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THE EFFECTIVENESS OF SOLUTION FOCUSED HYPNOTHERAPY TO MANAGE MENTAL HEALTH IN NORTHUMBRIA POLICE

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EXECUTIVE SUMMARY

BACKGROUND

The UK Police Force experiences elevated levels of anxiety and depression within their population where Police Care UK estimate 66% of the police workforce may have psychological or Mental Health issues and 71% of officers are likely to have anxiety and depression.

At present it is approximated that Mental Health issues costs Northumbria Police £1.87 million per year – through working days lost to absenteeism and presenteeism. Northumbria Police recognise that whilst provision of Mental Health support services is varied that uptake could be increased.

Psychotherapy is seen as the most effective treatment for common Mental Health disorders such as anxiety and depression. The most commonly used and validated psychotherapeutic tool is that of Cognitive Behavioural Therapy (CBT). However, it has been suggested that effectiveness is only marginally more than placebo. According to several meta-analysis studies, whilst current psychotherapeutic interventions may reduce symptoms for those who undertake therapy, over 50% do not respond to treatment, meaning they experience no significant reduction in symptoms. Recent studies have also highlighted that for those 50% who do respond to treatment and experience a reduction in symptoms, this is not necessarily associated with any improvement in their wellbeing and wellness even for those who have experienced recovery i.e., no clinical symptoms.

Solution Focused Hypnotherapy (SFH) is a modern, highly structured form of intervention which takes the best from Cognitive Behavioural Therapy (CBT), Neuro-Linguistic Programming (NLP) and Solution Focused Brief Therapy (SFBT), which is neuroscience based and solution focused rather than problem focused.

SFH is presenting itself as a viable alternative for psychotherapeutic intervention, with a high uptake and good outcomes, coupled with the fact that the process itself is comfortable, safe, and indeed often enjoyable and due to its highly structured approach, demonstrates consistency in outcomes across SFH therapists. This therapy does not focus on the problem or disorder and is therefore a suitable therapy regardless of a participant's presenting issue. Most Mental Health issues have their basis in anxiety and therefore this process is effective across common Mental Health issues such as anxiety, depression, OCD, PTSD, disordered eating or drinking and substance misuse including drugs and alcohol. SFH is therefore able to meet a variety of needs and due to its consistency across therapists is easily accessible and scalable. Thousands of hours of client data collected by practicing SFH therapists demonstrate a high uptake of therapy and positive results in terms of a

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reduction in symptoms of anxiety and depression and importantly, an improvement in wellness and wellbeing, both of which being essential to enhance workforce resilience.

INTRODUCTION TO THE PROJECT

The feasibility study investigated the effectiveness of online Solution Focused Hypnotherapy (SFH) with employees from Northumbria Police Force who identified problems with their general wellbeing and/or functioning at work.

The effectiveness of SFH was evaluated through qualitative and quantitative data collection from participants through the collection of pre and post intervention outcomes measures (to measure anxiety and depression symptoms), Life wellness indicator scores (to measure wellness), information gathering participant data, participant and therapist questionnaires, interviews with therapists and conversations with Police HR and Wellbeing staff.

Participant data included the measurement of outcomes on specific symptoms of anxiety and depression, using self-report measures at pre and post intervention. The outcome measures used in the project are widely used and well validated self-report questionnaires. The Generalised Anxiety Disorder scale (GAD-7) was used to measure severity of anxiety symptoms and The Patient Health Questionnaire (PHQ-9) was used to measure severity of depression symptoms and to enable comparison to other psychotherapeutic interventions such as CBT.

The therapists collected data from their client participant using a standardised data collection form to include presenting issue, other symptomology, and sleep patterns. At the Initial Consultation and all subsequent sessions therapists also asked a series of standardised questions which are a measure of Life wellness i.e., wellbeing and wellness – to include scaling 1-10 in terms of each participant's thoughts, interactions, activity, confidence, strengths, achievements, and happiness.

Therapist questionnaire data were also collected regarding therapists' experience and confidence to ascertain if there was any relationship to participant outcomes.

The following hypotheses were proposed:

1. Over 75% of participants will complete therapy once started
2. 100% of participants who complete therapy will respond (see at least 25% reduction in one outcome measure)
3. 75% of participants who complete therapy will recover (scores in the "non/normal" range on both measures, i.e. No clinical symptoms).

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Qualitative data was collected to assess the effectiveness beyond that of the reduction of symptomology and to capture improvements in wellness. The subjective experience of therapy is also useful to enable the design of appropriate future support for the Police Force. Data collection included the therapists' and participants' subjective experiences of therapy, using questionnaires and interviews. Particular attention was given to reporting on outcomes of wellbeing, quality of life, job satisfaction and ability to function at work and home. Conversations with the Police Wellbeing Officer and HR alongside attendance at therapist supervision meetings enabled insight into experiences on the ground outcome measure data alone would not have been able to capture.

A SUMMARY OF RESULTS

The reasons for seeking support through this study were varied but predominantly for anxiety and stress reduction. Participants also sought support for depression, sleep issues, loss of confidence, public speaking, and fertility issues. Whilst sleep was not commonly mentioned as a primary reason for seeking support, sleep quality data were collected through participant information gathering, where the majority reported sleep issues. Where trauma was mentioned, this was also addressed successfully.

100% of participants that completed treatment responded i.e., were getting better as a result of therapy. Furthermore 78% of participants completed therapy with no clinical symptoms i.e., they recovered completely. Data demonstrated that participants progressed regardless of their therapist's years of experience or confidence as a therapist. Life wellness score increases of 84% echoed the reduction of anxiety and depression symptoms demonstrating an improvement in participant wellbeing and wellness.

The average number of sessions participants received was 8-12 which reflects the average number for sessions for anxiety and depression in general. Completion of therapy was decided between the participant and therapist.

More than 50% of participants had previously experienced therapy, either independently, through the Force or both. Regardless of any prior therapy, expectations of SFH were varied, but themes emerging from the data suggest that the majority of participants were invested in the process and enjoyed the structured, logical and positive nature of therapy sessions, often sharing their experiences of therapy and newly developed tools with other work colleagues.

Participants noted a number of tools they had gleaned through therapy which they could now use to cope better with stress, gain perspective and to build their resilience. The impact of therapy moved beyond that of

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participants' working lives, with the majority commenting on the difference it had made to their home and family life – there being a positive ripple effect as a result of therapy.

THE WAY FORWARD

SFH has demonstrated its effectiveness in symptom reduction and improved wellness and resilience regardless of presenting issue for Police Force Officers and Staff. Its highly structured, logical, and understandable approach enables participant engagement and quick results. Any future studies or roll out could focus on the role of SFH in preventative work alongside trauma resolution (PTSD) and Mental Health recovery. To ensure buy in and to create a culture of embracing personal responsibility for wellness, a general shared language around Mental Health is essential and can be achieved first and foremost through the roll out of Mental Health Awareness training with a basis in neuroscience and an in depth understanding of how the brain works.

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1. THE CHALLENGE OF MENTAL HEALTH PROVISION IN THE POLICE SERVICE

This feasibility study was developed and delivered by Inspired to Change in collaboration with Northumbria Police to investigate the effectiveness of Solution Focused Hypnotherapy (SFH) in treating anxiety and depression in a UK Police Service. The study sought to investigate anxiety and depression due to elevated levels of anxiety and depression within the Police Service.

Northumbria Police recognise that whilst provision of Mental Health support services is varied that uptake could be increased. This is positioned within the context of the understanding that the UK Police Service experiences elevated levels of anxiety and depression within their population (Police Care UK, 2018). It is estimated that anxiety and depression (the most prevalent mental health disorders) are found in 1 in 6 people in the UK (McManus, et al., 2016) whereas Police Care UK (2018) estimate 66% of the police workforce may have psychological or Mental Health issues and 71% of officers are likely to have anxiety and depression. Furthermore, Avon and Somerset Police Federation (2021) state that whilst most citizens will experience three or four traumatic events in their lifetime, each police officer is likely to encounter between 400 and 600.

Northumbria Police are striving to provide support for their officers and staff through the provision of a variety of interventions to include support for trauma via TRIM – providing peer support and an opportunity to explain symptoms and Eye Movement Desensitisation and Reprocessing (EMDR) for appropriate cases. Furthermore, Mental Health counselling is provided via the Employee Assistance programme (EAP) which is an employer funded service giving staff 24-hour access to free and confidential counselling and advice services and Occupational Health which provides 6 sessions to reduce Generalised Anxiety Disorder symptoms.

At present it is approximated that Mental Health issues costs Northumbria Police £1.87 million per year – through absenteeism and presenteeism. In 2021, it is documented that there were 12,469 sickness days attributed to Mental Health – that is an average of 2.2 days per employee. Furthermore, early retirements due to complex health issues including PTSD average 9-12 per year. It is recognised that beyond these figures, a reduction in productivity due to Mental Health issues is harder to discern but relevant to acknowledge. It is for instance recognised that symptoms of stress can impair police officers' judgement and decision-making skills (Burnett & St Clair-Thompson, 2020).

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It is imperative to mention the importance of cultural issues within the UK Police Service which can act as a barrier to recognising, acknowledging or seeking support for mental health issues including trauma. These barriers include, but are not limited to, the fear of appearing weak and unable to cope, fear of a breach of confidentiality or that seeking help with harm their careers (Massey, 2019).

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2. GENERAL MENTAL HEALTH SUPPORT PROVISION

2.1 Background to psychotherapeutic interventions nationally

Currently psychotherapy is seen as the most effective treatment for common Mental Health disorders such as anxiety and depression. The most commonly used and validated psychotherapeutic tool is that of Cognitive Behavioural Therapy (CBT). However, it has been suggested that effectiveness is only marginally more than placebo. According to several recent meta-analysis studies, the majority of people undergoing therapy for anxiety and depression do not recover, meaning that they still have clinical symptoms after therapy (Cuijper et al., 2013, Springer et al., 2018) and about 50% or more do not respond to the available treatments (Leichsenring, 2019) meaning they experience no significant reduction in symptoms after therapy. Drop out rates also average 17-23% (Gersh, et al., 2017). It is recognised that more research into new or unused treatments is needed, not least because whilst current psychotherapeutic interventions may reduce symptoms for those who do undertake therapy and respond to treatment, it is acknowledged that this may not be improving wellbeing and wellness (Widnall, 2020) and the majority continue to experience symptoms without recovering.

2.2 An Introduction to SFH

Solution Focused Hypnotherapy (SFH) is a modern, highly structured form of intervention which takes the best from Cognitive Behavioural Therapy (CBT), Neuro-Linguistic Programming (NLP) and Solution Focused Brief Therapy (SFBT) which is neuroscience based and solution focused rather than problem focused.

Solution Focused Hypnotherapy was developed by David Newton who founded the Clifton Hypnotherapy Practice in the 1990s and later the Clifton Practice Hypnotherapy Training School. There are now training schools internationally and many therapists have contributed outcome data collected from over 7,500 clients and over 40,000 clinical hours which suggests that SFH could be a promising treatment method for anxiety and depression (Cahill, 2019), and one where the focus is not only on the reduction of symptoms but also the improvement of wellness and resilience. SFH is showing itself as a viable alternative for psychotherapeutic intervention, coupled with the fact that the process itself is comfortable, safe, and indeed often enjoyable and due to its highly structured approach, demonstrates consistency in outcomes across SFH therapists. This therapy does not focus on the problem or disorder and is therefore a suitable therapy regardless of a

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participant's presenting issue. Most Mental Health issues have their basis in anxiety and therefore this process is effective across common Mental Health issues such as anxiety, depression, OCD, PTSD, disordered eating or drinking. SFH is therefore able to meet a variety of needs and due to its consistency across therapists is easily accessible and scalable.

2.3 Issues in Northumbria police and remit for this project

There is recognition that uptake of Mental Health support services could be further improved at Northumbria Police with the goal of providing a range of options to fit the needs of the diverse workforce. In line with this observation, the research project investigated the effectiveness of online Solution Focused Hypnotherapy (SFH) with employees from Northumbria Police who identified problems with their general wellbeing and/or functioning at work.

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3. PROJECT DESIGN

3.1 Introduction

This feasibility study investigated the effectiveness of online Solution Focused Hypnotherapy (SFH) with employees from Northumbria Police who identified problems with their general wellbeing and/or functioning at work.

3.2 Research design and methodology

This was a mixed methods project, meaning the effectiveness of SFH was evaluated through qualitative and quantitative data collection from participants via the collection of pre and post intervention outcomes measures, Life wellness scores, information gathering participant data, participant and therapist questionnaires, interviews with therapists and conversations with Police HR and Wellbeing staff.

Quantitative data: Participant data included the measurement of outcomes on specific symptoms of anxiety and depression, using self-report measures at pre and post intervention. The outcome measures used in the project are widely used and well validated self-report questionnaires. The Generalised Anxiety Disorder scale (GAD-7) (appendix 1) was used to measure severity of anxiety symptoms and The Patient Health Questionnaire (PHQ-9) (appendix 2) was used to measure severity of depression symptoms. Table 1 below shows the different scores on each scale and the corresponding severity of symptoms.

Table 1: Summary of the cut-off scores for the outcome measures

PHQ-9 score	GAD-7 score	Severity Range
0-4	0-5	None / Normal
5-9	6-10	Mild
10-14	11-15	Moderate
15-19	-	Mod / Severe
20-27	16-21	Severe

It was considered essential to utilise these outcome measures as a way of determining the effectiveness of treatment in a way that is directly comparable to other psychotherapeutic interventions such as CBT.

The therapists collected data from their client participant(s) using a standardised data collection form to include presenting issue, other symptomology, and sleep patterns (appendix 3 include an I/C form). At the Initial Consultation and all subsequent sessions therapists also asked a series of

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standardised questions which are a measure of Life wellness (appendix 4) – to include scaling 1-10 in terms of each participant's thoughts, interactions, activity, confidence, strengths, achievements, and happiness.

Therapist questionnaire data were also collected regarding therapists' experience and confidence to ascertain if there was any relationship to participant outcomes (appendix 5).

The following hypotheses were proposed:

1. Over 75% of participants will complete therapy once started
2. 100% of participants who complete therapy will respond (i.e., at least 25% reduction in one outcome measure)
3. 75% of participants who complete therapy will recover (scores in the "non/normal" range on both measures, i.e., no clinical symptoms).

Qualitative data: The therapists' and participants' subjective experiences of therapy were collected using questionnaires (appendix 6) and interviews. Particular attention was given to reporting on outcomes of wellbeing, quality of life, job satisfaction and ability to function at work and home. Conversations with the Police Wellbeing Officer and HR alongside attendance at therapist supervision meetings enabled insight into experiences on the ground. It was considered critical to undertake qualitative data collection as the aim was to assess the effectiveness beyond that of the reduction of symptomology and to capture improvements in wellness. Furthermore, the experience of therapy is itself useful to capture to enable the design of appropriate future support for the police. Utilising outcome measure data alone would not have captured the anecdotal evidence currently gleaned by therapists through conversations with their clients regarding the wider impact of therapy beyond symptom reduction.

3.3 Research process

A global email was sent to all employees with details about the project, inviting participants to respond via email if interested in taking part. All participants completed a triage phone call with Dr Emily Barney, an independent and trained Clinical Psychologist, to assess risk, explain confidentiality, obtain verbal consent, and complete the pre-intervention outcome measures. Participants were then anonymised and randomly allocated a therapist (one of 20 SF Hypnotherapists) who made contact within a week to make an initial consultation and begin therapy. All therapists completed fortnightly group supervision led by the project manager and SFH supervisor, Gary Johannes. All members of the research team attended the supervision meetings. Upon completing their therapy, all participants

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completed a follow up call within several days with Dr Barney to complete post therapy outcome measures.

The participants were then sent the questionnaire which provided an opportunity for them to reflect on the therapeutic process and provide more information regarding any previous experience of therapy, their expectations for SFH and the impact it had on their work and home life.

All participants in this research were voluntary. From the small number of potential participants who initially expressed an interest and then did not take up the opportunity for an Initial Consultation or further sessions, the majority did mention that it has been suggested to them to take part.

Upon completion of therapy sessions each therapist was asked to complete a questionnaire regarding their own view of their confidence in their skills, years of experience and their view of how engaged their client had been through the process. This was a simple but important step as it has allowed us to explore how this SF approach is replicable regardless of a therapists' background, years of experience or other qualifications.

Throughout the provision of hypnotherapy sessions, the research team attended therapist supervision sessions in order to undertake a thematic analysis of issues raised. Thereafter, interviews with selected therapists were undertaken to glean specific information to ensure comprehensive coverage to include – those more inexperienced therapists, more experienced therapists, those with other therapy qualifications e.g., counsellor, psychologist etc., and those unable to contact potential participants.

3.4 Data analysis

Quantitative data from participants' pre and post evaluation scores and session-based wellness scores were analysed using descriptive statistics (mean, standard deviation, and percentages) alongside demographic data, the number of sessions undertaken and reasons for seeking therapy. Therapists' questionnaires were also analysed using descriptive statistics to ascertain the effectiveness of interventions according to therapist (professional) background, experience, and confidence.

Questionnaire returns from participants, therapist supervision sessions, interviews with therapists and conversations with the Police were analysed thematically. The participant questionnaire analysis included a particular focus on any prior experience of therapy, their preconceptions and experience of SFH, the impact of their therapy on the work and home life. The purpose of the questionnaires was to recognise that the effectiveness of any

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therapeutic intervention needs to measure the reduction of symptoms alongside any improvements in wellness.

3.5 Project scope

- A total of 51 officers and staff responded to an advert about the project between October and December 2021 and completed a triage phone call.
- Of these, 44 were recruited onto the research (7 did not attend their initial consultation).
- Of these, 36 completed treatment (6 'did not finish' = i.e., 4 asked to withdraw, 1 dropped out, 1 still ongoing. And 2 people finished after several sessions but were not counted in the final numbers due to their scores being too low at triage and the intervention did not meet the study criteria of a 'full course of treatment' - minimum 6 sessions)
- The majority of participants had between 8-12 weekly sessions of SFH. A total of 20 fully qualified SFH therapists were involved in the project.

3.6 Limitations

Any research is subject to bias however the research proposal was carefully devised with all efforts made to ensure the research was conducted in a rigorous and objective fashion utilising robust and established analytical techniques and participation in the study was completely voluntary.

In asking participants to take part in the project they accepted the conditions of the study at the triage call. Given that some participants chose to drop out of the study it would not have been ethical to make contact with them to ask more about why they chose not to proceed with therapy, despite the fact this would have been very useful information. It was possible to glean information about those participants who attended an Initial Consultation but did not proceed with therapy through interviews with relevant therapists.

This research project was purposely designed to include a large number of therapists in order to test the assumption that the Solution Focused Hypnotherapy model works effectively regardless of a therapist's background and other relevant qualification or years of experience. The potential for bias is limited as the Solution Focused process is highly structured. All therapists information gathered and provided a brain explanation in the same way, using the same forms and they attended supervision fortnightly for the duration of their involvement.

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3.7 Ethical considerations

All participants in this research were voluntary. Information regarding the study were widely available to employees and they were invited to take part if they wished to do so. We are aware that possible participation was recommended to some participants, but it was their choice to express an interest to take part and to continue with therapy.

All participants were treated equally, irrespective of officer or staff rank/status or protected characteristics.

Those participants who scored low on their pre-evaluation were not included in the data analysis as they fell beyond the remit of the research however it was considered ethical to offer the participants therapy given that they had volunteered to participate in the study. The project research team were not included in the group of 20 therapists providing therapy to reduce any potential conflict of interest, however they are all fully qualified SF Hypnotherapists themselves and therefore understand the process.

3.8 Data confidentiality, security, and anonymity

All participant data were anonymised and coded and kept securely in a password protected file and any paperwork was kept in a locked cabinet and in a locked room and was only accessible to the research staff. Participating therapists securely stored the participant session notes in line with GDPR and the Data Protection Act requirements and in accordance with their regulating body (i.e., the Association for SFH or the National Council for Hypnotherapy). When the final report is published, all research data will be stored by Inspired to Change in line with GDPR and the Data Protection Act requirements. Individual participant session notes will also continue to be securely stored by their corresponding therapists in line with the requirements of their regulating body.

No personal data have been disclosed to anyone beyond the project research team. The researchers have previous experience of managing confidential research data.

No payments were provided to participants in order to take part in this study. Participants were invited to take part in work time or personal time to suit the individual. The therapists worked with the participants on a voluntary basis.

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4. PROJECT FINDINGS

4.1 Main findings

Table 2: Main Findings (based on 36 participants who completed therapy)

All 3 hypotheses were supported:

Our Hypotheses	Our findings	Compared with current psychotherapy research
1. Over 75% of participants will complete therapy once started	86% completed once started (36 out of 42)	77-83% completed once started
2. 100% of participants who complete therapy will respond (see at least 25% reduction in one outcome measure)	100% response rate	50% response rate
3. 75% of participants who complete therapy will recover (scores in the "non/normal" range on both measures, i.e. No clinical symptoms).	78% recovery rate (28 out of 36)	37-47% recovery rate

100% of participants that completed treatment responded i.e., were getting better as a result of therapy. Furthermore 78% of participants completed therapy with no clinical symptoms afterwards i.e., they recovered completely.

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Table 3: Descriptive statistics for all sample and for treatment complete sample

	All	Recruited to Study	Treatment Complete - All	Treatment Complete - In Remission* (TC-R)	Treatment Complete - Responded (TC)	Did not finish	Not Recruited
n	**51**	**42**	**36**	**28**	**8**	**6**	**9**
Percentage of TC sample (n36)			**100.0**	**77.8**	**22.2**		
Mean Age in Years (SD)	43 (8.74)	42 (8.49)	42 (8.64)	43 (8.18)	41 (9.01)	44 (8.05)	44 (10.32)
Gender - n (%)							
Female	37 (72.5)	31 (73.8)	27 (75.0)	21 (75.0)	6 (75.0)	4 (66.7)	6 (66.7)
Male	14 (27.5)	11 (26.2)	9 (25.0)	7 (25.0)	2 (25.0)	2 (33.3)	3 (33.3)
Ethnicity - n (%)							
White Bristish	39 (76.5)	32 (76.2)	27 (75.0)	21 (75.0)	6 (75.0)	5 (83.3)	7 (77.8)
White Other	11 (21.6)	10 (23.8)	9 (25.0)	7 (25.0)	2 (25.0)	1 (16.7)	1 (11.1)
Other	1 (2.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (11.1)
Job Role - n (%)							
Officer	28 (54.9)	24 (57.1)	21 (58.3)	17 (60.7)	4 (50.0)	3 (50.0)	4 (44.4)
Staff	23 (45.1)	18 (42.9)	15 (41.7)	11 (39.3)	4 (50.0)	3 (50.0)	5 (55.6)
Mean Number of Sessions (SD)	8 (2.14)	8 (2.09)	8 (2.17)	8 (1.99)	9 (2.70)	4 (2.81)	n/a
Reached Caseness - n (%)**	42 (82.4)	37 (88.1)	32 (88.9)	24 (85.7)	8 (100.0)	5 (83.3)	5 (55.6)
Baseline measures - mean (SD)							
GAD-7	11 (4.57)	12 (4.06)	13 (3.99)	12 (4.01)	15 (2.99)	9 (2.94)	9 (5.98)
PHQ-9	11 (5.47)	11 (5.40)	11 (5.26)	11 (5.17)	13 (5.78)	11 (6.74)	8 (5.22)
Post measures - mean (SD)							
GAD-7	n/a	n/a	3 (3.43)	2 (1.39)	8 (3.11)	n/a	n/a
PHQ-9	n/a	n/a	3 (3.04)	2 (1.32)	7 (3.56)	n/a	n/a
Reduction in Scores - mean (%)							
GAD-7	n/a	n/a	9 (76.8)	10 (85.5)	7 (44.3)	n/a	n/a
PHQ-9	n/a	n/a	9 (72.1)	9 (80.1)	6 (41.3)	n/a	n/a

* Scores under 5 on both GAD-7 and PHQ-9
** Scores of 8 and above on GAD-7 and/or 10 and above on PHQ-9

From the data above we can see that of the 51 employees that first applied to take part in the study the average age of employees was 43 years old. This remained consistent across our participant groups with the average age of participants in our Treatment Complete group (n36) reducing slightly to 42 years of age.

Of those that applied, 72.5% were female and 27.5% were male and this gender split was also found to remain consistent across our treatment group with our Treatment Complete group consisting of 75% women and 25% men. This mirrored the expectation and experience of Northumbria Police Service who commented that fewer men than women currently take up the available support.

With regards to ethnicity the initial group of 51 consisted predominantly of White British employees (76.5%) with a further 21,6% of employers identified as White Other. Again, this ethnicity split remained consistent across our treatment groups with 75% White British and 25% White Other participants in our treatment complete group.

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We can see that a similar number of Officers and Support Staff applied to take part in the study and that our treatment complete group again had a roughly even split between these two groups (58.3% and 41.7% respectively).

4.2 Reason for seeking support

Table 4 – Reasons for seeking support

Primary Presenting Issue		Secondary Presenting Issue	
Anxiety	27	Depression	4
Stress	4	Confidence	4
Confidence	3	Drinking	2
Depression	1	PTSD	1
Fertility	1	Anger	1
		Motivation	1
		Public Speaking	1
		IBS	1

The reasons for seeking support through this study were varied but predominantly for anxiety and stress reduction. Participants also sought support for depression, sleep issues, loss of confidence, public speaking, and fertility issues. Whilst sleep was not always mentioned as a primary reason for seeking support, sleep quality was collected through information gathering with participants. It was found that 94% of participants (n34) reported sleep issues at the Initial Consultation. Whilst trauma and PTSD were not mentioned in information gathering, therapist supervision brought up a number of circumstances where these issues were managed and resolved as part of the therapeutic process.

The average number of sessions participants received was 8-12 which reflects the average number for sessions for anxiety and depression in general. Completion of therapy was decided between the participant and therapist.

4.3 Therapist experience and participant outcomes

Overall, the therapists we recruited had been in practice for an average of 2.7 years, ranging from as little as 0.5 years in practice up to 6 years in practice. Therapists self-reported levels of confidence were generally high, average 8.7 out of 10 and ranging from 7 to 10/10 (appendix 7).

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The data suggests that there was no discernible difference in participants outcomes due to the therapists' years of experience or level of confidence. For those participants that scaled as having mild to moderate symptoms at the end of the study, the data suggest that their level of engagement in the process may have been a contributing factor. The therapists working with these participants observed that that they had not been consistently writing down What's Been Good or listening to the audio download and reported these participants to have been 'Mostly Engaged' in the process.

Furthermore, these participants attended between 8-12 sessions in total, so it would be interesting to explore how many more sessions they would have needed to reduce their scores into the no clinical symptoms range.

4.4 Participant symptom reduction

In our treatment complete group, 32 out of 36 (88.9%) were found to reach caseness. To reach caseness, participants had to score 8 and above on the GAD-7 and 10 or above on the PHQ-9, indicating that their symptoms of anxiety and depression could be classed as clinical cases.

Table 5: Summary of Reduction of Symptoms Pre and Post Treatment Comparison (n36)

	Pre (n36)	Post (n36)
GAD-7		
None (0-4)	1	28
Mild (5-10)	6	6
Moderate (11-15)	21	2
Severe (15-21)	8	0
PHQ-9		
None (0-4)	4	29
Mild (5-9)	8	5
Moderate (10-14)	15	2
Moderately Severe (15-19)	7	0
Severe (20-27)	2	0

Overall, we found that symptoms on the GAD-7 reduced from a pre-treatment average of 13 to a post-treatment average of 3. This is a reduction of 77%. Regarding the PHQ-9, symptoms reducing from pre-treatment average of 11, to a post treatment average of 3. This is a reduction of 72%.

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There were 8 participants who had Severe symptoms on the GAD-7 prior to treatment, of these 3 reduced to No Clinical Symptoms after treatment. A further 3 saw a reduction to Mild and the remaining 2 went down to Moderate.

Of the participants who had Severe symptoms on the PHQ-9, one showed a reduction to No Clinical Symptoms and the other participant was scaled as Moderate after treatment.

Table 6: Severity of pre treatment symptoms and average number of sessions

n36	GAD-7 Severity (pre)	PHQ -9 Severity (pre)	Average No. of Sessions (SD)
5	NCS / Mild	NCS / Mild	7 (2.97)
9	Mild / Moderate	NCS / Mild / Moderate	7 (2.01)
14	Moderate	Moderate / Moderately Severe	10 (2.06)
6	Severe	Moderate / Moderately Severe	7.5 (2.00)
2	Severe	Severe	10 (2.00)

*NCS – No Clinical Symptoms

There were 2 participants who mentioned either PTSD or Trauma during their initial consultation. The first had Severe symptoms on the GAD-7 (with a score of 19) and Moderate symptoms on the PHQ-9 prior to treatment (with a score of 14). Following 7 sessions the scores on both scales reduced to 0, No Clinical Symptoms. The second participant also scaled as Severe on the GAD-7 before treatment (with a score of 16) and Moderately Severe on the PHQ-9 (with a score of 18). Following 8 sessions, this participant also showed a reduction to 0 on the GAD-7 scale and 3 on the PHQ-9, indication No Clinical Symptoms.

Furthermore, both participants saw an increase in the life wellness scores. The first participant increased from a score of 25 pre-treatment, to a score of 69 post-treatment (an increase of 176%). The second participant increased from a score of 39 pre-treatment to a score of 53 post-treatment (an increase of 35.9%).

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4.5 Life wellness data

The Life wellness data were collected at data gathering and all ongoing sessions. These data are useful in illustrating a progression of wellness beyond a reduction of anxiety and depression symptoms.

Table 7: Life wellness Data Pre and Post Treatment Comparison (n35*)

	All (n35*)	Men (n9)	Women (n26)	Officers (n21)	Staff (n14)
Pre treatment					
Mean	34.3	38.00	33.02	35.55	32.43
Range	19.5-60	21-58	19.5-60	21-60	19.5-46
Post treatment					
Mean	61.6	56.17	58.74	57.60	58.80
Range	28-70	44-67	28-70	44-70	28-70
% Increase	**84.0%**	**61.9%**	**91.7%**	**75.6%**	**96.7%**

* Treatment complete group reduced from 36 to 35 due to missing data

Some participants noted that their post evaluation scores did not reflect their improvement in wellness and ability to cope as they were experiencing significant challenges – however their response to those challenges was very different – they were in control.

The Life wellness questionnaire used by therapists consisted of 7 questions, each scored on a scale of 1-10, with low scores indicating a lower level of Life wellness and an increase in scores suggesting an improvement/higher Life wellness. The highest possible score on this questionnaire is 70 and participants are considered to have achieved a good standard of wellbeing once their scores reach 60 or above.

The average pre-treatment Life wellness score for our treatment complete group was 34.3, ranging between 19.5 and 60. There was little difference in these numbers across the gender and staffing groups.

Post treatment, the average Life wellness score increased to 61.6%, ranging between 28 and 70. This was an average increase of 84%. Again, there was minimal difference across gender and staffing groups regarding the average scores recorded. Female participants and support staff demonstrated a slightly higher average Life wellness scores and greater levels of improvement (91.7% and 96.7% improvement respectively).

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4.6 Participants' experiences of therapy

30 questionnaire returns were received – 28 of the 36 that completed therapy and 2 others (1 for whom therapy is ongoing and the other withdrew sooner than they would have wished). The participants varied in their length of service in the Police from 9 months to 29 years. In addition, therapist supervision was a rich source of data regarding participants' experiences of therapy and the impact it had on their lives in work and home.

Previous experience of therapy

Of the 30 questionnaire returns, 11 participants had not received any therapy in the past, and 19 had received therapy 5 through the Police Service, 11 privately and 3 through the Police Service and privately. The experiences of therapy varied enormously from positive outcomes to feelings of frustration at the short number of sessions or limited long term benefits they had received. A number of participants commented on their frustration that after talking through their issue they felt that going over it again just "raked up the bad feelings." Of those who had experienced hypnotherapy or EMDR before, they reported positive experiences.

Expectations of SFH

Expectations of SFH varied enormously. Of the 11 that had not received therapy before, all were open minded, and some had the expectation that the therapy would be "like counselling" and therefore talking over negative issues. If therapy had been sought before, expectations of SFH were positive but again varied between anticipating a similar experience i.e., they would talk about their past or that it might offer something more permanent. Many participants had no expectations but were willing to try this therapy.

Engagement in therapy

The participants were very invested in the process. Very quickly, even participants unused to therapy and possibly sceptical of its value engaged in the process. *"They need to commit to the process, and I think a lot of it is they don't want to lose face, or seem not to be coping, but they started talking about the research project with others and said, 'I want what they have', then things started to change."*

If it often assumed that Police Officers in particular are less inclined to engage in a therapeutic process and this is reinforced by research cultural barriers to mental health support in policing, but the highly structured process and neuroscience underpinning offered by SFH suits this behavioural style and as there is no need to revisit the past, this encourages those participants who might otherwise avoid therapy through fear of reliving past traumas. Therapist supervision highlighted that almost all participants were engaged

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and committed to the process. There is also some anecdotal evidence to suggest that of those who showed an interest in the study but did not proceed, it might be that it was not the right time rather than not being the right fit.

Therapist supervision and participant outcome data demonstrate that participants were motivated to take part rather than being told to engage and the majority of the participant group were committed to the process and when they engaged, they got better more quickly. This was reinforced by the thoughts of a therapist who is also a trained integrative counsellor who stated *"our structure is so helpful to the client as they know what to expect. They are calm more quickly and they become skilled in Solution Focused questioning themselves."*

Scheduling

There were some issues with regard to scheduling sessions. Therapist supervision highlighted a regularity in either having to reschedule appointments or a difficulty in getting participants booked in: "*Initially it was hard to pin them down. I know they had an over-scheduled diary.*" In addition to a busy diary there are added challenges for those working shift patterns: *"Sometimes weekly sessions were tricky with shift patterns."* Flexibility is key here. From private practice, therapists know that weekly sessions are not essential for the process to work effectively and there is an understanding that you have to work within the constraints of diaries and the expectation of uncertainty. *However, "from private practice we see that once they start to see a difference this is less of an issue."*

Valuable feedback regarding when sessions were taken are worth reviewing. For instance, being given the flexibility to take the session in work time or outside this time worked well for participants *"I liked that I had been authorised to complete sessions in work time."*

Undertaking therapy remotely can be extremely beneficial as it reduces time to access the support and it can fit into the participant's life as they wish. A number of participants noted that they found the process very convenient. *"My client was happy it was online, in fact it made it better as it was more convenient as she had a busy life."*

The experience of SFH for the participants

When the participants were asked about their experience of therapy it was overwhelmingly positive. Participants noted that they felt the therapeutic process was beneficial and they felt supported and understood.

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"The therapist's approach suited my way of interaction, the sessions never felt rushed or a burden"

Participants liked the highly structured and logical process to the sessions, there was a clarity about what was going to happen in each session and that the sessions made sense: *"The techniques were really easy to use and easy to remember and the results were fantastic."*

Participants liked the practical nature of the therapy – learning techniques to reduce anxiety and thinking about how they wanted things to be, motivated by the positive changes they were seeing in themselves week on week: *"It helped me to start building positive habits and time for myself little by little."*

The independence of this therapy was also alluded to with a number of participants commenting that it was good to talk to someone away from work. The following themes were dominant in the participants' engagement and reflection on their therapeutic experience.

Sessions as enjoyable

Feedback from the participant questionnaire and therapist supervision and interviews highlighted that the majority of clients saw the sessions as very enjoyable as well as beneficial and that not only did they report a reduction or removal of symptoms upon completion of treatment, but they also noted significant changes to the home and working life.

"I looked forward to our sessions. I miss them!"

The participants also understood that the intervention not only works well to reduce symptoms of anxiety and depression but can also help with improving confidence, calmness, approaches to parenting, dealing with difficult circumstances in life or work (i.e., building resilience) as well as being able to focus on being the best version of themselves – perhaps seeking support to perform better at an interview or in public speaking for instance. This reinforces existing anecdotal evidence from practicing therapists that Solution Focused Hypnotherapy helps people to cope better and also to live better i.e., with wellness.

Sessions as informative and comfortable

The sessions are highly structured with the process purposely constructed to enable the client to operate from the intellectual part of the brain in order to come up with solutions. There is comfort in the certainty of session content which enables the client to focus on making progress. Participants liked that logical process as it felt easy, informal, and relaxed.

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"I…really enjoyed being told how the brain works, this helped me make sense of why and how my anxiety was there and how changing the way I approach it would help."

In particular participants commented that they found the sessions 'made sense', they were able to think positively, develop an understanding of how their brain worked which made sense of how they felt, and they could take small steps to move forward.

Sessions as a positive experience

Therapist supervision noted that participants were engaged and enjoying the process. This was reinforced through participant questionnaire responses:

"It was so refreshing to focus on 'what's been good' and to have permission to actually say what's been good."

The feedback noted that whilst for some the focus on the good things felt unusual, all enjoyed focusing on the positives, some seeing this as an opportunity to 'take time for me'. Participants enjoyed learning new skills, using the power of visualisation and being able to come up with their own solutions.

Sessions providing tools to cope better

Through the questionnaire responses, frequent comments were made with regard to tools and strategies that were introduced to them or learnt by them:

"It's given me the tools to self reflect and be less harsh on myself."

Other participants noted the value of the following tools:

- Relaxation download
- Visualisation
- Focusing on Positive things
- Allowing time 'for me'.

Sessions building resilience

When asked about the outcomes of the therapeutic process beyond specific new skills which had been developed. The majority of participants noted the ability to maintain perspective, being able to cope well with challenges and come up with an intelligent response, including being able to prioritise a busy life:

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"I feel more in control and can assess what I can and can't do and think logically about solutions…rather than going straight into stress/panic mode."

The words 'perspective' and 'resilience' were mentioned regularly.

Starting the mental Health conversation

There is often a taboo in talking about Mental Health issues. As a therapist (and former Policer Officer) explained *"sometimes there is a need to just get on with it, not show weakness."* The Wellbeing officer and HR officer reported that participants openly talked about their therapy with others in work – which is unheard of. *"(Those participants) were reflecting a much more positive and resilient outlook which we felt could spread like a virus across the force."* Participants were seen to be better equipped to deal with the challenges of the day which mirrors the participants' feedback.

Creating a shared language around Mental Health where the focus isn't that we are somehow 'broken' when we experience stress and anxiety, but rather that our brain is trying to protect us and furthermore, that we can make changes to ensure we start thriving rather than surviving is empowering and the catalyst for more openness about our Mental Health.

"This process has brought people together to talk about Mental Health. My client mentioned that people are telling her how good this is at work. It is because they can see the results."

Therapist feedback reflects the same sentiment with reports of their clients sharing their new knowledge with work colleagues and family members, changing their language in meetings and utilising solution focused tools in their daily life.

Client led process

Whilst the SFH session is highly structured, the process is client led which is empowering. One therapist noted: *"I had a conversation with them in session 6 and they said that they would like session 7 to be their final session. They felt comfortable with where they had got to."*

The client led process also allows for participants to choose to focus on other issues if they wished – such as tools to perform better at interviews etc. or to address PTSD when they felt able.

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4.7 The impact of therapy

The weekly wellness (Life wellness) scores recorded by therapists and the therapist supervision alongside the pre-outcome measures identified (very) high levels of stress amongst participants at the outset but a very swift recognition of the wider impact of therapy in terms of accepting who they are and how they can cope differently.

Participant confidence increased "*I found my confidence had improved my performance at work.*" Alongside this was a reduction in social anxiety and in the negative impact of other life challenges: "*I am able to relax better, have more confidence…and interact with my colleagues more. I also feel I am able to cope better in my role and not dwell on the past.*" Therapists reported progress in line with their normal therapy practice clients i.e., variances in progress rates but good progress regardless of the reason for seeking therapy.

Coping better and doing more

The participant questionnaire asked the question – **'What can you do now that you couldn't do before therapy commenced'**. Many responses were focused on the following:

- Coping better with problems and manage stress
- Ability to prioritise, organise and focus
- Have perspective and find solutions
- Work/life balance – prioritise Mental Health as well as Physical Health
- Be positive
- Calmer, more rational and in control
- Sleep and relaxation
- Feeling empowered

"I've been sleeping a lot better and not dwelling on things as much"

"I am more able to handle pressures and come up with intelligent solutions to challenges"

"Now I can watch TV, read a newspaper, discuss issues and problems with my partner, manage family/life dramas better. Eat. Sleep. Be happy."

Impact on work

The majority of participants commented on the positive impact on their working life, mirroring their increased ability to maintain perspective, prioritise and be more resilient in the face of challenges.

"The therapy has helped me to remain in my current role."

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In addition, the therapy enabled participants to be more positive and focus on the issues they were facing: *"If someone isn't coping with work it isn't necessarily that causing the problem."*

Participants were able to focus on issues that were not work-derived, but in making positive changes here it had the additional benefit of improving their experience and attitude towards work. As a therapist commented: *"Control is a constant, as participants saw improvement in one area of their life, this increased their confidence and performance in work and outside work."*

Participants noted feeling happier and more in control:

"I have so much more control over my emotions towards work."

Impact on family life

The positive impact on family life was something all participants noted with many echoing the sentiment: *"I'm a nicer person to be around."* Participants noted an improvement in their relationships with partners and children to include feeling more connected and being able to communicate better. The process enabled them to prioritise a work life balance which in turn increased motivation and energy levels.

"I feel more organised, more calm, less exhausted at work and home."

Many participants talked through the wider impact of the therapy on their families, in essence, they are passing the knowledge on, and it is changing family dynamics. As one therapist noted: *"She brought her whole family into the Solution Focused model. She could see where others in her family were too and that they could benefit. She said it was a ripple effect across the wider family."*

Symptom reduction versus wellness improvement

Whilst it is important to demonstrate that SFH reduces symptoms of anxiety and depression it does not provide a complete picture. The pre and post outcome measures demonstrated symptom reduction and the Life wellness scores demonstrated an improvement in wellness, however, the participant reflections were particularly meaningful: with one participant commenting:

"I can't get over the difference it has made to me."

Looking beyond the quantitative data is useful. For instance, when post evaluation scores were conducted one participant who still had mild symptoms commented *"These don't reflect how well I am doing. I can't*

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believe how well I am coping (with a very challenging situation)." Life happens and of course the aim is not to eliminate the stress in our lives but to cope better with it.

A therapist remarked that "*when it came to the 8th session we talked about (the therapy) coming to an end and she felt fine, she had done what she had wanted to do… she was very confident.*" The post evaluation scores of this client demonstrate some symptoms remaining, but clearly the participant was very pleased with the outcome of the therapy.

The focus of the therapy is on wellness and symptom reduction is an inevitable consequence:

"I am back to myself, and it is an amazing feeling."

4.8 Areas of focus for future intervention

Appropriateness of SFH

The Police noted that current gaps in provision are for those with mild to moderate symptoms. These data demonstrate that SFH if effective for mild, moderate, and severe symptomology, working as well with trauma as with anxiety reduction. The project saw a significant reduction of anxiety and depression symptoms, with a 77% reduction in GAD 7 scores and a 72% reduction in the PHQ9 scores. Furthermore, the Life wellness scores illustrate an increase (in wellness) of 84%. These improvements in wellbeing and reduction of symptoms were across all groups – from those with mild to severe symptoms including a removal of all symptoms for those presenting with PTSD.

Whilst it fell beyond the scope of this project in terms of detailed evaluation the value of a participant receiving the Initial Consultation or just a few sessions should not be underestimated. For instance, some of those who volunteered to take part had very low pre-evaluation scores and as a result they only needed to attend the Initial Consultation or this and a couple of sessions.

"One of my clients was happy with 2 sessions, they felt they got out of it what they needed."

Moreover, another participant who withdrew after a few sessions commented that "*I found therapy very helpful but struggled to fit it in with my home life and this resulted in me withdrawing earlier than I would have liked.*"

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Therapy take-up

The take up of therapy was very high and of those who didn't attend the Initial consultation or make a follow up appointment, the feedback from the therapists suggests that it was mainly those who had been asked to attend by their line manager. This demonstrates how important it is for the client to make the decision to seek support themselves.

A few therapists commented that for any future work it could be helpful to raise awareness of what SFH is and how it works: *"I think a synopsis of SFH would allay people's concerns, it is the same as in private practice, once we are established and recommended it really helps."* This was reflected in a participant comment:

"I think advertising this on a bigger scale to let people know it is out there. I think a lot of people could benefit from this if only they knew how and where to go to access it."

There was suggestion that short videos from those that took part or bite-sized information as to the nature of SFH would be hugely beneficial for any future work. Moreover, feedback from therapists mentioned that any Solution Focused offering needs to highlight that you don't' have to talk about your problems, that therapy is more like a conversation and trance is just relaxation.

Access to therapy

In this small feasibility study, it was not possible to offer a more client-led approach to access the therapist. Any future work needs to consider the opportunity for face to face or online therapy or maybe more importantly the ability to choose a therapist. Whilst this work has demonstrated positive results, we know that rapport between therapist and client can make the process even more enjoyable. Participants in this study valued the opportunity to take the sessions in work time but being given the opportunity to undertake sessions at home or work as appropriate.

Many therapists mentioned some difficulties in getting sessions into the diary as participants were very busy. A useful solution here is to put 6 sessions into the diary at once.

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5. SUMMARY

This project demonstrated a 100% response rate to therapy and 78% experienced a complete recovery i.e., no clinical symptoms of anxiety and depression. Furthermore, the Life wellness scores also recorded a corresponding increase in wellness of 84%. Beyond these data, participant and therapist feedback highlight the benefits of this therapy for wellness and resilience. Within 12 sessions, SFH demonstrated its effectiveness in reducing symptoms and increasing wellness for a variety of presenting issues regardless of the severity of symptoms (mild-severe) at the onset of therapy. In summary, SFH is an effective therapy for treating anxiety and depression within the police service. The process works effectively regardless of the presenting issue – to include PTSD, low confidence, sleep problems or anxiety and depression. The therapeutic outcomes were consistent across client groups (i.e., staff or officer), presenting issue and therapists.

SFH has the potential to tackle presenteeism very effectively, being used as much as a preventative or early intervention strategy rather than being seen only as a tool to respond in a crisis situation. This study has shown the positive effects of this therapy in terms of the participants' ability to cope better with the pressures of work and to manage stress in a more positive way both at home and work. The SFH process empowers people to take control of their Mental Health and be aware of when they need to seek support to help them cope with challenging events in work or in life, in turn reducing the levels of absenteeism due to mental ill health.

SFH has the potential to do far more than treat an individual's mental health issues. Even this small sample size saw a wider impact across departments, thus demonstrating that SFH has the potential to change culture more widely. This learning has implications far beyond the importance of a Duty of Care and decreasing costs relating to sickness, absence and presenteeism.

Beyond the data demonstrating the reduction of anxiety and depression symptoms, the data effectively demonstrate the wider benefits of therapy to the individual, their families, and their work colleagues.

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6. THE WAY FORWARD FOR NORTHUMBRIA POLICE

Work with other corporates has demonstrated to Inspired to Change that preventative work can enable wellness, increase the rates of those seeking support before crisis and enable wider cultural changes across an organisation. This cultural change is widely recognised as a central precursor to any meaningful interventions in terms of training or management processes. In the first instance, this can be achieved through the rollout of Mental Health Awareness Training which provides everyone with a shared understanding of how the brain works in neuroscience terms and how we can be responsible for our own Mental Health needs. Such an approach demonstrates commitment to Mental Health support and allows a shared language to develop which enables staff and officers to talk about stress in a more positive way and to make small changes to their daily practices that enhance their wellbeing and performance.

Take up of therapy is influenced through the positive outcomes demonstrated in this project, the positive approach to the therapy shown by participants (recommendations), but importantly, more widespread buy-in is first achieved through wider staff training in Mental Health Awareness delivered with a Solution Focused approach.

Wider implications of this work/what next

Understanding the longer term and wider impact of this work on the Service as a whole was beyond the scale or scope of this project. With this in mind we would like to propose a follow-up study where we could compare and contrast units with no education/support, those just receiving Mental Health Awareness Training and those receiving Mental Health Awareness Training and Solution Focused Hypnotherapy with the intention of collecting live data and also follow up data 3 and 6 months after therapy.

Beyond Northumbria Police, we anticipate that the next step will be clinical trials to take this work to the next level and in order that it can be seen as a viable and effective alternative to current psychotherapeutic interventions available to the police service, wider blue light services, and NHS patients more generally.

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Amy Odd	Moving Mindset Hypnotherapy
Asha Berzon	MindAbility Hypnotherapy
Benn Baker-Pollard	Inspired to Change Sittingbourne
Carmen Harrington	Inspired to Change Market Harborough
Catherine Veits	Inspired To Change Lincoln
Ciara Foy	Inspired to Change Bishop's Stortford
Claire Noyelle	Inspired To Change Maidstone East
Cristina Motatu-Stanescu	Inspired To Change Skegness
Dawn Ibbetson	Inspired to Change Chelmsford
Elizabeth Lorimer	Yellow Rose Hypnotherapy
Emma Rose	Reset Hypnotherapy
Jenny Armitage	Jenny Armitage Hypnotherapy
Keeley Smith	Inspired to Change Southend-on-Sea
Lisa Moses	Lisa Moses Hypnotherapy
Lou Wilson	Nurture Hypnotherapy
Louise Squires	Inspired To Change South Birmingham
Nicole Woodcock	Hummingbird Hypnotherapy
Phillip Cohen	Clinical Hypnotherapy Practice LTD
Victoria Anderson	Inspired to Change County Durham

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APPENDICES

Appendix 1: GAD-7 questionnaire

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

Appendix 2: - PHQ-9 questionnaire

Patient Health Questionnaire (PHQ-9)

Patient name: ________________________________ Date: ________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❐	❐	❐	❐
b. Feeling down, depressed, or hopeless.	❐	❐	❐	❐
c. Trouble falling/staying asleep, sleeping too much.	❐	❐	❐	❐
d. Feeling tired or having little energy.	❐	❐	❐	❐
e. Poor appetite or overeating.	❐	❐	❐	❐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❐	❐	❐	❐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❐	❐	❐	❐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❐	❐	❐	❐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❐	❐	❐	❐

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Appendix 3: - Life Wellness Questions

Date: **Session:**	**Participant No.:**
Indicator	**Scaling 0-10**
Thoughts How Positive have your thoughts been?	
Interaction How interactive have you been with others?	
Activity How would you rate your level of activity?	
Confidence How would you rate your confidence?	
Strengths How well are you using your strengths?	
Achievements How much have you achieved?	
Happiness How would you rate your level of happiness?	
Total Score	

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Appendix 4: - Initial Consultation Information Gathering Form

Initial Consultation – Information Gathering

How are we going to help you?			
What would you like to achieve by coming here?			
Participant No:			
Date:		**Age**:	
Occupation:			
Brought up by:		**Position in family:**	
Married or in a steady relationship? (Yes or No)		**Spouse / Partners Name:**	
Do you have children? (Yes or No)		**Name/Ages:**	
IBS:		**Migraine:**	
Recheck things:		**Nail biting:**	
Drink too much:		**Smoke:**	
Any Irrational Fears: Height, Enclosed Spaces, Snakes, Spiders?			
Ever had a Panic Attack: (fast heartbeat, hot/cold flushes, fast breathing?)			
Difficulty getting to sleep:		**Wake up during the night:**	
Wake up too early:		**Difficulty waking up:**	
Are you on any medication:			
Other info / comments:			
GP Name:		**GP Practice:**	
Have you experienced solution focused hypnotherapy before?			

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Appendix 5: Post Client Questionnaire for Therapists

Post Client Question for Therapists
Northumbria Police Research Project

Please answer the following questions when you have finished working with your research participant and send the completed questionnaire back to admin.research@inspiredtochange.biz.

Therapist Name:	
When did you qualify as a Solution Focused Hypnotherapist?	
On a scale of 1-10, how confident are you in your role as a Solution Focused Hypnotherapist? (1 = not confident at all, 10 = as confident as you can be)	

Participant ID No.	
Did the client write down their What's Been Goods each day?	☐ Yes ☐ No ☐ Sometimes
Did the client listen to your audio download regularly?	☐ Yes ☐ No ☐ Sometimes
In your opinion, how engaged was the client in solution focused hypnotherapy process?	☐ Very engaged ☐ Mostly engaged ☐ Somewhat unengaged ☐ Very unengaged
In your opinion, how cooperative was the client during therapy sessions?	☐ Very cooperative ☐ Mostly cooperative ☐ Somewhat uncooperative ☐ Very uncooperative
Did the client indicate that had been told to sign up to the study by their line manager?	☐ Yes ☐ No ☐ Somewhat

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Appendix 6: Participant Exit Questionnaire

Northumbria Police
PARTICIPANT EXIT QUESTIONNAIRE

SECTION 1 : ABOUT YOU

1. **Length of police service (please state in years)**

2. **What aspects of your job role do you enjoy?**

3. **What aspects of your job role do you not enjoy or find very challenging?**

SECTION 2: PREVIOUS SUPPORT

4. **Have you sought or experienced therapy before?**

4a. If yes, which therapy was sought or experienced (please tick all that apply)

Type of therapy	Organised through work	Sought independently	Attended therapy	Completed therapy
CBT	☐	☐	☐	☐
Talking therapy	☐	☐	☐	☐
Counselling	☐	☐	☐	☐
EMDR	☐	☐	☐	☐
Complementary therapies (please provide details)				

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Other (please provide details)	

4b. If you decided not to proceed with therapy after seeking support, what were your reasons for this?

4c. If you did attend therapy, what was your experience?

SECTION 3: SOLUTION FOCUSED HYPNOTHERAPY VIA THE RESEARCH PROJECT

5. **What were your expectations of Solution Focused Hypnotherapy before commencing therapy?**

6. **Why did you decide to undertake Solution Focused Hypnotherapy?**

7. **What was your experience of this therapy?**

8. **What did you like about Solution Focused Hypnotherapy?**

9. **What are you able to do now that you weren't able to do before therapy commenced?**

10. **How has this therapy affected your day to day work life?**

11. **How has this therapy affected your home life?**

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12. **If a colleague was struggling what would be your advice to them?**

Please add any other comments that you think would be useful for us to know
(As this information is being used to improve support and services, any additional help you can give is very useful)

☐ Please tick if you consent to your feedback being used anonymously in any future materials for the purposes of marketing or sharing the value of this therapy?

Thank you very much for your time.

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Appendix 7: Therapists Self-Reported Years of Experience and Level of Confidence

Participant No.	Years in Practice	Confidence out of 10	Post GAD-7	Post PHQ-9	No. of Sessions	Engagement in the therapy process
1	5.5	9	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
2	0.5	9	No Clin Symptoms	No Clin Symptoms	7	Mostly Engaged
3	0.5	8	No Clin Symptoms	No Clin Symptoms	11	Mostly Engaged
4	6	9	Moderate	Moderate	12	Mostly Engaged
5	1.5	8	No Clin Symptoms	No Clin Symptoms	8	Very Engaged
6	2.5	8	Mild	Mild	12	Mostly Engaged
7	4.5	10	No Clin Symptoms	No Clin Symptoms	7	Very Engaged
8	3.5	9	No Clin Symptoms	No Clin Symptoms	8	Very Engaged
9	5.5	9	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
11	1.5	8	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
12	0.5	8	No Clin Symptoms	No Clin Symptoms	12	Very Engaged
13	2	10	Mild	Mild	10	(Missing data)
14	3	8	No Clin Symptoms	Mild	7	Mostly Engaged
15	0.5	8	No Clin Symptoms	No Clin Symptoms	7	Very Engaged
17	5.5	8	No Clin Symptoms	No Clin Symptoms	8	Very Engaged
19	1.5	9	No Clin Symptoms	No Clin Symptoms	13	Very Engaged
21	1.5	10	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
22	5.5	9	Mild	Mild	8	Mostly Engaged
25	5.5	8	No Clin Symptoms	No Clin Symptoms	8	(Missing data)
26	1.5	9	No Clin Symptoms	No Clin Symptoms	11	Very Engaged
27	3.5	9	No Clin Symptoms	No Clin Symptoms	7	Very Engaged
30	4.5	10	No Clin Symptoms	No Clin Symptoms	11	Very Engaged
31	0.5	9	Mild	No Clin Symptoms	4	Very Engaged
32	2	10	No Clin Symptoms	No Clin Symptoms	5	Very Engaged
33	5.5	9	No Clin Symptoms	No Clin Symptoms	8	Very Engaged
34	5.5	8	Moderate	Moderate	8	Mostly Engaged
35	0.5	8	No Clin Symptoms	No Clin Symptoms	7	Very Engaged
36	6	9	No Clin Symptoms	No Clin Symptoms	5	Very Engaged
37	5.5	9	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
38	0.5	8	No Clin Symptoms	No Clin Symptoms	7	Very Engaged
42	0.5	8	No Clin Symptoms	No Clin Symptoms	10	Somewhat engaged
44	0.5	8	Mild	No Clin Symptoms	7	Very Engaged

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45	1.5	10	No Clin Symptoms	No Clin Symptoms	9	Very Engaged
46	1.5	9	No Clin Symptoms	No Clin Symptoms	6	Very Engaged
47	0.5	7	Mild	Mild	11	Very Engaged
48	0.5	9	No Clin Symptoms	No Clin Symptoms	6	Very Engaged

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