

Abstract

Purpose:

UK mental health strategy calls for interventions that empower people to selfmanage their condition. In lifestyle coaching, coach and client work collaboratively on positive behaviour change to improve client health. There is debate about the appropriateness of coaching for mental health, yet claims have not been supported with evidence. Therefore, this study sought to explore the nature and scope of existing research literature in this field.

Design/methodology/approach:

Scoping review.

Findings:

The growing evidence-base shows positive outcomes of coaching; for instance symptom reduction, enhanced self-management and achievement of personal goals.

Research limitations/implications:

The evidence-base is small and of variable quality, offering insights that warrant further exploration.

Practical implications:

Coaching not only supports better self-management but also addresses further mental health strategy priorities (such as improved physical health and social functioning). Coaches need not be mental health experts; therefore coaching may be a cost-effective intervention.

Social implications:

As mental ill-health prevalence continues to rise despite widespread use of IAPT and medication, there is a need to explore how novel approaches such as coaching might be integrated into mental healthcare.

Originality/value:

This was the first study to collate the evidence on mental health coaching, highlighting its extensive potential, which should be further explored in research and practice.

Introduction

Increasing prevalence of mental ill-health is a key public health concern in the UK, as highlighted in the *Five Year Forward View for Mental Health* (Mental Health Taskforce (MHT) (2016)), a strategic document outlining a vision for mental healthcare in the coming years. The document calls for empowerment-based interventions, with empowerment in public health being defined as a process

whereby individuals take control of decisions that affect their wellbeing (Laverack, 2009). One such intervention is health/wellness coaching, which can be defined in basic terms as the application of life-coaching principles to health and wellbeing (Olsen, 2014).

A fuller definition for health coaching is more complex, a useful starting point being to distinguishing it from other types of coaching. Coaching is often directed at improving performance in an area such as sport (Merian and Snyder, 2015) or employment (Ladyshevsky, 2017), whereas health coaching seeks to support the client with lifestyle changes that enhance their wellbeing. This might be through health coaching programmes (whereby health is the focus of the intervention at the outset (Michie et al., 2008)), or through life coaching (whereby *any* issue may be the focus and the client selects health-related goals (Ammentorp et al., 2013)).

Collectively, these approaches might be labelled '*lifestyle coaching*', in order to distinguish them from *performance coaching*. For the remainder of this article, 'coaching' can be taken to mean lifestyle coaching unless stated otherwise.

Coaching has been critiqued for being an 'undefinable' concept due to variability in features such as coach credentials, intervention duration/frequency and mode of delivery (Olsen, 2014). However, operational details aside, coaching is grounded in some clear-cut principles that form the basis of the concept: coaching is about enabling someone to make life changes through working towards individual goals; a process which may include supporting them to develop confidence, skills, knowledge and self-awareness (Bora et al., 2010; Starr, 2013). Coach-client collaboration is key, with the coach's use of communication skills and coaching techniques being paramount (see Bora et al., 2010 for an overview of the skills and techniques of coaching).

Coaching has been shown to be beneficial in a range of health contexts. This includes supporting people to self-manage chronic illnesses, where outcomes include improved self-rated health, enhanced mood, increased self-efficacy and positive changes to health-related behaviours (Galantino et al., 2009; Wolever et al., 2010; Park and Chang, 2014). Coaching has also been utilised outside of the realm of chronic illness, and has been effective in health improvement programmes such as weight loss and smoking cessation (Tao et al., 2014; Boccio et al., 2017).

Furthermore, positive health-improvement outcomes from coaching are seen in demographic groups that traditionally have poorer health outcomes and lower health service engagement, such as offenders, war veterans, people with mental health problems and those with low income (Jennings et al., 2013; Shahnazari et al., 2013; Bailey and Kerlin, 2015; Willard-Grace et al., 2015). Ammentorp et al. (2013) suggest that the success of coaching in supporting such groups could be down to its

empowering nature, a notion corroborated by studies that have pinpointed mechanisms such as autonomy-building, collaborative problem-solving and enhanced self-efficacy as being key to success in health coaching (Cinar and Schou, 2014; Dufour et al., 2015; McGloin et al., 2015).

Given the accessibility and empowering nature of coaching, it appears to meet the current demand for interventions that support people to better manage their own mental health, an approach that might be termed 'mental health coaching'. This possibility has been explored previously by Bora et al. (2010), who recognised an overlap between coaching and recovery-based approaches, and offeringed a theoretical argument for the potential value of coaching in mental health. However, there is discrepancy of opinion as to whether coaching is an appropriate mental health intervention: a variety of organisations endorse the approach (Foundation for Recovery Coaching UK (2016); Soul Self-Help (Mahari, 2016); Rethink Mental Illness (Bora, 2012)), whilst multiple authors claim that it is inappropriate, even dangerous, for mental health patients (Jenner, 2014; Olsen, 2014). Others suggest that coaching has a place in mental health, but caution should be exercised in implementing such interventions (Ley, 2014). None of these authors have provided evidence to support their assertions, raising the question of whether any research has been conducted in the field. Therefore, this literature review sought to establish the state of the research literature on mental health coaching.

1.1 Research question

What is the current state of the research literature on mental health coaching?

1.2 Aims

To explore:

- 1) To understand the nature, and scope and findings of existing research on mental health coaching.
- 2) Research findings.
- 3) To explore the implications and directions for future research.

2. Methodology

The method chosen was scoping review, a method designed for exploring the state of a research field and highlighting directions for further research (Arksey and O'Malley, 2005), both of which were aims of this study. The review was conducted using Arksey and O'Malley's (2005) six-stage framework, with adaptations based on study-specific requirements and on framework enhancements proposed by later scoping review methodologists. As recommended by Joanna Briggs Institute (JBI) (2015), a protocol was developed (Appendix 1) ahead of study commencement, for enhanced transparency (Supplement 1).

Ethical approval was obtained from the Research Ethics Committee of the south England institution at which the study was conducted.

2.1 Stage 1: identifying the research question

Levac et al. (2010) suggest that concepts within the research question should be clearly defined prior to commencing the search, to enhance clarity in study selection. However, given the fledgling nature of this field, it was not feasible to refine definitions at the outset; rather, it was necessary to remain open to the possibility of adapting the scope depending on the nature of the emerging results. This , reflects Arksey and O'Malley's (2005) notion that scoping review is an iterative and, non-linear process. Defining 'mental health coaching' was an adjunct to the literature search itself, and the definition was not crystallised until the majority of the searching had been completed.

2.2 Stage two: identifying relevant studies

JBI (2015) advocates the 'PCC' framework (population, concept, context) for inclusion criteria, but thus far scoping review methodologists have not provided a tool for developing search terms; therefore the present study utilised PCC for search terms *and* inclusion criteria. The population (people with mental health difficulties) and concept (coaching) were easily designated, but it was unclear how context might be applied; therefore, this was replaced by 'type of paper' to accommodate a focus on *research* literature, resulting in a 'PCT' framework (population, concept, type). The search terms were built on Boolean logic, since the ability to build custom combinations of search terms using 'AND', 'OR' and 'NOT' operators (McKeever et al., 2015) was useful in applying the PCT framework. The search terms included lists of synonyms for 'coaching' and 'mental health difficulties', and the NOT command was used to exclude irrelevant forms of coaching (for instance "sports coaching"). The final Full search terms are depicted in Appendix 2 Supplement 2 (tinyurl.com/ydyysuak). As recommended by Arksey and O'Malley (2005), several searching methods were utilised in order to fully explore the scope of the literature

2.2.1 Step 1

The search was conducted in core health and psychology databases (CINAHL, Medline, PsycINFO and BNI) as well as and grey literature sources (Web of Science and OpenGrey).

2.2.2 Step 2

The search was conducted in a platform that covers a wide range of databases (available at the university at which the study was conducted), with a view to highlighting if any relevant databases had been omitted thus far: Where this located a relevant paper not retrieved in Step 1, the database from which that paper

originated was searched (namely ClinicalTrials.gov). This process allowed efficient coverage of appropriate databases without misguidedly searching irrelevant ones.

2.2.3 Step 3

As recommended by Hinde and Spackman (2014), 'bi-directional' citation searching was employed: in addition to screening reference lists of included studies, each one was located on Web of Science (if available), and the 'times cited' function used to generate lists of papers citing those papers, which were also screened.

2.2.4 Step 4

Although consultation is Stage 6 of the scoping review framework, it sits well *within* the search strategy, since one of its purposes is to locate further studies to be for reviewed (Arksey and O'Malley, 2005). Consultation was instigated with authors who had expressed opinions on mental health coaching and those of studies included in the review. Emails were sent to each party enquiring whether they were aware of any further research in the field, and, in the former case, what evidence their views were based on. As recommended in the responses, a number of key coaching journals were screened for eligible studies.

2.3 Stage 3: study selection

The eligibility criteria outlined in the protocol (Appendix 1 Supplement 1) were somewhat rudimentary, as they were developed prior to the finalisation of the definition for 'mental health coaching'. Whilst their essence did not change, the final criteria (Table 1) reflect this refinement of the definition. Given the scoping nature of the review, no limits were placed on geography, methodology or participant demographics., although a An English language limiter was utilised as translation resources were unavailable. The 'insufficient information' exclusion criterion accounted for papers that did not describe the population or intervention adequately to fully meet the criteria.

Table 1: eligibility criteria

All studies explicitly including participants with mental health difficulties were included, since a predetermined conceptualisation of mental health problems would have obstructed the aim of openly exploring the scope of the research. An anomaly was attention-deficit-hyperactivity disorder (ADHD), as there is confusion around whether this is a 'mental illness' or 'learning disability' (Foundation for People with Learning Disabilities, 2016). The coaching literature tends to view it as a learning difficulty, the intervention of choice being academic coaching (for instance, Prevatt and Yelland, 2015); thus ADHD was excluded in order to retain the focus on *lifestyle coaching*.

To accommodate the full scope of relevant literature, both peer-reviewed and nonpeer-reviewed records were included, despite claims that reviews should only include peer-reviewed results (Levy and Ellis, 2006). Peer-review does not guarantee high quality; moreover, the review process can generate publication bias, which is prevalent in mental health research (Smith, 2006; Fanelli, 2012; Waltho et al., 2015). Thus, limiting to reviewed papers would not have been conducive to the scoping nature of the review.

References were managed using EndNote x7 (Thomson Reuters).

2.4 Stage 4: charting the data

2.4.1 Data extraction

Arksey and O'Malley (2005) suggest that, to facilitate consistent analysis, predetermined items should be extracted from each included paper. This approach was employed by developing two charting tables which were used to extract data from each study. The first collated general study information, based on JBI (2015) scoping review methodology (with adaptations related to the specifics of the review), and comprised information such as author(s), year, place, purpose, mental health condition and outcomes of interest and findings/outputs. The second collated details about the coaching interventions, including purpose, label, coach credentials and intervention delivery characteristics.

2.4.2 Quality assessment

Choosing a critical appraisal tool (CAT) was challenging, since there is no standard CAT for scoping reviews. Many existing tools focus on specific research methods and are inappropriate for consistently appraising studies of varied methodologies, yet generic tools can neglect important elements of quality (Leonidaki, 2015). This said, method-specific tools are also prone to omitting salient points; for instance, the CASP (2013a) Qualitative Checklist considers researcher bias, whilst the RCT Checklist (CASP, 2013b) is preoccupied with statistical issues and fails to address bias, which is problematic since quantitative researchers also have the potential to produce bias (Turner, 2013). Further, these checklists focus solely on methodological rigour, which is insufficient for scoping review (a methodologically sound RCT would have limited value if it failed to properly describe the coaching intervention, whilst a less robust study might give rich insight into the application of coaching to mental health). It was therefore important to assess *applicability* to the research question as well as methodological soundness, much like the approach of Hawker et al. (2002), who developed a system for appraising data from varied

methodologies. As well as offering consistency in appraising disparate data, their approach is useful for scoping review as it uses a scoring system, enabling *exploration* of quality rather than discarding studies that do not tick particular boxes. For the present review, a custom CAT was developed (Appendix 3 Supplement 3, tinyurl.com/yce8dey9), based on Hawker et al. (2002) and adapted to reflect study specific needs. The adaptations included replacing the subjective language in some items with tick-lists of details that should be present for a top score, a more objective approach used for some items in the original CAT. Further, study-specific items were added, to assess how comprehensively the population and intervention were described. It is hoped that the resulting CAT provides a useful framework that can be adapted for use in future scoping reviews.

2.5 Stage 5: collating, summarising and reporting the results

The results were collated using narrative synthesis and presented in tables derived from the data charting process. Narrative synthesis is advocated by Ridley (2012) for review data that goes beyond effectiveness, since it enables open exploration of the data, an approach well-suited to this scoping review since the aim was to present an overview of the available literature, rather than focussing on 'effectiveness'.

2.6 Stage 6: consultation

In addition to the exercise described in Step 4 of the search strategy, consultation will be used to share the review findings with stakeholders such as authors of included studies.

3. Results

3.1 Study selection

Figure 1 shows the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses, Liberati et al., 2009) diagram of study selection, including how many full-text-reviewed records were excluded for each eligibility criterion. Twelve studies were eligible for inclusion, comprising fourteen papers (two pairs of which reported on the same study and were reviewed as one). One study (Discher, 2010) was available only as a preview as the full-text was not procurable. Although this meant that information was missing, it was included to retain fidelity to the scoping nature of the review.

Figure 1: PRISMA diagram of study selection

3.2 Included studies

The review findings are presented in the following tables:

- Table 2 summarises features of included studies.
- Table 3 depicts the outcomes measured and findings reported.
- Table 4 charts the features of coaching interventions.

Each study has an identification number from 1-12 to enable cross-referencing between tables. Expansions of acronyms are given in Appendix 4.

Table, 2: characteristics of included studies

3.2.1 Aim 1: Nature and scope of existing research on mental health coaching.

Table 2 shows the general characteristics of included studies, whilst Table 3 summarises features of the coaching interventions reported on. Included studies were reported between 2010-2017, 42% in the last year or so, demonstrating the fledgling nature of and growing interest in this field. It is a heterogeneous body of evidence, both in terms of research location, population, methodology and so on (Table, 2) and in terms of the features of coaching interventions, such as duration mode of contact, coach credentials and intervention purpose (Table 4). The majority of studies are concerned with the efficacy or impact of coaching, whilst two sought to analyse the coaching process, why and how it works.

Table, 2: characteristics of included studies

Expansions of acronyms used in tables 2 and 4:

- RCT randomised-controlled trial
- DSM-IV Diagnostic and Statistical Manual of Mental Disorders (fourth edition)
- PHQ-9 Personal Health Questionnaire
- ICD International Classification of Disease
- HAMD-101 Hamilton Depression Rating Scale
- GAD-7 Generalised Anxiety Disorder Scale
- ICG Inventory of Complicated Grief
- PTSD post-traumatic stress disorder
- GAD generalised anxiety disorder
- PSS-10 Perceived Stress Scale
- HADS Hospital Anxiety and Depression Scale

Table 4 Table 3: details of coaching interventions

Table 3: outputs of included studies

3.2.2 Aim 2: Research findings

Table 4 summarises the outputs of included studies. A range of outputs has been generated, and the results available thus far have been mostly positive; for instance outcomes reported for coachees include, symptom reduction, development of coping strategies, improved physical health, and goal attainment of life goals., and high intervention acceptability. The exception is Härter et al. (2016), who found that coaching had no significant impact on hospital readmission rates. Some studies offer insight into how coaching works and what makes it successful; for instance its

adaptable, client-centric nature and high acceptability for coaches are seen as paramount to the success of coaching.

Table 4: outputs of included studies

3.3 Quality

Since some studies were ineligible for the maximum CAT score (that is, if it was yet-to-be-completed or the full-text was unavailable or the study was yet-to-be-completed), scores have been converted to percentages of the number of points available for each study. These totals have been converted to quartiles (mirroring the four-level scoring system for individual items), giving a crude measure of overall quality level for each study.

Scores ranged from 33-97%, with a mean of 67%. No studies fell into the lowest quartile, whilst, 25% were in the second, 42% in the third and 33% in the top, suggesting that the overall evidence-base might be considered medium-to-high quality. Given the scoping nature of the review, quality reflects the extent to which the study provides insight into the field, as well as methodological soundness. The only pattern observed was that low quality was rife amongst trial registrations, perhaps indicating a need for improved reporting of these so that in-progress studies are able to contribute to an emerging evidence base.

Discussion

This review sought to scope the existing research on mental health coaching, to help elucidate a debate about the appropriateness of the approach. It transpires that this body of research is small but growing:, with multiple studies are still in progress at the time of the review., indicating the evidence-base could develop rapidly in the near future, and. tThe thus far positive findings give preliminary support that coaching *is* an appropriate form of mental health support. Although one study (Härter et al., 2016) did not produce positive outcomes, no harms were reported, suggesting the view that coaching is dangerous for mental health patients (Jenner, 2014) may be unfounded. This builds on the work of Bora et al. (2010), providing an evidence-base to support their theoretical argument for the use of coaching in mental health.

One finding of this review is a high degree of heterogeneity across coaching interventions, mirroring previous health coaching literature, whereby variance has been viewed as a *weakness* of coaching (for instance, by Olsen (2014), who conducted a concept-mapping exercise to address this). This heterogeneity critique overlooks that it is the *application* of coaching, rather than its *essence* that varies: its

universal applicability is an *advantage* of the approach, the present review demonstrating that mental health is a further area in which coaching is successful. This said, standardised coaching frameworks such as ‘Co-Active Life Coaching’ have been shown to produce consistently positive outcomes (Liu et al., 2015), yet only a small proportion of studies included in this review reported that interventions had followed such a framework. Thus, as the field of mental health coaching develops, there could be value in concept-mapping the approach, with a view to developing guidelines from which it could be delivered in a more standardised manner, which may alleviate concerns that coaching is an unregulated profession (Jenner, 2014; Ley, 2014). Development of such a framework would thus need to include exploration of the level of mental health training required: although being a mental health professional is not necessary to be a coach (Cully et al., 2014), coaches require mental health knowledge in order to support clients effectively, as highlighted by studies included in this review (Campone, 2014; Cully et al., 2014). This need might be addressed through Mental Health First Aid (MHFA) training, which is currently being widely implemented in the UK (MHFA England, 2017). The notion of ‘non-experts’ providing mental health support is controversial (Jenner, 2014; Ley, 2014), but this review demonstrates that there may be little difference between those considered experts and non-experts in mental health: in several included studies, cognitive-behavioural techniques were used by coaches; this closely reflects the role of a ‘low-intensity’ therapist, who uses coaching techniques to support clients in applying cognitive-behavioural strategies (Improving Access to Psychological Therapies (IAPT), 2015). Wider use of coaching would expand the workforce available to deliver mental health support, which sits well with the impetus for a ‘wider workforce’ in public health (Royal Society of Public Health, 2015). Further, there is mounting evidence that a strong client-practitioner relationship predicts positive therapeutic outcomes better than the intervention itself (Ardito and Rabellino, 2011). Since coaching is grounded in the cultivation of empowering, collaborative coach-client relationships, the knowledge that relationships are key to positive outcomes could be leveraged by implementing coaching interventions more widely.

In light of these considerations, it would be prudent to explore how coaching might be integrated into mental healthcare, and how cost-effective this might be. As well as potentially reducing training costs, the client-centred nature of coaching means it is conducive to addressing numerous mental health priorities simultaneously: studies included in this review highlight that coaching not only supports self-management of mental health problems, but also helps clients to improve their physical health and

social functioning, and to progress in education/employment (Hsieh, 2010; Naik et al., 2012; Campone, 2014; Cully et al., 2014), all of which are strategic priorities set out in the *Five Year Forward View for Mental Health*. This is corroborated in the wider health coaching literature, whereby physical *and* mental health benefits are often seen simultaneously (Galantino et al., 2009; Wayne et al., 2015; White et al., 2015).

The potential cost-effectiveness of coaching is salient given that current treatments of choice are not producing the desired outcomes in mental health: IAPT has transpired to be very costly financially (Mukuria et al., 2013), despite one of its main purposes being to reduce mental healthcare costs (Layard et al., 2007). Similarly, widespread use of pharmaceutical treatment is problematic, since psychiatric prescribing is rising disproportionately to mental ill-health diagnoses (Ilyas and Moncrieff, 2012; Spence et al., 2014). If medication were effective, logic would dictate that prevalence would decrease alongside increased prescribing, whereas actually prevalence of mental ill-health continues to rise (MHT, 2016). Although research shows medication to provide short-term symptom relief, deeper exploration of the (often hidden) evidence shows that *long-term* it generates poorer outcomes (Whilst comprehensive exploration of this issue is beyond the scope of this discussion, cCogent accounts of this literature are available in various academic and journalistic sources (Whitaker, 2010; Davies, 2013; Moncrieff et al., 2013; Healy, 2016)).

Despite these problems, support is rarely available to withdraw from medications, which is challenging due to their addictive qualities (Whitaker, 2010; Cassani, 2017).

This presents another possible role for coaching, since its success in smoking cessation (Boccio et al., 2017) suggests that it may be well-suited to overcoming addiction. This idea has not yet been tested, thus research is needed to explore how coaching might contribute to supporting psychiatric medication withdrawal.

Finally, coaching need not be mutually exclusive from other interventions: for instance, in one of the studies included in this review, the client reaped unique benefits from each support element of medication, psychotherapy and coaching (Campone, 2014), whilst in another, coaching alone was insufficient for a client with particularly severe depression. Thus, cCoaching has multiple uses and may offer an alternative from, adjunct to, or support to move away from, other interventions. All of these possibilities require further exploration, perhaps through a complete cost benefit analysis to understand the comparative risks and value of mental health coaching.

Strengths and Limitations

This was the first study to collate the evidence on mental health coaching, offering novel insights into an innovative mental health intervention, which is salient given the strategic current drive for empowering approaches to mental healthcare. Although only a small number of studies has reported results thus far, multiple studies several are in progress, meaning the body of evidence is developing rapidly. Due to the fledgling nature of the field, it has not been possible to conduct an analysis of gaps in the literature as is often an objective of scoping review (Arksey and O'Malley, 2005); rather, the insights gleaned present various possible directions for future research. There are some factors that could have led to the omission of relevant studies: first, studies reported very recently may have been omitted, since the search was conducted between July and August 2016, thus more recent studies will not be included. Second, it was not possible for the consultation to be fully comprehensive, as contact details were unavailable for some authors; although this number was minimal, the potential impact on leads to further studies is unknown. Studies not explicitly labelling interventions 'coaching' were ineligible for inclusion in this review, but may be of value in the developing evidence-base on lifestyle-based interventions. Future reviews may do well to broaden the scope of evidence collated to address this.

Another limitation is that the study was conducted by a lone reviewer, whereas methodology guidelines suggest two people should contribute to all stages of scoping review to maximise objectivity (Levac et al., 2010; JBI, 2015). The reviewer employed several strategies to minimise the potential for bias, including production of a search strategy protocol, use of a custom CAT for enhanced objectivity, and engagement with mindfulness practice to cultivate self-awareness (Bentz and Shapiro 1998). This supported the development of a systematic and rigorous review, which can be seen as a strength of the study.

Conclusion

As mental ill-health continues to rise, despite use of recommended treatments, innovation in mental health support is essential. The *Five Year Forward View for Mental Health* acknowledges this need, which must now translate to action for public mental health to advance. This advancement should include the exploration of mental health coaching, as the emerging evidence-base suggests that the approach could have extensive value in improving people's mental health.

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Inclusion Exclusion Population

1.1 Sample purposively includes people with mental health difficulties

AND

1.2 Participants are recipients of coaching

1.3 People with mental health problems not explicitly included

OR

1.4 Participants are not recipients of coaching

2. Concept

2.1: Health Trainer; health/wellness/life/recovery/peer coaching

AND

2.2 Evidence that intervention includes collaboration and is grounded in coaching techniques

AND

2.3 Coaching delivered to individuals with mental health difficulties

AND

2.4 Coaching aims to support people with their mental health difficulty

2.5 Performance coaching; other interventions such as counselling

OR

2.6 No evidence that 2.2 met

OR

2.7 Coaching recipients are not those with mental health difficulties

OR

2.8 Coaching not aimed at supporting people with their mental health difficulty

3. Type of paper

3.1 Research

OR

3.2 Research protocol/proposal

3.3 Non-research

4. Language 4.1 English 4.2 Non-English

5. Other 5.1 Insufficient information to determine whether criteria are met.

Records identified through database searching (Steps 1-2)

(n=506)

Included Eligibility Screening Identification Records identified through other sources (Steps 3-5, excluding duplicates)

(n=211)

Records screened after duplicates removed

(n=411)

Records excluded at screening

(n=289)

Full-text records assessed for eligibility

(n=122)

Records excluded at full text assessment

Population

(n=47)

Concept

(n=50)

Not research

(n=12)

Total

(n=109)

Records included

(n=14)

Papers combined

(n=2)

Studies included in review

(n=12)

Study number

b. Author (year)

a. Place

b. Record type

c. CAT score

a. Purpose

b. Method(s)/design

a. Mental health condition

b. Measure(s) to define mental health status

c. Other population characteristics

d. Sample size

a. 1

b. Chen (2013)

a. Hong Kong, China

b. Trial registration

c. 47%

a. Not stated

b. Single-blind RCT

a. Early-onset psychoses

b. DSM-IV diagnosis

c. Age 25-64; psychosis duration <5 years

d. Estimated 140

a. 2

b. Campone (2014)

a. California, USA

b. Journal article

c. 87%

a. Delineate coaching process, boundaries and whether/how it helps the client

b. Case study

a. Dissociative Identity disorder (DID)

b. Diagnosis

c. Age 54; female; married; social worker

d. 1

- a. 3
- b. Cully et al.(2014)
 - a. Texas, USA
 - b. Journal article
 - c. 93%
 - a. Examine effectiveness and pilot implementation strategy of coaching for comorbid diabetes/depression
 - b. RCT; implementation trial
 - a. Depression
 - b. PHQ-9
 - c. Veteran; rural-living; uncontrolled diabetes
 - d. 242
- a. 4
- b. Discher (2010)
 - a. USA
 - b. PhD thesis
 - c. 67%
 - a. Examine factors predicting completion of coaching programme, and improvements in self-management
 - b. Data unavailable
 - a. Depression
 - b. PHQ-9
 - c. Age 18-55
 - d. 267
- a. 5
- b. Härter et al.(2016)
& Dwinger et al.(2013)
 - a. Germany
 - b. Journal article
 - c. 97%
 - a. Evaluate effectiveness of coaching on outcomes and healthcare costs
 - b. Non-blinded RCT
 - a. Depression; schizophrenia

- b. ICD diagnosis
- c. Age 18+; insurant of KKH (study funder)
- d. 10,815
- a. 6
- b. Hsieh (2010)
- a. British Columbia,
Canada
- b. Journal article
- c. 37%
- a. Evaluate coaching support for overcoming
mental health-related barriers to returning to
education
- b. Focus groups
- a. Any
- b. Receiving community mental health support
- c. Prospective students

Study number

b. Author (year)

a. Place

b. Record type

c. CAT score

a. Purpose

b. Method(s)/design

a. Mental health condition

b. Measure(s) to define mental health status

c. Other population characteristics

d. Sample size

- a. 7
- b. Naik et al.(2012) &
Naik and Cully
(2014)
- a. Texas, USA
- b. Trial registration;
journal article
- c. 73%

c. 59%

a. Investigate barriers to mental health treatment engagement and impact of coaching on this

b. Double-blind RCT

a. PTSD; depression; GAD; panic disorder

b. Not stated

c. Age 18+; veteran; rural-living

d. Estimated 1,000

a. 11

b. Robson-Kelley and van Nieuwerburgh (2016)

a. London, England

b. Journal article

c. 67%

a. Develop a model of coaching for young people with poor mental health

b. Grounded theory; semi-structured interviews
Qualitative

a. Anxiety; depression

b. Experience of symptoms

c. Age 13-17

d. 68

a. 12

b. Fried and Irwin (2016)

a. Ontario, Canada

b. Journal article

c. 93%

a. Explore the impact of coaching on stress

b. Repeated-measures semi-structured interviews

a. Stress

b. PSS-10

c. Age 18-24; full-time student; not having mood disorder treatment

Study no.

a. Intervention label

b. Aim of coaching

a. Coach credentials

b. Coaching techniques

a. Delivery mode

b. Intervention duration

c. Session frequency

d. Session duration

1

a. Recovery-oriented coaching

b. Support recovery from first-episode

psychosis

a. Not stated

b. Goal-setting, cognitive-behavioural and solution-focussed techniques

a. Group

b. 6 months

c. Not stated

d. Not stated

2

a. Life coaching

b. Support client to develop life skills

a. Life coach with >20 years' experience and background in counselling/psychotherapy

b. Rogerian, client-centred life-coaching, including goal-setting

a. Face-to-face

b. >4 years

c. Weekly

d. 2 hours

3

a. Behavioural health coaching

b. Support management of depression &/or diabetes according to patient preference

a. Practitioners/trainees of various professions (social work, nursing, psychology); received 4 hours coach training

b. Goal-setting; action-planning; cognitive-behavioural and motivational interviewing techniques

a. Telephone

b. 6 months

c. Once-to-twice monthly

d. 15-30 minutes

4

a. Wellness Coaching

b. Support patients to self-manage

depression

a. Trained wellness coaches (further details unavailable)

b. Problem-solving; cognitive-behavioural techniques

a. Telephone

b. Details unavailable

c. Details unavailable

d. Details unavailable

5

a. Health coaching

b. Support to self-manage condition

a. Nurses, nutrition scientist, psychiatric experts; trained by developers of telephone-based-health-coaching

b. Motivational-interviewing; goal-setting

a. Telephone

b. ≤ 2 years

c. \geq once every 6 weeks

d. Mean 17.5 minutes

6

a. Coaching

b. Support students to re-enter education

a. Nursing students with mental health specialism; basic coaching and mental health training provided

b. Goal-setting and evaluation; action-planning

a. Face-to-face

b. 14 weeks

c. Approximately twice daily

d. Not stated

Study no.

a. Intervention label

b. Aim of coaching

a. Coach credentials

b. Coaching tools used

a. Delivery mode

b. Intervention duration

c. Session frequency

d. Session duration

7

a. Behavioural health coaching

b. Support management of depression &/or
diabetes according to patient preference

a. Range of non-experts in diabetes/depression (e.g.: psychology
trainees); structured training and ongoing supervision provided

b. Goal-setting, action-planning

a. Telephone, email

b. 12 weeks

c. Weekly

d. Not stated

8

a. E-therapy coaching

b. Support patients through internet self-help
programme The Journal

a. Clinicians

b. Goal-setting; problem-solving

a. Telephone, email

b. 12 weeks

c. Weekly

d. Not stated

9

a. Lifestyle coaching

b. Enhance motivation and confidence
practicing healthy lifestyle behaviours

a. Not stated

b. Motivational-interviewing

a. Not stated

b. 12 weeks

c. Weekly

d. Not stated

10

a. Motivational coaching

b. Enhance treatment engagement

a. Not stated

b. Motivational-interviewing

a. Telephone

b. 8 weeks

c. Fortnightly

d. 20-30 minutes

11

a. Positive-psychology coaching

b. Improve mental wellbeing

a. *Worth-It Projects* coaches

b. Cognitive-behavioural and solution-focussed techniques

a. Face-to-face, group

b. Not stated

c. Not stated

d. Not stated

12

a. Motivational-interviewing via Co-Active-Life-Coaching (CALC)

b. Improved stress management

a. Accredited CALC coaches

b. Motivational-interviewing; CALC

a. Telephone; face-to-face; Skype

b. 6 sessions

c. Variable (usually twice-monthly)

d. 30-60 minutes