Evaluating a Culturally Adapted Behavioural Activation Therapy (BA-M)

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Executive Summary

This report presents results from a randomised control trial and process evaluation of a behavioural therapy for depression that was culturally adapted for Muslim service users (BA-M). The trial was funded by Bradford District and Craven Integrated Care Board as part of its work on reducing inequalities. It included 142 service users and 27 therapists from both NHS primary care mental health (IAPT) services and voluntary sector organisations (VSOs). Qualitative interviews exploring participant views of BA-M involved 34 interviews with 18 service users, 9 therapists and 7 managers. A summary of findings from the trial and qualitative study is presented below.

Randomised control trial findings

The quantitative study was a parallel group randomised controlled trial of Culturally Adapted Behavioural Activation (BA-M) against Treatment As Usual (TAU) for the treatment of depression. Within IAPT, TAU was Cognitive Behavioural Therapy and within the voluntary sector TAU included a range of social interventions.

Analysis of quantitative measures (PHQ-9 and GAD7) showed a statistically significant and clinically important improvement for BA-M therapy compared to TAU. There was little evidence of difference in performance either by IAPT or VSO practitioners. The improvement in performance of BA-M could be explained by improved retention, that is, BA-M clients typically attended 3 more sessions that TAU clients, with depression scores improving by just over one unit per session attended. The trial thus provided evidence for the superior performance of BA-M within depressed Muslim clients compared to standard treatment.

Qualitative study findings

Access and Engagement: Muslim clients described a range of experiences in accessing and engaging with the therapy. For some, especially those seen by VSOs, this was a seamless referral but others faced challenges linked to long waiting lists and travelling distance. The location of services and availability of transport significantly influenced how easily people could access the treatment and local services were essential for some participants.

Cultural Adaptation**:** almost all service users found the approach helpful and a majority identified religion as a very significant value that was important for their therapeutic journey. Muslim identity was described by service users as 'very important'; the 'core of my identity'; 'more than everything' and a protective factor against thoughts of suicide. A small number of service users did not wish to discuss religion during therapy, and this was in general accommodated through a client-led approach. Service users could, however, drop out of therapy when therapists did not follow the BA-M guidance on how to discuss religion.

Therapists from all backgrounds could see the benefits of the approach for better engagement with Muslim service users and reinforcing therapy goals through values that were meaningful to services users. Some therapists expressed confidence in discussing religious matters during sessions,

I only managed to get this kind of therapy because I was a part of the [VSO] group and I just wish that it would have been easier […] if it was available through your GP or I could have known about it from somewhere else as well that would have been helpful.

(AT, female VSO service user)

I'm really grateful that I come across [BA-M] therapy [...] the fact that it connects you with your faith and explores them, it's got a lot more to it. So yeah, I would definitely recommend.

(CB, male VSO service user)

[The client] had a bit of like an aha moment, […] therapeutic values and like religious teachings are very similar in that like what we're saying to do for the treatment for depression. [,,,] So like bringing the two together was really helpful.

(ST, NHS therapist, female)

We really do need it within our communities so hopefully it will come to some kind of fruition and have some sort of impact in the future as well.

(BB, VSO manager, male)

especially after delivering the approach a number of times, and recognised they did not need to be Muslim or have expertise in Islam to deliver BA-M. Others developed this confidence over a period of time while delivering BA-M and valued the peer support and training opportunities. The client self-help booklet was seen as a key resource by both service users and therapists. Service users and therapists described positive outcomes from BA-M including increased self-esteem, independence and a return to activities that clients had enjoyed before becoming depressed.

Therapist-Client Relationship – this was a key influence on the therapy experience; participants valued warmth, empathy and a non-judgmental approach by therapists regardless of their background. Many service users reported feeling comfortable and emotionally supported during therapy, however, a few encountered communication hurdles and a lack of empathy. Service users did not want to have to educate therapists about Islamic practices and felt that a shared background could facilitate this kind of communication. However, not all service users wanted this and, even with a shared background, some Muslim therapists did not always feel comfortable discussing religious issues within the therapy space.

Issues for service development – the collaboration between IAPT and VSOs supported capacity building across both sectors and the approach facilitated increased knowledge and skills that significantly improved engagement with Muslim service users. Feedback from managers and therapists showed that the need to fill in research questionnaires for the trial placed considerable time pressures on therapists, which were a disincentive for inclusive practice. The demands of meeting IAPT targets are a further potential disincentive. VSOs could only continue delivering the approach with adequate resource and clinical supervision, which was not available after the research ended. This policy and resource gap is a barrier to the development of inclusive mental health services.

Recommendations

The following practical recommendations have been developed from study findings. They aim to ensure that the significantly better outcomes for Muslim service users continue in light of the positive response to the adapted therapy from service users, therapists and managers.

- BA-M should be adopted as a therapy choice that is routinely offered to Muslim services users within both IAPT services and voluntary sector organisations. This offer should be linked to ongoing staff training and support, including supervision by those with relevant skills and experience with the cultural adaptation.
- National and local funding and monitoring of mental health services for depression should redefine Key Performance Indicators to incentivise and resource inclusive provision. Current barriers to inclusive practice, such as inadequate resource allocation, time pressures on practitioners and lack of focus on engaging with Muslim service users should be addressed as a priority.
- Mental health services should aim to promote a message of social inclusion to Muslim populations that will support effective engagement through
    - promoting reflexive attitudes towards religion in general and Islam in particular
    - promoting the legitimacy of Islam as a value framework
    - ensuring that racism and stereotypes affecting Muslim service users are effectively challenged
- Care pathways for Muslim clients should facilitate continued collaboration between NHS and voluntary sector organisations to support service development in both sectors.

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Introduction

As part of its work to reduce health inequalities, Bradford Integrated Care Board (ICB) aimed to offer a culturally adapted version of Behavioural Activation therapy for depression (BA-M), for which there was existing evidence of feasibility (Mir et al 2015) and prior support from service users and providers (Mir et al 2019). Behavioural Activation (BA), on which the adapted therapy is based, can be effectively delivered by non-specialist mental health staff following training (Richards et al 2016; Ekers et al 2011) and the ICB was keen to increase such capacity within local voluntary sector mental health organisations (VSOs).

Primary care mental health (IAPT) staff within Bradford District Care Trust and in VSOs were consequently trained to deliver BA-M in 2020. This research study aimed to evaluate the impact of the adapted therapy on mental health service users and add to current knowledge on faith-sensitive interventions, for which evidence within minority faith groups is currently limited (Anik et al 2022; Koenig et al 2001).

The project ran between 2019 and 2023 and the principal research question was:

Does culturally adapted behavioural activation reduce depression in adult Muslims in Bradford when delivered by;

a) trained IAPT staff
b) trained non-specialist staff in voluntary sector organisations?

Secondary research questions were:

1. What impact does the intervention have on depression scores on completion of therapy compared with treatment as usual?
2. How is the treatment delivered in practice and what factors influence its delivery?
3. What impact does the intervention have on access to therapy, retention rates and recovery rates?
4. How relevant is the approach to a range of faith groups in Bradford and what adaptations might be needed for specific communities?

Trial design and sample size

A mixed method pragmatic randomised control trial with process evaluation was conducted to compare effectiveness of the BA-M intervention to the usual support offered (TAU) within each organisation. All procedures involving contact with research participants were conducted either online, by telephone or face-to-face, in accordance with relevant COVID-19 guidance on social distancing at the time.

Intervention and training

Culturally-Adapted-BA (BA-M) is an innovative adaptation of Behavioural Activation, an effective manualised psychological therapy for depression (Richards et al 2016; Mir et al 2015). The adaptation was developed and piloted by researchers at the University of Leeds and York with funding from the National Institute of Health Research (Mir et al 2015). The adapted treatment enhances standard BA through additional resources in the form of: a Values Assessment tool, a self-help booklet for clients that draws on religious teachings to reinforce therapeutic goals, a list of local resources with whom those delivering therapy are encouraged to collaborate where helpful; evidence-based guidance on how to engage with clients to treat depression and to understand the social context in which Muslim clients live. Involvement of family members and liaison with external sources of support is also recommended when helpful for treatment.

In order to prepare VSO staff, a one-off 5-day training course on BA was delivered to 18 staff from four community mental health organisations. The course was delivered by an academic at the University of Bradford and an NHS therapist involved in published studies on training non-specialists in BA (Richards et al 2016; Ekers et al 2011). The VSO staff were assessed as competent to deliver BA and clinical support to deliver the therapy from IAPT supervisors in Bradford District Care Trust was organised, including regular supervision and peer group meetings.

Training on how to deliver BA-M was then delivered to 30 staff members from both NHS Primary Care Mental Health (IAPT) Services and VSOs, drawing on materials and experience from relevant prior studies (Mir et al 2015). Managers and supervisors also attended the training to support implementation. Lessons from the pilot trial about engagement with Muslim clients and delivery of the therapy were presented and supplemented through feedback on use of the approach in practice and trainees' ideas on how the approach should be adapted to the service and context in Bradford. Existing successful strategies for retaining Muslim clients in therapy were also discussed.

During the course of the trial, the research team also worked with Sharing Voices, Bradford, one of the VSOs involved, to facilitate a workshop exploring the wider relevance of the culturally adapted approach to people with depression from a range of diverse faith groups. The potential for the self-help booklet to be adapted for different faith groups and, if relevant, mechanisms for producing faith-specific versions of the booklet was discussed a this event (Choudary and Mir 2021).

Recruitment

Trial participants were recruited through the following sites which also provided the BA-M therapy:
(1) Bradford District Care Trust (BDCT) primary care mental health (IAPT) service
(2) Naye Subah, a VSO
(3) Sharing Voices, a VSO
(4) Women Zone, a VSO

Over an 18-month period (October 2021 - March 2023), assessment staff within these organisations identified eligible Muslim clients and provided them with information about the study. Participating clients met the following eligibility requirements:

(1) clients had a baseline PHQ9 score of at least 10.
(2) clients described themselves as Muslim.
(3) clients were resident in the catchment of BDCT.
(4) clients were at least 16 years of age.

Eligible clients were randomised in blocks of 2 at a ratio of 1:1 and allocated to either BA-M or usual support (TAU). There was no blinding and clients were recruited on the basis of intention to treat. Recruitment supported inclusion of those with limited English ability. Routine practice within all organisations involved was for bilingual members of staff to support service users with limited English language reading skills through either translated materials (e.g. PHQ9 is available in a number of different languages) or verbal explanation of questions for languages in which staff had fluency. Languages spoken by staff varied across organisations but included Urdu, Punjabi, Bengali and Hindko, which are common languages in the Bradford Muslim community. For other languages interpreters were employed to support communication where possible. Staff involved in the study provided verbal explanations and support to fill in forms for service users who did not speak these languages or English or did not have literacy skills in any language.

Formal consent for involvement was taken by staff involved in recruitment or at the first therapy/support session by therapists to whom clients had been allocated. Clients agreeing to take part in the trial were allocated to receive either standard treatment/support or at least 6 weekly sessions of BA-M delivered by trained IAPT or VSO staff members. Four booster sessions were also to be offered following completion of therapy. Within IAPT, the BA-M treatment arm was delivered by trained therapists in the City IAPT team.

A Values Assessment was conducted early in the BA-M therapy process to identify clients for whom faith was an important value. Where clients did not identify religion as an important value, they received standard BA. Those who did identify religion as an important value and wished to draw on faith as a resource for health were offered a self-help resource. All staff delivering the adapted therapy had access to the BA-M manual (Mir et al, 2012), which supported understanding of the client's cultural context, such as relationships with family or community members, as well as guidance on engaging with religious identity.

Treatment as usual (TAU) was delivered by staff not trained in BA-M. In IAPT settings TAU comprised low intensity Cognitive Behavioural Therapy. TAU was offered across therapy sites in Bradford, Airedale, Wharfedale and Craven as well as by therapists not trained in BA-M within the City IAPT team. In VSO settings TAU comprised one or more of the following: one to one counselling, life coaching, exercise, peer to peer groups, walking & cycling groups, cooking sessions, arts and craft sessions, confidence building workshops, community travel, welfare and housing support, education and training sessions, befriending and wellbeing services.

Measures

The primary outcome was taken to be the score derived from the PHQ9 questionnaire (the PHQ9 score) at the final therapy session. Secondary outcomes included GAD7 score and PHQ9 score recorded at each session. A further outcome of interest was 'recovery' defined as a final PHQ9 score below 10 and GAD7 score below 7. Anonymised data was collected from BDCT and VSOs over the recruitment period.

The sample size calculation was based on the final PHQ9 score means of the two therapy groups, rather than the final PHQ9 adjusted for baseline score. This ensured that power was sufficient and based on known PHQ9 attributes. The standard deviation of the final PHQ9 score was taken to be 5.0 units. Then with 5% significance, a difference (two-sided t-test) in means of 3 units could be detected with 90% power given that there were at least 60 clients in each therapy arm.

Statistical analysis

The primary analysis was to use an ANalysis of COVAriance (ANCOVA) approach where the final PHQ9 score was regressed upon the baseline PHQ9 score and the type of therapy. Other

analyses were undertaken to provide more detail, but all subsequent analyses were considered to be secondary analyses. That is, conclusive evidence was based on the primary analysis only. An additional term for type of organisation (BDCT or VSO) was included in the ANCOVA model as a secondary analysis. A mixed effects model was fitted to the full set of PHQ scores, that is the scores from all sessions. The mixed effects model included a random intercept for clients and an interaction term of session number and therapy type. The residual maximum likelihood method (REML) was used. In addition a plot of trajectories together with mean values and a smooth was provided to graphically demonstrate the main findings. A similar multilevel model was used for GAD7 scores.

The number of sessions attended was compared between the two therapy arms with Wilcoxon's rank-sum test. The outcome of recovery was tabulated against therapy type and association assessed using Pearson's chi-squared test. A subgroup analysis was undertaken repeating the ANCOVA analysis for PHQ9 with the BDCT data alone. With smaller numbers this was not well powered.

Qualitative process evaluation

Qualitative research was undertaken in parallel to the quantitative assessment. Interviews were conducted with 34 stakeholders at IAPT and VSO sites - 18 service users who received BA-M treatment, including 6 who had dropped out of therapy, 9 staff who had delivered BA-M and 7 managers and supervisors. Interviews explored experience of the intervention in terms of: barriers and facilitators to implementation or access, impact, reach, acceptability, contextual and other influences on delivery and/or perceived impact, mechanisms of impact and unanticipated effects. Separate consent was taken from clients in the BA-M arm at recruitment stage to participate in the qualitative evaluation. Verbal informed consent was obtained if it was technically difficult to obtain written consent because of limited literacy. Interview data was translated, if necessary, transcribed and coded using NVivo software and analysed using framework analysis to identify key themes (Ritchie et al 2003).

In addition, implementation issues were noted by the lead researcher during peer support sessions for therapists and project steering group meetings during the course of the study.

Randomised Control Trial Results

The quantitative study was a parallel group randomised controlled trial of Culturally Adapted Behaviour Activation (BA-M) against Treatment As Usual (TAU) for the treatment of depression. The trial provided evidence for the superior performance within depressed Muslim clients for BA-M. Figure 1 gives a representation of the flow of clients through the trial.

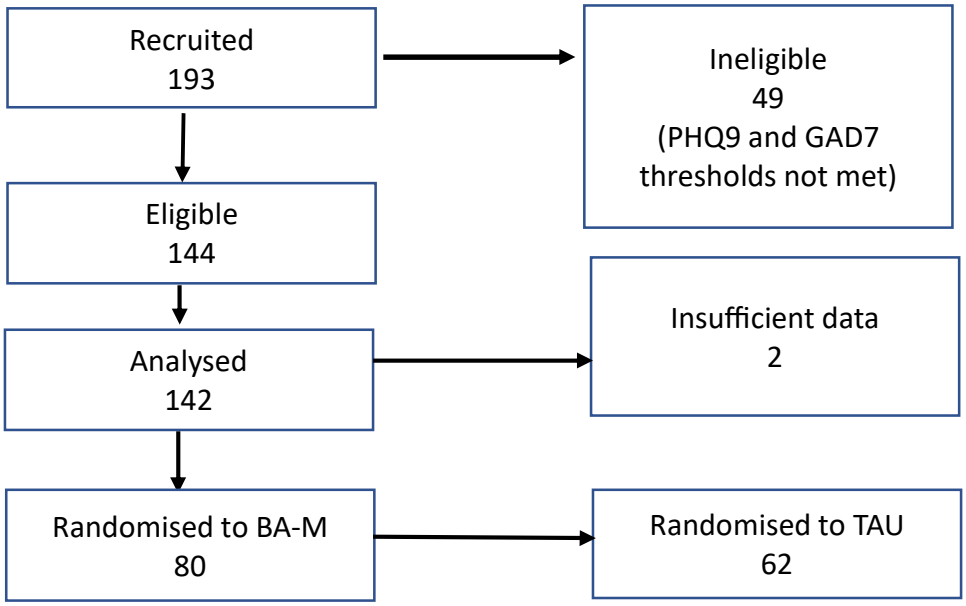

Figure 1: CONSORT flow diagram

Table 1a provides a tabulation of demographic details, baseline values and outcomes by therapy arm. Table 1b provides a cross tabulation of baseline values and outcomes by therapy arm. Means and standard deviations are reported for scores which are considered as continuous variables. Medians and Inter-Quartile Ranges (IQRs) are reported for the number of sessions. A column of p-values are provided relating to t-tests, Wilcoxon rank-sum test, and chi-squared test to enable simplified comparison. Note that these tests are not used for conclusive evidence except in relation to the recovery outcome and the number of sessions attended. Table 2 repeats this for IAPT services only.

Table 1a Cross tabulation of baseline scores and outcomes by therapy arm

	BA-M	TAU	p test
n	80	62	
Gender (%)			
Female	66 (81.5)	53 (88.3)	0.382
Male	15 (18.5)	7 (11.7)	
Ethnicity (%)			
Asian or Asian British	79 (97.5)	58 (96.7)	0.483
Black or Black British	0 (0.0)	1 (1.7)	
Not stated	2 (2.5)	1 (1.7)	
Baseline PHQ9 (mean (SD)	19.18 (4.09)	19.98 (3.54)	0.218
Baseline GAD7 (mean (SD)	16.34 (3.17)	16.56 (3.32)	0.679
Number Sessions (mean (SD)	3.83 (2.71)	1.50 (2.17)	**<0.001**
Final PHQ9 (mean (SD)	13.57 (6.85)	17.61 (5.13)	**<0.001**
Final GAD7 (mean (SD)	12.18 (5.80)	15.21 (4.32)	**0.001**

Table 1b Outcomes by therapy arm

	Level	BA-M	TAU	p-test
n		80	62	
Sector (%)	IAPT	34 (43%)	27 (44%)	0.999
	VSO	46 (58%)	35 (57%)	
Baseline scores				
PHQ90 (mean (SD))		19.18 (4.09)	19.98 (3.54)	0.218
GAD70 (mean (SD))		16.34 (3.17)	16.56 (3.32)	0.679
Outcomes				
Number Sessions (median [IQR]		4.00 [1.00, 6.00]	0.00 [0.00, 2.00]	**<0.001**
FinalPHQ9 (mean (SD))		13.57 (6.85)	17.61 (5.13)	**<0.001**
FinalGAD7 (mean (SD))		12.18 (5.80)	15.21 (4.32)	0.001
Recovery (%)	Recovered	24 (30%)	4 (7%)	0.001
	No recovery	56 (70%)	58 (94%)	

Table 2 Outcomes by therapy arm for IAPT

	Level	BA-M	TAU	p-test
n		34	27	
Baseline scores				
PHQ9 (mean (SD))		19.15 (3.84)	21.15 (2.44)	0.022
GAD7 (mean (SD))		15.15 (3.09)	16.52 (3.90)	0.130
Outcomes				
Number Sessions (median [IQR])		4.50 [1.00, 6.00]	2.00 [0.00, 4.00]	0.065
FinalPHQ9 (mean (SD))		13.12 (7.79)	17.07 (5.53)	**0.030**
FinalGAD7 (mean (SD))		10.65 (6.68)	14.37 (5.19)	**0.021**
Recovery (%)	Recovered	12 (35%)	3 (11%)	0.060
	Not recovered	22 (65%)	24 (89%)	

Note that in particular the recovery rate shown in table 2, for those provided TAU was 3/27 (11%) whereas the recovery rate in the BA-M group was 12/34 is 35%. An Intention To Treat (ITT) approach was undertaken. Specifically, treatment is regarded as the treatment assigned at baseline, even if treatment changed later.

The ANalysis of COVAriance (ANCOVA) regression of Final PHQ9 upon Baseline PHQ9 and type of therapy was the primary outcome. A table of coefficients is given in Table 3.

Table 3 Table of coefficients for the ANCOVA of PHQ9

Coefficients:

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	0.005157	2.371096	0.002	0.998
PHQ9(Base)	0.704333	0.120116	5.864	<0.001
Therapy TAU	**3.532442**	**0.937740**	**3.767**	**<0.001**

Note that this is the primary analysis. It shows that the Final PHQ9 is strongly associated with the Baseline PHQ9 and the type of therapy, with the TAU arm on average scoring 3.5 units higher than the BA-M arm. Specifically the BA-M clients report fewer symptoms than the TAU clients and the result is highly significant both clinically and statistically.

With type of organisation added as a further factor, the ANCOVA of PHQ9 yields the coefficients shown in Table 4.

Table 4 Table of coefficients with type of organisation

Coefficients:

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-1.2657	2.5030	-0.506	0.614
PHQ9 (Base)	0.7272	0.1205	6.035	<0.001
Therapy TAU	3.5414	0.9334	3.794	<0.001
Sector VSO	1.4273	0.9364	1.524	0.129

Note that the VSO performance appeared a little worse (1 symptom unit worse than IAPT), however, there is little evidence ($p > 0.05$) that the type of organisation is associated with a significant effect.

The mixed-effects longitudinal model fitted well with residuals ranging from -2.9 to +2.7 units with a median of 0.0 units. There was an ICC = 0.51, a high value as expected showing strong clustering of PHQ9 measures within clients. Fixed-effects are shown in Table 5. Note that the only statistically significant coefficient is that for the number of sessions indicating that the main effect is driven by the number of sessions attended. There is little difference in the effect of attending either a BA-M or a TAU session, the significant difference between the arms is explained by better retention in the BA-M arm than in the TAU arm.

Table 5 Coefficients for the fixed effects in the longitudinal model

Fixed effects:

	Estimate	**Std. Error**	***t* value**
(Intercept)	19.279828	0.669971	28.777
Therapy TAU	0.713132	0.796919	0.895
Session	-1.150087	0.091372	-12.587
Sector VSO	-1.224369	0.742339	-1.649
Therapy TAU:Session	-0.006764	0.205323	-0.033

For GAD7, the ANCOVA model results are shown in Table 6. Note that there is a significant effect of the baseline GAD7 score and that the BA-M therapy is associated with an improved performance of 2.9 units more reduction in GAD7. This finding is both statistically and clinically significant.

Table 6 Table of coefficients of the ANCOVA model for GAD7

Coefficients:

	Estimate	Std. Error	t value	Pr(>|t|)
(Intercept)	2.4089	2.1171	1.138	0.257
GAD7 (Base)	0.5974	0.1258	4.747	<0.001
Therapy TAU	2.9059	0.8144	3.568	<0.001

Figure 2 provides a plot of the trajectories of PHQ9 scores by session attended. Such plots are commonly referred to as spaghetti plots. The trajectories are coloured by type of organisation providing the therapy. Mean values at each session is marked with a black triangle and a smooth is added as a blue line complete with 95% confidence envelope.

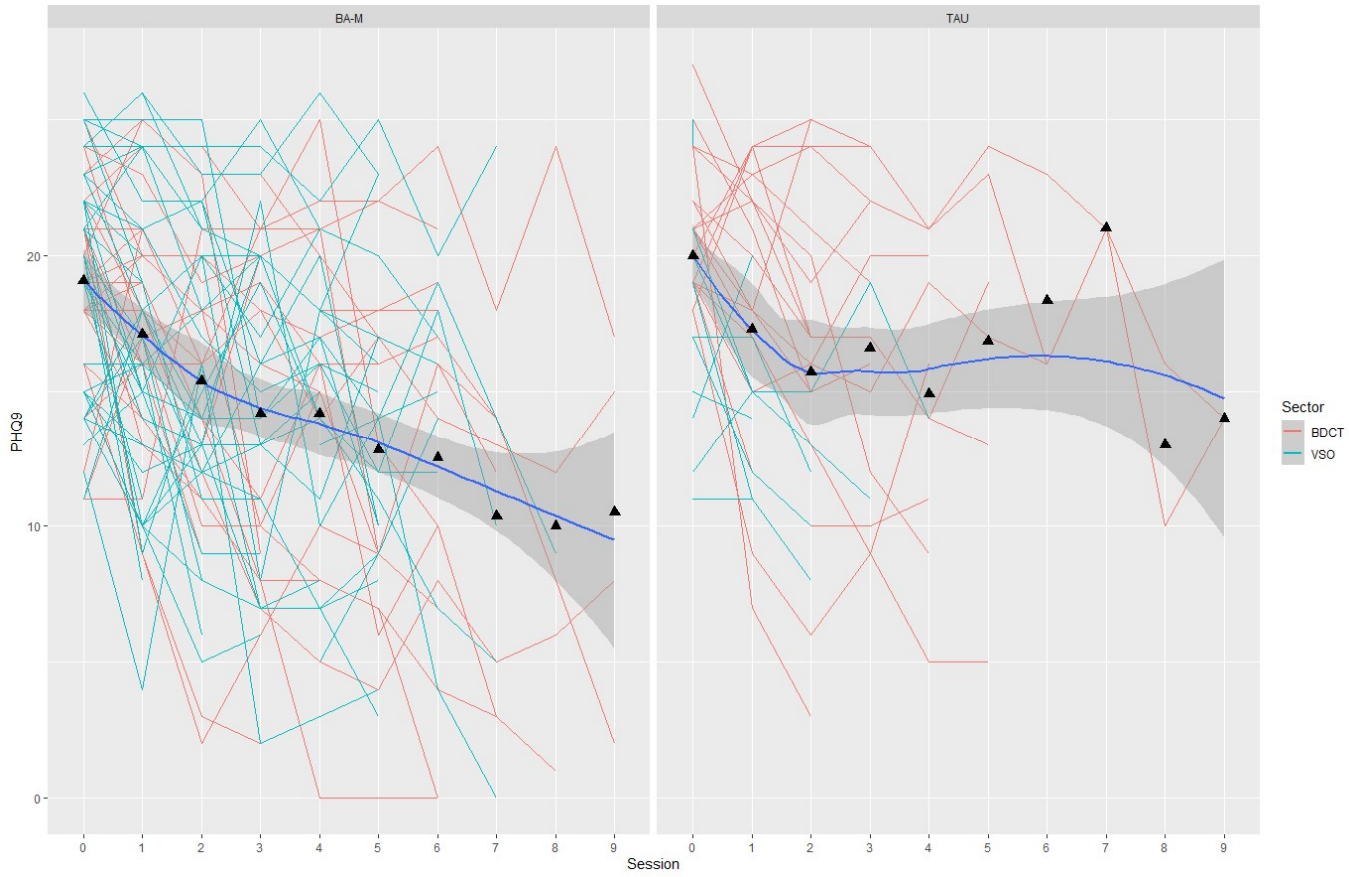

Figure 2 Spaghetti plots for PHQ9 trajectories

In summary, the analysis of quantitative measures shows a statistically significant and clinically important improvement for the BA-M therapy compared to TAU. There was little evidence in difference of performance delivered either by IAPT or VSOs. The improvement in performance of BA-M could be explained by improved retention, that is BA-M clients attended on average more sessions that TAU clients, typically 3 more sessions, with clients improving by just over one unit per session attended.

Qualitative Study Results

Interviews were conducted from participants from all groups (service users, BA-M trained therapists, managers/supervisors) and recruitment sites. One site did not provide any contact details since service users accessing their service did not consent to being interviewed for the research.

Researchers contacted 71 service users in total, 37 service users that had completed therapy and 34 who had dropped out of therapy early. From these 71 service users, researchers were able to interview 18 (see table below). Nine service users received BA-M from an IAPT therapist and nine from a VSO therapist. Three IAPT service users interviewed had dropped out of therapy. None of the VSO service users interviewed had dropped out of therapy early. Therapists, managers and supervisors were also contacted for interviews. In total nine BA-M therapists were interviewed. Eight IAPT therapists were contacted for interview and four were interviewed. Eight VSO therapists were contacted for interview and five were interviewed about their experience of delivering the intervention. Ten managers/supervisors were contacted and seven agreed to be interviewed. From this group of participants, three were working in IAPT.

Participant group	**IAPT** N=9		**VSO** N=9	
Service user	Completed therapy	Dropped out	Completed therapy	Dropped out
	6	3	9	0
Therapist	4		5	
Manager/ supervisor	3		4	
Total	16		18	

Table 6: Participants interviewed.

Access to therapy

Participants were asked about the ease of accessing therapy and support. One participant said as they were already part of VSO group, it made it easier for them to access that support and find out about the therapy.

"… I wouldn't have been able to access it if I wasn't already a part of Naye Subah so I wouldn't have known where to get help...there was no other place where I could've gone to find this out"
(AT, VSO, service user, female, completed)

Participants had mixed views about waiting times for accessing the programme. Two reflected that it took longer than they expected it to.

"It was quite a while I'd say… within 3 months…it didn't feel like 3 months because time flew by"
(AC, NHS service user, female, completed)

"Difficult…very…it needs time, there is a queue, that causes another headache (laughs)"
(NN, NHS service user, male, dropped out)

One participant felt it was easy to access the programme and didn't take as long as traditional therapy routes.

"It was pretty easy at first…they reached out to me... it was pretty simple"
(BJ, NHS service user, male, completed)

Language preference was considered in therapy. A participant (NN, NHS, service user, male, dropped out) shared that they had an interpreter in their sessions as they needed to *'speak deeply'* and felt they could do so better in their own language.

Other facilitators and barriers to access faced were location. Participants shared mixed views depending on where they lived. One participant (TN, NHS service user, male, completed) highlighted difficulties in getting there due to no longer having access to a bus pass and having no alternative transport. Another expressed that every community should have a centre to improve access.

"It is good in that it is local…in every single local community centre there should be something like that, so people can approach. I couldn't drive to go to further places, and knowing there was something very local that I can just walk into, makes it easy for me"

(TK, VSO service user, female, completed)

Opportunity to describe experience

The majority of participants said they were given the opportunity to describe their situation to the therapist and had felt comfortable with the response to issues they raised in session.

I think like the initial question, one of the initial questions was like, so what brought you here you know, like what led you to seek out therapy? So that let me share my kind of moment in time, yeah.

(NH, female, NHS service user, completed)

Sometimes I used to say I'm feeling like this […]. I would ask them a question like what should I do, how can I deal with this? […] they would give me tips and refer me back to the booklet and things like that and say or remind me of something I said earlier in another session […]so that was helpful.

(AT, female, VSO service user, completed)

Two participants, however, both of whom had dropped out of therapy, said that they had not received a satisfactory response when they tried to explain their problems to the therapist.

I talked about myself a little bit, but straight away he said, I'm not going to go for your personal life […].

(HI, male, NHS service user, dropped out)

I tried to tell them myself, but there was no interest from their side.

(NN, male, NHS service user, dropped out)

Factors affecting access

The reduced waiting list for the targeted project, compared to traditional therapy routes, was mentioned by some participants as supporting increased access[1]. Others mentioned encouragement to attend by friends or referrals to the organisations delivering BA-M. The mode of delivery could also influence how participants viewed their access to therapy. Telephone or virtual sessions via Zoom were acceptable to some participants but not others and the choice of either was valued

"I wasn't happy about it because I'd rather talk face to face than on the phone"

(QB, VSO service user, female, completed)

"Like in a COVID lifestyle that we all lived… it was very kind of, very aware and easy to access."

[1] NHS service user, female, completed; TI, NHS therapist, female

(NH, NHS service user, female, completed)

“I was given the option of having it face to face or over the phone or …I always prefer face to face so I did it face to face. My last two sessions I did over the phone because I was at university, so it clashed…”

(AC, NHS Service user, female, completed)

Difficulties in timing and scheduling sessions could prevent access, especially if sessions were not local and service users were reliant on others for transport.

“Because my daughter she got a bit busy and other things, and that’s why..."

(QB, VSO service user, female, completed)

“I don’t go long distance things because I’m still not that good with the driving."

(TK, VSO service user, female, completed)

Local services in community centres were essential for some participants who would otherwise not have been able to access the therapy. The lack of previous support for some people using these services was also raised by a clinical supervisor who was overseeing delivery in VSOs

“I think these [community centres] are really helpful, and I think the Government should never close them, please. We need them.”

(TK, VSO service user, female, completed)

I only managed to get this kind of therapy because I was a part of the [VSO] group and I just wish that it would have been easier. This kind of thing, if it’s available for people, just the fact that you can get this kind of therapy maybe if it was available through your GP or I could have known about it from somewhere else as well that would have been helpful.

(AT, female, VSO service user, completed)

...the client’s that [VSOs] were getting had schizophrenia and personality disorders.

(TH, female, VSO, therapist)

Access could also be affected by the extent of service flexibility when clients were unable to attend sessions. Some participants mentioned reasons for missing or cancelling therapy sessions, such as health issues, medical appointments, and personal circumstances. They appreciated the understanding and flexibility of voluntary sector services in accommodating these interruptions.

"I think a couple of times we had to reschedule because of my health - I wasn’t well"

(AT, VSO service user, female, completed)

"one session because I had an appointment with my doctor or something."

(SN, VSO service user, female, completed)

"When I felt like I wasn’t in the right mind frame to want to attend..."

(CB, VSO, service user, male, completed)

"They were understanding and said okay as long as we don’t miss it so that the development can keep going."

(AT, VSO service user, female, completed)

"She was very understanding and that was really helpful as well..."

(CB, VSO, service user, male, completed)

An NHS participant, however, left therapy early, and reluctantly, due to an unexpected trip to Pakistan, and had difficulties in resuming therapy upon return. In contrast with the VSO service users, he expressed frustration with the inflexibility and lack of understanding from the service.

“when I returned, I called so many times to be readmitted...I went to their office and spoke to them on the phone, I told them everything but even then, they said ‘no’ and behaved very roughly.”
(NN, NHS service user, male, dropped out)

Attitudes towards cultural adaptation

Acceptability of BA-M therapy

Service users were generally supportive of the therapy approach and highlighted the benefits and positive changes resulting from sessions.

"I came back after the trip and I was a different person... it was the last push that I needed."
(KT, VSO, female, completed)

"It is good. It was relaxed and a good experience."
(SN, VSO, female, completed)

Motivation to continue with therapy could come from the attention to religious teachings in therapy as well as the support to reframe their situation while acknowledging what service users were feeling.

"It was more about my faith actually, it’s different and I wanted to go and learn more and talk more... Going there and learning that again and talking about that thing really helps me."
(TK, VSO service user, female, completed)

" he was able to kind of reframe it and then, and I guess acknowledge what you were feeling, that helped."
(NH, NHS service user, female, completed)

Two participants dropped out of therapy, however, because of difficulty in communicating with their therapist. In one case the therapist appeared to have overstepped therapy guidance in terms of how to discuss religion and this was exacerbated by work-related issues. The other participant felt repeatedly being asked questions affected his motivation to continue.

"I found it a bit difficult like talking to a Muslim therapist…that was one of the reasons that why I felt maybe it’s better to stop it...and then like work started, that was one of the reasons I felt maybe it’s better to stop it."
(BJ, NHS service user, male, dropped out)

“being asked again and again, that is provoking me actually...affects my motivation”
(HI, NHS service user, male, dropped out).

Therapists discussed challenges in engagement and attendance, including forgetfulness and difficulties related to scheduling. Although the intervention itself was seen as helpful, the research process could be overwhelming due to the number of questionnaires and raise concerns about confidentiality and trust through a request for (optional) session recording to check therapist compliance with the manual.

“Clients that were home, they would forget their appointment at times."
(ZB, VSO, F, therapist)

"So maybe the whole research process is quite overwhelming then with a lot of the questionnaires… which was a shame because the client that I did get to see it through with, the intervention was really good."
(CT, NHS Therapist, male)

"As soon as you mentioned recording, it’s just that trust and what’s going to happen to mine..."
(BB, VSO Manager, male)

Importance of religion

Most service users said that religion was a key part of their identity[2] and signified their personal relationship with God[3] using terms such as '*very important*'[4], '*110%*'[5], '*number one*'[6], '*more than everything*'[7], or '*my religion is first priority for me*'[8].

Faith was protective and gave some a reason to continue when circumstances were bleak.

It's because of that [religion], that we ... keep going. [...] like prayer etc, it's built into the body.
(NN, male, NHS service user, dropped out)

I do a lot of the elements that come from religion, so it is very important to me, like it is my identity, it's part of who I am. [...] I'm a Muslim, I follow faith, I pray when I can, it's like me and God.
(NH, NHS service user, female, completed)

Some participants described how Islam helped them frame life events[9], and was a source of comfort and strength[10].

...Definitely important because it's these things that we know […] is trial and test for us.
(IC, NHS service user, female, completed)

Very important, absolutely, it's the core of my being as a Muslim woman […]. I think with mum passing away, [...] the way I live life now, is I spend every day is like my last day, not in a morbid way, but in a more fully way because you don't know when you're going to go back to Allah [...]. So yeah, it's the core of everything that I do [...] religion is absolutely core.
(KT, female, VSO service user, completed)

However, the way in which religion was raised and discussed by a therapist could be problematic even for participants who felt this was an important value. One service struggled to be honest about his thoughts in therapy with the Muslim therapist allocated to him as it seemed the space created to discuss this did not feel safe enough to discuss his conflicting feelings.

... very important, yes, that's one of the reasons I found it uncomfortable because […] sometimes I feel I might say something that I'm going against my religion [...]. Because obviously Islam teaches you to be thankful for whatever you've got. I sometimes got upset, a lot of my issues and stuff, I wasn't being thankful. Even when I was doing, you know dhikr (remembrance of God). […] I felt like I was believing it but was it sincerely? I'd question myself. So I'd say religion is very important to me.
(BJ, NHS service user, male, dropped out)

One participant said that although he did practise aspects of Islam, such as going for Friday prayers, he felt alienated from the materialism of religious leaders in his community.

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[2] NN, male, NHS service user, dropped out; NH, female, NHS service user, completed.
[3] NH, female, NHS service user, completed.
[4] AC, female, NHS service user, completed; NC, female, VSO service user, completed; KB, female, VSO service user, completed.
[5] QB, female, VSO service user, completed.
[6] CB, male, VSO service user, completed.
[7] TN, male, NHS service user, completed.
[8] SN, female, VSO service user, completed.
[9] IC, female, NHS service user, completed; KT, female, VSO service user, completed; TK, female, VSO service user, completed.
[10] AL, female, VSO service user, completed; NN, male, NHS service user, dropped out; AT, female, VSO service user, completed.

... I went to pray. I went to Jummah [Friday prayer], I just came back. But I don't believe on these mullahs, very simple because they are only money-making machines, nothing else.

(HI, NHS service user, male, dropout)

Therapist and manger responses

Therapists indicated that between 60-100% of Muslim service users with whom they engaged during the trial identified religion as an important value. Some of those who did not initially select this as important could also raise this later during the course of therapy.

....if they were offered that and they'd opted for it, all of them did, the ones that I worked with, they did identify that as being important.

(ST, NHS therapist, female)

A majority of them said that they found religion helped with their mental health. [...] I think 80%. I mean one of them said to me that if it wasn't for religion then I wouldn't be here. One of them said - because in Islam it is a sin to commit suicide so for that reason she didn't.

(TC, VSO therapist, female)

Most of them did. I mean, even if they didn't initially, it was while therapy went on. The values were introduced again because maybe I felt it's not the values they've chosen aren't actually quite as important to them. Maybe they realised as well and maybe they realised that religion could be incorporated as well. [...] I'd say about 80%, yeah.

(TH, VSO therapist, female)

One therapist highlighted that whilst a service user may identify religion as important, this may not be an area that they felt related to the goals they chose to address in therapy.

….Like some clients say no, relationship is the priority and some say it's the religion. So, when you go through the conversation, you find out, there is no religion there. [...] They might say, 'no religion is our personal thing, we don't want to talk about it'.

(MH, VSO therapist, female)

Another therapist appeared to believe that participants had identified religion as important in order to access therapy faster. This was a misconception, however, as inclusion in the study was not dependent on the service user practising their faith. If a service user identified as Muslim, they would receive either standard BA or the adapted BA-M therapy, depending on whether they identified religion as an important value.

I would say around 60% so more than half. I think quite a few people wanted to just get fast tracked for the assessment and then kind of backtracked on it. (TI, NHS therapist, female)

Feedback from an NHS manager endorsed the importance of the approach, but suggested this was already being used in a less structured way. This did not really align with our other data on previous experiences of therapy (see below).

So there's absolutely a need for it and I think it can be for certain clients an absolute priority and can make all the difference when somebody is acknowledging. It's part of obviously what this research is based on. It's about looking at what the values are of somebody and obviously if cultural and religion come up there high, then you want to be making sure that you are bringing that into the session. So I think it's something that we try to focus on in the service already, obviously not as structured as this, [...] It's more about giving more choice and more focussing therapy on what's going to be important to clients.

(OI, female, NHS, manager)

Values assessment and goal setting

The Values Assessment exercise is an essential part of the BA-M approach and enables service users to identify the importance of religion in their lives. This can then be followed up by introduction of a client self-help booklet that provides Islamic teachings to help service users draw on their beliefs to achieve their goals.

Some service users were clear that the Values Assessment was an empowering exercise that helped in ensuring that the therapy could focus on what was important for them to work on. For some it was the first experience of being asked about what was important to them and being understood in a truly empathetic way by their therapist.

.I think it sets a foundation for, I think yourself, you kind of feel that you're respecting yourself and you're actually having the confidence to actually voice that, and you feel kind of empowered because you're saying well this is me and these are my values.

(KT, female, VSO service user, completed)

it is useful. When you are asked questions, then you kind of think about the questions and, if you know what I mean, you kind of think why am I'm a feeling like this or why is it like that and what is more valuable to me and everything.

(AL, female, VSO service user, completed)

...because then she'd know what I wanted to get out of the sessions and tailor the sessions around me more specifically and stuff.

(AC, female, NHS service user, completed)

And I was like no one's really sat down and asked me what I want [...] and then to actually have that goal probed deeper and helped to sit down, it felt a very empathetic model, it was very holistic, it was very much like somebody's coming down into the world with you and sitting with you, you know that whole model that people use for empathy but they don't actually create the tools to do it. [...] so it felt really great that my therapist knew that about me and that's exactly what I kind of wanted with even going for this research was like, okay, so somebody knows some of the cultural backgrounds or context so I won't have to rehash those grounds, and even though he wasn't of the heritage/ faith he could kind of get towards some of those understandings of why there was [...].

(NH, female, NHS service user, completed)

Linking these values to their goals was similarly seen by service users and therapists alike as useful and important.

I find the way of looking at goals very useful, because sometimes it's such a large goal that nobody really goes over the steps to get over the barriers

(NH, female, NHS service user, completed)

just like focusing on myself and it's like a routine for me, like a goal every day and how I can focus. It is like a positive thing like looking at yourself

(KB, female, VSO service user, completed)

Therapists felt BA-M was helpful because it allowed the therapy goals to align with values important to the service user and this alignment could help service users develop important insights into how their beliefs could be a resource for mental health.

I love that tool. Yeah, I did use it a lot.

(ST, female, NHS, therapist)

I used it for all the clients as we were told we were supposed to, and also to make some goals around what values are important in their lives.

(TH, female, VSO, therapist)

I think it was really, really helpful. I think that is so important in doing therapy with someone, because when we're doing therapy with someone it is really important to elicit goals from them and when we're looking at goals it goes hand in hand with their values and what is important to them. And I think for a lot of Muslims I think when they are, you know, following the teachings and their religion, they would identify that as being very important to them, and so that is going to have a massive impact on their mental health. […] I think it makes sense to put the two together.

He was like, he had a bit of like an aha moment, […] therapeutic values and like religious teachings are very similar in that like what we're saying to do for the treatment for depression, Islam like sort of teaches you to do anyway and the religion sort of can help you in that way as well. So like bringing the two together was really helpful.

(ST, NHS therapist, female)

However, there was some evidence that the Values Assessment was not always carried out (see 'Taking Part in Research') and one participant[11] said that religion was not raised by the therapist in their sessions. This could have resulted from either the assessment not being conducted, or religion not being identified as an important value during the exercise.

Engagement with religion

Therapists who became confident in the approach saw their role as guiding and facilitating service users who had identified religion as an important value to achieve faith-related goals and explore how to address potential barriers.

.... It's not about me. It's not what I want, it's what they want and how much he or she can do to start that journey for themselves. So doing this once a day, so every night you are going to pray and this is the time you are going to pray, what's your barrier? She goes the barrier could be my sleep in that I am over tired and I fall asleep […] So we looked at what is it you are going to do then to stop that happening [...]. That was something that she was able to do for herself, not me saying well can you put an alarm on, or can you do this or can you do that or can you do that? It was something that a client is telling me what they could do to achieve what they set out to do.

(ZB, VSO therapist, female)

Service users also described how the therapist framed difficulties with reference to culture or religion, showing that they understood the service users' point of reference and then linked their values to goals. This felt personalised and relevant to the service users who described engagement with religion as a positive aspect of their therapy.

... so for instance if I started prattling on about one aspect of my life or family relationships or something like that, he'd [therapist] be like 'oh that's quite an important thing in your faith and culture isn't it' [...] and it's why it makes it harder to have these feelings or these reactions because I'm always aware of those things...

(NH, NHS service user, female, completed)

The whole therapy was to do with what was important to me as well, and religion was a part of it. I said that that is very important to me because I've got a strong faith and I want to keep that. [...] I didn't want to lose hope and that was one of the things, I said religion was important to me.

(AL, VSO service user, female, completed)

Most participants indicated that therapists made space to discuss religion, but two participants said that they had raised the issue of religion in therapy themselves.

[11] TN, male, NHS service user, completed.

I think I started to talk about it first [...] when I am engaged in prayer, I used to feel peaceful because the negative things sort of took a back seat and it wasn't important at that time. I started some conversation like that and then the therapist helped me to put that into perspective through other parts of my life, you know where my worries were and where my issues were.

(AT, VSO service user, female, completed)

Effective implementation of the approach by therapists could be affected by their understanding of the adapted therapy and the function of attention to religion within this. For example, one therapist found the approach easier as time went on, but her account suggests she was either raising religion when the service user had not highlighted it as an important value or else not making a link between the discussion and the Values Assessment exercise.

I think firstly it was just like I had to read through it [manual] quite a few times that it is therapy that's around your religion because they wanted to kind of like veer off and talk about other things so that was quite difficult at the beginning, but I got better at it. I think sometimes it made them feel uncomfortable in the sense that they weren't prepared for it I don't think [...].

(BI, VSO therapist, female)

Some service user accounts, however, suggested that although they found the sessions helpful, the BA-M approach of setting client-led goals may not have been followed by some therapists.

...I was asked a series of questions in terms of things like, you know, am I praying on a daily basis, am I connecting with my faith to try and use that as a means to heal or am I seeking help from God through prayer or supplication, and things like that [...] So it was helping me in a sense of psychologically it was troubling me so when I was answering them questions it was kind of helping me and reminding me that I need to go back to my prayers. [...] so to me yeah, it was really helpful because eventually I did start to read my prayers again […].

(CB, VSO service user, male, completed)

One participant commented that they thought it was good that religion was raised but the manner in which the therapist discussed religion made him uncomfortable. This participant was concerned that his answers to the questions asked by the therapist would make him sinful or that the Muslim therapist would judge him, which did not feel therapeutic.

...it's good for bringing up but [...] I remember it being, asking me so, you know 'Islam, how does this help you' and when they asked that question, how does something help you - how does your religion help – [...] I felt like, if I say something wrong here, if I said something like 'oh it doesn't', or I can't tell the truth, do you understand what I mean, it's not helping me, it wasn't really a therapy.

(BJ, NHS service user, male, dropped out)

Another participant was not happy about religion being raised during therapy in the first and only session that he had with an NHS therapist. He was classified as having dropped out of therapy, but his response indicates that he wanted further sessions but felt these were not offered because he may have offended the therapist.

maybe she got offended and that's why she never called me back. [...]. She asked me, how about going to the mosque.[....] Meet other people, pray five times. I said why? You are not here to lecture me or anything, you are as a therapist. You try talk to me, that's it, I don't want to go to the mosque. [...] She raised herself, not me. [...] I told her that I want to socialise but not with the mullahs.

(HI, NHS service user, male, dropped out)

The desire not to engage with religion in the therapy setting was not mentioned by many service users. One who did speak about this, said this was because they had other people where they could seek religious advice and support for religious activities and wanted other kinds of support from therapy.

... I've got friends who I know are more knowledgeable in certain things than me so I can talk to them. I've also got family members who I can talk to or I can just go to the Mosque and work on that. These therapies I didn't really necessarily go to them because I felt I needed them for help with other things. When it comes to religion I am fine, I have never really had much problem to do with that.

(AC, female, NHS service user, completed)

Two service users had mentioned that they did not agree with the way in which religion was raised by the therapist and this led both to drop out of therapy. In both cases participants felt the focus of the therapy was not tailored to their specific problems or that they were given the choice about whether or not to incorporate attention to religion within the therapy. The therapist in both cases appeared to have adopted an approach that conflicted with the manual guidance for BA-M.

...What I was going through was a lot of issues and family issues and stuff and it wasn't to do with religion because I practice religion. So for someone to say, how does this help you and how do you think this, I think there was a lot of focus on it, it was nothing to do with it. If I had an issue with my religion and I was going through a crisis or whatever you know, understanding my religion, that's different but I didn't have an issue with that.

(BJ, NHS service user, male, dropped out)

The manner in which the questions relating to religion were posed appeared to be part of the problem for these service users and the approach suggested by BJ below was, in fact, precisely in line with the therapy guidance.

"... he could almost have asked that question and said, how did you feel about that and then maybe I could have answered it a bit more openly. […] *I don't want it to be forced on me you see, I don't want my religion to be forced on me, asking me questions about my religion and how does that affect you, I don't want that. […] that was more of an interview/interrogation. You know 'how does Islam help you?' You know, it does help me, but obviously I'm still struggling* "

(BJ, NHS service user, male, dropped out)

Another service user said that they were offended by the therapist raising the possibility of using a religious activity towards achieving their goal in the one session that he attended. For this service user, his beliefs and practise were a private matter. In this instance, the therapist had asked the service user about whether he attended the mosque and whether it may be a place where he could meet with others. The service user felt that he may be judged by others to be a hypocrite by attending the mosque when he is not a religious person. He suggested that religion could have been raised in a more appropriate way, rather than the approach that he found to be imposing attention to religion on him.

" this is my personal faith, it's nobody else's faith. [...] It offended me [...]I don't know her, she don't know me but in my thinking, she might think that because I'm a Muslim, so I have to go other people, meet other people. But here as I said, it's a hard word, munafiq [hypocrite] […] just a simple question, 'would you like to talk on religion or not?'. That's it."

(HI, NHS service user, male, dropped out)

Religion, inclusion and motivation

The vast majority of service users said that they had found the inclusion of religion in therapy helpful or were happy with how this was raised by the therapist[12]. For many, the discussion of

[12] AT, female, VSO service user, completed; SN, female, VSO service user, completed; AC, female, NHS service user, completed; IC, female, NHS service user, completed; NH, female, NHS service

faith was motivating and acted as a reminder of teachings and practices that they already knew and helped them consider how to apply these to their problems.

... I think the person listening to me wasn't giving me information that was new and teaching me something. It was more about what I already knew but helping to deal with my problems and my issues and then relating to what I knew of my religion from my own knowledge.
(AT, VSO service user, female, complete)

...I found it very useful in that sense in terms of a reminder because I was praying before and then, when I found myself in a difficult situation I was away from praying and stuff, so to me yeah, it was really helpful (CB, VSO service user, male, completed)

Participants described the attention to religion as inclusive, affirming and motivating, suggesting that in part motivation to engage came from feeling valued and respected.

...she was really respectful of my religion and really like same time motivating like, you know, it's not always about the mental health, it can be related with your belief and faith as well.
(IC, NHS service user, female, completed)

I felt it reaffirming like [...] and I think [...] in some ways him [therapist] not being of the faith made that a bit easier because it made some of that like you know that inherent kind of judgement that […] might have had experience in the past. That wasn't brought into the room.
(NH, NHS service user, female, completed)

Therapist feedback was generally in support of the approach and positive even though some had reservations at the start. Feedback tended to focus on experiences of working with individuals who were Muslim and appreciating that service users found the inclusion of their beliefs helpful. There was less feedback about how the approach affected them as an individual or how their own beliefs may have had an impact on their delivery.

Being involved in the study led to some therapists changing their views about how therapy can be delivered and appreciating how standard approaches may be adapted to be more appropriate for the needs of the Muslim population in Bradford. A number of therapists had not considered cultural adaptation prior to being trained to deliver BA-M. One explained that the training helped him to become more confident in working with Muslim service users. He also explained that the service user responded to the adapted approach positively and this helped the therapist feel comfortable about working in this way. As mentioned earlier by a VSO therapist[13], seeing the adaptations applied in practice helped him to appreciate how religion could be included in therapy and understand the flexibility within Islamic teachings.

"…. I do work with a lot of Muslim clients and I think it's really important. [...] I think I definitely felt more comfortable after starting the project. [...]it's not something that I really considered that much. Yeah, I'm sad to say that but, yeah, I definitely feel more comfortable now. [...] I had a really nice experience with one client and they'd set this goal to do a morning prayer as part of their BA but they were struggling with it, and then we found this bit in the workbook that was about the fact that you don't have to be perfect with it […] So I think that made me realise that there's a bit of flexibility around the faith-related activities and it doesn't have to be so black and white."
(CT, NHS therapist, male)

user, completed; AL, female, VSO service user, completed; CB, male, VSO service user, completed; KB, female, VSO service user, completed; NC, female, VSO service user, completed; KT, female, VSO service user, completed.

[13] BI, female, VSO, therapist.

Another therapist recognised that her own feelings about raising religion could impact on delivery and used this understanding to work in a way that allowed religious issues to be raised with the service user in a non-judgemental or confronting way.

.... it just changed my perspective on how well we can alter it when we need to. You know, it doesn't need to be so set in stone, it is about the client and what we can offer them and there's no harm in incorporating faith-based activities and just anything that helps the client. You know, you don't want to feel like you're enforcing it on anyone or they're being judged. I think that was my own beliefs around it that came into it […]. (TI, NHS therapist, female)

Other therapists did not consider their views on this issue to have changed and were comfortable with raising religious issues as they felt they had ample information. However, they realised that therapy needs to be tailored towards service users and what is important to them. In both NHS and VSO contexts therapists recognised that support was not always tailored to individual needs within standard interventions.

.... with some clients where they didn't choose religion as a value, I realised it is completely up to the clients whether they choose to talk about religion and culture or not. [...] even though I've told them in this research therapy it is open for you to talk about these things. Maybe you haven't had a chance to talk about these maybe through interventions that you access through NHS or other services.

(TH, VSO therapist, female)

Similar issues were raised by a voluntary sector therapist, who described themselves as '*okay generally'* in using a religiously informed therapy because she was interested in helping service users. The therapist felt that some questions suggested for engagement were unsuitable but was unable to identify which questions these were. These reservations were, however, not shared by her clients and, in one case, when the therapist had suggested activities that were not linked to Islam (meditation and yoga) the service user had responded by raising helpful activities that were related to Islamic practices – listening to prayer (Isha) and listening to examples of behaviours of the Prophet Muhammad (sunnah).

... I've had clients telling me that, if it wasn't for religion, they would be worse off. It all depends on the individual clients to be honest how they feel about it. Personally I think a lot of the time clients do bring their religion into it and it does help them a lot of the times.

(TC, VSO therapist, female)

Therapists described using Islamic teachings to give service users positive messages about self-esteem and respecting oneself. This message could be difficult for some service users to receive if they had not heard it before, and some could choose to attribute difficulties to supernatural reasons, such as black magic, rather than acknowledging abusive relationships.

"…. you need to be hearing those things because you are valued. Allah has created you so you should know this and you should feel your worth in the sense that if you don't feel like you are not being listened to in life, but the fact is that Allah listens to you because Allah loves you and things like that. [...] Do you really think that God would want you to be in a situation where you're being abused daily that's impacting your faith? People separate their life into categories don't they, so you decided for this particular category of your life Islam's not going to be part of that."

(BI, VSO therapist, female)

Not all therapists were concerned about using Islamic teachings in therapy and appreciated that using religion as a reference point could help service users better understand the difficulties that they were facing. A clinical supervisor felt '*positive'* and '*excited'* about offering the adapted approach within the NHS. They felt that BA-M was particularly relevant because the Muslim population is diverse and so it was important to offer a therapy that could also match this. Recognising that service users should be able to decide whether they want to receive the adapted approach or standard therapy was also important in terms of therapy options.

"My only views were that it sounded really interesting, and I was really, really positive about it. And I just thought it was amazing that [this was in] an NHS service that's usually quite generic when we're offering therapy. […] I might have come in with a viewpoint that every Muslim with depression should access the culturally-adapted BA. But then what I'm finding is it should be a client choice, so it should be described to the client that, "This is something that we do offer. Do you think it'd be helpful to you to access that?" And then keep reviewing it as we go along as well, really."

(IN, NHS clinical supervisor, female)

Both NHS and VSO therapists indicated that they appreciated that the adapted therapy had a place in the service as an option to be offered to Muslim service users. They were keen to find out how effective the adapted therapy had been and indicated that it should continue to be offered. However, publicising the availability of the adapted therapy and increasing the number of therapists trained to deliver it was important to enabling access. There was a concern also that the project would not lead to longer term change.

...I think it seemed really promising, and I'd be really kind of keen to know what your findings are from it so do keep me in the loop.

(IK, NHS therapist, female)

...whenever I can now I still try and like promote it to people because I think it's, I think it can be so effective, but it's just yeah, I think the promotion within services off it is what's really important. Like if people who are assessing don't know that it's an option then they're not going to talk about it. So I think the fact that it was just with a small group of people in the service to start off with was a bit of a limitation because if everyone was trained to do it, then everyone could offer it.

(ST, NHS therapist, female)

...there has been benefit for clients – but in the future I hope somebody really does lift it up and do something with it rather than just being research.

(ZB, VSO therapist, female)

One therapist had highlighted that she felt that this was one of the best tools that she had, based on the feedback that she had received from older service users. This therapist also commented that they work flexibly with service users and so their style of working perhaps made them more amenable to the approach.

...in terms of my best intervention and how will I feel comfortable [...] BA is my best in terms of feedback from seniors and how well I do it. I think it probably it's because I'm very flexible with clients so I do think it probably helped me quite a bit.

(TI, NHS therapist, female)

Feedback from managers indicated that they perceived the adapted therapy to be appropriate and needed. They echoed the positive views of therapists and expressed that they hoped it would continue.

I mean from my point of view there were a number of people who really valued the input

(NS, VSO manager, male)

...we really do need it within our communities so hopefully it will come to some kind of fruition and have some sort of impact in the future as well.

(BB, VSO manager, male)

Talking about religious beliefs

Service users participants were asked about how easy it was to speak about their religious beliefs in therapy while therapists and supervisors were asked how easy it was to use or raise religion within therapy. In general it appeared that it was easy for service users to speak about their

beliefs, and therapists indicated they found that the manual facilitated the inclusion of religion in therapy.

Service users felt their ease and openness in discussing religious issues was facilitated by their therapist's approachability and encouraging responses or having a shared gender or faith background.

....the therapist was very open, and when I'd say something you can sort of tell in a person's eye and the way they're nodding that they understand it and then she'd make one or two comments which actually just confirmed that she's on the same level, so it just flows [...] and the progress is I find it's smoother [...].

(KT, female, VSO service user, completed)

...it was really easy because she was Muslim herself and of course she was a female so even easier. [...] She was a really down to earth person and I feel like it was really easy to talk to her about anything if I really needed to. (SN, female, VSO service user, completed)

Other factors that had an impact on the ease with which service users could discuss religious beliefs related to feeling heard and not judged. Therapists who conveyed competence and sincerity made clients feel confident and comfortable in speaking honestly about anything, including religion.

I was very confident speaking to [therapist]. […] She was genuinely a really good human being to me and she was definitely very good at her job. She was good at talking to me about Islam and about religion […].

(NI, male, NHS service user, completed)

I mean be it religion or any other matter or anything else I wanted to express. I never at any point felt like I was going to be judged or I was not going to be believed or, I was made to feel very, very comfortable and I think that was really important because when you're in, when you're at a very low point and you're finding it hard to speak, […]what the other person might think about me or will I be judged.

(CB, male, VSO service user, completed)

Because they could appreciate whatever I was saying about religion. They said it was good if you find you are helped by religion in this why, 'it's a very good sign'.

(NN, male, NHS service user, dropped out)

it was done very subtly, so it didn't kind of, it didn't interfere with the process as such. It was like kind of gently and then we'd mention what I'd learned from that. […] It was literally kind of integrated in her questions and the way she asked them, and I used to prepare as well. I kind of liked it, you know, like homework, and it's kind of felt good in the sense of, well I'm having to put in this effort, and I've got to put in this effort to actually do things. It tallies with the verse in the Quran that you know, you've got to change your own situation you know, it's like, that you've got to change your own situation and that Allah will help you, so it kind of tallied with it. […] tie the camel first, yeah, and then just have your trust in Allah.

(KT, female, VSO service user, completed)

A shared faith background was not, however, sufficient in itself. When therapists did not make enough space to discuss religion, this made it less comfortable for the service user to say how important religion was to them. Both the following extracts indicate that the service users may have been disappointed that attention to their faith was not included in therapy more.

I don't think it was that easy [to discuss] in a way. [...] but I don't think they talked about it that much. But for me, I am a practising Muslim, so I do things in an Islamic way anyway.

(KB, female, VSO service user, completed)

It's only one time that she approached it. [...]. And sometimes she would go like do you go to mosque, or do you like to be… and then I would say yes definitely, if there's yeah I love to go to gathering. If there's any like talk, Islamic event. Yeah, I do like to go there, and that really helps my mental health you know, really helped me.

(IC, female, NHS service user, completed)

For one service user having a non-Muslim therapist was perceived to make it easier to speak about their beliefs, although later in their interview, information shared suggested that other experiences with a Muslim therapist had been positive, and perhaps the way in which religion had been raised in the adapted therapy sessions underpinned some of the uneasiness about speaking to the BA-MT therapist.

For another participant, while having a non-Muslim therapist did not make it difficult to speak about his beliefs, the therapist's knowledge about Islam was seen as a limitation– although this point could also apply to therapists from Muslim backgrounds.

... because I'm like I kind of need somebody who can challenge me a bit more on that level or in that kind of intellectual faith level.

(NH, female, NHS service user, completed)

Most therapists from Muslim backgrounds felt comfortable about delivering the adapted therapy but also a little cautious about how the mention of religion might be received. The positive response from service users increased their confidence in delivering the therapy, especially in the context of having their own knowledge of Islam supported by detailed guidance in the manual.

Surprisingly I think, probably because it was my own faith, I felt really comfortable with it. I had no issues and I think it's really nice to kind of be able to provide that for clients. I think, maybe the first couple of times that I tried it, I was a bit like how is this going to be received but when I knew that it was being received well yeah I had no issues with it.

(TI, female, NHS, therapist)

I think I felt completely comfortable with it. I think myself as well as a Muslim, my journey has improved since 2020. So I think that helped with my confidence as well. [...] I think with the resources that were given, you didn't have to be an expert so you didn't have to know a lot to be able to deliver it. I think yeah, it was all there and sort of easy to understand anyway.

(ST, female, NHS, therapist)

Because I guess using the manual would quite rightly just bring up those conversations with people really because a lot of the focus is on specifics of the faith really. […] So let's say I had a client who didn't really know what Islam said about depression, the manual would answer their question.

(IN, female, NHS, clinical supervisor)

I felt comfortable because maybe in the past it's kind of I've held away from using religion and culture and I was given this flexibility to use religion and culture and talk about it openly.

(TH, female, VSO, therapist)

Interestingly a non-Muslim therapist did not raise concerns about not having enough Islamic knowledge or feeling unconfident about working in this way. This therapist spoke about concerns about finding the balance between showing curiosity in the session.

There's nothing around the teachings. I think one thing I did discuss in one of the peer support meetings was about how curious should I be about people's faith [...] I wanted to be curious but I didn't want it to be too much. So [researcher] spoke about how if it's relevant, if it's helpful for the client rather than it being about me.

(CT, male, NHS, therapist)

The client self-help booklet

For service users who identified religion as an important value the client booklet was a resource that included Islamic teaching aligned to therapeutic goals which they could choose to use during therapy. Many stated that they had found it useful, whether they had completed therapy or not. For some service users the booklet acted as a reminder of teachings that they were already familiar with, for others it was something that was used to support them in improving their situation and bring useful teachings together.

...You know like for different issues, maybe that could be something they could look up, but generally just how to pull yourself out of what you're feeling right now and what you're going through, so just a little nudge and I think it was just right for that.

(AT, female, VSO service user, completed)

I think it was helpful, I appreciated it because obviously it had duas in it. It's good to have. [...], the hadith: tie your camel, and the duas and stuff and the reminders [...]. I appreciated that they sent it out because it had the hadiths and you know, and the duas in there, and it's a reminder.

(BJ, male, NHS service user, dropped out)

....it was nicely structured as well I think. That's the way that I found it easy, I could even like click through, open a book, read through it and it will feel like it was like a good crib sheet, like a road map to just get over something, or look at something in like different ways you know.

(NH, female, NHS service user, completed)

...I think it's so much information in that, it's a really good booklet that. I think there's always bits that you can relate to and it's good in the sense that you can come back to it. [...] but I think the picture on the front is very, very appealing. I think because it's in colour and it kind of, it kind of attracts you in. [...] There are bits where I think there's goals and there's arrows and things you've got to fill in, so I do like the element, you've got to kind of reflect and like fill in.

(KT, female, VSO service user, completed)

A service user highlighted how they had stopped thinking about themselves – this can be true of those, particularly women, in caring roles and also those experiencing depression. The booklet helped this individual to consider their own needs and themself as worthy of this focus.

There was a part on focusing on myself. I think that was really helpful, because I had stopped focusing on myself at all. All I was thinking about was everybody else. I think that was a really good point in there which said what you want to do, what is it that you like doing. You know you do everything for everybody else and you forget about yourself and that's true, you do forget about yourself. I think that really kind of got me back on to thinking positive again, what do I like doing. Yeah, I think that was really good.

(AL, female, VSO service user, completed)

The booklet was not received by all service users that received the adapted therapy and, when it was described to them during interviews, some service users said that they would have found it useful to have received such material.

....it would have been nice, but no I didn't receive anything.

(AC, female, NHS service user, completed)

Participants were asked about whether they felt they were given the booklet at an appropriate time. Some service users could not remember but others described how therapists had discussed the booklet in ways that helped them after they had completed therapy so that they still felt supported.

....because I felt like we'd already talked through bits together and it didn't feel like I was being left to go off on my own. Like there was somebody there and that trust had been built up and then now there's a book that we can both kind of work through together.

(NH, female, NHS service user, completed)

... there was sort of the time in between so it was a good tool to reference back to because you know sometimes you need reminders [...] the gap I had between the 8 sessions and the booster sessions, it also helped me and kept me focussed.

(CB, male, VSO service user, completed)

Some service users struggled to remember which parts they found particularly helpful, indicating that the main function seemed to be as a form of helpful reminders of teachings they already knew. One service user mentioned that it was because the content was religiously focussed that made the booklet helpful, it was the religious teachings that kept him focussed on achieving his goals.

"...it was the religious aspect you know, that section of, I looked at quite regularly and just like I said before, just reminders to keep myself focused on what I should be doing as well. [...] the plans we put together, do you know, like the daily goals that we set like short term goals and long term goals as well, that was really important as well, because again it keeps me focused on what I should be doing rather than focussing on my faults and other things."

(CB, male, VSO service user, completed)

"There's a lot of things in it. I can't remember all of it but it's like when you struggle and can't focus on this and that and then that's when I use a booklet to remind myself how to keep positive. I use it when something is tough and I am feeling a bit down, that is when I go back to the booklet and it helps."

(KB, female, VSO service user, completed)

Service users also mentioned that they referred to the booklet once therapy had ended. It was something that they continued to find helpful.

....it still helps me. I can go through it anytime, whenever I want to, especially when I'm worried so I can just open it and look through it and there's a name of God. There's some verses there, so I take one of them out and start reading, and you know it really helps.

(TK, female, VSO service user, completed)

Beyond the content of the booklet, service users also commented on the accessibility of the booklet. Although one therapist commented that the booklet needed to be made more accessible.

The unhelpful part for me, that was it was very small and I'm partially sighted so for me that was a little bit of a difficult bit but what I did was I read it so I got to know what page was what. I also had a magnifying glass that would help me with that [...].

(ZB, female, VSO, therapist)

Receiving the booklet in a language that was appropriate to the service user, in this example, Urdu, was expressed as being helpful. This allows the service user to use this tool in a way and at times appropriate to them, whereas the Values Assessment and such tools may have been verbally translated by therapists to be used in session. The language used in the booklet was also found to be appropriate for service users with various reading abilities.

...writing in Urdu was very helpful.

(SN, female, VSO service user, completed)

It's not a really complicated booklet which I like because I am not a very good reader so it really helps when it's a small thing and it really connects to your roots, your God [...]. I love that booklet. It's not too complicated and that's what I like more. It's small. It's very easy. There is lots of explanation in it and I don't think I want to change anything about it and I think it should be more out there

(TK, female, VSO service user, completed)

Religion, activation and cognition

Both service users and therapists gave examples of how religion was used in therapy to encourage activity or as a way of framing difficulties to provide a perspective from which service users could gain encouragement and support when feeling low about themselves.

Therapists demonstrated how they used Islamic and BA principles to complement each other. For example, a religious teaching about doing good deeds that were small but consistent reinforced a similar principle within the BA approach of regular and incremental activity. Therapists also shared how they broke down larger goals such as praying or reading the Quran into smaller activities by suggesting that service users started with performing ablution and building this into a regular habit, starting with performing one prayer and slowly increasing it to all five obligatory prayers, or by reading a page of the Quran and increasing this over time.

...we're trying to target behaviours and then make that comparison between, well Islam teaches us that we're trying to, you know focus on our behaviours as well in that way. We're praying or we're doing pilgrimage or like giving charity or fasting, like these are a lot of the five pillars that are also behaviours. [...] I really liked that, making that comparison.

(ST, NHS therapist, female)

a big part of Islamic faith is your intention in anything that you do and if you have the right intention to do it, it counts. […] That's what BA does. It starts off like that and then you build on it based on your capacity, and it is all about your intention. I think I really liked using that because 99% of clients agreed to that because they knew that [intention] was a huge part of Islamic faith.

(TI, NHS therapist, female)

I broke it into very small pieces and didn't give them big tasks […] Maybe let's look to see if you are interested in just reading a small part of Quran you know so culturally adapted is what they wanted to work with.

(ZB, VSO therapist, female)

One therapist highlighted that service users may turn to religion when they become unwell, but some found that they struggled to implement religious practices into their daily lives when motivation and concentration was low.

…. previously they weren't praying anyway. When they started with the depression, I think they tried reading [prayers] once or twice but they found it really distracting and they couldn't concentrate so they stopped reading again. […] a lot of Muslim clients feel that they need to read the whole five so I was like, just try reading which one is the most easiest for you. [...] they felt like they have to read all the five or not do any. They would say they have missed reading one or two so what is the point reading the rest of it and that's when they felt worse. So they have already got anxiety and depression and then on top of that feeling like they are doing more sins by missing the prayers [...]

(TC, female, VSO, therapist)

Specific activities mentioned by service users included reading the Quran, praying in congregation and zikr/dhikr (remembrance of God) helped their mood[14] alongside other non-religious activities that could also be helpful.

Just to read the Quran ayaat [verses] and pray in mosque and zikr and make a feeling of happy and then you can go and make a friend and go outside and have a cup of tea with my friend.

(SN, female, VSO service user, completed)

One therapist spoke at length about how they used an exercise taken from the client booklet to focus on God's Mercy and how this could lead to service users being kinder to themselves. This could redirect service users from a negative perception of religion to one that focused on God as Merciful and human beings as fallible.

…it's getting people to think about what God means to them, the attributes of God. What I found fascinating about it and I think it's something like [Researcher] brought up was that not one of the Names [of God] has any negative connotation to it, like it doesn't have like hellfire or Punisher and things like that. […] So, if I start off with positivity and talk about 'think of the Name and what does that definition mean to you and why' and things like that, it made all the difference – because it was thinking outside of the box, wasn't it? It wasn't like the that typical well you didn't do this salah [prayer] so you're going to get punished, and you're going to go to hellfire […] So forgiveness - you know that the idea of like… basically forgive yourself and the fact that Allah forgives you for all your sins […]. We will sin but it did seem like some of these women were pressured into thinking that they had to be perfect all the time.

(BI, female, VSO, therapist)

The moral authority of Islamic teachings was mentioned by one therapist as a way of providing a challenge to the unhelpful views that service users may hold, such as a gender bias or focusing on supernatural explanations rather than abusive relationships, for example.

It is not me as a female saying to you that this is what you need to do, so I felt that he knew there was a backing to what I was saying so he couldn't argue with that.

(ZB, female, VSO, therapist)

"I think I've felt positively about it when I started it and putting it into practise just reaffirmed that. I didn't feel like it wasn't helpful and there was nothing about it that gave me any negativity surrounding it. I do think it's really valuable in the work that we do."

(TI, NHS therapist, female)

the idea of black magic, jinns…It's such a quick fix for when you are in abusive situations.... or you know we're in this situation because of the black magic…and it's not the fault of anyone. So it's kind of challenging the views"

(BI, VSO therapist, female)

One therapist highlighted that focusing on religious activities alone may not always be helpful - if an individual feels these have not led to change, they could feel more depressed or hopeless. This suggest that therapists might need support to encourage a wider range of activities when clients' religious behaviours seem to contribute to their depression.

...too much too much zikr, too much wazifay [religious recitations], and then nothing is happening what she wants, she's becoming more depressed and sometimes you put off with the religion but with that kind of client, it's so hard to tell them, stop doing these things and go move more yourself because that client is already on edge.

(MH, female, VSO, therapist)

[14] SN, female, VSO service user, completed; KB, female, VSO service user, completed.

There was diversity among therapists about how flexibly they engaged with religious teachings during therapy. VSO therapists sometimes promoted teachings not mentioned in the self-help booklet but made it clear that they had checked the teachings they promoted and gave clients the choice about whether to act on these. However, a clinical supervisor felt that this approach would not be acceptable within an NHS service, as it deviated from the therapy manual and could be misinterpreted by clients.

one of the [VSO] services was encouraging people to read specific duas [supplications] and things like that. [...] so where she was getting that from, I'm not sure. But again, this comes back to the point that I made really early on, is services work differently. So in her workplace, that was an okay thing to do […].
Whereas me saying to a client, "Read a specific dua," there's a question of ethics that comes into it. [...] because people can take it in a way that, "Oh, my therapist was saying that I'm not reading enough." So it's just about how people interpret it.

(IN, female, NHS, clinical supervisor)

There was also evidence from VSO therapists of worrying deviation from the therapy manual in terms of not making space to allow the client to discuss religious teachings and not taking the lead from clients on how much to do this. This appeared to be caused by therapist anxiety about adherence to particular religious groups causing conflict in the relationship, even though the manual described the booklet at avoiding sectarian sources of Islamic teachings. There could also be a lack of clarity about whether the client themself wanted to discuss religious issues.

I tried to kind of go by the self-help book, but I found I didn't want to go into religion in case someone's got a different belief, someone from a different sect. You know, I didn't want that conflict and I didn't want it to come in between therapy.

(TH, female, VSO, therapist)

Other VSO therapists gave examples of how they had used religious activities such as praying or reading the Quran or spending extra time after prayer to connect with God. At times, however, these activities did not appear to be discussed in terms of addressing barriers in achieving goals, and so such activities become prescriptive, rather than linked to service user values. This highlights the point made earlier by the clinical supervisor and her concerns about how such activities may be interpreted by service users.

I said do you do your prayer - praying? So just do your prayer five times, on time and after when you finish your prayer, just sit down on a musalla [prayer mat] and just talk to your Allah. So, this is the way I try and say, you will see how you will feel.

(MH, female, VSO, therapist)

Service users confirmed that focusing on God's mercy and forgiveness was useful and considering difficulties as a test could encourage them to keep trying in their efforts to get better[15]. Some service users could not remember any examples of how religion was used in their therapy but did remember that it had been used in sessions.

we try, we have to try our best and then same time we have to find the solution.

(IC, female, NHS service user, completed)

So one of the times I remember saying that I felt like I wasn't any use to anyone – you know like for my family because I'm unwell I'm not able to do certain things. [...] and then the therapist would say something like you don't have to be able to be good at things that you could do before given your health issues. What you can manage right now is enough. God doesn't want you to push yourself too much. God is kind. God is forgiving so we should take from that that we should learn

[15] IC, female, NHS service user, completed; AT, female, VSO service user, completed.

to be kind to ourselves and sometimes, if you feel like you didn't do something right, you should be able to forgive yourself.

(AT, female, VSO service user, completed)

There was also some confusion at the start of the project about whether attention to religion was needed for all clients rather in reference to its importance to clients.

…..initially we thought that religion was supposed to be a value that they're supposed to be working with. So I did ask [NHS supervisor] that she's not chosen religion and she feels maybe there's other things important in her life. NHS [supervisor] said carry on working with her and, as the sessions go on, introduce values again. Even if she hasn't chosen that value religion, prompt her to talk about it and ask her what does religion say around mental health. […] So, as the sessions went on that's what I started doing, and then she started talking more about religion. Then we started talking about certain surahs [verses from the Quran] that she can read if she can't go to sleep.

(TH, female, VSO, therapist)

This approach was not in accordance with the therapy manual and negatively impacted on how some clients felt about the therapy. Two service users said that the lack of attention to their own priorities was the reason they did not continue with the adapted therapy.

.... maybe it was just the therapist, maybe the training needs to change, give them a bit more you know.[...] From my experience with therapy,[...] they do ask you about you know, how you're feeling but they're a bit more relaxed about it, how's it going and are the family okay, it starts off like, softer and then sliding in you know slowly. I found this to be a lot more 'how's your religion', you know, stuff like that, I found that to be a bit more like I say interview type [...].

(BJ, NHS service user, male, dropped out)

...whenever the therapy is given, or whatever is written, it should be about finding a solution for that person. [...] His [service user] main issue should be what the worker focuses on [...] Everyone is different and they don't touch on that, they just give advice, so I think this is completely useless until you can come to his level and give a solution for his problem

(NN, NHS service user, male, dropped out)

Homework tasks were linked for some service users to the goals they identified in therapy. However, therapists were clear that tasks or goals were not always linked to religious values specifically.

They linked perfectly fine. They were helping me with my goals and stuff with me getting back to being normal. What she was doing was she was giving me general routine activities like what a person would do in their general life to get back to normal.

(NI, male, NHS service user, completed)

....they were always, yeah, funnily enough, constantly they were and if you want you can kind of tweak them and fit them in. They're not too far away from like your general goals and values.

(KT, female, VSO service user, completed)

....it's not always like we were turning to Islamic values. If something is bothering them, if we manage to resolve that issue, they were able to go back to what they were normally doing then because obviously sometimes when you're stressed you let go of everything.

(ZB, female, VSO, therapist)

Therapists and managers were asked if any new or enhanced service links were developed with community groups goods or with religious experts, to support the adapted therapy that was being delivered. Only one VSO therapist appeared to have initiated this in order to find appropriate groups for service users.

"maybe someone will say, we like to go to the mosque, you tell us, where is there something for women so, we do develop, we like to find out which one is good, [...] there are two places here, you can go, have a look to see which one is the best for you."

(MH, VSO therapist, female)

Inclusion of family or friends in therapy

Despite the involvement of family or friends in therapy being a client choice in the BA-M approach, the majority of service users interviewed said that they were not asked by therapists if they wanted to do this. Most participants, however, said that they would not have chosen to include family and friends had they been given the choice and two NHS service users that were asked chose not to do so. Two other service users did, however, say they would have liked to include their family or friends but were not given the choice.

There was also some evidence that service staff were not fully aware that the adapted therapy supported inclusion of family and friends or assumed that the therapist would need to go to the service user's home to support this. In one case the therapist appeared to think that involvement of a client's husband, whom she had not met, could lead to safeguarding issues. One VSO, however, used this approach as standard practice and openness to inclusion appeared to be influenced by usual treatment in both IAPT and VSO contexts.

"....in IAPT, I can't speak for the other service because I don't really know what they might do in those situations. But in IAPT, it's not generally encouraged .[..] it's normally sessions one-to-one therapy sessions, really. Unless of course there was a specific need for a family member or a friend to be there, really."

(IN, NHS, clinical supervisor, female)

Our client is not on that level where we can go and see the family [...] and plus if seeing the family, you need a lot of security, health and safety and all these things.

(MH, female, VSO, therapist)

"it was a very typical set up and it would be like the partner would be the one who had the overall say of what happened. Let's say [client] did exercise an opinion or said something, it would be laughed at or frowned upon or whatever […] I don't think I would be comfortable with a male coming into my therapy and me challenging them. Let's say [the client] told me something in confidence and I have said the wrong thing and they go home and have a load of other issues so in terms of safeguarding I have to really think about it."

(BI, VSO therapist, female)

"...I know our staff members tried to use it as much as they could and we always try to use it because we often have the family members sitting in a waiting room while there's a consultation going on and it works fantastically well."

(BB, VSO manager, male)

Reasons given for not including family and friends in therapy included not wanting to burden them or feeling they would not want to be involved, even if they knew that the service user was receiving therapy. The goal of being independent and not relying on others was a further factor.

I was not asked if I wanted anybody included or not. I wasn't aware of that but, on my personal level, I would say I wouldn't have wanted anyone else to be part of that because I'm a mother of four children and I don't like to put my stresses and worries to my children - I would like to leave them out of it. My husband is a hardworking man, very supportive and a very kind person so I think he always has a lot to do.

(AT, female, VSO service user, completed)

Because they have their own families and kids. They don't have that much time. I'm thankful that they come and check up on me at home. Or they help me with some paperwork.

(TN, male, NHS service user, completed)

I think she's mentioned it, but I always prefer to have a one on one, like a private independent one, because I don't like to depend on people, and I don't really think that I'd want to rely on others for my own wellbeing as well and stuff. I just like to do it myself so if I'm ever in a situation again, I know if I'm not with someone to help me and I can do it independently, then I can do it all the time.

(AC, female, NHS service user, completed)

One service user, however, felt that including a friend would lead to more support that would be helpful and another realised later on in the therapy that a family member could be involved as she had not previously understood this

"...yeah friends probably is because yeah, one of my friends and neighbour, yeah she is the one, always, I don't have no-one. So like I would give her example like, you know, if I feel sad or down and every day she would come and call me. How am I? She will come and see me."

(IC, female, NHS service user, completed)

I felt with one client that she could have really done with a family member being there as well but it wasn't until it got to the booster session when I got her mum involved. […] I just work on initiative and guidance from [clinical supervisor].

(TH, female, VSO, therapist)

Comparisons with previous experience

Participants were asked about how relevant they felt the therapy was to them and whether it met their needs. Many service users felt that the approach was relevant and helpful in terms of feeling positive and they felt more understood and valued than in their previous experience of therapy.

"I think it was the right time to get some [therapy] because I was feeling really down at that time. Although I do like... I've always looked to the positive side of everything... it did help me to be more positive again."

(AL, VSO service user, female, completed)

"I feel like it was a lot more client centred therapy... the other one [previous therapy] was just more like homework, a teacher telling you what to do."

(AC, NHS service user, female, completed)

"I feel like I wasn't restricted in what I wanted to do, and what I wanted to say... I was making progress with this one."

(BJ, NHS service user, male, dropped out)

Participants also felt that the culturally adapted approach incorporated their values and worldview effectively.

"Because a bit of religion was in part of this therapy... ... You can heal the physical self through the spiritual..."

(AT, VSO service user, female, completed)

"It made me feel like my social cultural kind of context was understood and acknowledged and heard but it also was woven into the rest of the therapies as well..."

(AL, VSO service user, female, completed)

Past therapy experiences were also compared to highlight differences in therapist engagement and a more flexible approach as key issues that supported the greater impact of BA-M.

"Those sessions didn't really match for me... didn't really get much input from that therapist at that time […] they listened more rather than they would just give a question here or there, or a prompt or remind something back and I think that's why it didn't work for me then."

(AT, VSO service user, female, completed)

The ability to engage with religious values was clearly very important to a number of participants, allowing them to find solutions that resonated with them at a deep level.

I've had therapy before with something else but that type of therapy didn't have the religious aspect of it - so the person I spoke to then was helpful but some part of it didn't actually fit for me and with the religious part of it, it helped me to find peace inside of me.

(AT, female, VSO service user, completed)

"I think this is more better because... this is more emphasised, religions more emphasised in it, the Quran is more emphasised in it. I think it's just more authentic and I think you relate on a more, you know, in more depth... you relate on a more, you know, in more depth."

(KT, VSO service user, female, completed)

"The culturally adapted one got really deep into what I believe, and I think the other one help me in a way that I can look at things in a bigger picture as well."

(KB, VSO service user, female, completed)

" I think the religious and the cultural element was, it made 100% difference."

*(*QB, VSO service user, female, completed)

Therapists were asked about to comment on whether they perceived the adapted therapy to differ from the approaches that they usually used in their work. Some emphasised the importance of value-linked goals which helped personalise therapy and made service users feel more in control of their recovery.

"I think it allowed for a bit more, it allowed a bit more time for exploring the goals and the values a little bit more... it wasn't as rigid as maybe normal behavioural activation would be."

(ST, NHS Therapist, female)

"that flexible approach and recognising that every person you're offering BA to is very different. It doesn't need to be set in stone, it doesn't need to be just house chores and you can make it very personal to the client. […] it's not very difficult to adapt BA if you really get to know and understand what a client's needs are and what they want from it."

(TI, NHS, therapist, female)

"it's definitely different. […] CABAT is more structured like with PHQ9 so you're finding definitely more about the emotional health but then it's more like with religious belief as well […]."

(TC, VSO therapist, female)

Others felt the attention to faith was the only key difference with other aspects of therapy being familiar.

I don't think it differed that much, really. I don't usually do the Values Assessment, partly just because of time constraints […] But I think it was just like it almost felt like […] I was doing it the same but then just this extra question around faith, like how can we incorporate your faith within this.

(CT, NHS therapist, male)

... It depends on the client really. Like I've booked five clients at the moment, I would say probably about two out of five I'm using a behavioural approach with at the moment.

(IN, NHS clinical supervisor, female)

I'm using it for my other clients as well indirectly, you know not follow the process totally but how I talk to them, I use it in a way to open them up so it doesn't have to be just Islam.

(ZB, VSO therapist, female)

There was some evidence that CBT trained therapists might revert to usual treatment, however, despite the focus on BA, in which unhelpful thoughts are also treated as a behavioural issue.

I mean the focus is on behaviour whereas there was times with clients where I had to bring the focus back on to CBT with managing the thoughts with clients and the negative thought cycle and I felt both go hand in hand.

(TH, VSO therapist, female)

The issue of dealing with thoughts was also mentioned by a small number of service users. However, this did not seem to detract from their overall satisfaction with the approach.

I think it was a good type of therapy but and also I think thoughts aren't mentioned, it's more like the thing, but I guess that would make it similar to CBT then wouldn't it? So I guess you have to differentiate it. But no, I enjoyed the experience, I felt I found it very, very valuable and very enriching for me as a person to the point that I was wanting to volunteer at [VSO] but what it gave me actually was confidence. Because the therapist was so warm

(KT, female, VSO service user, completed)

Being involved in the research could influence longer term changes in the way staff interacted with service users more generally, transferring knowledge from the BA-M approach.

I do like the adapted BA, I do like this approach. The other stuff that we do and the other support that we offer works but I think they can work hand in hand. They can work together […] we had a group and we used to have conversations about religion and things like that. […] because we [staff] happened to be there we could intervene and say well there's this and we can offer you this and this and that

(BI, VSO therapist, female)

we've got an elderly group and I was doing a project with them. Through the project, I find out they've got a lot of skill but they are alone and then I choose the people who needed therapy […] I only give them [researcher's name] a session for five minutes, […] I have seen practically change […] they were completely different, confused and now when they come to the centre, they're so happy.

(MH, VSO therapist, female)

Relationship with Therapist

A number of participants expressed a positive relationship with their therapist; describing them as a calming presence, someone they could trust, *"friendly" "pretty good"*[16] and *"nice"*[17]. Therapists were generally seen as attentive to service user needs and adopting a collaborative and client-centred approach. Service user accounts mostly described a *"good relationship"*[18] indicating a supportive therapeutic environment which supported their willingness to engage in meaningful dialogue. The following participant, for example, experienced intense emotions during certain sessions and emphasised the therapist's role in creating a safe space for emotional expression.

[16] SN, VSO service user, female, completed.
[17] QB, VSO service user, female, completed.
[18] CB, VSO service user, male, completed; NC, VSO service user, female, completed; KT, VSO service user, female, completed; TK, VSO service user, female, completed.

"I think my therapist was a really calm person and they didn't push me too much to talk about something I didn't want to talk about, so it was more led by myself…"

(AT, VSO service user, female, completed)

Others portrayed their therapists as approachable and *"easy to talk to"* likening them to an "*older sister type of figure"*[19] highlighting the importance of the therapist's ability to foster a sense of warmth and trust. One participant depicted the therapist-client relationship as a secure space in which they could talk freely in confidence without fear of information dissemination[20]. Another[21] highlighted the balance between warmth and professionalism in the relationship. The therapist's ability to maintain professional boundaries while demonstrating care and understanding was appreciated as *"caring but very professional, yeah, good boundaries in place,"*.

Some participants portrayed a mix of perspectives on their therapist-client relationships. One[22] noted that knowing the therapist beforehand facilitated communication, suggesting the positive impact of pre-existing familiarity on the therapeutic alliance. Others, said that their relationship was *"good"* but also described this as *"okay"*[23] *or "fine"*[24] suggesting a satisfactory but perhaps unremarkable interaction.

However, a small number of participants reported less helpful experiences. One participant[25] conveyed challenges around comfort and trust while another described an encounter with a therapist who came across as more *"abrasive"* and *"interview-like"* rather than therapeutic. One client felt a shared religious identity was problematic because (contrary to the therapy guidance) assumptions were made about him because of this.

"*I found it a bit difficult... shall I just finish it here... I found it a bit difficult talking to like a Muslim therapist... I felt maybe it's better to stop it "*

(BJ, NHS service user, male, dropped out)

Therapists' perception of client relationships emphasised the importance of rapport building and establishing a non-judgmental space to gradually encourage clients to open up.

"…their answer is different and then I explain to them, see after five, ten minutes, they will be little bit be comfortable and then we talk. Or sometimes you make the conversation, and you will get all the answers."

(MH, VSO, female, therapist)

Within VSOs the new way of working could mean changed relationship with service users that involved setting boundaries and encouraging change. There could also be more capacity within this setting to offer extended time to support this changed approach

" they saw it in a different way, they started to realise why change could be important [...] I had to put those boundaries in place. [..] she was one of my first clients so that's why the sessions went on for 90 minutes at times"

(TH, VSO therapist, female)

[19] SN, VSO service user, female, completed.
[20] AL, VSO service user, female, completed.
[21] KT, VSO service user, female, completed.
[22] KB, VSO service user, female, completed.
[23] NC, VSO service user, female, completed.
[24] NN, NHS service user, male, dropped out.
[25] TN, NHS service user, male, completed.

One therapist shared an experience of misunderstanding that led to initial aggression from a client. The therapist displayed patience and clear communication, focusing on the client's choice about whether to engage in therapy.

"He felt that I was calling him mental. I said no, I'm talking about mental health I didn't say you're mental… I said look just come down and we'll have a meeting, if you decide this is what you want then we'll go ahead with it and if you feel that it's not something you want, we are not imposing it on you…and he completed it in full".

(ZB, VSO, female, therapist)

Understanding of client experience

Participants were asked whether they felt that therapist demonstrated that they understood what the service user's difficulties were. In general, service users indicated a positive experience with most service users replying affirmatively.

"She was very patient and understanding, and she had the qualities that made her a good listener so it was easy to talk to her about things and I feel like I did get the most out of the sessions."

(SN, female, VSO service user, completed)

Definitely she [therapist] understood because she relayed information back to me in different forms. So I gathered from that that she has understood and then the sort of the type of therapy that she was giving me I was also understanding from that as well, the methods that she were using and stuff, they also sort of confirmed to me that she definitely understands what's going on.

(CB, male, VSO service user, completed)

"*...you want to see […] that they're empathising with you. And they're trying to understand as best as they can. And her facial expressions, I mean they weren't very emotional but there was warmth, there was warmth in there and then she'd only say one or two things that were very warm, […] but yeah, I got the sense that she was trying to understand and be there as best that she possibly could, and that's all I can expect."*

(KT, female, VSO service user, completed)

Some service users' responses showed that either they were unsure whether the therapist fully grasped the issues, or that the approach or rapport was lacking to give them this confidence in the therapist. Interestingly, two of the extracts are from service users who dropped out of therapy.

I don't think she had empathy, I think they were just – like […], I've never been for an interview with the police, but you know when they're just asking questions. […] I found it like that.

(BJ, male, NHS service user, dropped out)

I think everyone's [experience] will be the same. When you are fighting, during that time, one year, two years, three years, that's when you reach that point – you don't get there all of a sudden. So they give you that work to do, learn your 'A, B, Cs'. So no good. […] It was disappointing. I was hopeful towards how much effort they would put in […] not anything.

(NN, male, NHS service user, dropped out)

The service user felt that religion was forced into the therapy, rather than using it as a reference point to contextualise his experience, which had been used in a previous positive therapy experience for him.

….the therapy I had before wasn't religion based. But then again I suppose religion was a point for her, she knew. […] she understood she understood that what our cultural dynamics are, […] she understood it, she could relate to it, you talk about namaz [prayer] and everything, but she didn't bring it up as much. […] I think you understand that you're only going to use, you'll only

extend yourself towards a therapy session after you've been through your spiritual steps you know with namaz, dua [supplication] and everything.

(BJ, male, NHS service user, dropped out)

Therapists' religious background

Several participants[26] assumed the religious background of her therapist based on the name or the fact they wore a hijab. One interviewee[27] suggested that the therapist's examples and approaches contributed to their impression of the therapist's religious background. One interviewee[28] became aware that their therapist was not Muslim due to a discussion they had in session, narrating a Christian tale. Two participants[29] were not aware of their therapists' religious backgrounds and did not see their therapists face to face due to telephone therapy.

While some participants emphasised the benefits of shared values, understanding, and cultural sensitivity, others felt that the overall therapeutic relationship and effective communication and rapport was more important. In both cases the therapist's religious background was weighed in terms of comfort, understanding, and the service user's personal situation and needs.

Participants who were less concerned about having a Muslim therapist emphasised the significance of a positive therapeutic relationship, empathy, understanding and professionalism as more important.

"I think it's more to do with people just like having a bit of compassion and understanding that everyone has different problems."

(KB, VSO service user, female, completed)

"I think everybody is like feeling is good for your client...therapist can be of any religion if the relationship is good for a client I believe."

(SN, VSO service user, female, completed)

"It's not important for me…therapists should be shaved, showered, smell good, good dress…nice face, nice attitude…"

(HI, NHS service user, male, dropped out)

Many service users, however, highlighted how a shared religious background could enhance comfort and approachability in therapy sessions suggesting that a choice of therapist could be important to some. The benefits of a Muslim therapist were also noted in relation to addressing specific religious needs and guidance and in the relatability and cultural sensitivity that a therapist from the same background can offer.

"It makes you feel more at home and comfortable...it was easy to talk to someone with my own background."

(AC, NHS service user, female, completed)

"...having faith-based background...extra element...understanding some of the additional pillars that you hold up or carry...shared values...understand where the other person is coming from."

(NH, NHS service user, female, completed)

"A Muslim therapist was better...for my situation at the time...better...for me personally."

(NI, NHS service user, male, completed)

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[26] SN, VSO service user, F, completed; NC, VSO service user, female, completed; BJ, NHS service user, male, drop out; AC, VSO service user, female, completed.
[27] IC, NHS service user, female, completed.
[28] NH, NHS service user, female, completed.
[29] HI, NHS service user, male, dropped out; TN, NHS service user, male, completed.

"Relate to each other...culture and stuff...certain things that I explained...another person would not be able to relate to...understood the kind of religion."

(CB, VSO service user, male, completed)

"More understanding...therapist would understand...relate with the client issues...understand why the family is saying these things."

(MH, VSO service user, female, completed)

Removal of the need to educate therapists about the service user's identity was also an important factor in preferences for a therapist who had a Muslim faith background themselves.

"...it was very important...no obstacles...pure therapy...no little teaching sessions...just therapy."

(KT, VSO service user, female, completed)

... If you're talking to somebody that understands that, then the process it kind of flows, and I have done this where I've actually spoken to that with another therapist. [...] I just felt like a teacher explaining the thing, and there was slight irritation that I hadn't been given what I wanted. So I think absolutely it just helps the process flow and then you can tap into deeper kind of feelings.

(KT, VSO service user, female, completed)

Having an understanding of what that means to that person… somebody who doesn't have a strong faith-based background... would be like, why don't you just X, Y, Z..."

(NH, NHS Service User, female, completed)

There was recognition by a clinical supervisor that therapists' own identities were likely to influence their therapeutic approach:

" their own experiences definitely perhaps influenced the way they were delivering the therapy."

(IN, NHS clinical supervisor, female)

Having a shared religious background with a service user could, however, raise concerns about whether attention to religion within therapy might be perceived as negative and judgemental by the service user. Therapists found that the adapted therapy was able to achieve a balance between including discussion about religion without being '*preachy*'. A number of therapists also said that their fear of using the approach was removed once they realised it was not necessary to be a religious expert and they were comfortable in delivering the adapted therapy.

One of my concerns coming in was actually I practise the same religion and you know you don't want to get into a dispute or be preachy […] I felt like it struck that balance really well, where people were able to kind of take what they want from it as well as working on the core techniques of BA activation which is what we are the expert in. So I guess my fear was I don't know everything about my religion, but you didn't need to be able to do that to deliver this intervention and that was really comforting for me to be able to deliver it.

(IK, female, NHS, therapist)

Perceived efficacy of the therapy

Service users often gave a confident affirmation of BA-M's *"most definitely"* positive impact[30]. Feeling it *"definitely helped"*[31] *or "it was useful and it does help"* [32]. One participant[33] expressed

[30] AT, VSO service user, female, completed.
[31] AL, VSO, service user, female, completed.
[32] KB, VSO, service user, female, completed.
[33] AL, VSO service user, female, completed.

improving coping skills gained from therapy and attributed the positive effect of therapy to the opportunity to talk and express their feelings. A number of service users expressed their appreciation of being supported in a way that was necessary and seen as helpful.

"Yeah, I think it was very much needed at the moment."

(NH, NHS service user, female, completed)

“The therapy helped me 10 out of 10.”

(NI, NHS service user, male, completed)

"I started to feel a bit better."

(NN, NHS service user, male, dropped out)

Of those who dropped out of therapy, one felt that the two sessions he had attended were helpful[34] whereas two others felt that the way they were asked about their religious practice was inappropriate and unhelpful.

“I didn’t find it therapy, I thought it was more of like I say, like a survey or like a data collection thing.”

(BJ, NHS service user, male, dropped out)

Therapists acknowledged the effectiveness of the adapted therapy for clients whose faith was important to their well-being, emphasising the impact on recovery.

" for people that their faith is important, this is really effective”

(CT, NHS therapist, male)

"I think it was really, really helpful. I think for most people that I did the adaptive therapy with, I’m pretty confident that all of them did recover."

(ST, NHS therapist, female)

"I think it was very effective. I did notice a lot of recovery with the PHQ9 scores and again, I think it’s incorporating those values and making it personal."

(TI NHS therapist, female)

“I’d say it’s CABAT if it’s for Muslim clients.”

(TC, VSO therapist, female)

An NHS supervisor felt the inclusive approach had potential to support better engagement with a wider range of faith groups.

“...if a clinician is trained to incorporate somebody’s faith, they could incorporate any faith because it’ll be in their knowledge and skill base anyway.”

(IN, NHS clinical supervisor, female)

Other therapists emphasised clients' willingness to change and individual engagement as key factors.

"I can’t say because it depends on each client... it’s on them to make that change and if they’re not willing to make the change, then I don’t know if any therapy will work for them."

(TH, VSO therapist, female)

“Because it’s one to one whereas the other work that we do is group based...it’s comfortable for them, it’s a safe place for them and it is confidential to a limit.”

(ZB, VSO therapist, female)

[34] NN, NHS service user, male, dropped out

How BA-M helped

Participants expressed how BA-M therapy has positively impacted their mental wellbeing; helping some to share some of their thoughts and helping others with techniques to take responsibility and overcome day-to-day issues.

"My therapist relaxed my mind…you can talk about something, and somebody listens to your problems".

(SN, VSO service user, female, completed)

"Definitely, I'd say it helped me because it held me accountable… it was helpful."

(AC, NHS service user, female, completed)

"…there were times when I was feeling really down and feeling I'm hopeless…I feel a lot better".

(AL, VSO service user, female, completed)

"…she helps me, how to deal with this and it's really helpful and motivated me…how she advised me and gave me really helpful…it did impact on my work life, and daily life and it's a really good impact".

(IC, NHS service user, female, completed)

The role of religion was a key feature of the therapeutic journey for many participants; helping a return to what had been normal and enabling positive social interactions.

"…it helped me kind of realign to a meaning…gave me grounding of the strengths I had… there's talk about like destiny and those elements that are very kind of strong in truth to my faith…you know, it is as it's written (by God)."

(NH, NHS service user, female, completed)

"…this therapy unlocked me out of severe depression […] in such a short amount of time [… therapist] was guiding me on how to live my life again and woke me back up [...] she was guiding me [...] and it worked."

(NI, NHS service user, male, completed)

"…it was really positive, I was feeling myself again"

(CB, VSO service user, male, completed)

"There were a few clients where they started praying more [...] going to more faith-based classes... part of her activity was to go to a women's Islamic group [...] not only gain knowledge but also socialise and have more of a social circle as well".

(TH, VSO Therapist, female)

Changes achieved

Participants describe how therapy has led to a shift in their perspective and positive thinking, reflecting on improvements in their emotional and mental wellbeing.

"...I was focusing on a lot of things that were negative in my life [...] that person that I talked to helped me a lot."

(AT, NHS service user, female, completed)

"I think more positive thinking, be more kind to myself [...] do so much today, there's always tomorrow."

(KT, VSO service user, female, completed)

Participants talked about increased confidence and belief in themselves which ultimately led to behavioural and lifestyle changes.

"Sometimes it is other people holding you back [...] I became more independent of myself, and I know I can do a lot more now [...] I am a lot more confident now."

(KB, VSO service user, female, completed)

"I did start doing my workouts again every day [...] I had a painting business [...] the confidence in myself to do it again, the therapy helped me do that."

(AC, NHS service user, female, completed)

"Encouraged me to read some verses from the Quran, do my prayers..."

(NC, VSO service user, female, completed)

Participants also mentioned greater self-esteem and taking manageable and enjoyable steps towards their goals.

"I was feeling good about myself and feeling light

(QB, VSO service user, female, completed)

"Sometimes you just want to do everything and then it's like no just be kind to yourself [...] life's too short."

(KT, VSO service user, female, completed)

Participants discuss overcoming negative emotions and finding relief and expressed a sense of empowerment in being able to take control of their lives again.

"Therapy had kind of helped me to maybe not look at things in the same way as I used to look at them before."

(AL, NHS service user, female, completed)

"It brought me back to my normal self and basically I was more motivated to going out and enjoying life, reading Quran and having friends, talking to my brothers and sisters. I have got 16 nieces and nephews and I love the kids and my family. I didn't have much access to them when I was using drugs."

(NI, NHS service user, male, completed)

Signposting or referral

Therapists were also asked about developing new links with community groups or religious experts as part of the culturally adapted approach and a number mentioned trying to find develop such links during the project period but additional resources could be necessary for this.

"I did lots of signposting for him for finance... I had to make sure I got in touch with the Zakat Fund and get some finance sorted for him, get carer's support for him."

(ZB, VSO therapist, female)

"I remember, I think [supervisor] was trying to do some work with maybe like local imams and mosques to just tell them a little bit more about our service but I don't know how far she got with that."

(ST, NHS therapist, female)

"We were working on a bid to do some stuff in mosques, but that bit didn't come through... it would have been useful to explore."

(NT, VSO manager, male)

Community resources

VSO staff also took the opportunity to signpost BA-M clients to the organisation's other activities such as coffee mornings, workshops, and community classes. At one site, these initiatives aimed

to empower women by providing them with opportunities to engage, communicate, and support each other, to reduce feelings of isolation.

"This is the thing that we have with women in our community because they're so busy sacrificing themselves they don't feel heard... the smallest things make all the difference."

(BI, VSO therapist, female)

Similarly, some service users highlighted that after therapy had ended the service continued to help them access groups, including peer support.

One group was a parents' group who have special needs children where we can meet together and just talk to each other or go out together.

(TK, female, VSO service user, completed)

The place where I am in I made a lot of friends there

(KB, female, VSO service user, completed)

However, most therapists did not mention referring service users to other services and did not mention referral to religious experts, as recommended in the BA-M guidance for issues requiring specific knowledge of Islamic teachings. This may have been because such expertise was not required and therapists felt they could support clients in the study themselves

… if I feel like I'm out of my depth I'll definitely be like, no, I can't deal with this it's too much for me."

(BI, VSO therapist, female)

Feedback from service users indicated they did not need or want to engage with a religious expert such as an imam about their mental health, suggesting this would need to be perceived as relevant and also from someone with expertise in both mental health and religious knowledge.

I think with religious people to be honest, I get wary of them [...] they can sometimes advise you of something and it could be wrong and you don't know it's wrong. So I don't know, I've never ever approached an imam for questions like this. [...] I don't know if they have the qualifications as such. [...] To be honest I don't know what kind of values they've got

(BJ, male, NHS service user, dropped out)

...they didn't put me in touch with an Imam or anything like that. I don't think I would have wanted that either, I wouldn't have wanted any kind of religious authority or person to come in to intervene with it.

(AT, female, VSO service user, completed)

I don't really think I needed that much help and I thought what I was going to and what was happening it wouldn't make sense for me to.

(AC, female, NHS service user, completed)

Care pathways

The collaboration between VSOs and IAPT to deliver BA-M created a number of new care pathways for VSO service users, including self-referral into a VSO service and referrals into IAPT.

we normally get referrals coming from GP's and professionals, whereas for BA that wasn't the case. If anybody made a referral themselves, you know self-referral, and they wanted the BA therapy we did the assessment first with them to see what support is there and are they mild to moderate and so on. So we looked at that and then we took them on and this is something that we just did the BA therapy with them and discharged them then - unless they needed more support then we took on further and signposted them on to whatever support that they needed.

(ZB, female, VSO, therapist)

I think one or two, people who were delivering, I did hear from them that they had some people which they thought [the IAPT service] will be able to handle, so they signposted them to the higher services.

(SH, female, VSO, manager)

Informal feedback during peer support sessions also suggested that some of the people referred to VSOs had come via IAPT referrals but these individuals still needed considerable support for their mental health.

Feelings at the end of therapy

At the end of their therapy sessions service users' feelings ranged from a sense of confidence, accomplishment and readiness to face life's challenges to feelings of discomfort and dissatisfaction.

"I felt really proud and happy… She was giving me like words of affirmation…because I progressed really well…that was a massive confidence boost to me as well, so I felt really happy at the end."

(SN, NHS service user, female, completed)

"…my mind was really focused… and not focused towards what it was previously that was troubling me…I wasn't even thinking about I'm going to fall down again, or I'm going to relapse or anything of that sort, I felt like, no, no, I mean, I'm in a strong place in my mind and I'm really going to go out there and carry on with my life."

(CB, VSO service user, male, completed)

One participant reflected on the transition from therapy to self-help and seemed ready for this.

"I felt like this was the end…I have to kind of go on about in my own life kind of on my own, and that's fine, because that's what therapy's about. It's like holding your hand but then you have to let go of the therapist and kind of go on in life yourself."

(KT, VSO service user, female, completed)

Discomfort was related to a therapist's perceived lack of interest and an unwelcoming atmosphere during the sessions.

"I couldn't wait to get out of it… she suggested that I stop going to the sessions and…made me feel …she didn't want to be there."

(BJ, NHS service user, male, dropped out)

Other participants expressed a desire for further sessions, suggesting the therapy was ending earlier than they needed.

"I felt that I needed a bit more counselling."

(KB, VSO service user, female, completed)

"Okay, but I wanted more sessions."

(NC, VSO service user, female, completed)

In general most service users wanted to see the approach continue and had some suggestions for further development to support even better engagement and choice.

...I'm really grateful that I come across behavioural activation therapy because it's something that I didn't know existed. [...]I personally found that approach to be more helpful, [...] the fact that it connects you with your faith and explores them, it's got a lot more to it. So yeah, I would definitely recommend.

(CB, male, VSO service user, completed)

I think a group session is good for me.

(SN, female, VSO service user, completed)

...if you are going to roll it out, any chance of making it 10 sessions? And maybe make it that individualistic setting at the beginning of, like what's that person's information processing skill level

(NH, female, NHS service user, completed)

Standard elements of behavioural activation

The behavioural model

Therapy sessions introduced a simplified behavioural ('two-circles') model to clients as a tool for explaining the relationship between difficult life events and common responses. Some participants did not recall this[35] but those that felt it improved their understanding of how emotions and behaviours were linked. They expressed how the model helped them break away from repetitive cycles, understand themselves better, and shift their perspectives.

"It's like, you go round in circles… my mindset is a little bit different, so I don't get as down as I used to…. It's a repetitive thing isn't it, when you do the same thing you're going to be the same way all the time. If you start thinking differently a little bit…I stopped blaming myself for a lot of things and that has helped me as well."

(AL, VSO service user, female, completed)

Understanding the approach could, however, be hampered during early sessions when service users were emotionally distressed.

"At the first session I didn't understand really what I was going, because I was at a very low point. I was basically very emotional and I couldn't put my words together like what I wanted to say. In about the second session I started to understand what the person was saying and it made a little bit of sense, so I didn't want to not go to it, I wanted to go through the full sessions.."

(AT, VSO service user, female, completed)

Service users generally felt positive about the behavioural approach, emphasising its active nature and the goal-setting aspect. Many participants highlighted the usefulness of concentrating on behaviour to improve their mental well-being. They mentioned that changing their behaviour helped them break the cycle of negative emotions and experience positive changes in their emotions. The collaboration with therapists to identify effective strategies for this was also appreciated

"… it was a good approach because it was active, and I was given goals to achieve by the end of the week after each session. So, I was told to actually do stuff and I thought it was really good."

(AC, NHS service user, female, completed)

"…changing your behaviour does help mentally as well because, if you're doing the same thing and then you're getting into the same emotional space again and again, if you do something a little bit different then you're not getting into that emotional space."

(AL, VSO service user, female, completed)

[35] *(KB, VSO service user, female, completed; TN, NHS service user, male, completed)*

"…and then sort of like working together…this therapy was good…encouraged to think for myself and trying to provoke me to see how what I think might help, you know, rather than being told that it should be done this way or it should be done that way…it's kind of working hand in hand and working together and trying to see what's the best way to try and resolve it and try different methods as well…, it may not work and then we go back to the behavioural activation… the way I was behaving, and sort of looking at different ways…it was just a case of working everything out and then finding ways to help me to get back on my feet and back to my usual self."

(CB, VSO service user, male, completed)

Participants discussed the practicality of the behavioural approach in their lives. They mentioned engaging in activities, setting goals, and actively participating in the therapy process.

"…it wasn't a case of me just having to express what was on my mind, what was troubling me, but it was very specific and focussed trying to identify what was causing me to feel a certain way and trying to get to the bottom of the problem, diagnosing that, trying to understand it myself and then trying to like find ways to be able to fix it, if that's the way of putting it."

(CB, VSO service user, male, completed)

Some participants emphasised the importance of implementing the strategies in real-life situations.

"Like I'm saying it's sort of like, even though sometimes I'm not feeling like to talk but I force myself to talk, and obviously, sometime I did, in some situation I didn't know what to do and after speaking with the person or someone you know, sharing with them then obviously I got some idea, like how to cope with it."

(IC, NHS service user, female, completed)

Homework tasks

Participants generally expressed a clear understanding of the assigned tasks, which were seen as meaningful activities aligned with personal values and goals that felt manageable.

"...I would pick two or three things that I'm going to try and work through or work on for the next week or whatever. You know things that were important to me, my values and what I wanted to achieve"

(AT, VSO service user, female, completed)

"...I've got two short term goals...there was little tasks so every time in between, yeah, the therapist would come back and we'd discuss it."

CB, VSO service user, male, completed

Participants acknowledged that the tasks were perceived as homework, which contributed to their engagement and sense of responsibility. For one participant[36]. however, this was perceived as a negative and felt too prescriptive.

Participants were actively involved in selecting tasks and had ownership over the activities they engaged in. This collaborative approach and framing tasks as meaningful engagements or homework contributed to participant engagement and helped them meet task deadlines.

"They weren't really something that they picked out for me. It was something that they worked with me and said, what would you say was something you wanted to work on. You know what is it that's important to you right now...It was very much I would say sort of like it wasn't designed by the therapists, it was something that they used the tool and I could design it to help me with my specific issues."

(AT, VSO service user, female, completed)

[36] (BJ, NHS service user, male, drop out)

“I think they were good because I know if I didn’t treat them as like they were homework tasks, I wouldn’t have got them done at all. She asks me the next week, like the week after, did I do it and I’m like yeah I did do it - so yeah, I think it was helpful.”

(AC, NHS service user, female, completed)

“... made you reflect and really think, and then I think putting it down on paper, it kind of reinforces it and then you can re-read it and come back to it […] it’s actually putting things into practice, and again that comes back to the religion side, being productive in life."

KT, VSO service user, female, completed

For some, however, the homework tasks were seen as prescriptive; where the relationship with the therapist was positive, however, this could still lead to helpful reflections that aided recovery

“...feel as though I’m being told what to do... I know it’s a waste... it didn’t work for me to be honest with you.”

(BJ, NHS service user, male, dropped out)

“...at a point I did feel like I was like 7 again [...] working through a workbook [...]. But it actually felt reaffirming [...] your mind sort of regresses to a part of your childhood and you use like the creativity of play or the creativity of this to really come to terms with your feelings and nostalgia and all those elements. I felt like the activity [self-help] book did that [...] that felt quite unique and bespoke but also very warm.”

(NH, VSO service user, female, completed)

The initial challenge of getting started with tasks, particularly going out to engage in activities for oneself could be a key hurdle and service users described internal struggles such as feeling overwhelmed. However, once initiated, tasks were perceived as easier and enjoyable and provided motivation to continue being active and achieve bigger goals.

"I’d associate it with something bad. I just think to myself that’s just irrational there’s no point, so just try it and just do it...it’s dumb for me to be afraid so I just did it."

(AC, NHS service user, female, completed)

“...the main hard part is doing... but then after that it was so easy. I think when I went there I realised that I really enjoyed it and it was fun but only starting with this pushing myself to go out and to do something just for myself. Usually it’s only about my girls and when they are around I do things that makes them happy and we do things what they want to do but some things I did that just myself. That was weird but I did that.”

(TK, VSO service user, female, completed)

“ If I didn’t focus on it, I thought what was the point of doing it. So I’ve tried to focus on this because I know it was something that I needed to do for myself.”

(AL, VSO service user, female, completed)

"I think I just kept on reassuring myself that if I could do the smaller ones then why can’t I do the big ones and I just kept thinking of the end goal in mind."

(AC, NHS service user, female, completed)

Feedback and the ability to adapt tasks were seen as important for effective task completion. Visual aids and personalised plans assisted individuals in self-assessment and modifying tasks based on their needs and preferences. One participant mentioned the need for clarity about task evaluation and uncertainty about whether tasks were meant to be checked and evaluated as a reason for non-completion.

“If I managed that, then that was really useful because I found a couple of times I would not do a certain day or something, not do one of the things or two of the things that I wanted to do. I then

found that the having that visual reminder for me on a piece of paper just sort of made it a little bit easier to enforce myself..."

(AT, VSO service user, female, completed)

"...but in all honesty I probably didn't do them all, I didn't do them really well. I think I wasn't always aware if we were going to feed back on the homework tasks, you know, like whether or not it's like actual school and homework and like he's going to check it, I'm going to do it when I come back and I'm going to be marked on it."

(NH, NHS service user, female, completed)

For some participants, homework tasks added to the feelings of pressure and being overwhelmed and did not seem manageable.

"I felt kind of almost like pressured or rushed... I just kind of felt overwhelmed by that feeling...it just made it like a delayed task...it was my own kind of feeling."

(NH, NHS service user, female, completed)

"I was going through so much you know like, depression makes you low, you know when you feel low, I don't want to...."

(BJ, NHS service user, male, dropped out)

"They'd explain there [in the session] whatever it was to be done...but I couldn't write it. Them days it was too much low mood... on a mental level, I couldn't understand what I should or shouldn't do. And secondly, I'd completely given up. So that's it."

(TN, NHS service user, male, completed)

"...sort of battling with my thoughts and stuff...pushing towards, taking my mind away from things and then sometimes finding that my mind sort of going back to the same place again... it's like, same feelings sort of all come back again."

(CB, VSO service user, male, completed)

"I think it was just I don't know, it was too much for me. I just need to sit down to, relax. Sometimes I can't relax, I just have to keep moving around and things like that."

(QB, VSO service user, female, completed)

The BA strategy of breaking down tasks into smaller and more manageable tasks helped others to overcome their perceived difficulties. However, there was some evidence that this approach was not always being followed, despite its essential role in behavioural therapy.

"I'd write down what my goals were and what I'd find easy to do, and what I'd find hardest to do... tackle them bit by bit, with the easiest first and then the biggest stuff at the end...When it's written down then it's clearer to see so I'm not as scared or intimidated by it."

(AC, NHS service user, female, completed)

"...what might have made it easier would be like, okay, so these kind of goals or values hit upon these aspects of the religion or these things. Like for instance, one of my goals was praying, I was like oh well why don't you give me that little section and let me work through that one for a while, and then we can hit back onto it...I think that would have made me feel like okay, great, I can just do those bits when I'm thinking about those goals."

(BJ, NHS service user, male, dropped out)

Discharge practice

The BA-M manual recommended prioritising client retention as much as possible within organisation constraints but there seemed to be variation in how much this was followed and the

practice followed could depend on the practitioner. Standard practice in IAPT was to discharge after three failed contacts as this signalled reduced engagement, however, adherence to this protocol was balanced against individual considerations.

"We allow a combination of any three missed appointments... when we would discharge..."
(OI, NHS manager, female)

"Missed appointments sometimes indicate that there is that lack of engagement there…we've tried to, as much as there is a protocol, sometimes we have to take people on a case-by-case basis..."
(OI, NHS Manager, female)

"No, I would say we probably went beyond even what the manual says..."
(IN, NHS clinical supervisor, female)

Some service users, however, felt that discharge and referral to another service was not adequately supported

"they gave me a phone number for this other company... just a formality...if they wanted to refer me themselves, they would have called them..."
(NN, NHS service user, male, dropped out)
"if you want the session you have to come to me."
(ZB, VSO, female, therapist)

Therapist guidance and support

BA-M therapy manual

In general, therapists found the manual to be useful and had not presented any issues in clinical supervision relating to the manual content. One therapist gave positive feedback about the manual and client booklet and how useful it had been in practice.

...I think it was really nice to have that therapist guide as well, like the manual for the therapist in giving us the confidence that you don't have to know everything about Islam and I think it was helpful in there because it gave like examples of things that you could be saying or things that you could be recommending.
(ST, female, NHS, therapist)

VSO therapists found the structured approach to be useful and for most this was a new way of working with clients. Laying ground rules with service users was seen as helpful and several therapists found it useful to have the session breakdown even if they initially found the amount of guidance overwhelming initially.

I feel that working through a manual gives you a bit more boundaries […] and making the client aware that this is an actual therapy and there's some contracting to do at the beginning - my sense was that they might take this more seriously and know what they are here for.

I think initially just starting the session, how a session should be going, the first couple of sessions […] I do like it when there's some guidance on how a session should be done, what we can do and what's not on there what should be avoided.
(TH, female, VSO, therapist)

The manual has a lot of information and I think at some point I just thought […] I know what I know so I've just got to kind of trust myself with this information. So, recently I probably haven't been going back to it as much as I should have. […] initially it was very overwhelming, there was a lot of information in there and I was just like, am I doing this right. That was the issue I

think, you don't know whether you are doing stuff right do you?

(BI, female, VSO, therapist)

Use of the tools available within the manual was also tailored to select those felt to be most relevant to service users

the daily activities record. I didn't use that as much as I thought I would just because it wasn't interesting doing that. […] every day I have to write I've got to get this, I've got to do that or do this - it's not going to work. […] I just don't think it was something that our service users would do.

(BI, female, VSO, therapist)

Therapists felt the cultural perspectives on depression, dynamics within families and guidance on how to use religious teachings were accessible and useful and could help them avoid making assumptions based on their own experiences, even if they were Muslim themselves.

I think I found it really helpful. I think there were some aspects that I probably didn't know […]. Sometimes when you are from the same cultural background or religion, you just make assumptions or you don't think about it that level.

(TI, female, NHS, therapist)

There were certain bits that really stood out that I used more than others and that 'tie your camel' [religious teaching] bit is still something that I use now.

(IK, female, NHS, therapist)

And from what I've heard from the clinicians about when they've been describing that to the clients, that's been received quite well. [...} I think it's a good explanation and a good way of getting it across to people.

(IN, female, NHS, clinical supervisor)

The aspect of the barriers and strategies for barriers I found was very useful.

(ZB, female, VSO, therapist)

One therapist spoke about how the manual helped her to challenge cultural ideas that contributed towards an individual's depression.

We are changing that, we are saying you are valued, you are a person, you have every right to feel positive, every right to feel valued because Allah (God) created you and you can explain that to them […].

(BI, female, VSO, therapist)

A manager who had joined the project in its final year did not seem to be aware that BA-M had itself been developed through prior research involving extensive fieldwork and development and felt that further changes should be made to the approach. This was not however backed up by any of the feedback from those delivering the therapy

It seemed to me that it was set in stone that there was no flexibility in terms of changing or adapting the approach [....] If we had regular meetings where we discussed would you change things from all providers and if there was a common team theme [...] then that could have been discussed at a higher level and taken on board in terms of feedback and constructive feedback and saying this is what we're finding and this could have an impact on the outcome, shall we go back and change this

(BB, male, VSO, manager)

Another VSO manager suggested cultural issues could be covered more, however, this would also be difficult given the significant ethnic diversity within Muslim communities in the UK and

globally, although the manual was developed in Bradford, where the Muslim community is predominantly Pakistani

We need to prepare proper modules, not with just religious knowledge but the cultural knowledge
(SH, female, VSO, manager)

Therapy training

Therapists, managers and clinical supervisors were given training at various stages of the project. Before the COVID-19 pandemic face-to-face BA (for VSO practitioners) and BA-M training (for all those involved in therapy delivery) had been organised. Online training was provided on two more occasions afterwards to address the break caused by the COVID-19 lockdown and issues with staff turnover. The final training sessions were recorded and accessed by therapists and mangers that were involved later on in the research process. It was clear that there was a mixed approach towards whether the recordings were used in practice with some therapists relying on colleagues to relay training information and most but not all managers watching some of the sessions to familiarise themselves with the approach.

...when we had the refresher, two of my other colleagues were quite hands on with the CABAT, one of them has left now so we asked one of our managers for a bit of a refresher.
(TC, female, VSO, therapist)

So initially the training I went on was in 2020, […] I was on maternity leave then so I think I watched the recording when I came back.
(ST, female, NHS, therapist)

…. I wasn't actually going to be delivering it, so I just needed to get a grip of what the clinicians were going to be delivering from more of a supervisor perspective. So yeah, I caught up on the training through recordings.
(IN, female, NHS, clinical supervisor)

If I'm completely honest, I didn't get through absolutely everything because you're trying to supervise staff and […] so it's time constraints that made that a challenge as well. Some parts were quite rushed through but I did familiarize myself to a certain extent.
(BB, male, VSO, manager)

Therapists that did attend the training had positive views, indicating that they felt that it prepared them to deliver the intervention and to transfer the skills learned to other contexts.

I did find the training really, really useful. […] I remember the stuff on the values-based assessment was something that I felt was really, really useful. It's something that I use in my practise now but at the time in PWP work it wasn't something that I was very familiar with.
(IK, female, NHS, therapist)

…. the aspect of how we'd culturally adapt the therapy. It just gave us a bit more confidence and maybe, during the training, I had a lot of questions and I felt [researcher] handled them well and she guided us well.
(TH, female, VSO, therapist)

...the people that were doing the training they were really well informed, they had a really good way of delivering the training and actually how to apply it and they're really good with answering questions that we had as well.
(ST, female, NHS, therapist)

Views from VSO managers appeared a little more critical of the training and whether it trained therapists appropriately to deliver the intervention. For example, one manager suggested that if this had been arranged to run over several weeks rather than one full week followed by two full

days, it may have felt less intense. But in general, this manager appreciated the aim of increasing the skills of individuals who were not trained psychological therapists.

I think the basics we were told which I quite liked, the objective behind this training was that they wanted to train people who are not highly qualified counsellors or anything, but workers who could just be trained […] But I thought it was quite intense. It could have been a bit mellowed down. […] and stretched over maybe six weeks instead of putting all the modules in one day.

(SH, female, VSO, manager)

Another manager commented on the difference between training those with a background in psychological therapy, and staff from his service, who were not trained to deliver a mental health intervention and would have found this more challenging.

For a therapist say from the IAPT service, it would be much easier for them to step into the role of learning a bit about behavioural activation or whatever it is and about the adaptation, because they've got the kind of core skills there already as a therapist, whereas colleagues didn't have that.

(NT, male, VSO, manager)

Role play was incorporated into the face-to-face training but not incorporated into the online training and the opportunity to practice delivering the intervention was mentioned by a number of therapists.

I mean generally I like role play because it's like a bit of a practice so that's something that I would definitely recommend in training

(TC, female, VSO, therapist)

I personally think, you know when you go to one to one, you need a little bit more practice. […] May be role play […].

(MH, female, VSO, therapist)

The time delay between training and therapy delivery, due to COVID-19 lockdown, had an impact on how confident therapists felt about delivering the intervention. It was also clear that some of the issues covered in training had not been retained and needed to be regularly revisited. Ongoing peer support sessions, which were organised by the lead researcher once a month, were also seen as helpful in terms of addressing the practical aspects of delivery and research involvement, however, these were not always attended by those who needed advice.

...the only thing that was missing from it, really, was exactly what we need to be doing, especially for the first two or three sessions. It could be that I just missed it but that was the thing that I wasn't sure about, so I met up with [researcher] again and she explained it all to me.

(CT, male, NHS, therapist)

I think the support that you guys provided was very helpful and there was monthly meetings as well which was really good.

(TI, female, NHS, therapist)

" every time, she was very good, any problems, any questions that came up we see [lead researcher], and [Manager]. And then we had meetings with [lead researcher] as well…it was a good support."

(MH, VSO therapist, female)

the paperwork side of it and the recording was a little bit of a… maybe we could have gone through it a little bit more [...] because the training took place and then the covid happened but once you start doing it just becomes easier.

(ZB, female, VSO, therapist)

Being able to go back to the recordings and ask team members and the lead researcher for advice was also helpful. However, in the VSOs the lack of previous experience in therapy delivery could have been addressed by some form of additional mentoring as they realised the limits of their previous knowledge.

it was all on the internet so we could have all gone through it because most of training was then by recording.

(ZB, female, VSO, therapist)

...when I looked at the manual at that time I found it quite useful. Because we are a close knit team, anything we were unsure about we just used to ask each other so that is how we liaised with each other.

(TV, female, VSO, therapist)

I could practice with my colleague, but we're both in the same boat in terms of our training, our background and things like that. […] because we don't have a background in therapy, I feel like we should have been maybe mentored up or with someone who does have it. I mean we did have clinical supervision once a month but I feel like we could have done with a bit more.

I thought I had an understanding of mental health but obviously it's so much more now that I have spoken to people and I have delivered the therapy myself.

(BI, female, VSO, therapist)

Supervision and management

One-to-one and group supervision was provided for IAPT therapists, and group clinical supervision for VSO practitioners alongside their usual management support. The diverse layers of support aim to cater to the various needs of different staff members.

"One of the first things that we did was to get [clinical psychologist] and [doctor] to have clinical supervision with staff, with therapists... so we have those three different layers of support for colleagues..."

(NT, VSO manager, male)

Generally, therapists shared positive experiences with clinical supervision, emphasising the reassurance and support they received, both from individual sessions and team meetings.

"…we had clinical supervision once a month…it was really good... in case you need reassurance."

(BI, VSO therapist, female)

Participants that attended the supervision sessions found them to be useful for both practical matters as well as peer support.

And then through supervision, [...] more practical things were coming up more than clinical things, and also things around risk and questionnaires and paperwork were coming up more than actual therapy side of things really.

(IK, female, NHS, therapist)

We would spend about two hours in supervision and she would go through any issues that we'd had and she would guide us quite well. It was quite helpful with the peer support group as well so we shared ideas with other therapists.

(TH, female, VSO, therapist)

A clinical supervisor highlighted that having specific supervision for her role as supervisor to BA-M therapists would have been a welcome addition. This input by an experienced BA-M clinician was originally available but later withdrawn from the NHS team due to staff changes and left the next supervisor feeling somewhat unsupported herself.

...all the clinical supervisors have something called supervision of supervision, [...] I've still been able to speak to [lead researcher], I've been able to speak to my own manager, but apart from [lead researcher], none of them know about the approach itself. So I think maybe having somebody to reach out for clinical advice might have been good.

(IN, female, NHS, clinical supervisor)

Management and supervision challenges

An NHS manager mentioned difficulties in coordinating the project which involved multiple providers and was affected by differential organisation engagement, staff changes, progression, and the disruptive impact of COVID-19 are discussed.

"project became quite difficult to manage [...] so many different providers working on it […] some of the other VCS providers didn't seem quite as such engaged... some of them were good and really were much better with the recruitment targets than others[...] staff changes[...] training and then Covid hit... reasons that made it quite disjointed at times..."

(OI, NHS manager, female)

The need to extend session times in IAPT to manage the extra time needed for research questionnaires was raised by a number of therapists during both peer group sessions and supervision and this proved to be a contentious issue. From a management point of view this request needed to be balanced alongside the challenges of maintaining daily client quotas within a limited timeframe to meet Key Performance Indicators for IAPT. These indicators did not provide extra weighting for populations that are under-represented in IAPT and may be more difficult to engage as a result of high levels of need or more complex presentations. While it was agreed that each IAPT therapist had to make an individual case for longer sessions, feedback from therapists suggested that in practice they did not receive longer time to deliver the therapy, which could act as a disincentive to be involved in the trial. (see Taking Part in Research below).

Clinical supervision of VSO staff by an NHS supervisor could be complicated by the differences between different ways of working in the VSO sites, including longer session duration and risk management practices. Some of the issues raised with the VSO supervisor were also not about clinical matters, although they were important to the delivery of the therapy

" they have different ways of working [...] checking in with people and making sure that even if they were working with slightly riskier people, they had a safety plan in place [...]so I kept asking the clinicians to refer back to the risk criteria..."

(IN, NHS clinical supervisor, female)

"Am I a supervisor here or is this more like an administration kind of duty that I'm doing?...more like troubleshooting those kinds of difficulties rather than me being able to get to grips with a clinical kind of issue..."

(IN, NHS clinical supervisor, female)

Ethical concerns could sometimes lead to VSO clients being deemed unsuitable for BA-M and referred to more appropriate support, including crisis support. The type of support needed could sometimes be difficult to assess, however, when clients had complex issues. High depression scores and complex presentations for many clients meant that some had to be stepped up to more intensive treatments.

" [the] person is not suitable for this culturally-adapted BA and it's only ethical to move them onto the right place [...] even some of them needed immediate crisis support..."

"...problems around complexity of the clients... these are the clients where often it felt like we were doing the sessions with them and we were just [...]are they really taking benefit from what we're offering at the moment?"

(IN, NHS clinical supervisor, female)

Taking part in research

Recruitment and data collection were additional activities required by organisations involved in the trial alongside delivery of BA-M and usual treatment. Two VSOs required considerable support to understand these processes. Within IAPT, which was more familiar with research involvement, communication issues within operational teams adversely affected recruitment to the study and data collection. Issues were highlighted around sharing information between admin team members and potential study participants. Difficulties in coordinating information across IAPT, resulted in people who were eligible to receive BA-M being booked in for standard therapy instead. Disjointed processes for data collection also meant that some study data went missing and could not be retrieved.

"*Our communication could have been a bit more effective, to be honest [...] somebody who's potentially, could be part of the study, but they could have [instead] offered them a normal appointment before that,."*

(IN, NHS clinical supervisor, female)

"When things are all disjointed, I think sometimes it felt difficult to bring it all together at times... there are so many points of gathering the information then I think some of it got lost and when (lead researcher) was reviewing the data, there was lots of missing information and by the time it had got to her, it was too late to go back and get it, if that makes sense."

(OI, NHS manager, female)

Completing the questionnaire measures at the start of sessions was essential to the quantitative findings of the trial. However, this was raised by many NHS therapists as problematic because of the time needed in sessions to do this. Therapists were required to deliver the sessions in the usual allocated time they had per service user unless a case could be made relating to their overall workload. The research aspects of the therapy could thus add to individual client workload, making the approach more difficult to deliver than standard CBT because of organisational constraints.

I think that was more of a service issue where we weren't given enough time to do all the measures and [...]the measures are a bit tricky

(ST, female, NHS, therapist)

"...the questionnaires and the time we experienced like have 30 minutes for a session...when we have interpreter clients, we have an additional 15 minutes on top and I think that would have been really helpful because we had extra questionnaires to do with this in a 30 minute time frame and then also deliver the intervention like we normally would so that I really struggled with."

"an extra 15 minutes...to not have the whole session just be questionnaires."

(TI, NHS therapist, female)

It was concerning that in at least one case, the increased workload, which included administrative handling of the data as well as data collection, prevented the therapist from completing a Values Assessment - an essential part of the BA-M therapy process.

"I don't usually do the Values Assessment, partly just because of time constraints...a lot of extra questionnaires [...] we have to do the GAD7 and PHQ9 for everybody [...] initially it felt like a lot of extra work because we had to upload the scores and email them off to somebody and I think that was a bit of a challenge"

(CT, NHS therapist, male)

In both NHS and VSO settings, completing many forms could also affect engagement by service users who were not familiar with psychological therapy, or had concerns around confidentiality.

I mentioned the questionnaire was a bit of time and this is the first thing with the Muslim community, it was very hard to bring them and tell them, please come, especially when doing the treatment as usual. The people, didn't want to fill those questionnaires, then we have to explain them.

(MH, female, VSO, therapist)

I think the thing that was more difficult was all the questionnaires and I think people did drop out. Obviously, we don't always know why people have dropped out but I think it could've contributed to that. There's a lot of extra questionnaires to do and I think for people that were depressed, they were getting a bit confused by the opposite questioning and I think it just felt like a lot of work to do and it took away from getting going with the actual intervention […].

(CT, NHS therapist, male)

...people don't like to ask every week the same question because sometimes people they say, we don't want to be reminded of our past. […] we had one client, she completely refused to answer these questions […].

(MH, VSO therapist, female)

"...I found difficult was clients that struggle to open up... the paperwork that they really found difficult...I feel a bit uncomfortable because I felt like I was just bombarding them with questions and papers so that's the only thing that I struggled with a bit to be honest that they won't really feel comfortable about it."

(TC, VSO therapist, female)

"asking service users to do that level of paperwork is a daunting process. So if I'd been involved, maybe we could have discussed that as well but then I thought it is useful and, in terms of gathering the data and the amount of funding that's been put in, it is unavoidable. We do need that data to move forward and to justify further projects or further funding so it's a catch 22 situation. […] there was a lot of pushback in terms of the amount of paperwork to be filled in."

(BB, VSO manager, male)

Interviews also gave insights into why very little data had been obtained from the Religious Coping and Behavioural Activation (BAD-SF) questionnaires that therapists had also been asked to use with BA-M participants enrolled in the trial. In relation to the Religious Coping questionnaire, some questions elicited unexpected and uncomfortable reactions from clients.

"I think one of them was like, do you feel like God is angry with you...when asked that question, they looked a bit surprised...there were one or two questions I think the clients were a bit uncomfortable with..."

(TC, VSO therapist, female)

The BAD-SF questionnaire involved reverse scoring after completion which was confusing to several therapists, and it appears that some were expecting service users to calculate the reverse scores rather than doing this themselves.

"...the backward one was really confusing."

(TI, NHS therapist, female)

"...the opposite questioning, if that makes sense, I think people got a bit confused around that...the questions themselves were okay, but it was the time it took for the client to understand them...the sessions just became quite an effort for the client."

(CT, NHS therapist, male)

"I think because I probably struggled to understand it myself, it was hard to get clients to understand it"

(TI, NHS therapist, female)

Recording of sessions to check therapist adherence was another research request that received almost no data from organisations involved in the trial. Feedback during peer support sessions had indicated that therapists themselves felt anxious about such recordings and clients were also often unwilling to have sessions recorded or to be interviewed following completion of therapy.

"...they would not necessarily be confident about sharing all the information...clients were unhappy about their voice being recorded…there was quite a bit of anxiety about that"

(NS, VSO manager, male)

The only thing is, you know when they consent, [...] they don't want to be interviewed. [...] They made it clear that they didn't want that.

(TC, female, VSO, therapist)

Conclusion

As the most socioeconomically deprived religious community in the UK, Muslims experience a wide range of environmental stressors, which are exacerbated by cultural stereotyping and Islamophobia in almost all areas of their lives (Allen 2016). Current evidence on mental health in UK Muslim communities indicates that public mental healthcare services replicate and reinforce this social exclusion in wider society through poor levels of access, engagement and representation, lack of early intervention and poorer outcomes than in the general population (Mir et al 2019; 2020). Public healthcare services have little experience of constructive engagement with Muslim value frameworks or community resources and the use of PREVENT policies target Muslim identity in ways that further undermine levels of trust and create fear of discrimination for those within Muslim populations (Mir et al 2015; Younis and Jadhav 2020).

There is, therefore, an urgent need to transform mental health services for Muslim populations in ways that promote a message of social inclusion and reverse the current disadvantage and alienation they experience. Our research shows that this aim can, at least in part, be achieved through the better engagement that BA-M promotes between healthcare institutions, practitioners and Muslim service users. This culturally adapted approach enables better engagement through training that supports practitioners to develop reflexive attitudes towards religion in general and Islam in particular. The training not only provides the knowledge and skills that can challenge stereotyping and prejudice but lays the foundation for inclusive healthcare practice in which the value framework of Islam is recognised as both legitimate and a resource for health and wellbeing.

In the processes facilitated by our research, Muslim identity is valued rather than stigmatised and community organisations that work with Muslim populations are seen as collaborators with relevant expertise within the mental health system. The therapy itself continues this message of social inclusion and provides emotional, spiritual and practical support within a safe setting. BA-M therapy supports clients to address the adverse social circumstances that cause depression while improving mental health outcomes for many more service users than standard care was able to achieve. Our findings suggest that this approach also increases trust in mental healthcare services. Earlier intervention and offering BA-M at both Steps 2 and 3 of IAPT services would also better suit the high depression scores and complex presentations with which many clients presented.

Our previous research to develop the BA-M approach (Mir et al 2015) showed that therapists were far less confident to deliver this than those in the current study. This is likely to be a result of delivery by staff within teams rather than dispersed individuals and because of the refinement of BA-M resources through our previous research. While therapists in this study could initially feel overwhelmed by the expected change in practice, most engaged very effectively with the approach and were motivated to continue because of the impact they could see on service users, eventually feeling comfortable and confident to deliver the culturally adapted therapy.

The dynamics of therapy and the impact on individuals revealed by our research are very encouraging, however, institutional and policy level challenges remain. In particular, IAPT Key Performance Indicators may constitute a disincentive to the development of services for the whole population, in which BA-M can routinely be delivered. Furthermore, voluntary sector organisations will need to be resourced and supported through clinical supervision to continue delivering this approach. These policy and resource gaps require political and institutional action if this effective therapy for reducing mental health in Muslim communities is to have a lasting impact.

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