and experience great difficulties in accessing services that can support this (Sakellariou & Rotarou, 2017). Equal access to psychological therapies is essential for everyone.

This study aims to identify the free and low cost-talking therapies available in Gloucestershire. It aims to determine the barriers that disabled people in Gloucestershire experience in accessing free or low-cost talking therapies for their mental health and understand ways that we can make accessing therapies easier. By being an inclusive research study which is co-produced by disabled people with lived experience of accessing talking therapies, this study also aims to ensure the voice of disabled people shapes talking therapy service in Gloucestershire. Addressing the research question 'What are the barriers to accessing free or low-cost talking therapies for disabled people in Gloucestershire?'

The method used to identify these barriers and understand them is conducting interviews with disabled people who have accessed or tried to access talking therapies previously. This will provide us valuable insight into the challenges that this group face when attempting to access support for their wellbeing and mental health.

2 Method of data collection

Before recruiting participants, we identified a number of free and low-cost talking therapies available in Gloucestershire, creating a specific criteria for participants to meet to be eligible to take part. The therapies that were included within the study ensured the participant had one-to-one talking therapy where they had the opportunity to build a relationship with the therapist or counsellor, or they had tried to access these services. The service needed to be free or low-cost, for example any fees are income or benefits related. It was important that the support was not provided through specialist services, for example the learning disability team, and that the service was not a crisis or helpline. More services were identified once we started screening and interviewing people.

Participants were recruited through advertisements on social media platforms, including Facebook and Instagram, and shared with our extensive list of contacts (71 contacts from public bodies and VCSE organisations).

The study was promoted a number of times at different partnership boards (Learning Disability, Autism, Mental Health and Wellbeing, and Physical Disability and Sensory Impairment) and at a number of meetings across the county. It was also promoted at the Provider Forum, a meeting for social care service providers and commissioners, and Inclusion Hubs, which are a safe place with different opportunities every week across Gloucestershire, led by disabled people for disabled people. There are 4 inclusion hubs, based in Gloucester, Cheltenham and the Forest of Dean.

Members of Inclusion Gloucestershire's Research Advisory Group also shared information about this study with different pharmacies and community centres. This method was appropriate due to its convenience and ensuring we were reaching the target audience. We continuously shared and promoted the study, adapting promotional materials to different groups.

Data collection was in the form of individual semi-structured interviews. Semi structured interviews allowed the research team to co-produce and prepare the questions prior to the interviews taking place, whilst allowing them to be adapted in relation to the context. The format of the interview invited the participants to talk openly about their experiences, allowing the interviews to be participant led, whilst encouraging two-way communication.

An interview schedule was used in the interviews, which had 11 main questions and prompts within this. The prompts were used to trigger further responses and were useful for exploring more in depth.

An information sheet was given to each participant before the interview, giving participants time to read what the study is about, ask any questions and ensure they wanted to participate. The information sheet also signposted a variety of mental health services and support lines that may be able to provide any necessary support if required after taking part, as it was important to make sure that the participants wellbeing was not affected. Following on from this, they were also given a consent form, participation was voluntary, and consent was gained for each participant. Participants read and signed a consent form before the interview took place confirming their participation in this research and that they met the criteria to take part. This was previously confirmed with an eligibility criteria form prior to the interviews.

This included:

- Being aged 18 or over
- Disabled (This includes people with long-term health conditions, chronic illnesses, sensory impairments, learning disabilities and autistic people)
- Living in Gloucestershire
- Used or attempted to use a free or low-cost talking therapy within the past 5 years in Gloucestershire.

The interviews took place face-to-face in Inclusion Gloucestershire's office or online on Microsoft Teams, this was down to the participants preference. The audio was recorded both on a Dictaphone and via Microsoft Teams, allowing for the interviews to be transcribed at a later date for qualitative analysis. Each interviewee was briefed and reminded that the interview would be recorded. Whilst the topic of this study focuses on the talking therapies service itself, it was anticipated that this may be a sensitive topic for some people. They were able to stop the interview at any point if they felt uncomfortable and had the option to avoid questions.

Following each interview participants were given the opportunity to talk about anything that was discussed or ask any questions, they were then thanked for their involvement and verbally debriefed.

Interviews were subsequently transcribed by a transcriber, with some being automatically transcribed through the Microsoft Teams software and then checked by the Researchers for accuracy. The technique used ensured that the interview was presented in its fullness. Participants remained anonymous with names and personal information being omitted from the interviews. Every practicable measure was in place to ensure confidentiality. All data was stored in safe folder on a password protected laptop, which only the research team had access to.

Semi-structured interviews were the chosen method of data collection, and it was anticipated that interviews would last between 40 minutes and 90 minutes.

Interviews were conducted with 14 disabled people about their experience of talking therapies. Whilst we had hoped to recruit up to 30 participants for this study, the data from these interviews is significant and meaningful, allowing for necessary codes and themes to be identified informing an in-depth analysis.

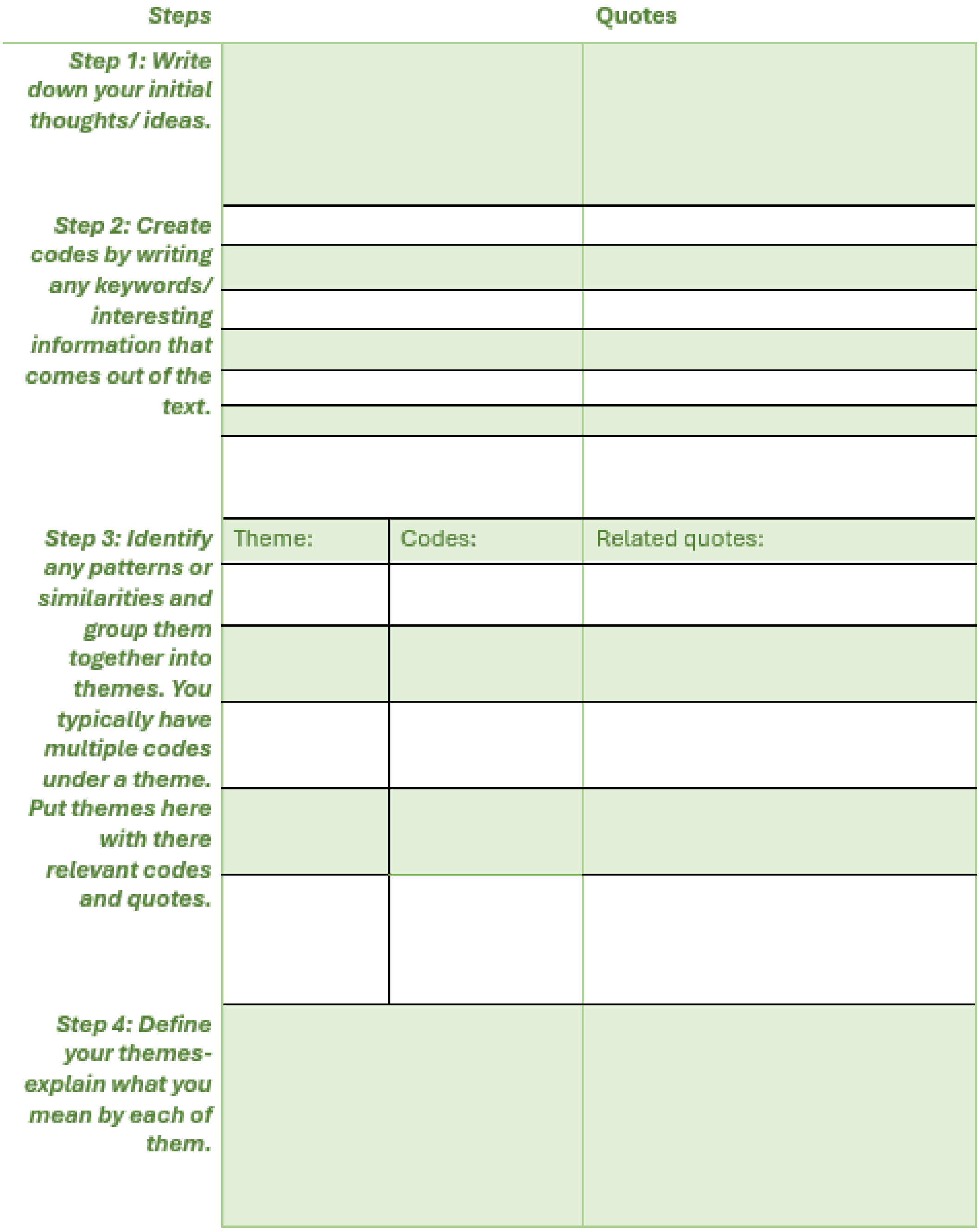
3 Analytical strategy

When approaching the transcription process the transcriber followed and adapted version of Braun and Clarke’s (2013) notation system, this method helped ensure the emotion of the participants was captured.

As a guide for the coding and theming process Braun and Clarke (2006) six steps of thematic analysis were followed. The analytical process commenced with the research team familiarising themselves with the interview transcripts, and after reading the text multiple times, it was then highlighted and annotated developing initial descriptive codes.

After the codes had been written, the process was repeated, and the team began looking for any commonalities that could be themes.

A table was produced to highlight each stage step by step. This table allowed master themes, subthemes and codes to be developed.



Steps			Quotes
Step 1: Write down your initial thoughts/ ideas.			
Step 2: Create codes by writing any keywords/ interesting information that comes out of the text.			
Step 3: Identify any patterns or similarities and group them together into themes. You typically have multiple codes under a theme. Put themes here with there relevant codes and quotes.	Theme:	Codes:	Related quotes:
Step 4: Define your themes- explain what you mean by each of them.			

After a finalised thematic table was created this allowed for the analysis to begin.

4 Co-production

Co-production was an integral feature of this study, with the study taking part in a disabled people's user led organisation, with approximately 80% disabled staff. The team comprised of a Research Manager, Research Coordinator, two Research Experts by Experience and a Transcriber. Four of these staff are disabled people and/or people with mental health conditions with experience of using talking therapies.

A research advisory group made up of disabled people who were not employees of Inclusion Gloucestershire supported the co-production element and provided an alternative perspective. They helped to decide upon the focus for the study and the method. They later assisted with developing and refining the research questions, sharing and promoting the study.

People employed in Expert by Experience roles were involved in all stages of the study design, data collection, analysis and write up.

5 Summary of findings

Scoping

From our scoping of local free or low cost talking therapy services for adults, we identified the following providers:

- The Listening Post
- Gloucestershire Counselling Service
- NHS Talking Therapies (formerly Let's Talk)
- Young Gloucestershire (for up to 25 year olds)
- Talk Well (formerly TIC Teens in Crisis, for up to 25 year olds)
- Cruse (specifically bereavement support)

From navigating the websites of these services we identified that little was specified on any website about accessibility of the service for disabled people and whilst some websites had an accessibility policy or statement, this wasn't always the case. When this information is provided it would be beneficial for this to be written in plain English and have different formats available to ensure everyone can understand. If the initial information isn't accessible, then people may assume that the service is not accessible for them. There was also no mention of physical accessibility of the service.

Some of the talking therapies websites had an accessibility software on their webpage, however, if this is not present this creates a barrier of using the website, and potentially finding out about the service and making a referral. For most services, a referral form is required to be filled out (either online or via a requested paper copy), however, this is often in an inaccessible format with no alternatives suggested. It is essential that these are available in many different formats, including via a screen reader, having easy read versions, braille and large print. It is also important to ensure that any information, documents or external links are fully accessible to screen reader software.

It would also be beneficial to state if staff are trained on how to work with disabled people and implement reasonable adjustments, to let users know that the service is accessible and that they have expertise in this area.

It is essential for all talking therapy services to acknowledge what they have in place and what they can offer in terms of accessibility, even if there is still more work to be done. Having this transparency helps disabled people gain trust with the service and lets them know what is available to them before going through the process.

Interviews

Following the transcription and coding process, three themes were interpreted: ‘Providing reasonable adjustments’, ‘treating disability as important in therapy’, and ‘the impact of living with a disability’, these were identified as the most salient themes in terms of addressing the barriers for accessing talking therapies in Gloucestershire for disabled people.

‘**Providing reasonable adjustments’** explores how not receiving or being offered reasonable adjustments can create a barrier for accessing therapy and getting the most benefit from it, due to lack of understanding and accessibility.

‘Treating disability as important in therapy’ looks at how disability was often not addressed, was forgotten about or not given any significance during therapy despite participants foregrounding their diagnosis and the relevance it has in their lives.

‘The impact of living with a disability’ explores ways in which day-to-day living with a disability can impact on the likelihood of being able to do certain things, health is constantly fluctuating, and many of these factors may impact whether someone is able to attend a therapy session.

The research’s aim was to determine the barriers that disabled people in Gloucestershire experience in accessing free or low-cost talking therapies for their mental health and understand ways that we can make accessing therapies easier and ensure their voices shapes talking therapies in Gloucestershire.

6 Findings

Providing Reasonable Adjustments

Reasonable adjustments are changes that can be made to ensure disabled people are treated equally and not put at a disadvantage. The Equality Act, (2010) states that reasonable steps need to be taken to avoid putting a disabled person at disadvantage by any provision, criterion, practice or physical feature in relation to a relevant matter in comparison with persons who are not disabled. These changes are made by any employers, health services etc. and are a legal requirement to ensure accessibility for all disabled people (Read et al., 2018). Reasonable adjustments can be things like giving easy read or plain English documents/letters, offering longer appointment times to ensure understanding and have a quiet space available for people when waiting for an appointment.

Disabled people are likely to require reasonable adjustments at all stages of accessing talking therapies support. We found that participants were mostly not asked whether they had a disability or were not asked about reasonable adjustments they might need. One person had experiences with a number of different services and none of them asked about their disability before their first appointment:

> *"first few appointments usually, you know, it's just: "I've got no luck because I'm not going to fit in there. Well, let*

> *me squeeze in that tiny gap. Let me reverse in so I can go out easy or whatever" (TT1)*
>
> *"I mean I get to the room and I'm like, "I can't fit". And they're like, "well, what do you want me to do?"" (TT1)*

We heard about some reasonable adjustments being requested, but they were either refused or the service could not provide them. An individual with a hearing impairment could not access the online portal during COVID due to it not having subtitles. When they were later able to attend in person appointments they were told that the therapist was not allowed to use a clear mask.

Participants also required reasonable adjustments to the mode of therapy delivered due to their disability, for example one person required video or face to face appointments to allow them to process body language fully and to aid communication and another required face to face, group therapy but they were not given an option for this.

Other participants required reasonable adjustments in the way the therapy was delivered. One person was unable to complete a workbook without support, but the therapy was not adapted to take this into account, instead they were recorded as having refused to engage. Other participants mentioned requiring more time due to memory issues, zoning out as a result of amnesia and switching or needing more time to understand and process information. None of these disability requirements were made despite individuals requesting adaptations to the way the service was provided to them. For someone with Dissociative Identity Disorder (DID) who is experiencing dissociative states during the session then this needs to be accommodated with reasonable adjustments.

A participant explained that it was quite usual for there not to be a space big enough to accommodate their power wheelchair and this led to having to squeeze into spaces or the therapist needing to take time to rearrange furniture at each appointment. Another participant said:

> *“For the initial assessment and the first session, it was at a community centre, and the only difficulty was the room was a bit small to get my wheelchair in. More of a cupboard than a room, but we managed by rearranging the furniture” (TT2)*

We heard from some participants that they were not able to receive a service or the same standard of service that everyone else does due to their diagnosis. One individual was told they could not access group therapy or other face to face therapy because they had a diagnosis of psychosis. They shared with the service that their psychosis was under control, and they were seeking support specifically for a bereavement but the service’s refusal to work with them face to face left them feeling discriminated and like they were less of a person.

> *“It's not the type of counselling that is a problem...it's this thing about mad axe people, psychosis. Can't do it*

> *because of that. We're not trained. Well, I would say to that: get yourself trained" (TT6)*
>
> *"Because I wanted to see them face-to-face, and they can't do it because of my psychosis. So, they must think we're axe-murderers or something. And it's all this discrimination. I call it discrimination because just because you've got psychosis, doesn't mean to say you're less of a person." (TT6)*

Another participant was refused a service as they were told that no therapists were available to work with their diagnoses of autism and trauma. Yet another participant was told their therapist was not trained to work with people with their diagnosis of schizophrenia. Like before, this individual's condition was under control and they were seeking support for their wellbeing not for an issue relating to or affected by their schizophrenia diagnosis.

Amongst the participants there was a disparity in whether or not someone with a serious mental illness was able to access talking therapies. One individual was able to access talking therapies but was not granted reasonable adjustments that would make accessing the therapy effective for them. Another was *only* able to access therapy via the phone due to unfounded safety concerns and another was not able to access any therapy due to their diagnosis. In addition, these participants had also not been able to access secondary mental health services at this time either due to their condition not being considered serious enough to be eligible, or because they were seeking support with lower level mental health conditions and their serious mental health condition (which may have made them eligible for their support) was under control. This resulted in these participants receiving an inaccessible or less effective service than non disabled people, or not receiving a service at all. Services being unable or unwilling to provide reasonable adjustments to individuals with serious mental illness leaves them at risk of worsening mental health.

Falling through the gap

Participants found it so difficult to access a service that met their needs, that they were either left with no suitable service or gave up trying. The criteria outlined for people to access talking therapies isn't always clear, meaning disabled people are 'falling through the gap' in services and not receiving the necessary support that they need due to not knowing whether the service is suitable for them. Delays in treatment can intensify pre-existing mental and physical symptoms, therefore delaying this support can cause unnecessary harm (Punton et al., 2022).

People told us that they feel like they are not receiving any support as they are not meeting the criteria for any service:

> *"secondary care are refusing to see me because apparently I don't fit the criteria because they keep changing the criteria, or so I'm told. So I go, you know, and I've I've said so many times, I feel like that little ball*

> *in the game of Pong and I'm getting batted between services too severe, not severe enough. You need this. You need that” (TT8)*

If people are unable to access the service that is offered due to not meeting the criteria, then there’s an automatic assumption that they can go somewhere else to seek support, however there are limited accessible and suitable options available.

> *“if I feel suicidal, I'm too high risk and if I'm not suicidal then I'm too low a risk. I can't seem to, you know, whichever I say to them, I'm not getting any support at all.” (TT8)*
>
> *“And I rang them, and they did the standard depression test. And the lady came back and said, “well, you're not depressed enough to get on our list”” (TT2)*

It is evidenced that people are not receiving any support despite how high risk or low risk they are, feeling like whatever they say they will not be able to receive help. It is important to recognise that there are limited therapy options available for disabled people, and as previously identified, it is difficult to identify what services are suitable especially when there is little information advertised around accessibility.

For some, after being refused by a service due to not meeting the criteria no other therapies were signposted or suggested. Another participant experienced this and wasn’t aware of any services available:

> *“in terms of just general accessibility… knowing about the service, I didn't know [service] had counsellors… I didn't know they provided the counselling service as well. So, from that point of view, had I known they had this service, I'd have, you know, been in touch with them straight away. But it was only the fact I broke down at this event that, you know, triggered the process.” (TT2)*

> *“they said that I couldn't do it because my home life was very chaotic and it's not reasonable to be unpacking a lot of stressful and stressing things when your home life is very chaotic. However, I am somebody who needs 24-hour care from people that call in sick, they go on leave…. they told me to come back when my care life was more stable. It’s not going to get more stable. So, they sent me on my way: no other options” (TT1)*

This refusal has made some people lose faith and trust in these services and has discouraged them from seeking future help:

> *“Why am I reaching out to a service that doesn't care?...why am I going to agree to sitting and talking with somebody for six weeks at an hour a week because either I've got to figure out how I'm going to get there again, but I've also got to figure out well, what am I actually going to tell this person” (TT8)*

People are also questioning the authenticity of potential new services that are signposted, having concerns around qualifications and if they are experienced enough to work with them and meet their needs. This lack of trust is a barrier in accessing talking therapies as there is little information advertised about these services and how accessible they are for someone with a disability.

> *"They said, "we can't give you the group therapy because we don't think you're in the right frame of mind. Here's a list of four organisations". And at that point, mentally, I wasn't in a good place... and I thought I don't know if these people are trained to deal with my needs. I don't know if these people have just had a one-day, two-day access course into mental health. I don't know what their qualifications going to be. Nobody explained to me what this organisation does. What this or what that organisation does. These would be the most useful for me near you." (TT1)*

When exploring different talking therapies websites, it was identified that there was often no mention of disabilities or accessibility, therefore if you are not explicit about what you can offer then people will presume that you can't support them (see 'Scoping' above). Through having a statement on equality can help build this trust that has often been lost, as evidenced above.

Treating disability as important in therapy

We found that there was often not enough time given to understanding the participants disability and how this might impact receiving therapy. This manifested in information not being passed on to therapists about their disability and therapists forgetting about their disability. This ultimately resulted in reasonable adjustments not being provided.

One participant told us that they had shared a lot about their disability in an assessment meeting, but that none of this was shared with their therapist meaning that they didn’t have important information about how to work with them.

> *“they hadn't got my notes, so all of that preparation that the [service] did was lost....It was just like they didn't have my diagnosis; they didn't have my notes; they didn't have the pre assessment, and it just broke down in communication at that point. So not accessible” (TT5)*

> *“Massively. I thought that they hadn't acknowledged that I had this diagnosis and disability and that they just weren't aware of it, and I didn't know that they weren't aware of it until the last session, when he said, “I didn't know you had that”. He's like, it's invisible, isn't it?” (TT5)*

They went on to say that the therapist then appeared to have forgotten about their disability so there were no reasonable adjustments made. One result of this was that the therapists expectations of their ability to do things outside of the sessions were inaccurate:

> *“There's one point where he referred to something during the therapy and I didn't know what he was talking about. And he told me to download something, but I downloaded the wrong thing because he hadn't given me the exact link. So, I downloaded the wrong thing” (TT5)*

We found that when an individual’s disability isn’t explored adequately, it can lead to presumptions or limiting beliefs impacting on the service provided. For example, a participant was refused group therapy due to their hearing impairment. The therapist presumed it wouldn’t work without consulting with the participant. Another participant experienced their therapist having limiting beliefs about their intellectual ability to take part in therapy due to the level of their physical disability.

> *“But the problem is the real bad thing is, ... but sometimes they go “oh they’re physically disabled so what are they gonna do?” (TT4)*

The impact of living with a disability

We heard from participants that services were often inflexible in the way in which they operated and were unable to accommodate the additional challenges that disabled people face in their day to day lives. These challenges meant that they could not fit within service’s expectation of regularly attending a limited number of sessions or completing work outside of sessions. At times, therapists appeared to not believe the participants experience of living with their condition, treating them as untrustworthy and refusing to engage with the therapy process. Limited and expensive transport options made attending sessions impossible or extremely stressful, and a low income impacted their ability to pay for private therapy. The inability or refusal to accommodate these challenges resulted in participants being refused a service, only being able to access a reduced number of sessions, being labelled as ‘not engaging’ or having no accessible or affordable options available.

Fluctuating Health

Participants were aware that their conditions would impact on their ability to attend therapy appointments;

> *“..mental health and physical health are very linked. I know that if I'm mentally struggling, my physical health declines and I hate having to be the one to phone up and say I'm sorry I can't make my appointment” (TT8)*

Many told us about times they missed appointments due to temporary flare ups of their condition or longer term health issues, but the service did not give them the opportunity to make up lost sessions and recorded this as ‘failure to attend’;

> “*I've missed out on appointments where I've been poorly” (TT9)*

> *“what I struggle with is like... It's energy levels. So, there were some times I would have to cancel sessions.” (TT10)*

> *“I'm on that countdown, well, they're going to class that as session one, so that's the window and what if session four comes along and I can't do that either but I've lost two out of my six sessions now because they haven't been willing to make any compromises.” (TT8)*

One individual told us about having a negative reaction from their therapist because of missing a session and having to prove that their invisible disability was genuine:

> *“It's ridiculous I've been told, “oh, you're not engaging”. It's because I can't physically get there, or I get migraines. Sometimes, when I get a migraine, I can't see, so I can't travel... it's like you have to kind of prove that “oh, no, I do have this issue as well” and I'm sure might be different if I was like maybe wheelchair bound or something but,... I think there is the issue with them believing that you're just making an excuse ... you're not seen as like a trustworthy source.” (TT3)*

As a result of having to wait months to access talking therapies, one participant found that an operation date coincided with the start of therapy. As they could not postpone the operation they were discharged from the talking therapy service and told they would have to go back to their GP if they wanted to access the service again, delaying their access by a number of months. At another point in time, the service also struggled to find an appropriate way to provide therapy to this individual. Their standard therapy would involve changing limiting beliefs into positive ones which reflect that this person was now safe from historical harm. However, this participant's disability results in a real risk of ill health or death. The therapist felt it was morally wrong to continue with therapy along these lines and agreed to come back to the individual with an alternative plan but this never happened. Disabled people have more complex health issues than the general population (Krahn et al., 2015) and talking therapies needs to be able to accommodate the lived reality of this.

Requiring support from others outside of therapy

Disabled people often require support from other people to complete everyday tasks such as making and attending appointments, reading and understanding information and filling in forms (Terras et al., 2021). However, we found that a participant was labelled as not engaging in therapy because they weren't able to complete a workbook they were given for homework between sessions. Due to the nature of their disability, they require support from another person to understand the language used in the workbook and to physically record their answers. The only people available in their life to do this were paid carers, who they did not feel comfortable sharing the answers to the workbook questions with. Despite communicating this to the therapist and requesting that they take a different approach, they refused and said that they were not engaging with the therapy.

> *“they could have been a bit more understanding as to why I didn't wanna do the book ...sometimes I think people think you're just being... ‘Oh, I can't be bothered’ and actually, that's not the case.” (TT4)*

Disabled people’s living and support circumstances can take many formats, and if someone relies upon a team of carers in order to be washed, dressed and transported to attend appointments they are likely to experience times when they cannot attend due to carers absence or transport difficulties. This is something that it is very difficult to have any control over or to mitigate for as every aspect of their life may need to be planned in order for an appointment to take place. One carer’s absence or a taxi driver cancelling can mean that an appointment does not happen.

One participant was refused a service as their support situation was often chaotic in the ways described above and they were told to come back when there was stability in their life.

> *“they said that I couldn't do it (attend therapy) because my home life was very chaotic. However, I am*

> *somebody who needs 24-hour care from people that call in sick, they go on leave….they told me to come back when my care life was more stable. It's not going to get more stable. So, they sent me on my way: no other options". (TT1)*

As this participant describes, when someone requires a significant level of support to live their life, there will never be the type of stability that a non-disabled person experiences.

Transport barriers

One significant way in that disabled people's ability to access therapy can be affected is through transport. The barriers disabled people face in this area are significant and can impact on their ability to get to appointments, to do so consistently and to afford to get there.

An individual told us that they had to spend a considerable time during their assessment very strongly advocating for having therapy on the phone or online. However, the assessor wasn't aware how prohibitively expensive a wheelchair accessible taxi is, how scarce they are and that this was this individual's only option for travel.

"…sometimes getting a disabled taxi is really not an option…" (TT4)

There are very limited options for power wheelchair accessible taxis, and they are often booked up for school travel. From our experience as an organisation, booking wheelchair accessible taxis for a return journey of 15 minutes can cost up to £80.

When an individual's only option is public transport, getting to talking therapy services can provide an additional physical and emotional burden. People told us about extremely long journeys, having to travel most of the day to get to and from their appointment, meaning the process of attending therapy added to their physical symptoms;

> *"...sometimes I'll be leaving in the dark... the whole day was taken up by mental health." (TT7)*
>
> *"It would have been at least one bus, possibly two buses, depending on where it was held... on two occasions, once at [service] and once at [service], I actually ran out in tears because I was told that they couldn't help me, so I felt like I'd travelled all that distance, they could've written me a letter or phoned me and I could have had that distress at home." (TT8)*

By not taking into consideration the physical effects it may have on a disabled person, merely to get to an appointment, let alone to engage during it, demonstrates the very barriers that disabled people are facing at every turn.

Living on a low income

Another area that can disproportionally impact disabled people is having a low income (Pu & Syu, 2023). A number of participants were told about alternative services they could use instead of, or whilst waiting to access their preferred service. These services were shared on the basis of being low cost and available on a much longer-term basis. However, we heard a number of times that this was still unaffordable due to living on a very tight income.

> *“the other thing I keep finding is that all the therapies offered are just short term… it is hard to find someone who will offer longer courses of therapy without having to pay… essentially it all comes down to money and whether you have the financial means to access appropriate mental healthcare at the end of the day” (TT8)*
>
> *‘Oh, there is other services we could recommend but for a lot of them, you would have to pay money”. (TT4)*
>
> *“he said, ‘oh, there's schemes where they can help you out if, like, you're a low earner’, or something like that. And I said, I still can't afford it.” (TT3)*

When alternative services are suggested that are income related or low-cost then this is not always an option as there can be the burden of having to explain your income to the service. One participant told us that they gave up accessing income related therapy as in their experience the process of proving your income and benefits required time and energy they don’t have, in addition to being a demoralising process to go through. For some people, low-cost services are not an option due to not having spare money for this. Disability benefits are often not sufficient enough to cover additional costs that are associated with having a disability, which services don’t always consider or recognise.

> *“They need sorting. It's not fair. So, why don’t they get training on these things? Then we could have therapy. I was advised to go to [service]; we have to pay for that” (TT6)*

The reality of living on a very low income is that even low cost alternatives were not accessible to participants.

7 Reflection

It is important when doing research to reflect on our own influences and how our position may have impacted the interpretation and analysis of the data, particularly the challenge of being close to the subject matter. Whilst it is imperative to recognise that it is impossible for the researchers to not have been moulded by their own experiences, beliefs and social backgrounds, it is also vital that necessary steps have been taken to reduce this potential bias.

We addressed this by using open ended research questions, giving participants the opportunity to say what they wanted to say and lead the interview process. We used proven analysis techniques to determine any themes and patterns within the data, not relying on our own assumptions. Positive experiences were also taken into account to avoid any confirmation bias. We also attempted to recruit participants from a diverse range of backgrounds.

Between the research team there are different skills and experiences; the Project Manager and Coordinator both have research skills, and the Project Manager and Experts by Experience (EBE) have lived experience of disability and of receiving support from talking therapy services. Two of the EBEs also took part in the study as participants, as the team felt that their experiences were too impactful to not be included. There is precedence for researchers also being participants in their studies and evidence of its potential to increase quality of user led research (Probst, 2016; Kirkman, 1999). However, it was important to be transparent about the coproduction process and any biases that occurred as a result of this.

One of our experts by experience have shared how they tried to avoid and acknowledge their own bias:

“In undertaking this study, it is important to acknowledge a potential bias that may have influenced my approach and interpretation of the research. My own personal experience of talking therapies - specifically, a negative one - may have influenced how I engaged with participants and interpreted their responses. This lived experience brings valuable insight and empathy, but it also introduces the possibility of projection or selective attention to experiences that echo my own. I have sought to mitigate this by engaging in reflective practice throughout the study, actively considering how my views may impact the research process and outcomes, and by maintaining transparency in data analysis. By acknowledging this potential source of bias, I aim to enhance the trustworthiness of the study and remain open to a wide range of perspectives and experiences within the research”

Whilst being aware of any influence our lived experience might have brought to this study, it is also important to acknowledge the significant benefits it brings. User led research is acknowledged for providing a unique and rich understanding of data and for redressing power imbalances so control is “in the hands of the researched not the researcher” (Oliver, 1997). Our perspective on what participants told us in interviews is not impacted upon by the boundaries or limitations that service providers have to work within. Instead it is influenced by the values of our employer (Inclusion Gloucestershire, 2025), by disability equality law, dismantling ableism and an aim to improve life outcomes for disabled people.

8 Recommendations for practice

Taking into account the findings from this study, we have made the following recommendations for practice for both providers and commissioners of talking therapy services. These relate directly to the experience of participants in this study:

1. Have a positive and ‘can do’ attitude to providing reasonable adjustments. Let the patient know you want to be able to provide a service that meets their needs.
2. Ask patients about their need for reasonable adjustments before the first appointment and again at the assessment stage. They may be needed in order to attend the first appointment, don’t presume that it is as easy for them to attend appointments like non-disabled people.
3. Assessment processes should include a collaborative exploration around reasonable adjustments with the patient. Don’t rely on the disabled person to always tell you everything you need to know. It would be important to let patients know what might be expected of them in therapy so they can explain what reasonable adjustments they need to make the most of it e.g. there will be a workbook you need to complete at home, is that something you need support to do? Do you have

support? Do you mind the person supporting you knowing about what you write in the workbook as it could be personal?

4. Avoid simply asking patients ‘do you need reasonable adjustments?’. Not everyone is familiar with the term. Ask questions about specific things, for example; are there likely to be any disability or health related reasons that you cannot attend every session? What can we do to make the room/talking therapy sessions accessible for you? If I have to give you any written information, how can I make it accessible/understandable for you?
5. Ensure reasonable adjustments are recorded and shared with anyone providing the service, as a priority. Treat them as a necessary part of providing a service to disabled people, rather than an add on or a preference.
6. Ensure that alternative ways of delivering therapy are possible such as online, in groups, face to face.
7. Do not include appointments missed due to disability or health related reasons in ‘three strikes and you’re out’ rules.
8. Complete a risk assessment with the patient if there is a valid reason to believe there may be a risk in delivering face to face therapy. Ensure that controls are put in place to minimise any risk that is identified. Don’t refuse to provide a service on the basis of a diagnosis.
9. Ensure there is clarity within services about being able to provide talking therapies to people with a diagnosis

of a serious mental illness who are seeking help with lower lever mental health concerns. Can they receive a service if the condition is controlled? Is specialist training really needed for the therapist?

10. Provide clarity to patients about whether a serious mental illness will prevent them from accessing talking therapies and why.

11. Provide clear, accessible information on websites and other promotional material about how your service is accessible to disabled people. This will make them feel reassured about the service they can receive and that they will be welcomed. Information could include; what skills do therapists have to work with people with certain conditions e.g. Autism? What is the physical accessibility of your building like? Will you have conversations about their reasonable adjustments? Will you accommodate their need to rearrange sessions due to disability/health related reasons? Etc

12. Ensure you have options for receiving a referral e.g. phone, paper, email. Only being able to accept referrals one way, such as the website, will mean that this will not be accessible to a number of disabled people. Don’t presume they will have someone to do it for them.

13. Provide information about your service, referral forms and workbooks in alternative formats, for example audio versions and Easy Read.

14. Improve understanding and confidence in providing a service to disabled people. This should include awareness of conditions including Autism, neurodiversity, Dissociative Identity Disorder and ‘invisible’ conditions, disability equality, limiting and ableist beliefs, reasonable adjustments, The Equality Act 2010, trauma and disability and the impact of living with a disability on an individual’s life, mental health and wellbeing. Disabled people themselves are the best source of this information and any training should be user-led by Experts by Experience.

15. Consider changing the language used to describe when disabled individuals cannot complete part of the therapy due to reasonable adjustments not being provided. ‘Not engaging’ places blame with the disabled person.

16. Ensure that flexibility is provided as a reasonable adjustment to disabled patients in order to fit in with a condition or life which is not predictable or controllable.

17. Consider the ability to provide transport bursaries for those who can only use power wheelchair accessible taxis to access your service.

18. Ask disabled patients about the impact of travel barriers on their ability to attend and engage with therapy and provide reasonable adjustments to accommodate this. This could include appointments coinciding with transport availability, options for closer

venues or online appointments if transport provides too many challenges.

19. Use a straightforward way to prove eligibility for discounted or low cost therapy. This will relieve some of the administrative burden that disabled people repeatedly face.

20. Commissioners to consider the ability to provide a greater range of options for free talking therapies that are accessible to all disabled people.

21. Commissioners to work with services to improve their accessibility to disabled people in the ways covered in this report, in order to minimise the likelihood of there being no suitable, accessible service for them.

9 Conclusion

This study explored a number of barriers for disabled people in accessing talking therapies. The main barriers identified were a lack of reasonable adjustments being provided when receiving therapy, disability not being treated as important in therapy, when the impact of living with a disability is not understood or recognised and people with disabilities falling through the gap in services available. It was identified that these barriers had a significant impact on the participants and their attitudes towards talking therapies and mental health support, finding it difficult to access and feeling as though they are not treated the same, discouraging them from going through this process despite needing help.

It was identified for some people that when they received talking therapy support that was accessible to them it was very helpful and beneficial in helping their mental health and being able to somewhat manage this independently when the sessions ended. However, when accessibility was not considered throughout the process it was difficult for people to engage appropriately and receive these benefits, as the difficulty of getting to the sessions, completing assigned homework and other factors impacted this. In multiple cases a lack of understanding and acknowledgement of someone’s disability was detrimental to receiving support.

The strengths of this study include collecting data that was representative of a range of disabilities, including autism, sensory impairment, chronic illness, physical impairment, neurological condition and mental health conditions. Reaching lots of different disabilities helps us identify if barriers are prevalent for all disabled people and to what extent.

The co-production throughout the entire process was very valuable, with experts by experience being involved at every stage, including the designing of interview questions, conducting the interviews, transcribing the interviews, analysing the data and making recommendations. This was a strength because it ensured that there was understanding of people’s lived experiences and a sense of relatability which ensured trust was built and helped create in-depth, meaningful interviews. This study fulfils the criteria of being emancipatory disability research. That is, research designed, undertaken, analysed and disseminated by disabled people, about disabled people (Barnes and Mercer, 1997).

The limitations include not meeting the number of participants as initially planned. In future studies it would be useful to consider more ways of going out into the community to reach more people with disabilities, whilst this was actioned to some extent there we were unable to recruit/reach people with learning disabilities and a visual impairment, despite promoting it in these areas.

The recommendations that we have made aim to remove ableist barriers within services that prioritise meeting the needs of non-disabled patients, whilst treating disabled patients as untrustworthy, disengaged and problematic. When disabled people’s access needs in talking therapies are not understood or accommodated we have seen from this study that it creates a mutual lack of trust between patients and services. This ultimately prevents access to support for mental health and wellbeing that non-disabled people can rely on.

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Appendix A: Participant Information

Title: Disabled people's experience of free or low cost talking therapies in Gloucestershire

We would like you to take part in this study by Inclusion Gloucestershire. Before you decide if you want to take part, it is important you understand why it is being done and what it will involve. Please read this information carefully and if you have any questions contact:

Harriet Roberts Research Coordinator at harrietr@inclusion-glos.org

What is the aim of the research?

We are doing this research because we found that a lot of disabled people in Gloucestershire have poor mental health, but talking therapies were not accessible to them.

We want to find out what the barriers are to disabled people using free or low-cost talking therapies.

To help us find this out we will be doing interviews with disabled people who have accessed or tried to access these services.

The results of this study will be made anonymous, analysed and put into a report and video on the Inclusion Gloucestershire website. They will be shared with people who have the power to make changes in talking therapy services.

Who can take part in the research?

You can take part in this research if you:

- Are over 18
- Are living in Gloucestershire
- Have accessed or tried to access free or low-cost talking therapies in Gloucestershire within the last 5 years.
- Are disabled as per the definition in the Equality Act 2010 that is, you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. This will include people who have visual impairments, hearing impairments, learning disabilities, autism, physical impairments, chronic illness, long term health conditions etc. If you are not sure if your condition meets this definition then get in touch on the details above.

Do I have to take part?

You do not have to take part; it is up to you to decide whether to take part or not. You can decide to withdraw your consent at any point.

If you decide to take part, you will be given a copy of this information form and asked to sign a consent form.

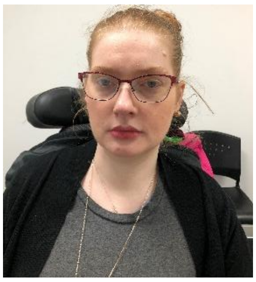
What will happen if I take part?

If you take part, we will first make contact with you in your chosen way to confirm you meet the eligibility criteria.

Then you will be asked to read the information form and sign a consent form.

We will arrange to complete an interview with you at a time and place that suits you. This could be in person, online or on the phone. The interview will need to be in a place where we can maintain confidentiality.

The interview will be conducted by one of the research team at Inclusion Gloucestershire.



Your interview will be recorded in a way that you choose. In person interviews will be audio recorded, online interviews can be audio or video recordings, and phone interviews will be audio recorded.

What might be the benefits to me of taking part?

There is unlikely to be much personal benefit to taking part. However, it is possible that you may feel some relief at telling your story.

You will be contributing to a study which will aim to show the barriers there are for disabled people using talking therapies and which may have some impact on the accessibility of talking therapies in the county.

What might be the risks to me of taking part?

We do not anticipate or foresee any significant risk to you in taking part in this study. We will take all possible steps to anonymise your data however, it is possible that someone who knows your situation well may be able to identify you from our report.

It may be difficult for you to talk about your experience if it was frustrating or distressing in any way, however the interview schedule has been designed with this in mind and the research team are sensitive to these issues.

What will happen to my information?

All of your information will be kept in the strictest confidence. Your details will be kept separate from your interview recording which will be anonymised once saved. Any recordings will be deleted permanently once an anonymous transcription has been made. Any personal or identifying details will be anonymised.

How will you keep my details private?

Your details will be kept separate from your interview transcript in a password protected file on a password protected computer, on a drive only able to be accessed by Inclusion Gloucestershire staff.

Where will the results be published?

A report will be written with our findings. An Easy Read version of the report will be produced as will an accessible summary video. These will be published on the Inclusion Gloucestershire website www.inclusiongloucestershire.org and via our social media pages. The findings will be shared in meetings across the county with people in positions of influence who can make the changes that the study shows need to be made.

A copy of the report will be made available to all participants if they choose.

What if something goes wrong or I have any questions?

In the first instance, use the contact details above. However, if you wish to pursue the matter further, please contact Debbie Worrall, Research Manager at debbiew@inclusion-glos.org.

If you would like to talk to someone about your mental health after doing this research, then here are some services that could help:

Advocacy and Mentoring Support, at Inclusion Gloucestershire

Email: advocacy@inclusion-glos.org

Phone: 01452 234003

Connect and Offload- CandO Mental Wellbeing Helpline

Phone: 0808 801 0606

Text: 07537 410 022

Webchat: gloucestershirecando.org

Email: cando@rethink.org

The Cavern- Listening support and low-level interventions such as board games and inclusive activities

Address:

56 Westgate Street,

Gloucester,

GL1 2NF

If you want to complain about your experience of talking therapies, you can contact the British Association for Counselling and Psychotherapy:

https://www.bacp.co.uk/about-therapy/get-help-with-counselling-concerns-service/

Phone: 01455 883300

Email: gethlep@bacp.co.uk

‘Barriers to disabled people using free or low-cost talking therapies in Gloucestershire’

Consent to take part in research

Please tick yes/no	**Yes**	**No**
I have read and understand the participant information sheet OR the study has been fully explained to me		
I have been given the chance to ask questions about the study		
I agree to take part. I understand that taking part will include being interviewed and the interview being recorded.		
I understand that taking part is voluntary and I can withdraw from the study at any time. I do not have to give a reason for withdrawing and there will be no consequences for doing so.		
I understand that my details will not be revealed to anyone outside the study		
I understand that my words may be quoted in the reports or video and shared online, on social media or in meetings but I will not be personally quoted.		
I understand and agree that my data may be used by Inclusion Gloucestershire in future research studies.		
I give permission for my interview data to be securely stored so it can be used by Inclusion Gloucestershire for future research studies.		

Name of participant printed Signature Date

Name of researcher printed Signature Da

Appendix B: Research Information

‘Disabled people’s experience of free or low cost talking therapies in Gloucestershire’

We would like you to take part in this research.

It is important to read this leaflet so you can understand why we are doing it and what you will have to do.

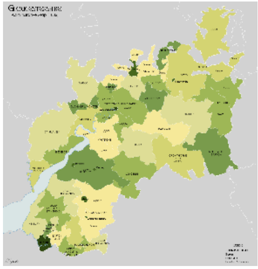
Why are we doing this research?

We are doing it because we found out that disabled people find it hard to use talking therapies.

We want to find out why so we can tell these services how to change.

Who can take part?

Anyone who is over 18



Lives in Gloucestershire

Has used or tried to use free or cheap talking therapies in the last 5 years.

Is disabled.

Do I have to take part?

You do not have to take part; it is up to you.

You can stop taking part even if you agree to start with.

What will happen if I take part?

You will have to sign a consent form to say you agree to take part.

We will do an interview with you in person, online or on the phone.

We will record the interview so we can listen to it after we meet you.

We will give you a £25 voucher after you have done the interview.

Why should I take part?

You will help us to understand the things that are barriers to disabled people using talking therapies.

You might like telling us your story.

Are there any risks?

Someone might be able to recognise you from your story when we write about it.

You might find it hard to talk about using talking therapies.

What will happen with my information?

We will delete your interview recording once we have written it down.

We will keep your details on our computer and database in a password protected file.

We will change your name and anything else in your story that could let people know who you are.

What will happen with the research?

We will write a report and make a video to share online and in meetings.

You can have a copy if you would like one.

If you would like to talk to anyone about your mental health after doing this research, then here are some services that could help:

Advocacy and Mentoring Support, at Inclusion Gloucestershire

Email: advocacy@inclusion-glos.org

Phone: 01452 23400

Connect and Offload- CandO Mental Wellbeing Helpline

Phone: 0808 801 0606

Text: 07537 410 022

Webchat: gloucestershirecando.org

Email: cando@rethink.org

The Cavern- Listening support and low-level interventions such as board games and inclusive activities

Address:

56 Westgate Street,

Gloucester,

GL1 2NF

If you want to complain about your experience of talking therapies, you can contact the British Association for Counselling and Psychotherapy:

https://www.bacp.co.uk/about-therapy/get-help-with-counselling-concerns-service/

Phone: 01455 883300

Email: gethlep@bacp.co.uk

Consent to take part in research

✓ Tick yes or no	Yes	No
 I have read and understood the information sheet, or someone has explained it to me and I understand.		
 I have been able to ask questions about the research.		
 I understand that taking part means I will do an interview, and it will be recorded.		
 I understand that I do not have to take part, and I can stop taking part at any time.		
 I understand that my details will not be shared with anyone outside of the research team.		

	I understand that my words may be written in the report or on the video and shared with other people.		
	I allow Inclusion Gloucestershire to safely store my interview on a laptop to use in more research in the future.		

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

Date:

Who should I contact if anything goes wrong?

First contact: Harriet Roberts
Research Coordinator

research@inclusion-glos.org

07517994765

Then if you need to speak to someone else, contact Debbie Worrall.

research@inclusion-glos.org

01452 234003

Appendix C: Interview Questions

1. **How did you first go about getting help for your mental health?**

2. **What help did you want? / Did you know what help you wanted?**

3. **Did your GP refer you or did you seek further help yourself?**
   - If your GP referred you to (…), did you face any problems with getting the help that you wanted?

   - How did you find this process?

4. **Can you tell us about how the service contacted you?**

If they didn't contact you- **'How did you contact them?'**

- Did they ring, send a letter?
- Was this easy to understand?

5. **Can you tell us about the first appointment you had with someone from the service?**

- Where was it?
- How easy was it for you to get there?
- Could you have someone with you if you wanted?
- Did you understand what you talked about in the appointment?
- What happened in the appointment?
- Did you feel comfortable speaking to the person?
- Did you have a choice of who you spoke to?'

6. **What happened after the first appointment?**

- Were you sent a letter or contacted by phone about what will happen next?
- 'Was this discussed at the first appointment?'
- How long was it before you began treatment?

- If you had a long wait did, they offer any support or advice if things got difficult for you in the meantime?

If not been able to access the service:

- If you started treatment, what lead you to stop having the treatment?
- Did you need any more treatment?
- What would have made you carry on having the treatment?

7. **Can you tell us what the treatment was like for you?**

- Was there anything about the treatment that wasn’t accessible for you?
- Did you ask for anything to be done differently to accommodate your disability?
- Were you given work to do in between appointments? Was it possible for you to do that work or was it not accessible to you?

If they dropped out:

What lead you to stop having the treatment?

What would have made you carry on having the treatment?

8. **Overall, how accessible was your involvement with the (…) service?**

9. **What would make it more accessible for you?**

10. **What went well and/or was accessible for you?**

11. **Do you have anything else you want to tell us about your experience with the (…) service?**

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