Addressing depression in Muslim communities

Piloting an adapted intervention with Primary Care Mental Health Teams in Bradford

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EXECUTIVE SUMMARY

Policy guidelines promote the use of culturally appropriate therapies for service users from minority faith groups . More evidence is needed, however, about the effectiveness of culture-sensitive models of therapy.

People from Muslim backgrounds are likely to use religious coping techniques in response to depression. Interventions that draw on faith can be effective in addressing and preventing depression and improving quality of life. For Muslim clients such therapies have also resulted in earlier improvements in depressive symptoms compared to secular approaches.

The research partnership formed for this study was multidisciplinary and multicultural; it aimed to develop an intervention for depression that meets the needs of Muslim service users. Research partners felt that Behavioural Activation (BA), with its focus on client values, could be adapted in this way.

METHODS

A project management group (mental health practitioners, managers and researchers) and three expert advisory groups (one consisting of Muslim service users) oversaw the study.

Development of the intervention

Evidence from a literature review and interviews with Key Informants, who had experience of mental health in Muslim communities, was synthesised to identify the adaptations needed. An existing cultural adaptation of BA was developed to produce a therapy manual for use with all Muslim clients. Whilst the BA approach remains constant regardless of the religious inclination of the client, the focus on Islamic teachings within the therapy can be varied.

A self-help booklet was also developed as a resource for clients and therapists. This aimed to raise awareness of relevant teachings from Islamic scriptures and promote positive use of religion to support therapeutic goals.

Field-testing

Therapists were recruited from primary care mental health teams in Bradford. A two day training event was held, covering the basic theory of Behavioural Activation, reflexive exercises to highlight potential stereotypes and assumptions about Muslim clients, contents and use of the adapted therapy, opportunities for role play, recruitment issues and supervision arrangements. Feedback from the training led to further manual refinements before its use with Muslim clients recruited to the study.

Bi-monthly meetings were arranged for therapists and supervisors to discuss use of the manual, supported through a web link to BA expert Professor Jonathan Kanter from the University of Wisconsin-Milwaukee.

Therapy sessions were recorded to monitor therapists' adherence to the adapted manual. Three standard self-report measures,PHQ-9, GAD 7 and WSAS, were used to explore their acceptability and suitability . Verbal or written translations of the measures were used by therapists for clients with limited fluency in English, who received support from either a bilingual therapist or a therapist and interpreter.

On completion of therapy, qualitative interviews with service users (n=13) and practitioners (n= 15) were conducted. Data was analysed thematically and used to further refine the manual or describe its use in practice.

FINDINGS

Eight therapists with their supervisors were trained to deliver the intervention, however, only two stayed throughout the pilot. Others left due to: sickness (2), manager refusing permission (1) not sure how to work with the client booklet (1) new job (1) no recruitment (1).

Recruitment was very slow and referral sources were consequently widened to GPs and the voluntary sector. Findings revealed a number of reasons for poor recruitment:

- Some therapists felt uncomfortable taking consent and felt this was not their responsibility
- Team dynamics could be a barrier, particularly if middle managers were not supportive.
- The client group could be seen as more complex than appropriate for BA and 'unsuitable' clients approached in order to recruit to the study.
- There appeared to be under referral of Muslim clients for therapy, especially people with limited English. Stigma was suggested as a barrier by one interviewee, however others felt the problem related to lower rates of GP referral and services that did not meet the needs of Muslim clients.
- Manager selection of therapists removed choice and caused resistance to the study

The therapy was delivered to 19 service users; for just over 50% this was in languages other than English compared to 8% normally seen by teams. Adherence checks showed that therapists had good rapport with clients but sometimes failed to explore their use of religion as a resource. Follow up and discharge procedures outlined in the manual differed from normal practice and were not always followed.

The BA approach

There were a range of attitudes to working with the BA model of depression. Some therapists felt it was appropriate and evidence based whereas others felt it was too simplistic and preferred models they routinely used. Service users felt the model was easy to understand and often appreciated the focus on behaviour. Findings suggested a need for therapist training on how to use BA in relation to clients' social context and attendance. Attendance at the bi-monthly meetings where such issues could be addressed was low, however, due to time pressures on therapists.

A values assessment form facilitated detailed discussion about clients' values, which therapists felt otherwise might not have occurred. Psychological Wellbeing Practitioners (PWPs) said they needed more training both on how to use this form and on dealing with thoughts in BA.

The adapted therapy

Most therapists found that guidance in the manual on including family members in sessions and on cultural norms for understanding depression was helpful.

Service users responded extremely positively to incorporation of religious activity, this could help them feel better and religious teachings could be a "tool for tackling depression". All service users felt that religion was important to their life even if they were not particularly religious. Findings confirm recommendations in the manual that all Muslim service users should be asked about the importance of religion and assumptions should not be made on the basis of client appearance.

Therapists generally agreed that incorporating religious activity could be very helpful to clients; some struggled to conceive how they would deliver such therapy but were willing to try if the client wanted this and others felt apprehensive about working with people from a Muslim background. Findings suggested that confidence in delivering the adapted therapy may be less related to content and more to familiarity with the intervention.

The self-help booklet was generally very well received, particularly by service users. However, therapists appeared to be handing out the booklet with little or no explanation and both service users and therapists felt a greater link to the therapy and more guidance on how to use the booklet was needed.

Both service users and therapists said that a shared background could work positively in the therapeutic relationship but could also be a hindrance. Most service users felt it was more important that therapists had knowledge of Islam and a genuine belief this could be helpful, and that they maintained professionalism and confidentiality.

Some therapists did not consider it within their remit to build links with community resources and felt this should be left to the client; others had experience of collaboration, e.g. with imams and voluntary sector organisations. The amount of work involved in signposting to non-NHS services was a barrier and therapists needed help to establish such links. Service users could value therapists facilitating such contact, particularly if they needed advice about Islamic teachings. Some therapists had experience of service users bringing family members to sessions but managing the dynamics of additional people in the therapy could be difficult.

Homework could be seen as a burden by service users but some spoke positively about tasks that helped them be more active and develop a routine.

RECOMMENDATIONS

Implications for services:

- Muslim clients should be asked about the importance or otherwise of their religious background. Therapy choices should include approaches that support their religious values.
- A choice of therapist may make service users feel more comfortable to express their religious or other values. Therapists who are not Muslim will need to be prepared to work with material with which they may be unfamiliar to support client preferences.
- The under referral of Muslim service users, particularly those with limited English, should be addressed. Collaborating with community organisations could potentially facilitate partnerships, address stigma and support service development. Easy access to someone with religious expertise would benefit both clients and therapists.

Implications for research

- Therapists should self-refer rather than be allocated to the study to reduce resistance and support reflection on willingness/ability to work with the adapted intervention.
- Recruitment should include a wide range of sites, including community organisations and GP practices.
- Researchers should work with therapy teams including managers as early as possible and attend team meetings to improve communication and support for therapists. A research team member should take consent from participants.
- Further research could explore adaptation of BA for service users from a range of faith backgrounds and delivery by a wider range of professionals.

Implications for intervention training:

- Preparatory training should support therapists to practise using the values assessment tool and self help booklet and develop confidence in using these within therapy. Working with negative thoughts in BA should also be covered.
- Therapists should discuss feelings about working with families and community resources and strategies for supporting this.

- Procedures for follow up and discharge should be emphasised, particularly if these differ from routine practice.

- Attendance at bi-monthly meetings should be mandatory.

Conclusion

Findings suggest the adapted therapy can be introduced successfully into the NHS and is acceptable to service users and therapists. A number of strategies could improve recruitment to a full trial of the intervention.

INTRODUCTION

A number of policy statements and guidelines promote the use of culturally appropriate treatment for service users from minority ethnic and faith groups[1,2,3] . Reviews of clinical trials and interventions provide little evidence about minority religious groups, however[4], and detailed descriptions of the form and content of interventions for Muslim clients are not generally available[5]. More evidence is therefore needed about the effectiveness of culture-sensitive models of therapy and treatment outcome data is needed to assess whether these yield better results with specific religious groups than standard therapies[6].

Muslims make up the second largest religious group in Britain[7]. The Care Quality Commission's annual census of inpatients and out patients in NHS and independent mental health services in the UK showed that 4% of the 31,786 people recorded identified themselves as Muslim[8].

People from Muslim backgrounds are more likely to use religious coping techniques than individuals from most other religious groups in the UK[9]. Interventions that draw on faith can be effective in addressing and preventing depression and improving quality of life[10-13] .

Reviews of religious and spiritual therapies for depression have shown that incorporating religious components into therapy can have positive results and that adapted therapies can be at least as effective as existing secular therapies. For Muslim clients such therapies have also resulted in earlier improvements in depressive symptoms. [14, 4]

The aim of this study was to develop an intervention for depression that would meet the needs of Muslim service users. Research partners felt that Behavioural Activation (BA), with its focus on client values[15], was a therapy that could be adapted in this way. Behaviour theory suggests that a lack of access to sources of positive reinforcement can lead to and maintain depression. Behavioural activation works by identifying behaviours that a person with depression may no longer be carrying out but which would allow the person to access positive reinforcement were the behaviours to be introduced or reintroduced. Some versions of behavioural activation use a detailed assessment of the person's values across a number of areas, including religious values, to identify what these helpful behaviours may be on the assumption that behaviours that are consistent with a person's values are likely to be positively reinforced. If a person identifies religious values as important, then behavioural activation would seek to help the person act in a way consistent with these values. The study therefore focused on adapting BA and on approaches that could potentially be delivered by therapists from a range of religious and non-religious backgrounds.

The research partnership that was formed to develop the intervention was multidisciplinary (health service practitioners, community based service providers

and academic researchers) and multicultural, including people from Muslim and other backgrounds.

METHODS

Advisory groups

The project was overseen by four groups, a project management group (PMG) made up of mental health practitioners, managers and researchers, and three expert advisory groups, one involving professionals and service users, another exclusively made up of Muslim service users and a third virtual group involving academics and practitioners

Development of the intervention

The first phase of the study involved synthesizing evidence from existing literature and interviews with 'key informants' (KIs); KIs were individuals with experience of mental health in Muslim communities. The research partners also took advice from the three expert advisory groups described above.

Literature review

Four specific areas of literature were explored to determine the components of appropriate therapy:

1 Therapies for depression developed specifically for Muslim service users based on psychological theory and delivered by a trained practitioner

2 Faith-based coping strategies from non-psychological therapies developed for Muslim service users with depression (eg social groups in community settings)

3 Behavioural activation therapy and its potential to accommodate faith beliefs

4 Secular psychological interventions that have been adapted to accommodate needs of Muslim service users.

The lack of reliable and systematic research evidence in relation to (2) above meant that a wide and comprehensive search strategy was necessary. The literature review included grey literature such as work undertaken by community-based organisations, where expertise and innovation in relation to addressing faith and ethnic identity is most often found and work from outside the UK where Islamic perspectives may be more predominant.

The research team developed search strategies in collaboration with an Information Specialist and the Project Advisory Group. Search strategies were developed from

the search concepts: depression, Muslim population, psychological interventions (including BA) and faith-based coping strategies. The searches were not limited by publication date or language, relevant non-English language articles were acquired and screened for inclusion (see Walpole et al 2012).

Key Informant interviews

Themes developed from the literature review were used to develop a topic guide for semi-structured interviews with KIs. This included questions about the potential principles and methods for treating depression.

Key Informants (KIs) were selected on the basis of experience of delivering mental health services to clients from Muslim backgrounds (n=27) or experience as a Muslim service user of mental health services (n=4). There were 18 male and 9 female respondents including a mental health support worker, five clinical psychologists, a GP, an expert in BA, two service managers and three psychiatrists. Two male and two female mental health service users, were also interviewed. Themes arising from KI interviews were presented to the Muslim Service Users Advisory Group for validation and additional feedback. The data from these KI interviews was used to inform the initial adaptations to the pilot manual.

Muslims make up the second largest faith group in Bradford, [7] suggesting that the city was an appropriate site for this study. Bradford District Care Trust, NHS Bradford and Airedale and Sharing Voices, Bradford formed a collaborative partnership with the Leeds Institute of Health Sciences on the basis that all partners recognised the need for mental health interventions to take account of the perspectives of Muslim service users

Synthesis

A synthesis of the evidence from existing studies and data from KI interviews was conducted to identify the adaptations needed to BA therapy and mechanisms by which these could influence outcomes[17].

The specific areas that we were aiming to identify were grouped into the following categories:

- guiding principles in the treatment of depression in patients from Muslim communities
- models of therapeutic change including goals at different stages of therapy
- central interventions used by therapists including effective components of BA
- appropriate methods for engaging with Muslim patients
- underlying mechanisms that positively or adversely affect healthcare and mental health in this population
- specific issues relating to diversity between and within Muslim communities (eg gender, ethnicity, religiosity and age)

- similarities and differences between Muslim populations and other social groups.

We found no existing faith-based adaptations of BA, although an adaptation to meet the needs of people from Latino populations in the US has been developed and forms one of the foundations for this manual[18].

Client considerations

Project partners agreed that the adapted manual should be appropriate for use with all Muslim clients including: those who would benefit from BA with an intertwining of Muslim faith teachings, those for whom faith was not a major consideration in terms of their values and those who had an ambivalent or unsettled view on the role they wanted faith to play in their treatment.

The flexibility of the manual meant that whilst the BA approach would always remain constant in therapy, regardless of the religious inclination of the client, the focus on Islamic teachings within the manual could be varied. This allowed for the manual to be relevant to all clients, whether the focus on Islamic teachings was or was not relevant to their identity or value framework.

The client booklet

The idea to develop a self-help booklet came from a research project adapting a psychosis recovery manual for Somali service users in Sheffield.[19] The booklet for our study was designed as supplementary material that could be used by clients and therapists to support the therapy. It included relevant teachings taken from the Qur'an and Hadith (sayings and actions of the Prophet Muhammad) that supported the principles of BA. The Islamic teachings contained in the booklet were contributed by Mohammad Shabbir (Sharing Voices Bradford) and additional psychological and religious advice was sought from Dr Wali Wardak, a clinical psychologist also qualified in Islamic jurisprudence.

The booklet was not intended to be given to every client; it was for use with only those who had expressed an interest in including religion in their therapy. It was designed to be a resource for therapists also so that they could familiarise themselves with relevant Islamic teachings, in order to support clients to develop positive interpretations of their experience from an Islamic perspective.

A sample page from the booklet is included at Appendix 1. The booklet was designed to be interactive, and included space for the client to write and add what they had found useful. It also included action points on which the client could reflect, in line with the BA approach.

Training and recruitment of therapists

Therapists were recruited from primary care mental health teams in Bradford, through their managers at the request of senior managers involved in the project. A two day training event was held for eight therapists who had been either selected by their managers or shown an interest in delivering the intervention. Their supervisors were also requested to attend for the two days. The training covered the basic theory of Behavioural Activation, adaptations to the manual, recruitment, and supervision arrangements. The training placed less emphasis on the BA model since the research team were advised that therapists attending would be familiar with this approach, as their basic training covered behavioural techniques.

Attendees took part in reflexive exercises aimed at making them aware of their own assumptions based on visual cues such as appearance. There was also the opportunity to role play the assessment process, based on case studies developed by a clinical psychologist in the research team.

Trainees were also consulted on the feasibility and acceptability of recruitment targets, session plans and supervision arrangements. Supervisors raised the need for extra allocated individual supervision time for therapists taking part in the pilot.

Feedback and evaluation from the training highlighted that participants reported that they had developed understanding of: how to differentiate between cultural and religious internal dialogue; the parallels between psychological and religious coping concepts and techniques; the need to include a discussion around religion in assessment and not expect this to be volunteered by the client.

Trainees also said that they would have preferred more information on the theory of BA; handouts in relation to the content of the manual; shorter slots, delivered at a slower pace; and a focus on the practical aspects of the sessions rather than what one therapist described as ‘Islamic studies’.

Following this feedback further adaptations were made to the manual, for example, the inclusion of a values assessment form to facilitate the discussion and process of identifying the service user’s goals.

Field-testing the intervention

In order to test how the adapted therapy worked in practice, the intervention was piloted with service users and therapists. After service users completed, disengaged or were stepped up or discharged from therapy, they were interviewed about their experience. Therapists were interviewed also and the ‘findings’ section represents matters that arose during delivery and also the views of service users, therapists and managers, about the pilot.

Therapist involvement

Ten therapists attended the training event, with eight expected to deliver the intervention. As the recruitment phase got underway, therapist numbers dropped to

four. Those that did not continue with the study after the training left due to: sickness (N=2), manager refusing permission (N=1) and not being sure about how to work with the client booklet (N=1).

Two other therapists were recruited outside of the training event, however one dropped out due to bereavement and the other was leaving her role and did not manage to recruit within the short period of time before leaving.

Of the remaining four recruited to deliver the intervention, only two therapists delivered the intervention over the course of the pilot. This was due to one therapist leaving for a new job, and the fourth therapist had not recruited anyone by November 2011. This therapist felt that lack of recruitment was the result of service users who met the criteria for the study being already picked up by her colleague, who had been trained but later assessed as not meeting the therapist criteria for the pilot.

One of the therapists who had been off sick returned part way through the pilot and managed to recruit five clients. This therapist then left due to another period of sickness and these clients were picked up by the two therapists remaining in the study.

Recruitment and retention of participants

The recruitment of participants with whom the manual would be piloted, was planned to take place between April - September 2011; however the first participant was not recruited until July 2011.The recruitment period was extended to compensate for this and the final client was recruited in January 2012 – 4 months after the original expected end date to recruitment and the delivery of the intervention. (See Appendix 3).

During this phase a number of issues arose which alerted the research team to difficulties that therapists were encountering with recruitment of participants. Some therapists found that demography of the areas which their team covered meant that they struggled to recruit service users from Muslim backgrounds. Other therapists, despite working in a team with a significant number of referrals from people with Muslim backgrounds, also found it difficult to recruit. Although this team was based in an area with a significant Muslim population, the referrals to the service did not reflect this:

> " so I didn't work with many Muslim clients at all, so I'm not particularly sure why that is, maybe it is they don't have enough information that they can, you know, go and speak to their doctor or what the referral process is, but whenever I went to [local voluntary organisation] they were saying that they had a lot of women there".
>
> Psychological Wellbeing Practitioner

One of the therapists in this team also reported difficulties with clients continuously declining to take part due to therapy sessions being audio recorded. Therapists and

the manager of this team they felt it was not appropriate for them to promote the therapy and they were not comfortable taking part in the consent process or answering questions about the study. They said they felt it was their role to present the service user with the various treatment options but not to be part of taking consent to take part in the research.

A 2-step process (Appendix 2) was subsequently introduced to aid therapists with recruitment. The aim was for therapists to indentify potentially suitable service users, give them the study information sheet and gain agreement for client details to be passed to the researcher. The researcher then met the service user and took consent if the service user chose to take part. The researcher was also able to address any questions relating to the research that service users might ask.

As well as the 2-step process, the research team worked with the Northern and Yorkshire Primary Care Research Network (PCRN) and a Research Support Officer who allocated some of her time to support the project. Using these multiple approaches recruitment improved through the PCRN identifying a GP practice interested in supporting the study. The Research Support Officer was also able to follow up information that had been circulated within Bradford District Care Trust to encourage health professionals to refer any suitable service users to the study. Through the collaborative work between PCRN and the GP practice, 13 service users were identified as being suitable for the study and from these patients, six agreed to be assessed. The Research Support Officer liaised with a psychiatrist with suitable clients (N=2) and both these service users were recruited to the study. Alongside these recruitment routes Sharing Voices, Bradford also contributed by identifying services users for whom the intervention could be suitable. They identified three service users, one of whom was recruited to the study.

The professionals and service user interviews highlighted a number of reasons why recruitment did not go as expected and issues for future studies, these are listed below.

- Some professionals felt that having a researcher take consent would have worked better than the therapist doing so. One therapist felt uncomfortable in taking consent because it was not the therapist's 'job' to do such.
- It was suggested that team dynamics could affect recruitment particularly if middle managers were not supportive. For example at one stage it was suggested that therapists take on service users from other teams but not all managers were happy with this attempt to improve or address recruitment issues and stopped therapists taking on these service users.
- One therapist pointed out that local voluntary services were working with service users appropriate to the study; however the mental health team in which the therapist worked did not seem to receive many referrals from people from Muslim backgrounds.
- A team manager remarked that there was not enough consideration from higher management with regards to recruitment. It was felt that the client

group was perhaps wrong for BA and due to struggles with recruitment and in order to achieve the numbers required, clients not suitable for their service were included:

"I think the client group was maybe wrong, I think there was a panic to get people in, you know, we had to find some clients to take part, we had to find clients that agreed to take part, and agreed to be, well, most of them agreed to being taped and things, and they probably weren't all actually suitable, and I think that raised problems then."

Team Manager

- With regards to the therapists that attended the training some therapists were allocated to the study by their managers and others attended out of interest. It was suggested by therapists and supervisors that the selection of therapists removed any element of choice and caused resistance to the study in such therapists.

The recommendations made at the end of this report address these points in terms of implications for future research

Client demographics

The pilot manual was delivered to 19 service users, recruited from Bradford and Pudsey. The group consisted of five men and 14 women, aged from 23-56 years old, with the sample being more skewed to older service users. Service users include four ethnic groups and were predominately from British Pakistani backgrounds 84.2% (16/19), with one African (5.3%), one Indian (5.3%) and one White British (5.3%) participant. The group included those in employment (N=6), unemployed (N=2), a student (N=1), a carer (N=1) and housewives (N=9). The higher number of Muslim women reflects current evidence of mental health prevalence in Pakistani and Bangladeshi communities, which are predominantly Muslim.[20]

Almost equal numbers of service users received the intervention in English (n=9), or in Urdu or Mirpuri (9); one individual received therapy in Hindko. Nine service users reported taking medication and nine were not currently on medication; medication use was unknown for one service user. The duration of depression reported by service users ranged from 3 months - 6 years.

Whilst 50% of the sample in this study was made up of service users for whom their primary language was not English, this is not the case for referrals received by Primary Care Mental Health Teams (PCMHT) generally within Bradford and Airedale District Care Trust (BDCT). Between June 2010 and May 2012 only eight percent of referrals to a PCMHT were for service users who spoke a language other than English (see Appendix 5).

Therapy sessions

The manual was based on the delivery of a minimum of six sessions and a maximum of 12 sessions delivered to the service user. The guidance in the manual was focussed mainly on sessions 1, 2 and the final session. Sessions 1-2 were aimed at allowing the service users to tell 'their story' and for the therapist to explain the BA model of depression. The therapist would also ask if the service user would like to involve a family member in their therapy. Family involvement did not require the family member to attend the sessions. Sessions 3-11 made up the main body of the therapy and followed a format focused on reviewing and scheduling activity linked to valued goals.

Sessions included completion of depression measures and setting homework assignments. Homework would be based on getting the individual active and enjoying aspects of their life. It was suggested that therapists start with easier activities and work collaboratively with the service user to build up to more difficult, but achievable tasks.

Depression measures

Three quantitative measures routinely used in evaluating depression, the Patient Health Questionnaire (PHQ-9)[21], the Generalised Anxiety Disorder Assessment (GAD 7)[22] and the Work and Social Adjustment Scale (WSAS)[23], were used to measure the impact of the therapy. These measures were translated verbally by bilingual therapists and written translations into some relevant languages were available. The Urdu version of these measures had also been discussed with bilingual service users on our Advisory Group to test linguistical and conceptual equivalence.

Therapist adherence

Therapy sessions were audio recorded so that adherence to the manual by therapists could be monitored and judged. Although there are checklists aimed at measuring therapist competence, we were interested in measuring whether therapists adhered to the adapted BA manual. For this reason we used the checklist developed by Ekers et al (2011) and adapted it to include an assessment of an appropriate focus on religion.

Adherence to the manual was checked by two members of the research team, one of whom was a clinical psychologist. The two researchers independently rated a selection of the sessions of the therapy recordings against a series of adherence criteria (Appendix 4). The checklist included criteria such as:

- whether there was evidence that a behavioural rational underpinned interventions within sessions;

- whether homework tasks re-introduced environmental positive reinforcement and reduced avoidance;
- whether the therapist discussed religion when reviewing the values assessment sheet and
- whether the therapist dealt with religious behaviour from a BA perspective.

The beginning, middle and end sessions were checked for approximately a quarter of clients (n=5) from a range of backgrounds.

Supervision

In addition to routine therapist supervision, bi-monthly reciprocal supervision meetings were arranged for therapists and supervisors by the research team. These were designed to be peer supervision sessions for therapists with a web link which allowed the input of a BA expert from the University of Wisconsin-Milwaukee, Professor Jonathan Kanter.

These supervision sessions were advertised to all therapists within BDCT who were working with Muslim service users or interested in BA, so that they could also share their experiences with the study therapists, and benefit from the link with a BA expert.

Evaluation of the therapy

Therapy impact was explored on completion of therapy using qualitative interviews with service users and practitioners covering acceptability, feasibility, impact on depression and perceived usefulness of faith-sensitive components. Data was analysed thematically and used to further refine the manual and describe its use in practice.

The group of participants that were interviewed comprised therapists, supervisors, team managers who had delivered the intervention and/or attended the training (n= 15) and service users (n=13) that had received at least one session of the intervention.

The topic guide for these interviews covered the sections of the manual, the training received (for therapists and supervisors) and the client booklet. Our aim was to elicit information relevant to their experience of delivering or receiving the intervention that could then be used to develop the manual, training and client booklet. We also explored issues relating to recruitment, supervision and management to inform recommendations for future research.

Participant interviews

Once service users had stopped receiving the intervention, they were contacted and an interview was arranged at a suitable time, place and location. Service users had

either completed therapy, disengaged from therapy early or have been discharged from the Primary Care Mental Health service.

Of the 19 service users recruited to the pilot, 13 were interviewed. The six participants who were not interviewed had not yet completed therapy by the extended project deadline (n=2), were out of the country (n=1), did not want any further contact from the researchers (n=1), were not well enough (n=1) or were not available to speak to the researchers within the study period (n=1).

Therapists, supervisors and team managers were also interviewed. Therapists included those who had delivered the intervention (n=2), and therapists who received the training but did not deliver therapy (n= 5), as well as one trained therapist who was delivering the therapy but not included in the pilot because she did was assessed as not meeting the minimum qualifications required. Supervisors (n=5) and team managers (n=2) were also interviewed to ensure that management and supervisory issues relating to delivering the intervention were adequately explored.

Analysis

The qualitative analysis of the Key Informant and post therapy interviews was conducted using a thematic approach to identify areas for adaptation of the existing therapy manual and suggestions for further refinement[25].

For the quantitative analysis reliable improvement on the PHQ-9 was calculated to require a change of 5 points or more. Clinically significant change was calculated to require a move from 10 or above pre-treatment to 9 or below at post-treatment. As most of the pre-treatment scores were missing, the first and last recorded PHQ-9 scores were used to determine the change[26].

FINDINGS

Therapist adherence to the manual

It was found that therapists had generally delivered BA in accordance to the adherence criteria. Therapists demonstrated good rapport and relationships with service users, and a non-judgemental approach. It was noted, however, that clients' use of religion as a resource could have been explored further at times. For example, service users sometimes mentioned religious beliefs that were not followed up in the session.

Key themes from participant interviews

Professionals took the stance that one particular therapy model is not more relevant to Muslims than to service users from other backgrounds. It was suggested that

Muslim service users must be treated at an individual level, as with any service user, to judge the best treatment approach for that person:

> *"because I don't think somebody's religion necessarily dictates their experience of depression really, so it just depend what somebody came with and how sophisticated their sort of psychological understanding of emotion was, as to how simplistic or detailed that was really"*
>
> Psychological Wellbeing Practitioner

The BA approach

There seemed to be a range of attitudes with regards to using BA and working with the two circles model. Some therapists felt it was an appropriate model and were comfortable with the BA approach and evidence base for work with depression, whereas other therapists felt that the 2 circle model was too simplistic when it came to helping service users understand their experience of depression and often referred to three or five area models, which they routinely used, as being more comprehensive. Service users that were interviewed did not profess any strong opinions about the model but felt that it was easy to understand

It was suggested that whilst the modality of BA was appropriate for working with depression, there may be difficulties when sticking strictly to the model for service users from minority backgrounds:

> *"BA has a value and relevance to all depression presentations. It's an umbrella type intervention and is included often in some form with every patient I encounter. However, often with the BME clients I found before i could even begin addressing the BA aspect of the model I needed much more time for stabilisation, engagement, building a trusting relationship and repeating the purpose and function of BA to their recovery. Some clients had been experiencing depression for more years than they had not experienced it. So it was something very meshed into their DNA, if one can say such things. So just applying a BA model was restrictive and often my own practice would mean I felt I wasn't meeting the client's needs by pushing forward activity and homework when their attendance and presentation showed they could only handle talking (and even sometimes that was a challenge for them to summon the functioning aspects of their minds and spirits to even talk because they felt so hopeless and emotionally drained by life and their circumstance).*
>
> Psychological Wellbeing Practitioner

Whilst the majority of therapists and supervisors interviewed did not question whether BA was appropriate for Muslim service users, the above comment suggests there is a need to ensure that therapists understand BA approaches can be used to

focus on the client's social context and attendance at sessions, where these are key issues.

The adapted therapy

With regards to therapy that incorporated religion, service users responded extremely positively, highlighting how by incorporating religious teachings into their lives by "reading the Quran and praying" they subsequently started feeling better and that religious activity and advice could be very helpful as a "tool for tackling depression". One therapist gave the example of how two of her female clients expressed that they "very much wanted to be more religious and have Islam as a refocus in their life. This was not the case for everyone, for others they wanted other types of therapy".

The cultural issues covered in the manual were found to be informative by most. It gave therapists the insight to consider family members in sessions, and to consider other ways of interpreting and understanding depression. One therapist commented on how they may have disregarded physical symptoms had they not read the manual that explained the link with somatic expression of emotional distress. The manual was also used for reference by therapists to refer back to when they had queries.

Some therapists struggled to conceive how they would deliver therapy that involved faith and religion, but admitted that if the patient was willing to try it, they would try too. Others admitted to feelings of apprehension about working with people from a Muslim background. . It was suggested that confidence in delivering the adapted therapy may be less about the actual content and more about being familiar with the intervention. One therapist said that from their understanding the adapted therapy was not promoting an 'apartheid' but rather an approach that any therapist could use, regardless of their background. From other interviews it was clear that some therapists understood that delivering the intervention did not require them to be an expert in religion or Islam. This is explored further under *client-therapist match*.

Some therapists doubted the relevance of using faith within therapy, but accepted that if people within the Muslim population find their faith important to them, then to provide faith related therapy may be worth consideration. One commented that you have to be "careful about bringing faith into therapy".

Spiritual understandings of health, illness and depression

> *"If you've got a strong, sort of, faith and you believe in something, it makes you become a lot stronger person. I think if I didn't have no belief in anything, I wouldn't be here today."*
>
> Service User

Service users who received the intervention, regardless of whether they completed therapy or not, all felt that religion was important to their life. One service user said that although they were not particularly religious, they felt that it was intrinsically linked to her identity in some way and so it would come up at some point:

> *"I think it is when it's a part of you it has to come up either way or not because it's a part of you, that's it. It's one of those things. [...] because I'm Muslim it would come up."*
>
> Service User

Negative impact of religion

Interviewees felt that negative beliefs related to religion could impact on the wellbeing of an individual. For example one service user felt that he was being punished for a sin that he had committed. Some service users reported neglecting themselves and becoming more depressed through religious activities such as fasting and prayer by which they hoped to earn forgiveness from God. Beliefs related to possession were raised by therapists and supervisors from Muslim and non-Muslim backgrounds. Service users who believed they had been possessed equated this with being a bad person. A supervisor who had experience of working with someone with this belief said that it would be their role to help their supervisee understand the function of the belief, rather than work to change the belief.

Positive impact of religion

Other interviewees talked about the protective role that religion had played in their life. For example, a service user said that had he not had the five daily prayers to keep him 'sane' he would have given up on himself a long time ago. Service users mentioned a number of helpful Islamic teachings: that difficulties experienced are a test from God and that God would not test them with more than they could manage, that human beings were fallible and prone to making mistakes and that God is The All Forgiving and The All Merciful in dealing with people, that the body is a trust from God and it is the individual's responsibility to look after themselves and maintain good health, and seek necessary treatment.

Some of the service users who took part in this study did not present themselves as observant Muslims but when interviewed suggested that religion was important to them and to their wellbeing. Evidence from the service users and therapists interviewed suggests that all Muslim service users should be asked about religion and assumptions should not be made on the basis of how 'religious looking' a service user appears to be.

Consistency with client values

Service users who were not very religious reported that they were still interested in receiving a therapy that could incorporate Islamic values. One service user talked about how religion was not really raised, although she expected it to be, and had been disappointed with this:

> *"But I think that's a thing that attracted me, because I thought 'Oh, brilliant, this could be more useful to me', than just sitting talking to someone, if they can bring my religion in, because I do have a lot of conflicts and a lot of…and I thought bringing in religion would help me, but with my…I didn't think there was much involvement there."*
>
> Service User

Service users felt that it was appropriate to include religion in therapy and one service user said that she felt it was particularly relevant because religion contained the solutions to all problems. Religious activity was reported as helping counter boredom and inactivity, particularly in in-patient settings . Provided that a belief or activity was not detrimental and was helpful to the client, therapists and supervisors felt this should be encouraged by the therapist.

Client-therapist match

Some service users, when asked about the importance of having a shared background between therapist and service user, initially felt that it was important. However, both service users and therapists said that having or not having a shared background could work positively in the therapeutic relationship but could also be a hindrance. For example, a service user might take the option of working with a therapist from a different background if they were using coping strategies that were not consistent with an Islamic lifestyle or were concerned that people in the community could find out about their depression. Having someone from a different background meant that such service users felt they could talk freely and not worry about being judged, particularly if the therapist was visibly a practising Muslim.

Most service users, however said that it was not important to have a shared background provided that the therapist had some knowledge of Islam and showed that they were open to discussing it. Clients who had worked with a therapist from a different background said that they felt comfortable and able to talk about religion.

In general even those service users who initially said that having a Muslim therapist was important changed their mind after their initial reaction, and said that a shared background or a visible Muslim identity (such as wearing the hijab) could be both conducive to the relationship and off putting at times.

> *" I think I would have given an honest answer either way; whether she had the hijaab on or not, but I think you do feel that certain pressure because you*

think 'oh, God, she's wearing a hijaab, what if I say this and she thinks 'oh, no, not like that.!' 'So, I think it would have been that, but I would have still been honest with her. I would have told her straight: 'this is how I feel about it. I know you're wearing a hijaab, but for me this is how it is.' So that's what I would just basically stuck to"

Service User

It was suggested by one interviewee that not having previous knowledge of Islam may be seen positively by service users because it allows them to explain how they understand their religion. However, most interviewees felt that having some knowledge of Islam was important. In contrast to the recommendation from KIs in our initial phase, most therapists were emphatic that although they may be open to working with, discussing or incorporating religious activity within therapy, they would not normally raise the issue of religion themselves and would wait for the client to mention it:

"I don't know how I feel about asking a person whether they want to do it, you know, to sort of bring their religion into it or whether I would wait for them to bring it up and say 'actually, this is important to me.' Because I've had patients from all different religions that have said that to me, particularly Muslim and Jehovah's Witness clients you get saying that a lot, you know, that their religion is very important and we do use it as part of the therapeutic process."

Psychological Wellbeing Practitioner

Therapists said that if clients presented religious beliefs or ideas in therapy they would work with them, and some therapists showed a good understanding that the intervention should include religion for those for whom it was relevant, including those therapists who had not delivered the therapy. None of the therapists appeared to be averse to using religion with therapy, however the actual process of doing this seemed to cause some uncertainty or leave the therapist unsure as to how they might approach this. It was also stated that when a client visibly demonstrated religious behaviour (such as holding 'prayer beads' or wearing a scarf) it may make it easier for the therapist to bring up religion because they would assume it is important to the client. However, with service users who did not present such obvious visual cues, the therapist could be hesitant because they did not want the service user to feel that religion was being imposed on them.

In some instances it seemed that the therapist's own lack of familiarity with service users' religious beliefs interfered with their willingness taking part or in the delivery of

a faith-sensitive intervention, and particularly with the prospect of working with the client booklet:

> *"I have to have, I always feel like I have to have an understanding of what I'm going to tell somebody in order to make them understand and I know that wasn't the aim of the study, it was even if you don't have an understanding of this you can still deliver it. I found that really hard to get my head around because I'm not coming to contact with a lot of, you know, like the things in the booklet, the sort of, I don't know what you refer to them as, like, the phrases and proverbs that people might find useful. I never really come into contact with them before. As much as I can understand what they were saying and why they were saying it, I just felt I needed a bigger understanding to be able to deliver it myself"*
>
> Psychological Wellbeing Practitioner

This was interesting because many therapists talked about times when they had worked with religious beliefs in the past. The examples given were of working with service users with Christian beliefs. It could be that although a therapist is not religious, these beliefs and practices are more familiar to them, coming from a White English background. This was corroborated by a therapist who commented that a therapist's own religious identity and views, and the views of, particularly senior, colleagues in a team could impact on their willingness to deliver the therapy.

Therapists were aware that not all service users would want to explore their religious beliefs, but it was suggested that if a service user is expressive about not acknowledging religious beliefs then there may be a need to explore why this is so to avoid missing important information about the service user and their experiences.

The religious identity of the therapist and awareness of spirituality was felt to impact on therapy and the therapist's ability to ask the right questions:

> *"I was just really curious about that because people's experiences and interpretations, everybody is different, it's very individualised. Because I kept asking lots of questions, she was able to start to reprocess that, but I, can see that another psychologist, who really is not aware of spirituality or faith, may not ask any more questions; 'oh, right, is that what Islam says, oh.'*
>
> Clinical Psychologist

Therapists' own religious identity or openness to spirituality could mean that they may not take clients' statements at face value and explore the meaning behind expressed positions. Therapists' own religious background could also give insight into how religion could work both as a resource and at other times be used negatively.

Therapeutic tools

Values assessment

The use of the values assessment form seemed to provoke mixed reactions amongst therapists; it was clear early on in the pilot that one therapist felt it was a complicated and clumsy form (Appendix 4). From the adherence assessment it did not appear that therapists were using the values assessment in Session 1, as outlined in the manual. Although one service user felt that it would have been more appropriate in a later session, this view appeared to be based on a misunderstanding that the assessment was about how her values could be changed. In general, it seemed that therapists were using the form in later sessions, and some service users had difficulty remembering whether they received the values assessment form at all. Service users did nevertheless sometimes recall making a hierarchy of their goals and appeared to understand that it was important to them to focus on their goals and values in therapy.

An issue raised through the interviews was that, as Psychological Wellbeing Practitioners (PWP), the therapists who delivered the intervention would not use values assessments as part of their usual practice and would expect to be trained in the use of the form. This lack of familiarity could explain why there was some resistance or scepticism about using the tool.

Others commented that regardless of an individual's background, the values assessment is a worthwhile exercise because it focuses on aspects of life that are familiar and important to the service user such as faith and relationships:

> *"I think some..... some people struggled with it, because they weren't sure what their values, or they've lost their values and they struggled with that, and say I don't really understand, and then sometimes they didn't have, you know, when you're working with sort of Muslim women who've never worked before, so they were like well I don't think that's, that's important to me, but relationships and other things, you know, my faith is important to me and stuff, so it's a worthwhile exercise to do really. Again it's about understanding people and connecting with people and working on their model of reality."*
>
> Mental Health Support Worker

Therapists recognised that without the values assessment form, a discussion between the client and therapist regarding the values that are fundamental to the client and their wellbeing may not occur, given that PWPs do not work with this tool as standard. The inclusion of the values assessment focuses therefore facilitated this process for the client and therapist.

Homework

The intervention requires that homework should be set every session by the therapist, however it was found that service users often did not complete homework tasks for a variety of reasons:

> *"I did understand them, and they were explained to me, but I felt that it was more like college work than school work, which I…I thought if I'm here I don't want to do any college work, I'm here for some help, but maybe all therapies are like that where they do give you a lot of paperwork to fill in. I don't know."*
>
> Service User

> *"the reasons would have been like being busy, busyness, or forgetting about it or not having any motivation, like that."*
>
> Service User

Other service users struggled due to physical health problems, relationship problems or caring responsibilities that meant homework was not a priority to them:

> *"no, I was trying to do it, but I just could not. For me, as a father, as a husband and I have been diagnosed and all the other appointments, doing things for my wife, like going to the bank, interviews with the social support workers, interviews with them and get her medication; it's too much hassle. So, I used to leave it. Taking my son and bringing him back walking and many other problems I had; going to the Mosque, taking him and bringing him back, that kind of thing and she [wife] doesn't help me with anything, not any kind."*
>
> Service User

Therefore homework was in some instances seen as a burden that caused stress and anxiety for service users.

Creative alternatives to written tasks were suggested in the therapy manual and some therapists did suggest examples of these:

> *"…faces, characters, that sort of stuff that you would use, that you can use with adults. I mean I've used Russian dolls with adults and stones, all that sort of stuff. That's what counsellors, that's what you're trained to do, when communication is a problem."*
>
> Mental Health Practitioner

Therapists also suggested using mobile phones to keep notes or take pictures of homework in case clients forgot to bring forms to the session. Some service users suggested that they would have preferred to be able to verbally record tasks that were set, whereas others struggled with aspects of motivation to complete goals but found therapists understanding and accommodating. Service users who had completed homework sometimes spoke positively about the tasks that helped them to get active and set a routine for themselves.

Client booklet:

The general feedback regarding the client booklet was overwhelmingly positive, particularly from service users. However, through the interviews it became apparent that therapists were handing out the booklet with little or no explanation about its function. Service users who received it said that whilst they were happy to receive it, and often found it useful and interesting, they lacked the guidance that was required on how to use it. As a result, for some service users the client booklet remained largely unused as a resource and was not utilised in therapy even though their interviews suggested that they would have found it beneficial:

> *"I got a booklet to read, and I took it home, and I didn't even look at it to be honest. I looked at it once and the children were like 'What's that mother?' and every time I read, it was more of a common sense to me. I wasn't practicing but when I was reading, you know 'This is me, this is me, this is me', this is how I feel and this is what I should be doing. But then I didn't even entertain it, I just left it, so I'm not quite sure how you are going to bring the religion into how…"*
>
> Service User

One service user, however, had continued to use the client booklet although she only attended therapy for three sessions. This had become a resource that she often looked at and felt supported her well-being some service users also felt that the booklet helped to *"just try harder".*

Therapists had mixed opinions about the client booklet, with some reports highlighting their misunderstanding of its use within therapy. One therapist remembered "struggling" with using the booklet, and reported that, "when I handed it to them I mentioned, this is a booklet which is also part of the research, but maybe it's something you can look at".

A recurrent theme within reports from therapists was self- doubt about their knowledge of Islam and its teachings:

> *"with things that you're presenting to clients in sessions, you would want to sort of feel comfortable with it yourself, in terms of understanding before you presented it, like you were saying about any kind of interventions and things, whereas I think I might feel a bit uncertain about some of the things that we were looking at, that I didn't have an equal knowledge to the patient about what we were looking at. "*
>
> Psychological Wellbeing Practitioner

This same therapist, however, went on to comment that therapists did not "necessarily have to be the experts in things that we're looking at together" in therapy.

Therapists did not usually think that the client booklet was aimed at converting or making people more religious. They understood that that it was a tool for helping "bring people back to their religion", as an "extra resource". For those Muslims who felt they had perhaps drifted from Islam, it provided a helpful and appropriate resource since religion held an important place in their life previously:

> *"And I think if people have come away from Islam it's kind of nice and easy to flick through, isn't it and just, kind of, to dip in and out and remember why, you know, the religion was important in the first place"*
>
> Psychological Wellbeing Practitioner

One therapist described her use of the client booklet when a service user she was working with became upset during the session. The therapist was able to draw on relevant sections of the booklet, for example the section about showing mercy to oneself, and go through these with the service user, using the booklet as a resource that was relevant to the service user and in line with her values.

Sensitivity to support and resources available

Interview feedback suggested that some therapists did not consider it within their remit to build links with community resources and felt this to be the role of the client. For example, a therapist described a situation in which the service user spoke to a religious leader based on work that was done during therapy, but the therapist herself never had contact with the priest:

> *"We never have any contact with anybody, usually, outside of the patient. It's up to them what they want to do, so she went and did the speaking to, yeah."*
>
> Psychological Wellbeing Practitioner

Service users could value therapists facilitating such contact however, particularly if they had questions about Islamic teachings. For example, one client said that she would have found it useful if she had had the opportunity, through therapy, to check questions that she had about prayer with an imam.

Other therapists had experience of working alongside individuals from the local community, such as hakims, and used their knowledge of Islam to help the service user understand the need to look after themselves and receive psychological intervention as well as traditional treatment. Although therapist could be willing to consider signposting to non-NHS services, the amount of work involved in searching for appropriate services was not anticipated:

“With BME clients I found it interesting to make enquiries on what is available for them outside of the NHS in the community but didn't realise how each case would require much more signposting focus and time to schedule this in.”

Psychological Wellbeing Practitioner

Some service users included a family member in their therapy for some sessions, and others chose to tell a trusted family member at home that they were receiving therapy. In this way the family member was able to support the service user to remember appointments or to complete homework:

“it was definitely, because we'd both do the certain things, we wouldn’t drink so much water during the day or we wouldn’t do so much exercise in a day. So it kind of helped me because I knew I had someone to say 'oh, I haven’t done this. How do I do this?' And she would just pick up on it.”

Service User

It appeared that some therapists had allowed service users to bring a family member into the session for moral support in their previous practise. However, some supervisors interviewed suggested that therapists were not enthused about including family members in therapy, based on past experiences of having to manage the dynamics of having extra persons in the therapy session.

One service user did not remember being asked about including family in sessions, although the therapist had in fact asked her this at the start of therapy. This suggests that it may be useful for therapists to check with service users again, once therapy is progressing, if the individual would like to include a family member at this point.

Social context

One therapist suggested that the stigma of mental illness may affect Muslim clients from accessing therapy. Other therapists commented that there is unmet need in Bradford and Airedale, with regards to service users from Muslim backgrounds being referred to or receiving appropriate services:

“I’m not sure, I mean we, near us we have this place called [voluntary organisation] and a lot of, you know, I’ve been there as well, and a lot of the people go there, they are Muslim women, and I think whenever they’ve been, either they might find it difficult to tell, you know, somebody or, you know, a doctor or whatever that they are suffering from depression etcetera, so maybe it’s a stigma thing, I’m not sure, but yeah, our referrals definitely did not reflect [local] population at all.”

Psychological Wellbeing Practitioner

Some teams had made efforts to address this by appointing specific staff with the task of increasing referrals from people of BME (Black and Minority Ethnic) backgrounds. The level of social isolation that service users may be managing was also commented on:

> *"For me, predominantly, the BME clients i saw for the study were experiencing isolation in levels i hadn't come across before. [...] I didn't anticipate how desperate most of the BME patients i saw were in their lives. How severe things had become for them and how little had been done by other organisations because the clients didn't know other organisations existed or didn't have the means or language to make contact. Therefore, I found my role altering from 'therapist' to 'case worker actively involved in sourcing information and opportunities for the clients which would support their recovery. Passing them onto other agencies in some cases was not possible due to engagement issues the client was experiencing or the reliance factor they felt that someone had finally arrived to help them or my own personal sense of ownership or responsibility to be their main key worker."*
>
> Psychological Wellbeing Practitioner

This issue could be linked to the lack of appropriate referrals to PCMHTs highlighted earlier and the gaps in service provision that remain despite the existence of some non statutory services.

One service user highlighted negative cultural influences that could cause or maintain depression for women within Asian communities and the potential for religious teachings to empower women when biased interpretations of Islam were challenged:

> *"it depends of your family circumstances, the way that I was brought up was my parents are responsible for me, and they can basically do as they please with me and I can't say anything. whatever they decide, that's what we go by because if you don't they throw the religion card and say because you're disrespecting your parents, you're going to go to Hell, this is going to happen, that's going to happen, you cannot make choices in your own life, basically, yeah[…].I was basically treated like crap, and I was a daughter in law and that's what daughter in laws are supposed to do, take the crap. I was the wife so whatever the husband did I had to accept, and I was a mother so my job was to look after the kids and not ask any questions, and that's what my life was basically about. And a lot of women are still suffering that, they are still putting up with that because they get the religion card thrown at the. And it's like you can't disrespect your husband, you're this, you're that, so you know that's why what I say is….that when a woman goes through what I went through is told, no, hang on a minute, you as a Muslim have choices, read it in the Qur'an. A woman needs her education; she has to be educated…"*

Service User

Stigma outside the Muslim community could also influence clients' social context. For example, a service user was told that due to a previous long term period of sickness, if her health status interfered with her ability to carry out her work she would be sacked:

> *"The next day he rang me and said we are happy to tell you you've got the job, but if you are off at any time, we are going to take robust action to get rid of you…"*

Service User

Service users suggested holding recruitment sessions at community centres or recruiting through GP surgeries to address low referral rates to mental health services. Professionals echoed some of these views and it was also suggested that that for future studies, researchers could consider alternative recruitment sites:

> *"I mean you could…doctors surgeries, I was gonna say like schools, because that's where mums and dads go to pick their children up, so…"*

Team Manager

It was also suggested that using schools and surgeries could also reduce some of the stigma that may be associated with using a mental health service.

Impact of therapy

The impact that the therapy had for service users varied, for most individuals interviewed it made an 'extremely helpful' or positive change to how they felt about life, and the motivation to carry on:

> *"Just that I had some satisfaction. It is like, I feel like living again, to work again, too*."

Service User

For others it was more like a stepping-stone to their recovery, helping them understand the importance of staying active and making an effort and boosting their self-esteem. Some service users felt the approach had had been more beneficial than their previous experiences of mental health therapy or purely social interventions. Positive impact was sometimes reported despite service users receiving only a small number of sessions.

One severely depressed client who had withdrawn early from therapy, felt there had been no benefit and that the therapist could not change anything. However later in her interview she asked the interviewer to find her some voluntary work, suggesting that she was still open to the possibility of becoming more active. A therapist who had used the intervention outside the pilot with a variety of clients, not all Muslim, reported positive impact, including for someone with longstanding depression.

Reasons for withdrawal/non-attendance/stepping up

In total seven service users withdrew from therapy early. The point of withdrawal varied from after one session up to after five sessions. Reasons for this included: wanting to deal with problems within the family (N=1); wanting a cognitively focussed therapy (N=1); therapy not covering religion in a way that was expected by the service user (N=1); not feeling any benefit from attending (N=2); feeling that therapy had provided the 'closure' required (N=1); therapy sessions were held on a day that clashed with a social group the service user attended (N=1). Of these seven service users, five service users withdrew themselves from the study by not attending the next arranged therapy session. Two service users informed the therapist that they would not be returning to therapy.

Those service users that were interviewed included five participants who dropped out and one who was 'stepped up'. These interviewees spoke positively about the intervention in general and the therapists that they dealt with. It was found that there was some discrepancy between recall of sessions and the content of the session for some service users. As highlighted earlier, for example, one client did not remember being asked about family involvement; another service user said that the first session of therapy had not covered how religion would be incorporated into therapy clearly enough. The recording of the session shows that the therapist did, however, go into detail about using religion in the therapy.

One service user was 'stepped-up', to receive a different therapy because his depression was linked to relationship problems. At interview the therapist explained that she had judged this to be appropriate for this individual based on the issues he was presenting in sessions and based on his physical ill health. When the service user was interviewed he felt that he was referred on without enough explanation being given and felt rejected as he would have chosen to continue receiving the BA therapy. This suggests that there needs to be adequate opportunity for service users to negotiate about being referred to a different therapy or service so that they can be involved in the decision making about this. Therapists also need to be clearer that BA can be used for depression linked to relationship problems.

Training issues

It was clear that the training event had not addressed all the issues on which therapists required support despite the generally positive post-training evaluations.

For many therapists, it was useful to have a re-cap on behavioural activation theory as they felt it provided good preparation for delivering the therapy. Others however felt that they were still unsure of what they were supposed to do after the training, with another saying they learnt nothing new from the sessions.

Attendees were given the opportunity to role play the assessment process and therapists felt that the case studies that incorporated faith and behavioural activation were sufficient as they understood that they "didn't need to be experts", but needed to be "aware and facilitate". Therapists said that receiving the training for the adapted therapy had made them realise the importance of including values and asking about these explicitly within usual practice.

Therapists said they would have found it useful if the researchers had demonstrated some of the techniques, or if the exercises had been more focussed on the manual. Therapists and supervisors also wanted the manual and training to have clearer guidelines and script available regarding how and what to say to clients when recruiting them to the study. It was suggested that the function of the client booklet needed to be made clearer in training so that it was used more effectively in therapy. Team managers also said that therapists needed explicit guidance on how to respond if clients did not want to return to therapy and what was expected from therapists with regards to follow up.

It was suggested that regardless of the level of training, therapists may have felt unconfident working with a religion that they were unfamiliar with. Some therapists did not overcome this doubt which related to not understanding the religious aspect of the intervention. They "didn't feel confident enough to deliver to people" because they felt as though they were "preaching" something they did not understand. Therapists that actually delivered the intervention demonstrated increased confidence in delivering the therapy as they increased their practice of using the intervention. Another suggestion for improving the training was to have a session on Islam itself, covering education on common beliefs and values. In addition to this, others suggested more teaching on how to assess a Muslim client's perception of mental illness, for example, common ways to express emotion. They felt that more time, perhaps with shorter half-day sessions spread over a period of a week rather than two days would help them to take in the information, ask questions, and get to grips with the subject matter better.

One therapist commented on how training does not always correlate to the reality of therapy, and emphasised the need for support following the training session. It was suggested that delays between the training and recruiting clients may have affected the level of confidence that the therapists had in delivering the intervention.

Even after the two day training some interviewees demonstrated that they were unaware of major aspects of the intervention, for example a therapist and supervisor showed a lack of awareness of the evidence base for BA in their interview; also one therapist had failed to grasp that family work was not obligatory to the therapy, but an option for the service user.

Some interviewees suggested that recruitment of therapists or their interest in taking part may have been affected by the information they were given previous to the training. They were misinformed that the study was recruiting therapists from Muslim backgrounds. However, this did not deter all therapists since one therapist asked to take part despite thinking it was for Muslim therapists only.

The confidence and views of therapists regarding the training and what was covered seemed to vary with regards to the general confidence levels of the therapists themselves in relation to the intervention. For example, two therapists were clear that they felt that the training needed to be improved but were unable to give examples of how we could achieve this.

Supervision

Attendance to the peer supervision meetings was poor. It was suggested by interviewees that therapists may not access supervision due to feeling over-supervised or spending too much time in supervision for different aspects of their work. However, one supervisor reported concerns that there was not extra supervision time allocated to discuss working with service users involved in the study.

The need for an extra hour of supervision time to allow discussion abound clients recruited to the pilot was raised at the training event. Feedback suggested that this was not authorised by senior managers although no further detail was provided.

Supervisors were asked whether issues raised in supervision were specific to the pilot or whether they were general supervision issues; one supervisor suggested that issues presented in supervision were those that would usually be discussed, whereas another felt that issues such as recruitment of service users were specific to the therapist being involved in a research study. Some therapists suggested that it could be useful to be able to ring someone who had Islamic knowledge, where this was missing from their support structure:

> *“if something came up that maybe was out of the booklet that you weren’t sure about then, maybe...yeah it would be good to have somebody to ring up and say 'this question's come up and I’m really not sure. I haven’t got a clue.' “*
>
> Psychological Wellbeing Practitioner

Depression measures

The general feedback, regarding the measures that service users were asked to complete, was that, on the whole, they did not mind having to complete them. The function of the measures was understood in terms of allowing them to keep an eye on their mood and see whether there was improvement from week to week:

“no. I think it was quite good because then she would show me the previous week and she would show where I’d had a change in and what had been more happier and where I’d gone down a bit more on. So it was nice to know that there was actually a change going on than just doing it every two weeks or doing it just the once and then at the end you’re like 'wow, I didn’t even realise that was going on.' So I think I was glad that it was happening every week so then I know what was going on”

Service User

Difficulties with the completion of the measures arose when either therapists did not read the written translation of the measure, although they may have been able to speak the language (for example Urdu), or the available translated version of the questionnaire provided by IAPT was either too complicated or not accessed by the therapist (for example in Arabic).

Analysis of scores from the PHQ9, GAD7 and WSAS measures used showed a high rate of non-completion for the three measures. This was partly due to drop out from the study but also because clients sometimes attended sessions without completing the measures. Measures were also not always provided to service users by therapists during the session when appropriate language versions were not to hand. The small number of patients in the study combined with the large amount of missing scores means that statistically valid results could not be obtained from the depression scores.

We were, nevertheless, able to calculate change in PHQ scores for 14 clients for whom initial and final PHQ scores were available. Of these four showed increased final PHQ scores and 10 showed decreased scores. Four clients had reliably improved scores (i.e. a reduction of 5 or more) and one client’s score increased by 5 points. One client's final score showed clinically significant improvement[26] from 14 pre-treatment to 4 post-treatment (See Appendix 6 for the statistical summary).

Considerable caution is needed in interpreting these results given the absence of a control group. It is possible that observed improvements reflect spontaneous recovery, as occurs in depression or regression to the mean effects.

Practical considerations

Team managers and supervisors commented on the process through which the study had been introduced to the Primary Care teams and the therapists. Although it is not unusual within the NHS for initiatives to have a top-down approach, interviewees felt that communication between commissioners, middle management and team managers needed to happen much earlier in the process in order to get

everyone on board. It was suggested that in future these should be face to face meetings between researchers and the teams being asked to deliver the intervention. This was echoed by a few of the therapists and it was suggested that researchers should attend team meetings on a regular basis so that they can remind teams about the project and the importance of the work to encourage recruitment.

There was also a suggestion that there may be some resistance to new ways of working or changes, and that any flexibility in working practices could be regarded negatively. This response could also be influenced by information passed on between teams.

General comments about the intervention were that the manual came across as a research document rather than a therapeutic manual. It was suggested that it contained too many references. One therapist compared the pilot manual to another manual being trialled for a different study in the NHS. These comments related to the aesthetics of the manual presented to therapists and suggested that even pilot material need to be presented in a glossy, final-looking version.

Two interviewees suggested that BA should be compared to CBT or another modality to highlight the effectiveness of the manual and the approach. This would suggest that some therapists had overlooked that BA has an established evidence base for use with people with depression, despite this being highlighted in the manual.

Often it appeared that the guidance in the manual was not dissimilar to the usual practice within Primary Care teams. However, at other times it seemed that usual practice was considered to be very different to the approach outlined in the manual. It became apparent that procedures such as discharging service users from therapy needed to be made much clearer because at times guidance from managers and supervisors seemed to be different to the manual. Guidance in the manual suggests that therapists discuss with clients how to work on obstacles that the service user may encounter in relation to their attendance to sessions. This is something that will need to be highlighted in the training since our fieldwork suggests that there is not a standard approach whereby therapists work collaboratively with service users to remind them of appointments. Some services send the service user a reminder text message which may help particularly if an individual has difficulty remembering appointments.

With regards to the BA model, the range of views indicates a need to address therapist preferences for cognitive models within the therapy and training to prevent resistance to the BA approach.

It was suggested that recruitment could be improved by engaging with GPs and doing some promotion work with them. Our own experience reinforces this as we enlisted the support of the YREN and they were able to recruit a GP practice, which helped significantly with recruitment.

Some therapists mentioned that service users being able to self-refer may also improve recruitment. It could be that if service users are not being recognised as having depression being able to self-refer would make access to appropriate psychological services easier. A couple of therapists suggested that the intervention could be delivered by mental health nurses or practice nurses who could be trained to deliver the intervention.

RECOMMENDATIONS

Implications for services:

- If services are able to provide a choice of therapist, this may make service users feel more comfortable to express their religious values. A shared or non-shared religious background was preferred by some service users, for others religion and ethnicity were less important than the gender of the therapist.

- Service users, regardless of how religious they were, mentioned that they were interested in receiving the intervention due to the faith adaptations that it included. Giving examples in earlier sessions of how religious beliefs can be incorporated into therapy may make it easier for service users to understand how their values will be addressed within therapy.

- Findings confirm the importance of identifying positive and negative religious coping and suggest that Muslim clients should be asked about the importance or otherwise of their religious background and whether they feel religion is a helpful resource or contributes to their depression.

- Although some therapists were unsure about how to work with the client booklet, service users were clear that they felt it was an important and useful resource. Therapists will need to be prepared to work with material that they are unfamiliar with in order to support Muslim service users in line with client preferences.

- Therapists and team managers talked about the lack of referrals to therapy services, even when teams covered areas with significant Muslim populations. Staff appointed to address stigma and other reasons for underrepresentation of Muslim service users could help address under-referral. Building links with voluntary organisations and community centres to boost referrals is also suggested as a potentially useful approach.

- Placing services within community centres and organisations may help break down some of the stigma associated with having mental health difficulties.. It may also be easier for individuals to access services if they are based in accessible environments, such as schools, so that they do not have to search for appropriate support, so that they do not have to search for appropriate support.

- Although interpreting and translation services are available in the NHS, findings suggest that GPs are not referring people who do not speak English as their primary language for psychological therapies. PCMH teams should therefore work with GPs to ensure rates of referral for non-English speaking Muslim service users reflect the local population.

- Both therapists and service users would benefit from having easy access to someone with expertise in religious knowledge as part of their support circle.

Implications for research

- Therapists should self-refer to take part in future research rather than being allocated to the study. This would reduce resistance to delivering the intervention and allow therapists to decide whether they are willing/ able to work with the model of therapy that has been developed.

  To improve recruitment, a number of therapists suggested that in future we should consider recruiting from GP practices and a wide range of other recruitment sites, including children centres and schools. Working with the Primary Care Research Networks early on to identify interested GP practices could also help recruitment run more efficiently.
- Working with whole teams and including team managers in the process as early as possible may also aid recruitment and help address any managerial issues early on in the process. Researchers should also attend team meetings on a regular basis would help improve communication and support for therapists delivering the intervention.

- A designated member of the team or a study researcher should take consent from participants, to address the fact that some therapists may feel uncomfortable about being involved in this aspect of the research process.

- Attendance to peer supervision sessions was poor but issues raised by therapists as the study progressed suggested that there was a need for such a forum. For this reason making attendance to supervision sessions

mandatory would improve not only attendance but therapist knowledge of how to deal with problems they have encountered.

- The synthesis of evidence carried out to develop the intervention drew on literature about a wide range of religious groups alongside a particular focus on Muslim service users with depression. Further research could potentially explore whether the manual would support adaptation of BA for service users from a range of faith backgrounds.

Implications for Training

- Training should provide an opportunity for therapists to practise using the values assessment to become familiar with the tool and its function and more confident in using it within therapy.

- Training needs to provide space for therapists to express how they feel about working with families and discussion around strategies for supporting this within therapy.

- Some therapists struggled with how to deal with issues typically dealt within CBT (such as working with negative thoughts) from a behavioural perspective and this also needs to be covered in the preparatory training.

- The fieldwork also suggests that training needs to make explicit the need for therapists to make links with community resources and the reasons why it is important for them to be prepared to do so.

- Procedures for following up and discharging service users need to be clarified in the training, particularly if these differ from routine practice.

Conclusion

Feedback from service users and therapists suggests that the adapted therapy does have a role to play in delivering appropriate mental healthcare for Muslim service users. Difficulties with recruitment of clients and therapists in the pilot project appear to have been related to the research process rather than the model of therapy itself.

Findings suggest the manualised therapy can be introduced successfully into the NHS, that it is acceptable to the majority of service users and therapists and that a number of strategies could improve recruitment to a full trial of the intervention.

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Appendix 1: Extract from the client booklet

Tie your camel: do your part

One day *Prophet Muhammad*, (pbuh), noticed a Bedouin leaving his camel without tying it. He asked the Bedouin, "Why don't you tie down your camel?" The Bedouin answered, "I put my trust in *Allah*." The Prophet then said, "Tie your camel first, then put your trust in *Allah*"[1]

Muslims must never become fatalistic. Although we know only *Allah* is in control and that He has decreed all things, we are each responsible for making the right choices and doing the right thing in all situations of our lives. "Indeed, *Allah* does not change people's condition unless they change their inner selves"[2]

⇨ ***Change starts with the individual. There is a cause and effect of our actions and we cannot change things unless we make an effort to change.***

Show yourself mercy

We are reminded throughout the *Qur'an* and *Hadith* about *Allah's* Mercy towards his creation. We are also told to be merciful towards others and ourselves

⇨ ***Don't forget to be merciful towards yourself.***

My space

[1] Narrated by Tirmidhi
[2] Qur'an: chapter 13 verse 11

Appendix 2: Recruitment flow chart

YES

Identify clients by referring to the criteria below:

Clients must have **depression**

or if the client has another diagnosis then the primary focus must be on the client's

NO

Do not recruit if the client has bipolar depression/ psychosis/ PTSD/ anxiety disorder

SPEAK TO SHAISTA MEER

Does the person identify themselves as **Muslim (or coming from a Muslim family or community),** even if they are not personally observant?

e.g. "I'm not religious but I am a Muslim"

If the client is not Muslim then do not recruit

If the client is **Muslim and has depression** then ask if you can tell them about the research that is taking place in BDCT.

If they are not interested, thank them for their time

What to tell them:

1. The research is aimed at making therapy more sensitive to the needs of Muslim clients, whether they are religious or not.
2. We have adapted a therapy and we are interested to find out if it meets the needs of Muslim clients.
3. Patients who take part will be referred to a therapist taking part in the study
4. Give them the Phase 4 Patient Information Sheet to take awav.

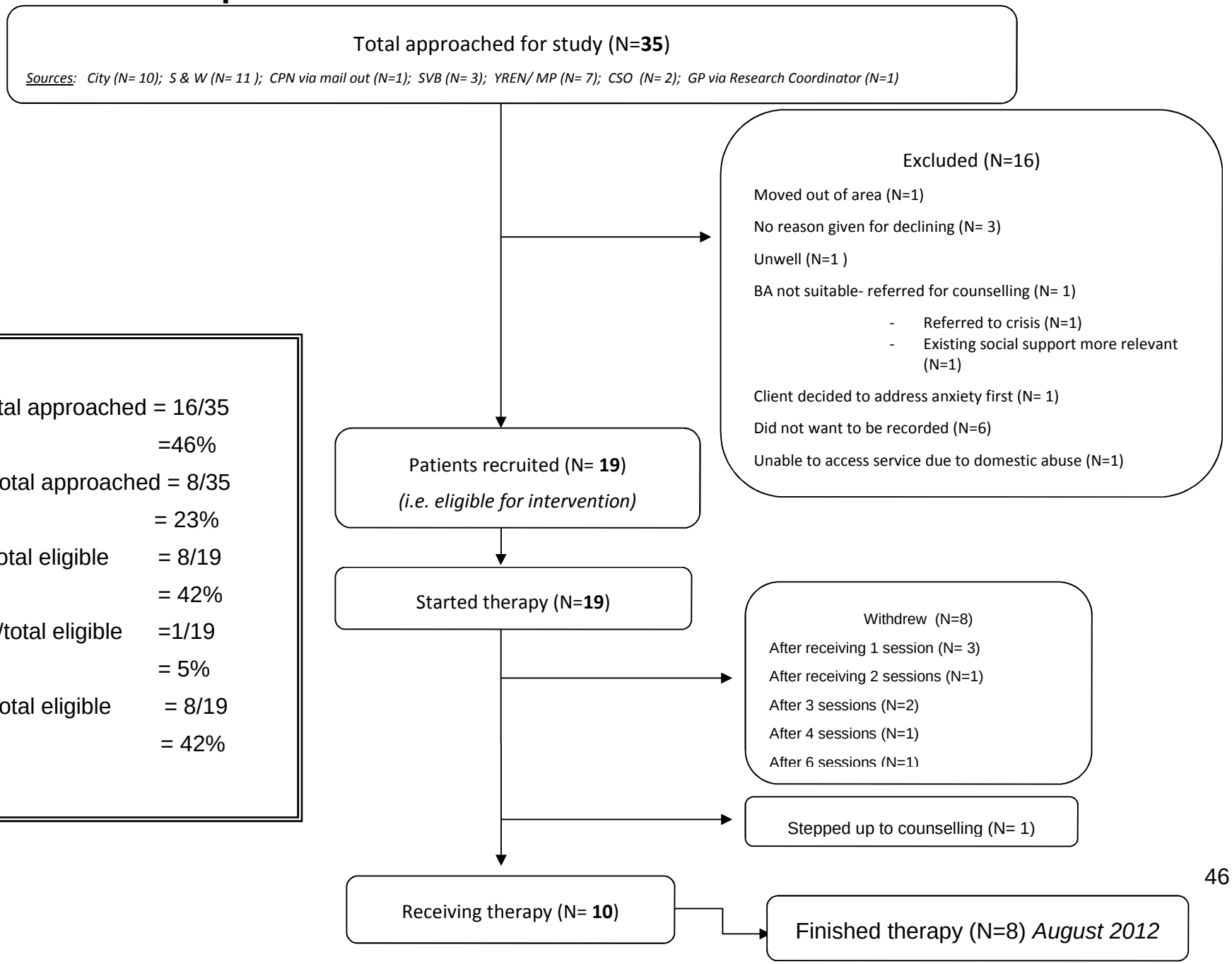
If they are happy to take part then tell them Shaista Meer will contact them about the research, to answer any questions and make sure they are happy to take part

Pass on the client's details to Shaista
s.m.meer@leeds.ac.uk 0113 3430826

trict NHS
e Trust

UNIVERSITY OF LEEDS

Appendix 3: Participant recruitment



Analysis

Total excluded/ total approached = 16/35
=46%

Total completed/ total approached = 8/35
= 23%

Total withdrew / total eligible = 8/19
= 42%

Total 'stepped up'/total eligible =1/19
= 5%

Total completed/ total eligible = 8/19
= 42%

Appendix 4: Adherence checklist

Tape ID	Reviewer	Date reviewed	

	No evidence present	Some evidence present	Clear evidence present
Was there evidence that a behavioural rational underpinned interventions within sessions • Reflection on shared BA rational in session to explain exercises • Checking understanding of BA approach with patient • Self monitoring of mood behaviour link • Activity scheduling • Using approaches to tackle avoidance (TRAP-TRAC , ACTION etc) • Exploring values- goal setting • Dealing with ruminations by exploring consequence • Relapse prevention using a behavioural model	No examples of the behavioural approach were present in the session	There was a mix of behavioural approaches but these were not specific nor linked to a clear shared rational	The interventions were clearly behavioural in orientation, shared, specific and linked to a collaborative rational
Was there evidence homework tasks were designed primarily to re-introduce environmental positive reinforcement-reduce avoidance • Shared understanding of homework tasks in place • Self monitoring to draw mood-behaviour link • Developing meaningful goals linked from session to homework • Scheduling activities based upon session discussion • Exploring problems with scheduling and examples reviewed in session-homework	No examples of the behavioural approach were present in the homework-no homework discussed	There was a mix of behavioural approaches but these were not specific nor linked to a clear shared rational for the homework task	The homework interventions were clearly behavioural in orientation, shared, specific and linked to a collaborative rational

• Use of approaches to manage avoidance as homework (TRAP-TRAC Healthy –unhealthy behaviour sheets • Monitoring rumination and/or RCA sheets explained and used • Relapse prevention tasks specific and linked to model			
Was there evidence that other therapeutic models (i.e. cognitive therapy) were central to session content or homework (if so please briefly note what was used and how)	There was no evidence any other therapeutic models governed session content	There appeared to be a mix of therapeutic models guiding the session but BA was prominent	There was clear evidence the interventions used were primarily of a therapeutic model other than BA
Additional questions: **sessions 1 and 2** • Did the therapist discuss religion when reviewing the values assessment sheet? • To what extent did the therapist explore in an accepting, non-critical way whether the client wanted faith to be a focus of BA? **later sessions** *For clients who wanted faith to be a focus of therapy:* • Did the therapist discuss thoughts with a religious content or about religion? • If so, did the therapist consider these thoughts from a behavioural-activation perspective (i.e., considered the function of these thoughts for depressive symptoms)? • Did the therapist discuss religious behaviours? • If so, did the therapist consider these behaviours	Yes There was no evidence of this present in the session Yes Yes Yes	No There was some evidence but it was not linked to a clear shared rational No No No	It was clear that The interventions were clearly behavioural in orientation, shared, specific and linked to a collaborative rational

from a behavioural-activation perspective (i.e., considered the function of the behaviours for depressive symptoms)?	Yes	No	
• Did the therapist ensure the approach was sensitive to the client's wishes about the integration of therapy and religion?	Yes	No	
For client who did not want faith to be a focus of therapy or whose views were not clear cut: • Did the therapist inappropriately try to discuss thoughts with a religious content or about religion even though the client did not want faith to be a focus of the sessions?	Yes	No	
• If so, did the therapist insist on trying to consider these from a behavioural activation perspective?	Yes	No	N/A
Overview: • To what extent did the therapist take an accepting, non-critical stance towards the client's religious beliefs?	There was no evidence of this present in the session	There was some evidence but it was not clear	It was clear and the therapist was open to discussing the client's religious beliefs.
• To what extent did the therapist's focus on religion in the session match the extent to which the client wanted this to be a focus (based on information gathered in sessions 1 and 2)?	There was no evidence that this matched the client's needs	There was some evidence that the therapist was trying to match the focus to that which the client wanted	It was clear that the therapist had matched the focus of the session to match that which the client had expressed

Overall would you say the session was behavioural therapy/activation	Yes	No

Appendix 5: Languages spoken by service users referred to Primary Care Mental Health Team between June 2010-May 2012

Language	No of patients
English	***5910***
Gujerati*	***5***
Punjabi*	***209***
Mirpuri*	***7***
Pashto*	***23***
Urdu*	***258***
Arabic*	***23***
Lithuanian	1
Flemish	1
Polish	43
Chinese	1
Bengali*	***17***
Cantonese	1
Czech	2
French	7
Hausa	1
Hindi	5
Mandarin	1
Spanish	3
Swahili	1
Sylheti*	***1***
Tamil	4
Persian*	***5***
Kurdish*	***10***
Italian	4
Albanian	1
German	4
Portuguese	2
Amharic	1
Dutch	1
Lingala	1
Finnish	1
Slovak	17
Slovenian	1
Malayalam	1
Hungarian	4
Estonian	1
Irish	1
Latvian	4
Georgian	1
Malay	2
Hindko*	***1***
Dari*	***7***
BSL	8
Patient refused to give language	26
No language recorded	***103***
Incorrect data	65
Total	**6796**

8% (566/6796) most likely to be from a Muslim background had their first language recorded as something other than English.

87% (5910/6796) had English recorded as their main spoken language.

1.5% (103/6796) did not have their language recorded by their GP

1.7% (118/6796) spoke a language other than English or a language spoken by someone from Muslim background

A small minority of people spoke British Sign Language (0.1%) or refused to say which language they spoke (0.4%).

1% of people referred had their spoken language recorded incorrectly (65/6796)

* Languages most likely to be spoken by people from Muslim backgrounds since countries linked to these languages have a majority Muslim population (N=566)

Appendix 6: Depression Scores Data – Summary Statistics

Measure completion rate.

Using the PHQ, GAD and WSAS scores we can determine the rates of non-completion up to the maximum of 12 sessions as follows.

	PHQ number completed	GAD number completed	WSAS number completed	Non completion (%)
1	18	18	13	1 (5%)
2	13	13	9	3 (16%)
3	11	11	7	8 (42%)
4	9	9	8	10 (53%)
5	10	10	8	9 (47%)
6	8	8	6	11 (58%)
7	7	7	6	12 (63%)
8	7	7	6	12 (63%)
9	3	3	3	16 (84%)
10	2	2	2	17 (89%)
11	0	0	0	19 (100%)
12	0	0	0	19 (100%)

It is clear that the drop out from completion of measures is very high and is in excess of 50% before seventh measurements are taken and reaching 100% (complete drop out) after the tenth measurement as most clients did not attend all 12 sessions.

Because we know at which stage each patient left the study we can calculate the total amount of PHQ scores we would expect in the study. For the PHQ data we can expect 108 possible scores if every available score was completed prior to drop out for all patients.

In terms of missingness, 13/108 (12%) of the scores are described as ‘attended session but did not complete measures’; 15/108 (14%) are ‘not available’; 2/108 (2%) are ‘not provided by therapist’ and 5/108 (5%) are missing with no further information available. In total 35% of the data are missing based on the 108 data

items for the PHQ score that should be available taking into account when patients left the study.

Changes in Score between first and final PHQ score

The scale of interest is PHQ-9. Reliable improvement on the PHQ-9 requires a change of 5 points or more. Clinically significant change requires a move from 10 or above pre-treatment to 9 or below at post-treatment. As most of the pre-treatment scores were missing, the first and last available PHQ scores were used to determine the change. The table below shows the calculated results and also which PHQ score was used to calculate the change.

Patient	Number of PHQ recorded	Number of sessions attended	Initial PHQ	Final PHQ	Change
ADMC5	10	10	7	6	-1
ADMC2	9	8	24	22	-2
ADMC4	9	8	9	7	-2
ADMC23w	2	3	9	6	-3
ADMC7	8	8	20	16	-4
ADMC14	10	11	23	19	-4
ADMC26w	3	3	25	19	-6
ADMC19	9	8	14	4	-10
ADMC10	7	5	27	17	-10
ADMC27og	4	10	22	12	-10
ADMC6	6	8	19	21	+2
ADMC12 og	2	5	13	18	+5
ADMC16	5	5	22	26	+4
ADMC11w	3	4	24	26	+2
ADMC1w	0	1	NA	NA	NA
ADMC9w	1	1	20	NA	NA
ADMC3w	1	1	18	NA	NA
ADMC24w	1	3	13	NA	NA
ADMC25w	1	3	25	NA	NA

w=withdrawn og=ongoing