Organisational considerations necessary to introduce a health coaching service in NHS settings for mental health patients

Organisational considerations necessary to introduce a patient health coaching service in NHS mental health settings.

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Abstract

This thesis aims to determine the organisational consideration required to establish a health coaching service for patients within a mental health National Health Service (NHS). This takes place within the context of growing pressure on mental health services in the United Kingdom, where there is an increase in demand and access to mental health provision in conjunction with a decrease in mental health professionals, funding and resources. An approach to alleviate these issues can be derived from business settings where coaching has evidenced the positive impact on individuals through empowerment, self-efficacy and goal attainment. Whilst coaching has taken place within health settings, predominantly in physical health, there has been no wider thought given to the considerations required to introduce a health coaching service which is safe, timely, equitable, efficient, effective and patient-centred.

To address the aims of this thesis, two studies were conducted. The first study was a systematic review which examined the impact of health coaching on patients. Searches identified 3813 papers, of which only five met the inclusion criteria of using validated measures of mental health conditions. Four of the five studies evidenced that health coaching has a positive impact on mental health status and condition-based reporting. However, all five research papers noted the absence of long-term data as a limitation of the literature, which is due to the cessation of the health coaching once the research has concluded. Health coaching as an intervention can no longer be provided as the systemic considerations are not implemented to sustain a new intervention. Using the NHS process for establishing and evaluating an intervention as outlined by Skivington et al 2021), it was determined that there is sufficient evidence to progress research from identification of the intervention to the organisational feasibility of introducing a service. Therefore, study 2 used a qualitative design to explore the organisational considerations needed in order to be able to establish, sustain and evaluate a health coaching service. Eleven qualified coaches working in a mental health NHS Trust were recruited to take part in a semi-structured interview. The participants were supportive of a dedicated coaching support service for mental health service users, recognising the potential positive impact that the service could provide. Through template analysis five over-arching

themes were identified: safety, infrastructure, readiness, equitable, and effective. The themes were clearly interconnected with participants highlighting how one area of a theme impacted or had implications on another theme. For example, the need to ensure that the administration of the service and ensuring the delivery of safe care (to the service users and the coaches) had sufficient mitigations in place. Together, these findings reflect the complexity of endeavouring to establish such a health coaching service. These findings present a novel contribution to the literature as they provide a comprehensive set of organisational considerations from the perspective of the individuals who would be providing the service. The perspective of this vital group is often overlooked yet can help to anticipate challenges and enable organisations to take mitigative action. The information generated from the themes can be utilised in other NHS mental health settings to provide the foundation of progressive research in this field to progress the intervention further.

This thesis contributes to the evidence base in two ways: (1) it consolidates the results from extant literature in relation to health coaching from a mental health lens and highlights the positive impact of health coaching on anxiety and depression and opportunities to better determine the impact of health coaching through a more consistent use of outcome measures. ; and (2) it provides novel learning which can progress the research base further by presenting the practical considerations required to introduce a complex service in the NHS. By adopting the Skivington et al., (2021) model the findings presented in this thesis provide the logical and evidence-based next step in progressing the potential implementation of health coaching. Building on the outcomes of this research, it is necessary to broaden the pool of stakeholders (e.g., invite commissioners, organisational executive, service users and carers etc.) to be involved in determining the organisational considerations required to establish the intervention. The outcomes of this research, within the context of significant resource challenges in the NHS, provides the opportunity to tailor existing resources in mental health services to provide a novel and enabling service for service users.

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Professional Practice Statement

This thesis marks the end of a four-year journey of learning at Birkbeck, University of London. In years 1 and 2 I completed part one of the Professional Doctorate (Professional Practice Portfolio) and subsequently registered with the Health and Care Professions Council as a practitioner psychologist in occupational psychology. This thesis satisfies the requirements for part two (years 3 and 4) and brings together two-years of part-time study. The following statement provides a summary of how my professional practice informed this thesis.

My professional experience in psychology began in 2008 having completed an undergraduate degree in the field. I subsequently pursued a career path leading to clinical psychology. As part of my work in this pathway I was exposed to the world of occupational psychology to develop my formal research experience. This was achieved whilst working with an organisational consultancy service which operated in-house of a mental health NHS Trust. Within this service, I was fortunate to work with a diverse range of individuals who came from different professional backgrounds. This was a crucial learning point where I learnt the application of the core areas of occupational psychology through the different professional lens'. I realised that this was an area of work that brought me joy, fulfilment and challenge on a daily basis. I recognised that there was ample opportunity to develop knowledge, skills and abilities within occupational psychology. I was encouraged to engage in programmes and courses which enabled continuous professional development. This began with my foundational certificate in Executive Coaching. I was subsequently able to build on this and achieve my Practitioner (Level 7) qualification in Executive Coaching. I have used these skills as part of my process consultancy approach to working with internal and external clients. I furthered my development by completing multiple different courses in psychometrics, achieving registered Test User; Occupational, Personality and Ability status with the British Psychological Society.

Concurrent to these I completed a Master of Science (MSc) in occupational psychology. This began my journey towards this professional doctorate. I saw the possibilities of applying a coaching approach with mental health patients in a mental

health Trust. I have a passion for working in the mental health field with the fundamental belief that individuals can have a fulfilling, meaningful and enjoyable life regardless of a mental health diagnosis. The importance of this work was propelled by the recognition of dwindling NHS resources coupled with a significant increase in demand. By completing this thesis, I believe I have presented work which contributes to bridging this gap and fully intend to work with my Trust to bring this to life in order to make a difference to the local community

Through this professional doctorate I have enhanced my skills within the field of occupational psychology, relating to theory, practice, research and analysis. This has empowered me to apply these skills in my employment, share with my colleagues and, through continuous professional development progress my skills further.

Chapter 1 – Introduction

This thesis aims to examine whether a health coaching service for mental health service users, in addition to their treatment as usual, could form part of the solution in supporting people with mental ill-health. In this section I will position the work within the national context of mental health services and the opportunities that health coaching can provide to improve patient care and outcomes.

There is a growing crisis in mental health services across the country with latest census data showing that one in six adults will experience mental ill health (Baker & Kirk-Wade, 2023). Statistics show that in the last two years there has been a 30% increase in the number of people engaging with mental health services, and a 28% increase in the number of new referrals (NHS Digital, 2023). Despite this ever growing demand for services, accelerated by the impacts of COVID-19 (Suleman et al., 2021b), the mental health workforce is shrinking (Taylor, 2020) with records showing one psychiatrist for every 12,567 people in England (Royal College of Psychiatry, 2022), resources are dwindling (Buchan et al., 2017, 2019), and staff morale is at an all-time low (NHS Staff Survey, 2022). Service users are suffering as a result, with long waiting times (NHS Digital, 2023) and suboptimal health outcomes (Reichert & Jacobs, 2018). The current situation is unsustainable (NHS Confederation, 2022) and requires review and considerations of a new way forward, only then can the system go beyond surviving and into thriving. One possible way forward is the introduction and use of health coaching as an intervention for working with service users. There is growing evidence as to the positive impact of coaching on service user experience and health outcomes, which in turn reduces the demand on health services (Ammentorp et al., 2013a; Boehmer et al., 2023; Kivelä et al., 2014; Wolever et al., 2013).

1.1 Brief history of mental health services in the UK

Mental health services have changed significantly over the centuries. Whilst individuals experiencing mental ill health were not unknown to society, the treatment of these individuals were kept within the confines of families or small communities for fear of embarrassment or discrimination (Fink, 1992; Heney, 2022). In the 13th

century, following the gifting of estate by Simon FitzMary to the City of London, a charitable hospital was established to provide care for 'paupers' (Arnold, 2008). This hospital evolved to predominantly caring for individuals with mental ill health. Bedlam, as it came to be known, became Europe's oldest and most infamous mental institution. The hospital was often the centre of scandal and associated with barbaric and abusive treatment. By the 18th century societal views on the treatment of mentally ill patients evolved, predominantly owing to King George III's own experience with mental ill health. This marked a shift in how patients should be treated and saw the beginning of multiple acts enshrining these views into law. For example, (The 1774 Madhouses Act, 1774) (14 George 3, c.49). stipulated that institutions were subject to an annual inspection and required all patients to be admitted with a medical certificate. There also began a movement which rejected physical interventions, promoting holistic care based on empathy led by William Tuke (Tuke, 1855). The 19th century saw mental health reforms through the 1808 Lunacy Act which, with the establishment of the Lunacy Commission, which identified the state's responsibility to establish asylums in every county. Further iterations of the Act, strengthened through other related acts (e.g., 1834 Poor Law Amendment Act, 4 & 5 William IV, c.76), placed increasing responsibility for care provision on the state. However, care provision was rudimentary and did not distinguish between different types of diagnoses providing all with the same intervention and environment. Encouraged by the results of holistic care approaches, psychiatrists advocated for moral treatments, ones without restraints or seclusion (Topp, 2018). However, due to limited implementation of care principles, resources and treatments, asylums became overcrowded, and the use of physical restraints and seclusion rose.

In the early 20th century, the biggest shift in mental healthcare provision was marked by attempts to support patients to re-enter society through concepts of deinstitutionalisation (Eghigian, 2011) or decarceration (Turner et al., 2015). There was also a move towards disintegrating psychiatry from pathology and psychodynamic approaches owing to the success of psychopharmacology and neurology (Shorter, 1997). However, this also came at a time which saw a rise of the professionalisation of the role of psychiatry (Hess & Majerus, 2011), where psychiatrists became concerned with "professional dominance" (2011, p. 140) and embedding the 'medical model' as the primary approach to care (Huda, 2021).

A criticism of the medical model is that despite advances in the understanding of psychiatric ailments, its causes and its treatments, the number of service users and complexity in presentations continues to rise. Interventions and treatments do not meet the needs presented, socio-political contexts (Deacon, 2013) and new conceptualisations of recovery (Slade et al., 2014). One shift to address this has been reflected in a current core value stated by the Royal College of Psychiatrists (Richards & Lloyd, 2017) which explicitly states the requirement for co-production as a way to promote person-centred care. Co-production has been evidenced to improve patient care and outcomes (Boyle et al., 2006) as the approach involves individuals who use the system to contribute to service design, development and delivery by virtue of their previous use of services. Service users are recognised as having a valuable perspective as their experience will make them best placed to advise on opportunities for improvement and change (NHS England, 2023b). In so doing, health providers can work with service users to maximise the potential for recovery and for individuals to live confidently in their community. This concept aligns with alternative and complimentary disciplines which have been established within healthcare, e.g., occupational therapy, as a means to understanding people, behaviours and how to work approach mental ill health (Farre & Rapley, 2017). The Model of Human Occupation (Kielhofner & Burke, 1980), a fundamental approach used in occupational therapy, states the importance of goals and motivation as a mechanism to change behaviours and how they interact with the world around them. This definition does not place the ill health at the centre of the intervention, but rather the want of the individual to interact with the environment around them.

Whilst different approaches to supporting individuals with mental ill health are simultaneously adopted in health settings, it is clear that there is a difference in the definition of recovery and living with mental ill health (Slade, 2010).

1.2 Recovery and mental health in UK

Modern recovery conceptualisation predominantly began in the 1980's with Anthony (1993) proposing personal recovery as being "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of

living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (1993, p. 527). This is in contrast to the clinical definition of recovery which Slade (2009) summarises as:

- Being observable and measurable, rather than subjective
- Based on clinician expert impressions, rather than patient experience
- Applying an invariant definition of recovery across all individuals, rather than recognising the broad and complex presentations of ill health
- The 1959 Mental Health Act (7 & 8 Eliz.II. c. 72) brought together the two ways of understanding recovery. It emphasised the requirement for organisations to provide holistic care (clinical and personal interventions) and encourage individuals to live in a way that aligns to their own definition of recovery.

Whilst these were the espoused principles the clinical definition, measurement and concept of recovery remain prevalent. Gillard et al., (2010) reviewed, synthesised, researched and presented a number of systemic barriers in mental health settings to supporting self-care – a concept strongly aligned to principles of personal recovery (Department of Health, 2002; NHS, 2019) – and identified:

- The application of personal recovery is strongly dependant on the clinical context. Senneseth et al., (2022) provided an example of a service user who is under the care of forensic mental health services and therefore under the custody of the Ministry of Justice (MoJ). In this case the restrictions may cause a disconnect between the individual's personal recovery, the clinical recovery and the MoJ's custodial conditions.
- To embed personal recovery ways of work, a fundamental change in clinician/ service user relationship is required. This includes involving the service user as a partner and collaborator in care plans and making a shift from "doing to" to "doing with" (Pietroni, 2003; Wilson et al., 2005).
- Current serious investigation and governance frameworks place ultimate responsibility of patient care and outcomes on designated responsible clinicians. Clinicians may 'do to' in order to mitigate against incidents, and manage and contain risks (Gillard et al., 2010).

- Gillard et al., (2010) also noted that service users and carers have come to expect the clinician as expert and healer and so a shift towards a more personal recovery centred care provision causes a mismatch in expectations.
- Organisational structures, processes, documentation and key performance indicators are crucial as they are the measures by which organisations are assessed and rewarded and use objective measures (Atherton, 2015; Nakanishi et al., 2021). Personal recovery is based on subjective experiences and pose a challenge to measure (between, within and longitudinally for individuals).
- The NHS struggles to consistently introduce changes, implement systems and policies due to its large size and failure to account for the psychological adjustments required for widespread adoption of changes. This leads to the perspective that newly introduced concepts are 'fads' and so not worth investing time and effort, and even lead to resentment (Gillard et al., 2010).

The research by Gillard et al., (2010) summaries that the success of personal recovery principles relies on frontline staff in the services they deliver, adding an additional responsibility and task onto already strained services.

It is therefore imperative to ensure that an additional offer be identified which can enable organisations to authentically promote and live the values of personal recovery. One such additional offer is coaching and, more specifically, health coaching. Coaching has evolved to offer a broad number of different approaches and focus areas since it emerged in the latter part of the 20th century (Grant et al., 2010; Passmore & Theeboom, 2016). To better understand the potential of coaching and the different application of coaching, it is important to understand the origin and existing evidence base of the approach.

1.3 Coaching

In the latter part of the 20th century, coaching emerged and was widely adopted in business and organizational contexts as a means of improving performance, satisfaction, effectiveness, and efficiency through supportive and enabling environments and communication styles (Passmore & Theeboom, 2016; Whitmore,

1992). Whitmore (1992) consolidated many disparate definitions of coaching to offer a new definition stating that coaching is about “unlocking a person’s potential to maximize their own performance by facilitating their learning rather than teaching them” (p. 8). Subsequent definitions have been proposed, including:

- “a powerful alliance designed to enhance the lifelong process of human learning, effectiveness, and fulfilment” (Whitmore, 2002)
- “a powerful strategy for unleashing the human spirit into action by setting ambitious goals and aspirations to create new possibilities” (Hargrove, 1995, p. 13).

A universally accepted definition of coaching has yet to be established, notwithstanding the existence of similarities and overlapping definitions. This absence presents a significant obstacle to the development of an evidence base for coaching and makes it challenging to determine appropriate measures for evaluation (Passmore & Tee, 2020).

As coaching has grown, the application of coaching has broadened leading to multiple different subtypes (Grant et al., 2010). For example, executive coaching (which is aimed at individuals at a middle manager level and above to support their development, growth and progress within the organisation (Stokes & Jolly, 2010)), life coaching (for individuals who are focussed on enhancing their wellbeing (Grant & Cavanagh, 2010)), and career coaching (for those considering their employment and career choices and progression (Hazen & Steckler, 2010).

All different types of coaching have the same philosophical underpinnings, emphasising the inherent worth of individuals and the importance of self-actualisation (humanistic) (Maslow, 1943; Rogers, 1959), the development of strengths and virtues in supportive environments (positive) (Maslow, 1943; Seligman & Csikszentmihalyi, 2000), individual responsibility (existentialism) (Kierkegaard, 1992), and the uniqueness of each individual’s experience (constructionist) (Kelly, 1955).

Despite the lack of a universally agreed definition, a literature review by Hayes and Kalmakis (2007) noted that many researchers’ definitions of coaching originate from

similar philosophical and psychological standpoints. They state that coaching is considered an “example of applied ‘positive’ psychology with a person-centered, humanistic philosophy for helping clients (2007, p. 556).

1.4 Impact of coaching

In the last decade there has been an increase in attempts to bring together the literature and evidence base of coaching. This has led to a number of meta-analyses (e.g.: Jones et al., 2016a; Sonesh et al., 2015a; Theeboom et al., 2014; Wang et al., 2022) which have indicated that coaching is successful at an individual level and an organisational level. Theeboom et al., (2014), for example, analysed 18 studies and concluded that there were significant positive effects for individuals reflected in their performance and skills coping . Sonesh et al.’s, (2015a) meta-analysis of 24 studies determined that, at an organisational level, coaching had a significant positive impact on goal attainment and work-related attitude change.

However, given the different subtypes, definitions and areas of focus for coaching there is significant variation in coaching provision and how it is measured (Jones et al., 2018; Lai & McDowall, 2016) causing fractures in establishing a solid evidence base (Wang et al., 2022) and consequently a “lack of rigour” (2022, p. 83) in the profession. The evidence base is also challenged by the publication of research and work which do not state the coaching design, paradigm or intervention (Jones et al., 2016a) compromising the replicability of studies. This directly impacts the ability to determine return on investment for individuals and organisations (Passmore & Fillery-Travis, 2011).

More recently, the question around coaching and its impact has turned to understanding how and why it works (Bono et al., 2009; Smither, 2011; Theeboom et al., 2014). This is crucial to understand as it can be used to optimise coaching outcomes (Lai & McDowall, 2016). Research in this area has benefited from drawing on the depth and breadth of literature from counselling, psychotherapy and broader psychologically informed interventions. It has been well established through multiple sources that the coaching relationship, between coach and coachee, are integral to the positive outcomes of coaching (Baron & Morin, 2010; Boyce et al., 2010; de

Haan, 2008; de Haan et al., 2013; Palmer & McDowall, 2010). They expand further and identify that the relationship benefits from a psychologically safe environment. Passmore & Fillery-Travis (2011) have evidenced that the positive outcomes of coaching is, in part, attributable to the reflective process the coachee engages in. This allows the coachee to become more self-aware and tap into areas of intrinsic motivations, therefore enabling them to consciously and intentionally identify and set goals on areas important to them (Williams et al., 2002). Whilst these components of a coaching relationship can be established through a skilled and competent coach, it is important to note that research has shown that the outcomes of coaching is culture and context dependant (Daouk-Öyry & Rosinski, 2010; Rojon & McDowall, 2010). Wang et al., (2022) brought together the evidence base of effectiveness of workplace coaching through a meta-analysis. They identified that coaching was most effective when it was informed by principles from psychotherapy and positive psychology, when it was conducted with a model or construct in mind, and when multiple frameworks were utilised to ensure a broad offer of resonant styles.

The meta-analyses, however, are not without limitations. Jones et al., (2016b) note that some of the original data source coding was estimated due to the absence of detail in the papers they reviewed which meant that the review of moderators for coaching could not fully take place. This was also true for Sonesh et al., (2015a) where the implication of data quality and absence of reporting resulted in the inability to determine relational components between intervention and outcome. Theeboom et al., (2014) also notes the limitation that all included research relied on self-reported measures which may cause inconsistency and overestimation of the impact of coaching. All the meta-analyses reflected the implication of the low number of papers that were included in the review owing to poor research quality adopted by researchers. This impacts the interpretation and generalisability of the outcomes. An additional limitation of all the meta-analyses incorporated was the inability to determine the long-term impact of coaching and its efficacy.

In summary, these meta-analyses present the gaps in extant literature relating to the fracture in research evidence due to the absence of clear and routinely used definition of coaching, the ambiguity, and sometimes lacking detail, around the coaching interventions themselves and the research designs not incorporating long-

term impact of the intervention. The meta-analyses also presented the positive impacts of coaching on a variety of different areas, including, but not limited to, self-efficacy, coping skills and goal attainment. These are crucial to attend to as the learning and benefits of coaching can be extrapolated and applied into a health context setting, making a meaningful difference to those as part of their health journey.

1.5 Health coaching

One type of coaching, health coaching, applies the philosophical principles and the components of a successful coaching relationship within a healthcare context. Health coaching assimilates a number of evidence-based psychological theories to support effective and long-lasting behaviour change (Frates et al., 2011), including self-determination theory (Ryan & Deci, 2000), social cognitive theory (Bandura, 1986), goal-setting theory (Locke & Latham, 2002), positive psychology (Seligman et al., 2005), transtheoretical model of change (Prochaska et al., 1994) and appreciative inquiry (Watkins & Cooperrider, 2000). Health coaching enables patients to collaborate in their care journey and work towards meaningful self-identified goals. This dovetails with the expectations of the World Health Organisation (2003) who determined it insufficient for healthcare providers to merely provide information to patients but to "understand the psychological principles that underlie self-management" (p.57). Multiple seminal literature reviews on health coaching (Ammentorp et al., 2013a; Kivelä et al., 2014; Wolever et al., 2013) have concluded that there are many promising benefits and impact of health coaching on service users. For example, Kivelä (2014) identified a significant improvement in physiological, psychological, behaviour and social outcomes in patients. More specifically, these literature reviews have evidenced how health coaching has been successful in supporting weight loss, diabetes control and medication adherence. Health coaching typically involves two parties: the coach (i.e., the person asking the questions) and the service user. To better understand the mechanics of who and how to deliver coaching, Wolever et al., (2013) conducted a systematic literature review on health and wellness coaching. Through this work it was shown that there is no agreement on who is best placed to offer coaching (i.e., coaches came from a wide range of professional backgrounds), there is no coaching 'dose' (i.e., number of

optimal sessions) and there is variation in what the coaching intervention consists of (i.e., psycho education, motivational interviewing, etc.). This same literature review concluded that future health coaching interventions should be patient-centred (where the patient is facilitated rather than dictated to make a change on the goals that matter to them) with coaches being appropriately trained in behaviour change principles and "to simultaneously hold the patient's agenda, convey that the patient is resourceful and a lifelong learner, and guide them toward sound health decisions without advising, all the while respecting patients as the best experts on what may work in their individual lives" (Wolever et al., 2013, p. 53).

Despite these literature reviews, a shortcoming with extant literature within the field is that little research has considered the mental health impact of health coaching. Considering the positive impact that health coaching has on physical, psychological and behavioural outcomes, it is important to progress literature and evidence as to the impact health coaching may have on mental health. Where research has considered the mental health impact of health coaching, (e.g.: Suen et al., 2021; Williams et al., 2019; Kivela et al., 2014) this has been predominantly as a secondary outcome, with the primary outcomes relating to physical health measures. In the few instances where mental health has been considered as the primary outcome, data captured has either been qualitative in nature (e.g.: Cyrus, 2021) - and thus does not provide researchers with theories of change or logical models to apply to future research - or has used pre and post quantitative measures (e.g.: Wu et al., 2021) which precludes assessments of the long-term impacts of the intervention.

Regardless of the health focus, literature has not yet considered the organisational considerations required in order to establish and provide a context specific health coaching service. The implication of this is that where coaching services are being offered they are being done so as a 'bolt on' to existing services (Bosmans et al., 2007; Brook et al., 2005; Slade, Bird, Clarke, et al., 2015), without considering the wider organisational context, the commissioning structure and the requirements needed to establish a high quality replicable service. It is therefore imperative that attention is turned to the organisational considerations required when establishing a high-quality health coaching service.

1.6 Coaching in a south London mental health Trust

This research benefitted from being conducted in a south London mental health Trust where there is a well-established internal coaching and consultancy service. In this Trust the service provides interventions to the organisation staff around coaching, consultancy, conflict resolution, recruitment centres and evaluation. Specifically, in relation to coaching the teamwork with staff and offer executive, developmental, individual, team and leadership. The service has been established since 1999 when there was a need for the skillset to support the merging of two large mental health organisations and is one of the first NHS institutions to offer in-house coaching and consultancy. It established and maintained a reputation for enabling individuals to bring meaningful, impactful and sustained changes and improvements. The team is comprised of six individuals, all with longstanding NHS tenure which brings the intricacy and nuanced knowledge of working in a complex institution like the NHS. The coaching service (not consultancy) is complemented by associated coaches who have all received in-house Practitioner level coach training which has been accredited with the European Mentoring and Coaching Council.

More broadly, the Trust employs over 6000 member of staff and serves a population of 1.3 million individuals. On average, 5,000 individuals are cared for in inpatient settings, and more than 40,000 in the community each year. The Trust has local as well as national services (i.e., they are commissioned by other parts of the country to provide mental health interventions). The organisation takes pride in providing the highest quality of care, not only through the day-to-day support offered, but also through maintained involvement in cutting edge research, training and continuous improvement. This allows the organisation to offer unique interventions (or combinations of) which may not be taking place elsewhere.

Within this organisational culture and context, the research conducted as part of this thesis complements the way in which the Trust approaches the care they provide to their service users. Health coaching as part of the organisational offer would be new and in conjunction to treatment-as-usual and on their terms (i.e., it cannot be a ‘prescribed’ form of treatment), however the important role which this thesis presents

is the importance of following a framework and logic step-by-step process to identify, introduce and sustain such a new offer.

1.7 Introducing change in the NHS

The NHS has been a dynamic institution since its inception in 1948. It has required constant evolution to ensure that the service provided meets the needs of the community it is serving. It has often been cited that around 70% of change initiatives fail (Miller, 2001). Over the last 74 years there has been much to learn from, consider and do differently to identify, introduce, implement and sustain change. Many reasons have been identified (Institute for Innovation and Improvement, 2017; Carmichael, 2023) which act as barriers to successful implementation, including:

- Not considering the human side of change
- Not being realistic in terms of timeframe for change delivery
- Not having clarity on aim/ goal of change (or seeing the programme through) – often a symptom of poor leadership
- Not having due consideration al all components to realise change (including the involvement of stakeholders and the complexity of the NHS system (Katikireddi et al., 2014)

There are higher stakes than ever to make sure the changes are done right the first time around (Sustainable Improvement Team & Horizons Team, 2017). The risks of change not working is the additional burden and instability it created for those at the heart of the change, the financial implication and morale.

Daniels et al., (2021), through a review of seventy-four studies, identified three components related to successful change implementation:

1. Embedding change into everyday practice
2. Continuous learning and development about the intervention
3. Effective governance (with engagement and involvement from stakeholders)

There are recent examples of novel interventions which have been successfully implemented and sustained in the NHS, for example, Increasing Access to

Psychological Therapies (IAPT). The lessons learnt from IAPT (Hutten et al., 2010) identify the importance of:

- Maintaining momentum
- Having clarity of service design and model
- Having consideration of the implementation process (including timescale, vision, communication, the wider system awareness of service and where the new service sits within the existing system)
- Working with partner services and stakeholders
- Maintaining a safe service through supervision and continued professional development
- Service delivery through demand and capacity and continued service review

More specifically, Turpin et al., (2009) reviewed the factors which made the greatest impact at workforce level and determined that service need should be guided by service user need, the service should be delivering against measures aligned to high quality and that all workforce are equipped to deliver safe, best and evidence-based practice.

The incorporation of this learning from IAPT can support other programmes of change to be successful as it highlights the multifactorial considerations required prior to embarking on a change programme. It is also crucial that a change model which is rooted in complex system theory is adopted (Fitzgerald & Biddle, 2020). The models will provide a stepwise, comprehensive and considered approach to making changes and improvements. The NHS and related bodies have provided different frameworks in this regard, for example Change Model (Sustainable Improvement Team & Horizons Team, 2017) or the Developing and Evaluating Complex Interventions framework (Skivington et al., 2021).

Alongside these change and implementation models, it is crucial to consider what is known to establish effective and ethical coaching into an organisation. Contracting is a fundamental component of coaching within an organisation as it provides context and expectations of the respective individuals within a coaching space (Schein, 1980). The contract within an organisation should incorporate the different stakeholders who would be impacted by the change. It is therefore important to

explore what this may involve when introducing a health coaching service, particularly as it will incorporate multi-party contracting processes. It is also necessary to recognise the importance of the role of supervision in coaching. Supervision is explicitly noted with the Code of Ethics of the different coaching governing bodies e.g., International Coaching Federation (International Coaching Federation, 2020). (Hawkins, 2014) (Hawkins, 2014)defines supervision as "the process by which a coach with the help of a supervisor, can attend to understand both the client system and themselves as part of the client-coach system and by doing so transform their work and develop their craft" (p.393). This then aids the coach by supporting their thinking and practice in relation to the wider context in which they are working. Supervision can take place through three different perspectives (Bachkirova et al., 2011). Firstly, through a systemically, where a coach reviews their work through the lens of the entire system in which they are working. Secondly, relationally where the coach reflects on themselves and their practice in relation to others and, lastly, developmentally where the coach is being safely challenged to consider their work in ways they may not have thought of before. Within the NHS there is an expectation that all staff (regardless of role or position) engage in monthly supervision with the most appropriate person/ people relevant to their role. Incorporating supervision as part of a health coaching service would not be novel but this area would benefit from additional exploration to unpick the nuances of this function in reality.

1.8 Aims of this work

Equipped with the knowledge of previous attempts to introduce change in the NHS and core components of coaching required in an organisation, alongside the necessity to provide an alternative service provision in a struggling NHS context the overall intention of this thesis was to answer the Research Question:
'Can health coaching be delivered in a mental health service setting, and if so how and to what benefit?'

Specifically, to determine:

1. The use of health coaching in mental health settings to date through a systematic literature review

2. Feasibility of delivery of health coaching in a mental health setting
3. The potential benefit of health coaching in a mental health setting
4. The organisational considerations required to establish a health coaching service in a mental health setting

These aims are considered within the context of the current socio-political context of the national health service and the increase in mental health service demand. There is a need to consciously and intentionally make a shift from the current service model as there is an abundance of data and experience indicating that the system is being left to fail (NHS Confederation, 2022).

To address this, the thesis incorporates two studies:
First, the SLR aimed to answer the research question: '**What is the evidence for health coaching in mental health service delivery?'**. This intended to determine the evidence for health coaching in the context of mental health outcomes and/or settings. More specifically, what is known about:

- the extent of the use of health coaching interventions?
- the impact of health coaching on mental health outcomes?

The evidence available was limited with regards to the number of studies which determined the impact of coaching on mental health outcomes. This was caused by the different coaching definitions adopted, the heterogeneity of measures used to measure same mental health diagnoses and the limited breadth of different diagnoses measured. As a result, there were a number of potential avenues for future research. For example, focussing on progressing work around a universally agreed definition of health coaching or the barriers to sustaining the delivery of an intervention. These avenues were abandoned as work by Wolever et al., (2013) has already proposed by a definition which has been promoted by Gray (2019) to enable an effective economic evaluation of health coaching. Once this definition has been adopted there can be more consistency in what and how to measure the effectiveness of health coaching. With regards to exploring the barriers to sustaining a health coaching intervention, it was firstly necessary to understand more about the considerations required to establish a health coaching service from the coach's perspective. This then would enable better understanding of what is required to

establish an appropriate infrastructure to support the delivery of a health coaching intervention.

Second, utilising the Skivington et al., (2021) model to guide the stepwise approach to developing and evaluating complex interventions the empirical study sought to answer the question '**How feasible is it to deliver a health coaching service in a mental health service setting in the South London & Maudsley NHS Foundation Trust**. This study aimed to understand the perspectives of stakeholders with regards to the feasibility of establishing a health coaching service for mental health service users. This qualitative study aimed to answer the sub-questions:

- What are the specific considerations to ensure a high-quality service which is safe, timely, efficient, effective, equitable, and timely?
- What are the skills, knowledge and competencies required by coaches to provide a high-quality service?

In so doing, this thesis aimed to set out recommendations for next steps in designing and delivering a health coaching service.

1.9 Reflexive statement

My own personal interest in this area began when I transitioned from patient facing services into occupational psychology. Having joined the NHS in 2010 I became aware of patients routinely requesting their clinician to resolve issues relating to housing, interpersonal disputes/ difficulties, etc. Whilst mental health services are obliged to provide support in these areas (as they are part of the holistic wellbeing package offered), it is not always the clinician's responsibility nor are they the most appropriate person to resolve the issue. Exacerbated by the ever-growing strains on mental health services, and the acknowledgement that service users are not always having their needs met I have been fascinated by the opportunities to empower and champion the patient as the resolver of their own issues. This would promote service users identifying and progressing meaningful goals in a way that works for them and reduce the emotional and resource burden on clinicians.

1.10 Thesis structure

This thesis contains five chapters. As part of this first, introductory chapter the context of the thesis has been presented. It sets the context of the historical and current mental health position in the UK. It explores the organisational complexities and barriers to introducing and sustaining meaningful change and consolidates the learning and opportunities that coaching has to offer which can be extrapolated to a healthcare setting.

Chapter two outlines the epistemological stance behind the research design and methodology adopted which informs chapter three and four.

Chapter three presents a systematic literature review (SLR) of coaching in a mental healthcare context. The SLR reviews the extant literature in relation to health coaching in mental health service delivery. From this it became clear that very little exists around such a provision in mental health settings but that there has been significant use, and benefit, within physical health settings from which mental health can extrapolate and learn. Other limitations identified is the absence/ ill-defined concept of coaching which has led to inconsistent research. There is also very little knowledge and information about the process, need and challenges of providing health coaching. This, therefore, provided an opportunity to consider the feasibility of such a service from the deliverer's perspective. This opportunity was explored in chapter four.

Chapter four presents a qualitative study on the feasibility of introducing a health coaching service for mental health service users and the organisational considerations required for such a service: the process, need and challenges of establishing a service which would be offered alongside their treatment as usual.

The final chapter, chapter five, provides an overview of the findings from each study as well as the associated limitations, and concludes with the implications and contributions to the knowledge base within Occupational Psychology.

Chapter 2 – Methodology

This thesis sets out to determine the feasibility of a coaching service for mental health service users. Initially, a systematic literature review (chapter 3) was conducted to determine the use and related outcomes of coaching in a healthcare context. Literature relating to this area has increased with findings indicating a positive impact on health status and outcomes, including improved medication adherence, reduction in weight, better controlled diabetes type 2 status, etc. (Boehmer et al., 2016, 2023; Kivelä et al., 2014; Wolever, Moore, et al., 2016). However, the review revealed that no empirical research had yet considered the organisational requirements to establish a health coaching service, particularly within a mental health Trust. As a result, once research into the impact of health coaching concludes, it is often the case that the intervention ceases to be provided as it has not been introduced within the wider context and needs of a health organisation (Boehmer et al., 2023; Kivelä et al., 2014). To better understand perspectives of these requirements, the empirical study (chapter 4) adopted a qualitative approach. This was designed to enable exploration into the organisational considerations needed to ensure high quality service provision.

2.1. Philosophical underpinnings

This thesis is underpinned by a social constructionism epistemology using a transformative lens. Both adopt the principle that there are multiple realities which are socially constructed (Willig, 2013; Willig & Rogers, 2017), with the transformative paradigm emphasising the importance of the role that social, political, economic and other factors can play in defining the version of reality one experiences (Mertens, 2007; Watkins & Cooperrider, 2000). Social constructionism is a relatively new term within psychology and has been increasingly used in the field (Burr, 2003) but the approach, concepts and beliefs have been practiced in other disciplines for many years (e.g., linguistics) (Burr, 2015). Social constructionism challenges the historically more widely adopted epistemological approach within psychology – positivism (Tolman, 2012)- which is characterised by the search for an objective and measurable reality (Park et al., 2020). Social constructionism argues that reality and experience is created as a result of interactions and social conditions and thus an absolute truth cannot exist regarding human and social phenomena (Gergen, 1973).

Social constructionism complements qualitative approaches (Flick, 2014) as it allows for the incorporation of multiple different perspectives within the same field of research. As such this provides a basis for this research as it invites the views from all participants and holds them equally as important as one another. Epistemological underpinnings of social constructionism is that reality is co-constructed by participants in the space which they share together (Burr, 2003, 2015). Therefore, any methodological analysis, and its respective presentation, aims to identify patterns which provide an (not 'the') interpretation of the phenomenon being researched. This is also the basis of the transformative lens which goes further and, as a central tenet, states that power and hierarchical systems, of which we are a part, undoubtedly informs and shapes the constructed reality of an individual, and part of the role of the research is to reduce social injustices that exist (Mertens, 2007). As such it is necessary to acknowledge that there are multiple ways to understand a phenomenon because we understand it relative to other groups and structures around us (Mertens, 2008). The transformative lens is important for this study as the research is taking place within a complex national organisation which is at the behest of multiple political, societal and individual influences. The establishment of a health coaching service has the potential to improve patient care and outcomes through the focus on personal recovery (Slade, 2009) and thus reduce injustice and stigma of mental ill health in society. This stigma has been an outstanding negative legacy of mental health exists internationally, and for the UK is based on historic treatments and interventions which were provided for those experiencing ill health (Henderson et al., 2014; Wu et al., 2017). More recently, the establishment of the NHS has perpetuated the inequality in service provision as funds and resources have not been equally provided between mental and physical health services (Docherty & Thornicroft, 2015; Wenzl et al., 2015). Whilst these issues have progressed for the positive further change is required to bring the services to equal standing.

2.2 Study 1 – Systematic Literature Review

A Systematic Literature Review (SLR) was conducted to consolidate and learn from existing evidence relating to coaching in a healthcare setting. This generated insights

and gaps in current literature which informed the empirical study. SLRs are a widely acknowledged and utilised methodology to systematically and replicably approach aggregating, analysing, and synthesizing data and evidence (Aromataris & Pearson, 2014; Denyer & Tranfield, 2009; Rojon et al., 2021; Tranfield et al., 2003). Originating from the medical field (Davis et al., 2014; Denyer & Tranfield, 2009) SLRs were a response to the growing abundance of research (Centre for Reviews and Dissemination, 2008) to facilitate evidence-based decisions. Hammersley (2001), however, challenges the transferability of a medical approach into social sciences and argue that there are competing fundamental philosophical differences between the two sciences, i.e., positivist and interpretivism/ social constructionism, which may limit the utility of SLRs. Additionally, the process of SLRs can be seen as labour intensive, process driven and time consuming (Bimrose et al., 2005; Nolan & Garavan, 2016) and can therefore discourage researchers in conducting them. Researchers also face practical challenges when conducting SLRs, as some may exclude grey literature sources due to limitations in resources and time, regardless of the diversity, breadth and depth they can provide (Adams et al., 2017). Consequently, this may result in the absence of potentially pertinent real-world experiences and data, which, in turn, hinders the attainment of a comprehensive understanding of the field's knowledge landscape (Burke, 2011; Rojon et al., 2021). Furthermore, this omission in research practices may lead to a failure to build upon an ever-expanding body of literature (Snyder, 2019), ultimately contributing to fragmentation within the research field and a failure to correctly or fully identify research gaps. Whilst SLRs are deemed to be an impartial and scientific process, they have been scrutinised for contributing to researcher waste where too much emphasis is being placed on the production of SLRs (Chalmers & Glasziou, 2016; Ioannidis, 2016; Siontis & Ioannidis, 2018). There have also been challenges relating to the quality of reporting and methodological approaches in primary research as well as SLRs (Page et al., 2018). Researcher bias is also a source of challenge to SLRs and the reality of this being truly eliminated. Primary researcher bias can infiltrate SLRs through the decisions researchers make about their work, for example, hypothesis, intervention, data collection, analysis, interpretation, and recommendations for future research (Kirkham et al., 2010; Uttley & Montgomery, 2017). My own stance is informed by my social constructionist approach. I undoubtedly assessed the quality and findings of literature through my own lens of

experience and understanding of coaching in a healthcare context. As a reflexive practitioner the importance of a second reviewer and maintaining standards relating to SLRs allowed to balance the bias with which I was reviewing, synthesising and learning from research. An additional strategy was to use of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement which enables those conducting SLRs to appraise literature with methodological rigour and determine quality of papers (Moher et al., 2009).

Nevertheless, the inherent rigour of SLRs is rooted in the predefined procedures and parameters relating to process (Denyer & Tranfield, 2009) and a clear justification of the lens through which the analysis and meaning making will take place (Adams et al., 2017; Briner & Rousseau, 2011). SLRs provide a transparent and methodical process to present the current landscape of a research area and where gaps remain. Using this information researchers are then informed about future research and next steps, ensuring a clear and coherent progression of knowledge (Adams et al., 2017; Paul & Criado, 2020; Rojon et al., 2011; Tranfield et al., 2003). SLRs should therefore serve as an initial step preceding empirical data collection (Rojon et al., 2021) and plays an important role to propel advancements in a particular research field (Hulland & Houston, 2020; Kumar et al., 2020; Palmatier et al., 2018). One main strength of SLRs, in comparison to more traditional approaches such as literature or narrative review, is its critical approach to synthesising learning and findings from literature (Aromataris & Pearson, 2014; Pae, 2015). Denyer & Tranfield (2009) acknowledge the limitations of SLRs but that the methodology should not be discounted as a crucial approach to progressing learning and that the quality of an SLR is retained so long as it is tailored to meet the context of the research field.

In summary, SLRs are a reliable and rigorous approach to collating, synthesizing and learning from literature related to a research area. SLRs provide an up-to-date insight into evidence and future research opportunities. Outputs of an SLR can be utilised beyond academia, informing decisions of policy makers, practitioners and wider stakeholders. By distilling complex and diverse information into concise summaries, SLRs can provide insights that influence policy formulation,

organisational strategies, interventions and practices. It is for these reasons that an SLR formed part of this thesis.

2.3 Study 2 – Empirical research

In this section I will describe the key considerations of the empirical research including the underpinning ethical principles adopted as part of the study which were used throughout to ensure the sampling and analysis were in line with expected standards. The Journal Article Reporting Standard for Qualitative Research (JARS-Qual) produced by Levitt et al., (2018) was used to ensure the incorporation of integral information when writing up the empirical research.

2.3.1 Ethics

The British Psychological Society (2021) and Health and Care Professions Council (2016) ethical standards were used to ensure safe and ethical practice during the course of the empirical research. Reviewing the standards there are three overarching areas needed to take into considerations and mitigations developed.

1. Respect
    a. Consent and issues of power: Obtaining informed consent is fundamental to any research. Robson (2002) notes the possible power imbalance between researcher and participant which may pressurise individuals to take part in research with Emanuel (2000) noting the importance of informed consent in providing participants with the opportunity to decide for themselves whether to take part in research which aligns with their values and interests. Ultimately, informed consent is a crucial component of ethical practice rooted in respect for individuals and their autonomy in decision making (Hendriks et al., 2019; United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral, 1978). Specifically for this research, researcher power was an important factor to consider. The Principal Researcher is a longstanding team member of the internal coaching and consultancy service from which potential participants were identified and invited to take part. As such, it was necessary to ensure that participants did not feel compelled to take part and, if they

did, to respond in a manner that the researcher would deem desirable. To mitigate this full disclosure as to the research aims, objectives and process was provided to the sample group. To ensure participants were not aware of researcher opinions, no discussion about the project took place between individuals until the completion of the project.

b. Privacy and confidentiality: As part of informed consent, the assurance and process to protect participant privacy and confidentiality were provided. Participants were informed that their demographics would be pooled and only ever presented as a full sample to ensure that identity couldn't be inferred by the unique combination of their demographics. This was especially important due to the small sample size in line with data analysis processes and the length of job tenure that many of the participants had within the organisation. Participants were also assured that any quotes used throughout the thesis would be done so with a pseudonym. This was also assured through the way in which their data would be stored, analysed and used during and after the research had concluded. It was also important to reassure the participants that the content of the interviews would not be discussed with their participants (who were essentially their colleagues). This was important so that it did not breach the confidentiality of the interview but also so as to not influence the opinions of others.

2. Competence and Responsibility
    a. Appropriate skills and an awareness of researcher competency and responsibility: A reflexive approach to researcher skill and competence was crucial to the completion of this thesis. It required the researcher to be aware of when and where to signpost participants to appropriate professional services when there were outstanding queries that were outside the limits of researcher competency. This was explored prior to ethical approval being granted and was continuously reflected on as part of supervision.

3. Integrity

a. Boundaries: Important to this research was the preservation of boundaries due to the existing relationship between researcher and participants. The assurance of their involvement in the research being optional was reinforced throughout the project, with clear opportunities provided to withdraw data up until the analysis stage. Participants were also provided with details to speak directly with the researcher's supervisor should they prefer. Additionally, where any questions relating to the detail of the research (e.g., where participants sought the opinion of the research with regards to the research question) these were not discussed. This helped to ensure that no desirability biases were introduced into their responses.

b. Honesty, openness and candour: Providing participants and the sponsoring organisation with a summary of the output of this research was important to provide transparency and reflect the value in their involvement. For this research, it is intended that a summary will be presented to the Service Director and their respective leaders to showcase the outcomes of the work. This is hoped to generate support to progress a pilot of establishing one circumstance in which health coaching can be offered to an individual. The research participants will be kept informed of progress through the quarterly Continued Professional Development and monthly supervision sessions in which they take part.

2.3.2 Approach

The use of qualitative approaches have been adopted within the field of social sciences throughout the 20th century (Johnson et al., 2020; Kvale & Brinkmann, 2009; Rahman, 2016). The epistemological approach to this project lends itself to a qualitative approach in order to better understand the participants' socially constructed realities and incorporate a breadth and depth of perspectives (Kroeze, 2012). This is, in part, due to the flexible nature of the approach which can be adjusted through exploration as the project is delivered (Maxwell, 2013) allowing for complex topics to be more thoroughly explored. Qualitative research is defined as

“any type of research that produces findings not arrived at by statistical procedures or other means of quantification” (Strauss & Corbin, 1990, p. 11). Semi structured interviews are frequently utilised within qualitative research with interview schedules being informed by objective knowledge, as a means to explore and understand a particular topic, especially where subjective knowledge is lacking (McIntosh & Morse, 2015; Merton & Kendall, 1946; Morse & Field, 1995).

The interview schedule (Appendix 1) was informed by STEEEP (Institute of Medicine, 2001), which presents a framework consisting of six aims to determine high-quality healthcare services. STEEEP relates to safe, timely, equitable, efficient, effective and person-centred. The framework originated following a detailed review of literature synthesising the necessary components of quality healthcare services. This objective knowledge informed the questions explored with the participants to determine their perspectives as to the necessary organisational considerations to establish a high-quality service in a mental health setting.

However, as with any research method challenges to qualitative research revolve strongly around the bias’s which emerge from the project. As Leech (2002) states “what you want to know determines which questions you will ask, what you already know will determine how you ask them” (p. 665). In order to mitigate for this, attention was paid to what and how the questions were asked by the researcher. Questions were open and non-judgemental, phrased in such a way to eliminate researcher influence (e.g., “what would be needed to provide a safe service?”). The interview schedule also benefitted from the adoption of STEEEP as it provided a neutral framework to establish an interview schedule.

The semi-structured interviews were conducted online using Microsoft Teams, the use of which have generally increased in the 21st century as technological advances have progressed (Jowett et al., 2011). Many advantages have been identified associated with online interviews; reduced burden on travelling and finding appropriate location (James & Busher, 2009), reduced burden and resource on transcription (Voida et al., 2004), and reduced bias that may occur when transcribing (Ayling & Mewse, 2009). Online interviewing has historically posed challenges, e.g., internet connectivity and appropriate hardware (Jowett et al., 2011) but these are

less often an issue nowadays considering the post-pandemic hybrid working style as well as general attitudes and necessity of using technology in everyday life. In preparation of the interviews taking place the interview schedule was checked with course supervisors and peers. It was not possible to pilot the schedule due to the small existing participant sample group. However, the benefit of adopting of a semi structured interview approach is that the "agenda is never carved in stone" (Adams, 2015, p. 498) and thus benefitted from evolution and amendments following different interviews. Using semi-structured interviews allows for the interviewer to steer and contain the conversation that will answer the research question, whilst allowing space, reflection and exploration around the topic for the interviewee (Willig, 2013).

2.3.3 Organisational and participant context

The organisation is based in south London in which there is an established coaching and consultancy service. The coaching component of the service provides executive, team, leadership and individual coaching to the c.6000 staff employed by the organisation. The coaching service is comprised of five organisational consultants, a Head of Service and a Director. The researcher holds the Head of Service role. All these individuals provide coaching. The service is also complemented with Associate Coaches who support the provision of coaching to the organisation. All coaches (substantive and Associate) are accredited with the EMCC (or equivalent) coaching body. This ensures that, when asked about coaching as part of this research, all participants are working from the same understanding, values and expectation of what the offer stems from (i.e., there is no confusion between coaching and another approach such as mentoring).

Despite the service being in place for 25 years, health coaching specifically, and particularly for those with mental ill health, has never been explored. This therefore would be a novel, potential, addition to the offer of the service but would be an adjunct to the care/ treatment that is provided to the service user.

2.3.4 Participants and recruitment

Participants were recruited through an existing relationship with the researcher. The researcher is part of an internal coaching and consultancy service within a large

south London mental health Trust. The participants were all current team members or associate coaches for the service in which the researcher worked and accredited at Coach Practitioner level with the European Mentoring and Coaching Council. It was important to recruit participants with the same fundamental coaching training and skills to ensure that the coaches all work from the same understanding, core values, approach and ethical principles which inform and align the proposed health coaching intervention (Bachkirova, 2023).

Considering the interview schedule was informed by STEEEP categories, template analysis (King, 2012), a subtype of thematic analysis, was adopted to analyse the data. Sample size in thematic analysis is challenging to precisely determine, causing many repercussions, for example, when applying for ethical approval (Fugard & Potts, 2015; Guest et al., 2006). A review on literature adopting qualitative methodology was conducted by Fugurd & Potts (2015) who reported a vast range of sample sizes, ranging from 2-400. Research has made attempts to empirically quantify sample sizes in qualitative research, for example Guest et al., (2006) who determined that no new themes were identified following the analysis of twelve transcripts, whereas Wright et al., (2011) determined a significantly larger number was required (sixty-three). Leaders in the field of thematic analysis (i.e., (Braun & Clarke, 2021b; King & Brooks, 2016) have both discussed the challenge in setting a standard number of an adequate sample size. Rather, they emphasise the importance of reflexivity to determine when a sample size is 'enough'. Sample size is not the only consideration at play when conducting thematic analysis. More importantly is the dataset and its respective depth, breadth, complexity etc. within the context of the research question which will inform the necessity to continue or discontinue data collection. This therefore requires researchers to make a decision in-situ as to when to end collecting data.

As part of this research eleven coach practitioner participants were sufficient to provide the breadth and depth required for the analysis and sense making. This number also aligned with the pragmatic issues such as potential sample, time and resource limitations. The sample size was finalised following continuous discussion with the researcher's supervisor to ensure no additional novel information was identified in line with recommendations from leading scholars in the field of

qualitative research (Braun & Clarke, 2006, 2021; King, 2012). This discourse allowed for check and challenge in coding and any biases that may have unwittingly been introduced into the analysis. The supervisor received a sample of the transcripts, one from the first 5 participants, one from the second 5 and the final transcript. They reviewed the transcripts and confirmed that no further novel information was identified. Additionally, this research focussed on discovery and wider considerations required for a new intervention being introduced into the NHS, rather than the information being used to determine causality or broader conclusions.

For all participants, interviews lasted no more than sixty-minute, though participants were invited to make contact with the researcher should any subsequent comments, reflections or considerations arise. The interviews were recorded on Microsoft Teams which also automatically transcribed the conversation. Following each interview, the researcher reviewed the transcripts to ensure accuracy and improve familiarity with the data set in anticipation of analysis. In total, the eleven interviews generated 184 pages of dialogue which to analyse.

Consideration was given as to the scope of stakeholders invited to take part in the interviews. Freeman (1984) noted that there is a challenge in determining who should be identified as a 'stakeholder'. This is emphasised in the works of Craig and Campbell (2015) where they discussed that who should be involved as a stakeholder is dependent on the nature, stage and maturity of the intervention. Freeman (1984) therefore provides a broad definition of concept through his Stakeholder Theory identifying a stakeholder as anyone who is impacted by the decision or, in this case, intervention. There have, however, been challenges to this definition in that different people would class different individuals as a stakeholder (Akin, 2022) thus if the work was repeated it could cause variation in who is included in the work. Additionally, Orts and Strudler (2002) argue that using a broad definition of stakeholder lacks structure and therefore incorporates too many perspectives and insights leading to information which is too complex to be meaningful. In contrast they argue that a narrow definition may be more suitable and consequential. They encourage the application of certain criteria to identify appropriate stakeholders e.g., what insights the group of stakeholders can offer to demonstrate the direct impact of the intervention on them. Whilst acknowledging the importance of incorporating

multi-stakeholder views when considering introducing an organisational change (Freeman, 2010), this research only invited those who were qualified coach practitioners. This narrow stakeholder group approach is justified by the fact that these individuals would be the ones providing the intervention. The coach practitioner group would provide in-depth understanding of the organisational considerations required to enable them to deliver a health coaching intervention. If, from their perspective, the intervention was not feasible then it would not be a worthwhile avenue to pursue. In the context of resource constraints, wider stakeholder participation would not be appropriate until an initial proof of concept had been made Their insights would also provide additional information about future stakeholder groups and refining the interview schedule based on their responses.

2.3.5 Analysis

Template analysis is distinct from other subtypes of thematic analysis, namely, reflexive thematic analysis (Braun & Clarke, 2006, 2021b) and coding reliability (Boyatzis, 1998) and is seen as sitting between these two alternative approaches. Template analysis is more structured (Braun & Clarke, 2021b) and centres around the development and use of a codebook. This codebook uses a priori codes which is informed by research, literature, theory, quantitative data and practitioner/ researcher experience (Roberts et al., 2019), in this instance STEEEP. As a result, it is seen to be an approach used in applied research and is particular helpful for those coming from practice (Braun & Clarke, 2021b; King, 2012). However, this has potential to pose a challenge to researchers, causing them to end analysis too soon having had the codes confirmed (Braun & Clarke, 2021b; King, 1998, 2012). This may cause the omission of the full richness that the data has to offer and exclude the identification of novel codes. A process (Figure 1) to develop a codebook was presented by Roberts et al., (2019) which enables a transparent and consistent approach for researchers to follow.

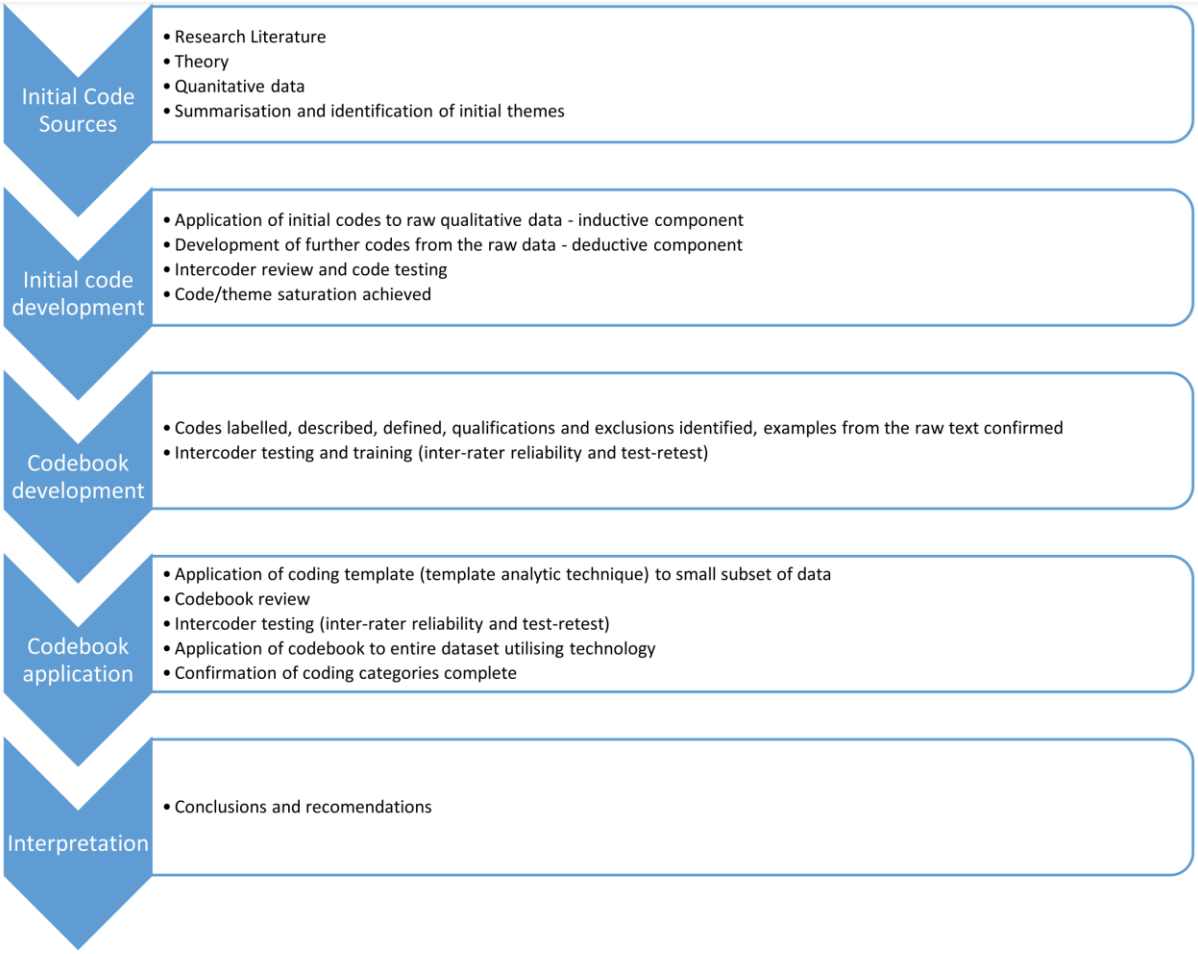

Figure 1: Process of code creation and testing. (Roberts et al., 2019, p. 3)

Template analysis is positioned as being theoretically independent and not specifically associated with a particular philosophical assumption, or ontological or epistemological position allowing it to be flexible and used in different paradigm approaches (Brooks et al., 2015; Hammersley, 1992). Additionally, template analysis encourages researcher reflexivity and the influence it has on the coding and evolving code book. These advantages are not exclusive to template analysis but applies in the main to all thematic analysis approaches. A summary of the different forms of thematic analysis and their associated advantages and disadvantages are presented in Table 1.

	Reflexive (Braun & Clarke, 2021b)	**Coding reliability (Boyatzis, 1998)**	**Template analysis (King, 2012)**
Approach and theory	Closer to a method than a methodology. Theoretically independent or flexible – with a wide range of theoretical positions possible: critical realist; relativist; constructionist.	Not its own method(ology) a process used as art of many qualitative methods. Theoretically flexible, but claimed flexibility limited by postpositivist assumptions.	A technique (method) not a methodology. Theoretically flexible or independent – realist, critical realist (phenomenology), constructionist (broad patterns of discourse only).
What is a theme?	Patterned meaning making across dataset. Relevant to the research question. United by shared idea/ concept. Can have semantic or latent focus. Themes actively generated by the researcher, not discovered.	A pattern that describes and organises meaning; potentially also interprets. Can be identified at the manifest (directly observable) or latent (underlying level). Themes identified by the researcher.	Recurrent features of data relevant to the research question. Themes reflect data topics, rather than storied, conceptual patterns. Themes created by the researcher, not discovered.

What is a code/ coding?	Coding is an organic and evolving process of noticing potentially relevant meaning in the dataset, tagging it with a code, and ultimately building a set of codes from which themes are developed. Codes (analytic 'outputs') have 'labels' that evoke the relevant data meanings. Can focus on meaning from semantic to latent levels.	Coding is a process to identify themes using a predetermined set of codes, organised within a codebook. Codes (analytic tools) are developed from themes, as a way to identify each theme. Codes and themes are sometimes used interchangeably (e.g. thematic codes).	Coding is a process to identify evidence for patterns (themes). Codes (analytic tools) are labels applied to data to identify it as an instance of a theme. Codes can be descriptive and interpretative. Codes and themes are organised hierarchically, and sometimes laterally, into a layered template that guides coding for theme identification.
Analytic orientation	Works for more inductive ('bottom up') to more deductive ('top down') orientations).	Inductive or deductive.	A middle-ground: can be used inductively, but mainly deductive(ish), with a priori themes tentative, and can be redefined or discarded.
Analytic process	Organic process; starts from familiarisation; coding and recoding; theme development; revision and	Development of themes and codes from prior theory and research or inductively; construction of codebook;	Some a priori themes developed first from interview guide/ literature; coding to evidence these and other themes;

	refinement in relation to the coded data and then the full dataset. Themes as analytic 'outputs'.	application of codebook to data by multiple coders to find evidence for themes; testing coding reliability. Themes as analytic 'inputs'.	themes and codes refined after some initial coding; development and refinement of template; coding guided by template for final theme development. Themes as analytic 'inputs' – but they can also evolve and new ones can be developed, so can also be 'outputs'.
Researcher subjectivity	A resource to be utilised; the researcher is both active and positioned.	A 'risk' to the validity and quality of the analysis. Needs to be 'controlled' and minimised.	Acknowledged and accepted. Reflexivity encouraged.
Quality	Deep questioning data engagement and a systematic, rigorous analytic process. Analysis moves beyond summary or paraphrasing. Researcher reflexivity and explication of choices.	Multiple independent coders. Inter-rater reliability. Reliability conceptualised as consistency of judgement in applying codes to identify themes.	Participant feedback. Audit trails. Multiple researchers code and compare. Measures of inter-coder reliability not recommended.

What they offer	Theoretical flexibility (within qualitative paradigm). Potential for analysis from inductive to deductive. Works well from experiential to critical approaches. Open and iterative analytic process, but with clear guidelines. Development of analytic concepts from codes to themes Easy to learn but requires a 'qualitative mindset' and researcher reflexivity.	Theoretical flexibility (within positivist/postpositivist paradigm). Potential for analysis from inductive to deductive (but fully inductive rare). Focussed on experiential approaches. A highly structured analytic approach, which might seem reassuring to new qualitative researchers. Potential to 'speak within' the language of postpositivist quantitative research. Potential for 'hypothesis testing' (deductive thematic analysis). Requires research team (more than one coder) for reliability.	Theoretical flexibility. Can be used inductively or deductively, but typically occupies a middle ground between these. Particularly suited for experiential approaches but can used critically. Structured and systematised, but flexible, techniques for data analysis can be helpful for new qualitative researchers. Structured process offers some efficiency in analysis. Useful for exploring perspective of different groups. Can be used by single researchers or teams.

	Works especially well for a single researcher; can be used with team research. Works with wide range of datasets and participant group sizes.		Fairly easy to learn. Works well with large dataset.
What can go wrong?	Failure to discuss theory to locate the use of the method. Analysis not grounded in qualitative values, or in broader theoretical constructs. Failure to explicate the particular way(s) the method has been sued. Use of topic summaries instead of themes. Too many fragments and particularised analysis, presenting	Failure to discuss (big) theory or conceptual frameworks for the analysis. Inconsistency of judgment in coding data. 'Bias' from the researcher affecting the coding and identification of themes. No data interpretation; simply descriptive summaries.	Failure to discuss theoretical or methodological orientation. Codebook (the template) treated as purpose of analysis; lack of development of themes during data engagement. Overemphasis on (hierarchical) thematic structure at the expense of depth of meaning. No data interpretation; simply descriptive summaries.

	many themes and a complex thematic structure without depth of interpretation. Absence of interpretation; simply descriptive summaries.		

Table 1: Comparing Thematic Analysis; a quick overview of different forms of TA and their respective advantages and disadvantages. Adapted from Braun & Clarke (2021b, pp. 236; 248)

Other forms of qualitative analysis were considered. Whilst Interpretive Phenomenological Analysis acknowledges and incorporates the researcher's own experience in understanding the data, the coding method is different, focussing on between participant themes as well as the individual unique details of each participant data (Braun & Clarke, 2021a) and has been criticised for its lack of theoretical flexibility (Braun & Clarke, 2013). Grounded theory (Glaser & Strauss, 1967), another qualitative analysis methodology, focuses on theory development from data which does not serve the purpose of this research. Thematic analysis as a whole allows for general patterns and convergence in ideas and perspectives to be identified. Template analysis (a subtype of thematic analysis) benefitted from this whilst also bringing together participants' perspectives under the broader STEEEP framework and, in the context of this research, determine these in relation to a dedicated high-quality health coaching service.

Ensuring the quality of the findings was integral to establishing the credibility of the research. Quality in quantitative research is determined by replicability of methods/ intervention, analysis and outcomes (Brown, 2015), which is challenging in qualitative research. The underpinning philosophical approaches to qualitative research accepts the premise of the existence of multiple realities, and so being able to replicate this in future research in unreasonable (Braun & Clarke, 2013). Instead quality in template analysis is assured through a series of stepwise protocols, checklists, audit trails and multiple researchers to support a systematic and defendable process and thus use trustworthiness and dependability of data as a more appropriate measure (Braun & Clarke, 2021b; Roberts et al., 2019). As part of this study, clear stepwise protocols were completed to ensure transparency of process which was refined through supervisor interactions. The evolution of the codebook has been documented, which took place both digitally (on the coding software), but also where manual notetaking was done during discussions with colleagues and supervisors.

In summary, this chapter has presented the methodology for the two components of this thesis. The SLR, whilst having its disadvantages, is generally noted for representing the gold standard when synthesising existing knowledge in a research topic as it uses a transparent and rigorous approach, using predefined criteria, to

provide a comprehensive overview of knowledge. The information identified as part of the SLR provides insight that highlights gaps in knowledge where future research can contribute, allowing stakeholders to make informed and evidence-based decisions. The second component of the thesis, the empirical study, builds on the gap identified as part of the SLR to conduct semi-structured interviews with coach practitioners. The interviews were informed by the STEEEP (Institute of Medicine, 2001) framework to ensure considerations around establishing a health coaching service incorporated topics which are directly related to high quality services. Utilising this framework resulted in the use of template analysis to interrogate and understand the data generated.

2.4 Reflexive statement

As an employee of the organisation and having spent my entire career in mental health services I acknowledge the influence that this has undoubtedly had on the approach, questions I asked and the way in which the analysis was interrogated. It was important to acknowledge this from the offset and thus worked closely with my supervisor, who is external to the organisation, to ensure as much of an inclusive analysis and ensure that I paid attention and incorporated all views even if they were different to my own. To enable me to distinguish between my internal views and those of the participants, I took steps to fully adhere to the principles of template analysis. This helped to ensure the robustness, rigour and trustworthiness of the outcomes.

Chapter 3 – Systematic Literature Review

3.1 Abstract

This systematic review examines the extent and impact of health coaching on mental health outcomes. Three databases were searched which yielded 3,813 papers, of which five papers met the inclusion criteria. The five studies were scrutinised using an adapted version of the PICOS framework and by conducting a quality assessment following the guidelines outlined by Hong & Pluye (2018). The five papers highlighted that overall, there was a positive impact of health coaching across the validated measure and that, where investigated, recipients of the intervention found it impactful, meaningful and empowering. The studies also identified similar limitations and gaps of their research allowing for a clear need in next steps to be identified, specifically around the longer term and sustained impact of health coaching. The studies ranged in quality (from 3 to 5, with 5 being highest quality) and thus requiring caution when interpreting and applying results for learning. Following the steps outlined by Skivington et al. (2021) for developing and evaluating complex interventions in the NHS, the appropriate progression of applying health coaching in this context is to determine the organisational needs and readiness. This study adds to the extant literature by consolidating the impact of health coaching specifically from a mental health perspective.

3.2 Introduction

Mental health services in the UK are experiencing an ever-growing crisis. Most recent census data (2014) reports that one in six adults will experience mental ill health in their lifetime (Baker & Kirk-Wade, 2023). Reviewing more recent statistics, in the last two years there has been a 30% increase in the number of people engaging with mental health services, and a 28% increase in the number of new referrals (NHS Digital, 2023). COVID-19 has exacerbated the number of individuals accessing mental health services at a time when the NHS experienced significant service delivery disruption (Suleman et al., 2021b). Resources are dwindling (Bloom et al., 2012; Buchan et al., 2017, 2019; Meetoo, 2008) and the NHS workforce is shrinking (Taylor, 2020) with data indicating that there is one psychiatrist for every 12,567 people in England (Royal College of Psychiatry, 2022) culminating in staff

morale being at an all-time low (NHS Staff Survey, 2022). The combination of these factors has resulted in patients experiencing significantly longer waiting times than is targeted (NHS Digital, 2023) contributing to suboptimal health outcomes (Reichert & Jacobs, 2018). It is widely acknowledged that the current situation is unsustainable (NHS Confederation, 2022) and the expectations of service providers has expanded where it is now deemed insufficient for healthcare providers to merely provide information to patients but to "understand the psychological principles that underlie self-management" (World Health Organization, 2013, p. 57). The recently published Community Mental Health Framework for Adults and Older Adults (NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019) has also identified the responsibility of community mental health team's (CMHTs) to provide mental health care in the community through social prescribing, social care as well as encouraging activities of daily living to promote autonomy and independence. The importance of self-management to enable healthy lifestyle choices is well documented (Ammentorp et al., 2013b) and research has shown that coaching has had positive effects on self-care, goal attainment and self-directed care management (Hayes et al., 2008; Kivelä et al., 2014; Koenigsberg et al., 2004; Wolever et al., 2013) and thus a worthy consideration as a healthcare intervention.

Health coaching, contrasts with the traditional health approach in which the practitioner is the health expert (see Table 2 for a summary of differentiating characteristics). Health coaching requires clinicians to engage and converse with patients around their health and care goals which takes time and resource but has been shown to reduce costs associated with health care (Cassatly, 2010; Harrison et al., 2012). Coaching literature from business settings has shown it to be an effective means to improving performance, satisfaction, effectiveness and efficiency (Jones et al., 2016b; Sonesh et al., 2015b; Theeboom et al., 2014; Wang et al., 2021) through more supportive and enabling environments and communication styles (Whitmore, 2002). These outcomes are important to service users to enable them to increase their participation and responsibility in their health care through promoting autonomy and independence, and work towards personal recovery (Gray, 2019; Slade et al., 2014).

Traditional approach	Coaching approach
Practitioner is the health expert	Patient is respected as the expert in their own life
Practitioner provides advice and solutions	Practitioner offers information on the basis of what the patient identifies as needed
Practitioner decides the health priority	Patient chooses the health goals, strategies and targets
Practitioner focus is on why the patient has not made the required changes	Practitioner looks for positives and affirms client
Practitioner assumes client is ready to change	Practitioner identifies client readiness and offers strategies to increase confidence and importance.

Table 2: Comparison between traditional care approach and health coaching (Conn & Curtain, 2019)

Personal recovery relates to a patient's right to engage with all components of life as an equal member of society (Perkins, 2012) rather than 'getting better' or 'being normal' (Slade et al., 2014). Individuals play an active role in their own recovery and wellness (Villagonzalo et al., 2018) but the reality is that this may be hampered by previous disempowering experiences in clinical settings (Hughes et al., 2009; Tew et al., 2012) or due to internal factors such as low self-esteem and low self-efficacy (Andresen et al., 2003; Buckley-Walker et al., 2010; Jones et al., 2013; Mancini, 2007). By addressing these areas through coaching, service users would be able to work towards self-identified goals and build motivation, increase self-esteem and self-efficacy. In so doing, service users will become more empowered to address their challenges without (or without as much) support from health providers which reduces the burden on health services whilst also enabling service users.

Systematic literature reviews (Ammentorp et al., 2013b; Boehmer et al., 2023; Kivelä et al., 2014; Wolever et al., 2013) have identified that whilst health coaching as an intervention has been increasing, there are very few high quality papers exploring coaching, and the impact of, in a health care context, thus limiting generalisable conclusions to be reached. Central to this is the absence of a universal definition of coaching, which causes fragmentation in what and how to measure the intervention. Whitmore (1992) brought together many strands of disparate definitions of coaching

to state that it was about “unlocking a person’s potential to maximise their own performance. It is helping them to learn rather than teaching them- a facilitation approach” (1992, p. 8). Over the years many other definitions have been proposed (Hadikin, 2004; Hargrove, 1995; Whitmore, 2002) but none have been universally accepted. This is a key limitation to the development of a coaching evidence base (Passmore & Tee, 2020) and makes it difficult to know how and what to measure for evaluation; as Schneider et al., state “how can we measure the impact of an outcome which we do not know we need to measure?” (2022, p. 71). This is echoed by a report commissioned by the NHS, conducted by Gray (2019) which stipulates the necessity of an agreed definition in order for there to be robust and high-quality empirical research conducted in this field. This is compounded, particularly in a health care context, by the absence of an agreed term for the intervention. Wolever et al., (2013) initially highlighted, and has been reiterated by Boehmer et al., (2023), that there have been a number of variations of the most appropriate term for coaching in a health context, such as “health coaching”, “wellness coaching” or “life coaching”. More recently, the field has come together to bring the different terms under the same umbrella of “health and wellness coaching” with respective standards and certifications being developed (Wolever et al., 2013, Jordan, et al., 2016). Despite this the variation in practice, terminology and approach is ongoing and thus continues to contribute to the fragmentation in evidence base (Ammentorp et al., 2013b; Johnson et al., 2018). Notwithstanding these issues, previous systematic literature reviews (SLR) have established a strong basis from which to progress research into health coaching.

The aim of this review is to build on the existing SLRs as it is now more pertinent than ever to review the extant literature and will serve as a foundation for understanding the potential use of health coaching in a mental health care setting. This can then inform future possibilities of a novel intervention. Therefore, the purpose of this systematic literature review is two-fold:

1. What is known about the extent of the use of health coaching interventions?
2. What is known about the impact of health coaching on mental health outcomes?

3.3 Method

An SLR of peer-reviewed literature relating to health coaching in a mental health context was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The rigour of SLRs is rooted in the predefined procedures and parameters relating to process (Denyer & Tranfield, 2009) framed around a clear and precise research question. Nolan & Garavan (2015) provide an overview to the protocol and steps typical associated with completing an SLR. This process was adhered to ensure a comprehensive and appropriate SLR. Figure 2 shows these typical steps associated with an SLR.

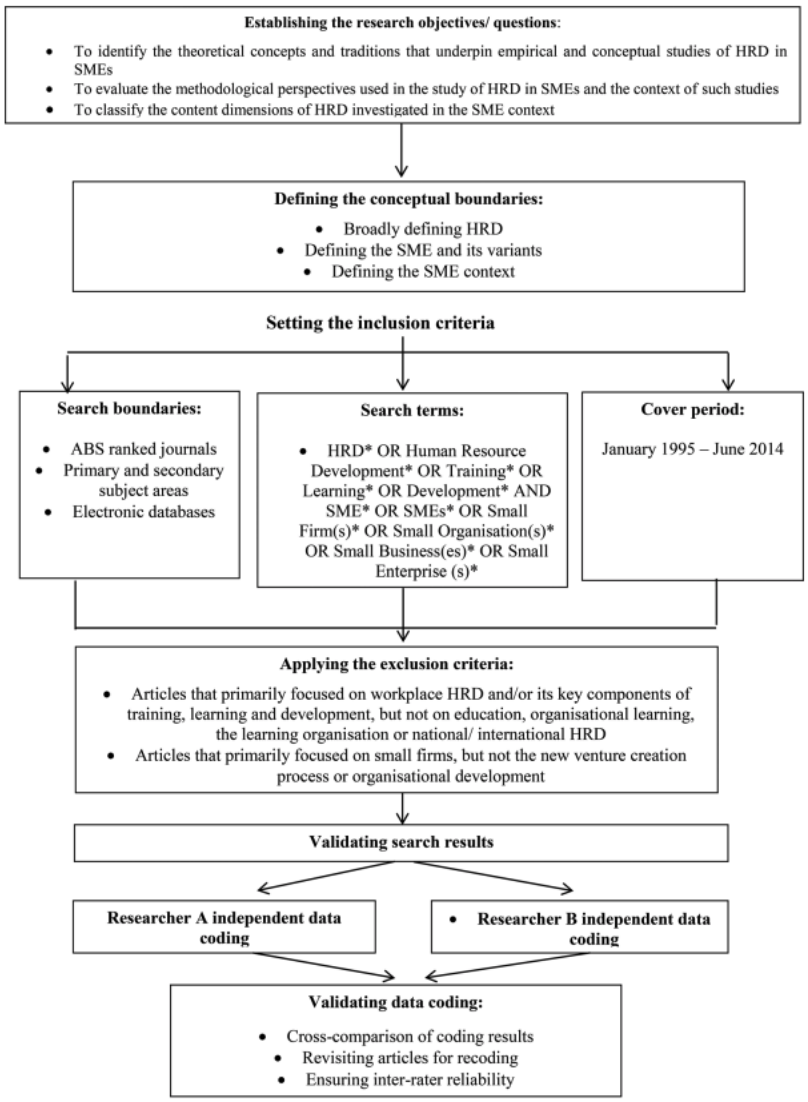

Figure 2: Outline of SLR protocol (Nolan & Garavan, 2015, p. 4)

3.3.1 Search strategy

To identify relevant papers for this review, the following databases were searched:

- Scopus
- APA Psych Info
- Pub Med

Search terms were identified informed by a PICOS table (Richardson et al., 1995) which was reviewed and agreed with a professional subject matter expert librarian and supervisors. Not all categories were used to ensure a broad enough capture of relevant articles with appropriate search terms. The strings (Table 3) were brought together to ensure the presence of relevant categories across the literature identified. Specific mental health terms, e.g., psychosis, were used following a review of the census data (Baker & Kirk-Wade, 2023; Mental Health Foundation, 2016) which identified the most frequently diagnosed mental health conditions in the UK. Whilst this may have limited additional specific mental health conditions, other population terms, e.g., disorders, would have allowed for those results to be returned. The SLR was conducted from January 2023 to September 2023. The process involved continued collaboration and input from the researcher, supervisor and programme directors to ensure rigour and methodological alignment (more detail about this process is presented in 3.3.4 and Figure 4).

Population	patient OR service user OR healthcare OR “health services” OR anxiety OR depression OR psychosis OR SMI OR “serious mental illness” OR PTSD OR “post traumatic stress disorder” OR bipolar OR schizo* OR disorders
Intervention	coach* OR self-care OR “self care” OR self-management OR “self management” OR “life-coaching” OR “life coaching” OR “health-coaching” OR “health coaching” OR “wellness-coaching” OR “wellness coaching”
Outcome	impact OR motivation OR goal OR wellness OR health or “behavio?r change” OR independence OR achievement OR attainment

Table 3: Search terms used for systematic literature review

3.3.2 Study criteria

Inclusion/ exclusion criteria were identified, as per protocol, prior to the SLR being conducted. Through discussions these criteria were refined to ensure inclusivity and exclusivity of the appropriate articles. These criteria can be found in Table 4.

	Inclusion Criteria	Exclusion Criteria
Study Design	● Qualitative, quantitative and mixed-methods research design ● Time period 2000-present ● Articles available in English ● Published in peer reviewed journals	● Anecdotal accounts ● Case studies ● Research protocols ● Other grey literature
Participant population	● Adults (18+) ● Any health diagnosis ● Any health care context	● Outside of health settings ● Patient/ service user not the intervention participant
Intervention	● Any modality of intervention delivery (e.g., telephone coaching) ● Any health professional as provider (inc. pharmacy)	● Unstated (or unsearchable) definition of coaching/ health coaching ● Coaching/ health coaching definition relating to advice/ mentoring/ motivational interviewing ● Coaching delivered by peer ● Coaching delivered by artificial intelligence
Outcomes	● Qualitative ● Quantitative ● Patient oriented outcomes ● Validated measures ● Mental health impact (as primary or secondary outcome)	● Physical health outcome impact only ● No mental health outcome measure included

Table 4: Inclusion and exclusion criteria

3.3.3 Rationale for inclusion and exclusion criteria

An important component of the inclusion criteria was that the empirical research was focussed on mental health outcomes, either as a primary or secondary measure. This was necessary because the focus of this work is to understand the measurable impact of health coaching on mental health service users. Recognising the complexity of measuring impact of interventions on physical and/or mental health status, qualitative and quantitative research design was part of the inclusion criteria.

Whilst some measures can exist to objectively measure the impact of an intervention (e.g., therapeutic dosage of a drug in blood levels), this may not directly impact the experience or wellbeing of a service user. Therefore, by also incorporating qualitative methodologies more knowledge about the impact of health coaching interventions can be determined. This is also a relevant component to ensuring that the individual receiving the health coaching intervention was the service user themselves. Whilst acknowledging the crucial role that families, carers, and wider support systems play in the health and wellbeing of an individual (Hannan et al., 2016), to understand the impact of a health coaching intervention on a service user the accounts and measures needed to come from them.

One of the other crucial components of the inclusion/ exclusion criteria was the need to be able to identify the definition adopted as part of health coaching. Reviewing other systematic literature reviews (Boehmer et al., 2016; Gray, 2019; Kivelä et al., 2014; Wolever et al., 2013) it is highlighted that whilst much research uses the phrase 'coach' there is huge breadth in the actual intervention being applied. The definition adopted as part of this SLR was proposed by Wolever et al., (2013) and states that health coaching is *'a patient-centred process that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds. The actual coaching process entails goal-setting determined by the patient, encourages self-discovery in addition to content education, and incorporates mechanisms for developing accountability in health behaviours'* (2013, p. 52). From these previous SLRs, in the absolute majority of cases 'coaching' has been used to describe interventions which included scripted guided conversations, directives on what an individual should do, advice on what and how an individual should do 'something', identifying goals for an individual, motivational interviewing, psychoeducation, therapy etc. Therefore, where research explicitly mentioned one of the above approaches the article was excluded from the SLR. Additionally, if it was not possible to determine the definition adopted as part of the research, the paper was excluded from the final selection.

3.3.4 Selection process

The article review protocol was developed by three reviewers. In line with Professional Doctorate programmes, the primary reviewer was the author of this thesis and the other two reviewers were supervisors on the doctoral programme. The primary researcher reviewed all articles and sent a random 10% sample of the articles to the second reviewer for corroboration. The completed scoring of the 10% were checked for agreement using Kappa coefficient. The reviewers worked independently of one another so as not to be influenced by each other. Where any disputes arose, these were resolved by a third reviewer. This process follows the PRISMA flowchart as initially developed by Moher et al., (2009) and can be seen in Figure 3.

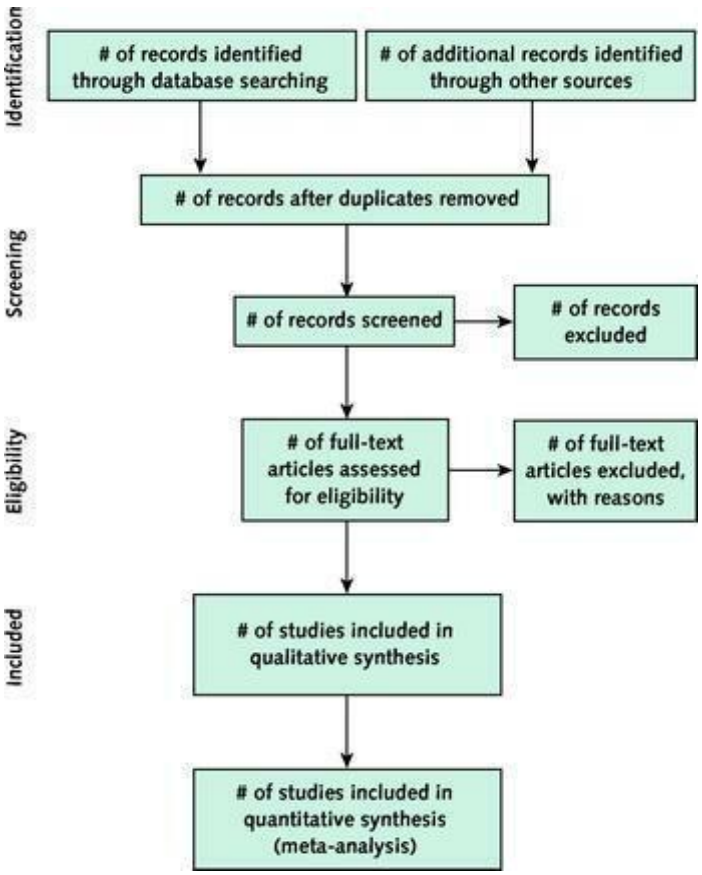

Figure 3: Article flow through different stages of screening (Moher et al., 2009)

3.3.5 Data set

4176 papers were identified through the literature search. Using an online repository (Zotero), 215 duplicates were identified and removed, leaving 3813 paper for review. Initially, the primary researcher applied the inclusion/ exclusion criteria to each title to review for relevance and sent a random sample of 382 papers for review to the second reviewer. When cross-checked a moderate agreement level was determined, and 139 papers were taken forward for abstract reviews. The inclusion/ exclusion criteria were applied to the abstracts, with 14 being sent to a second reviewer. On return, a substantial agreement level was achieved, leaving 32 papers for full paper review. The primary researcher read each paper and 5 were accepted for inclusion in this SLR. Figure 4 shows this process as a flowchart.

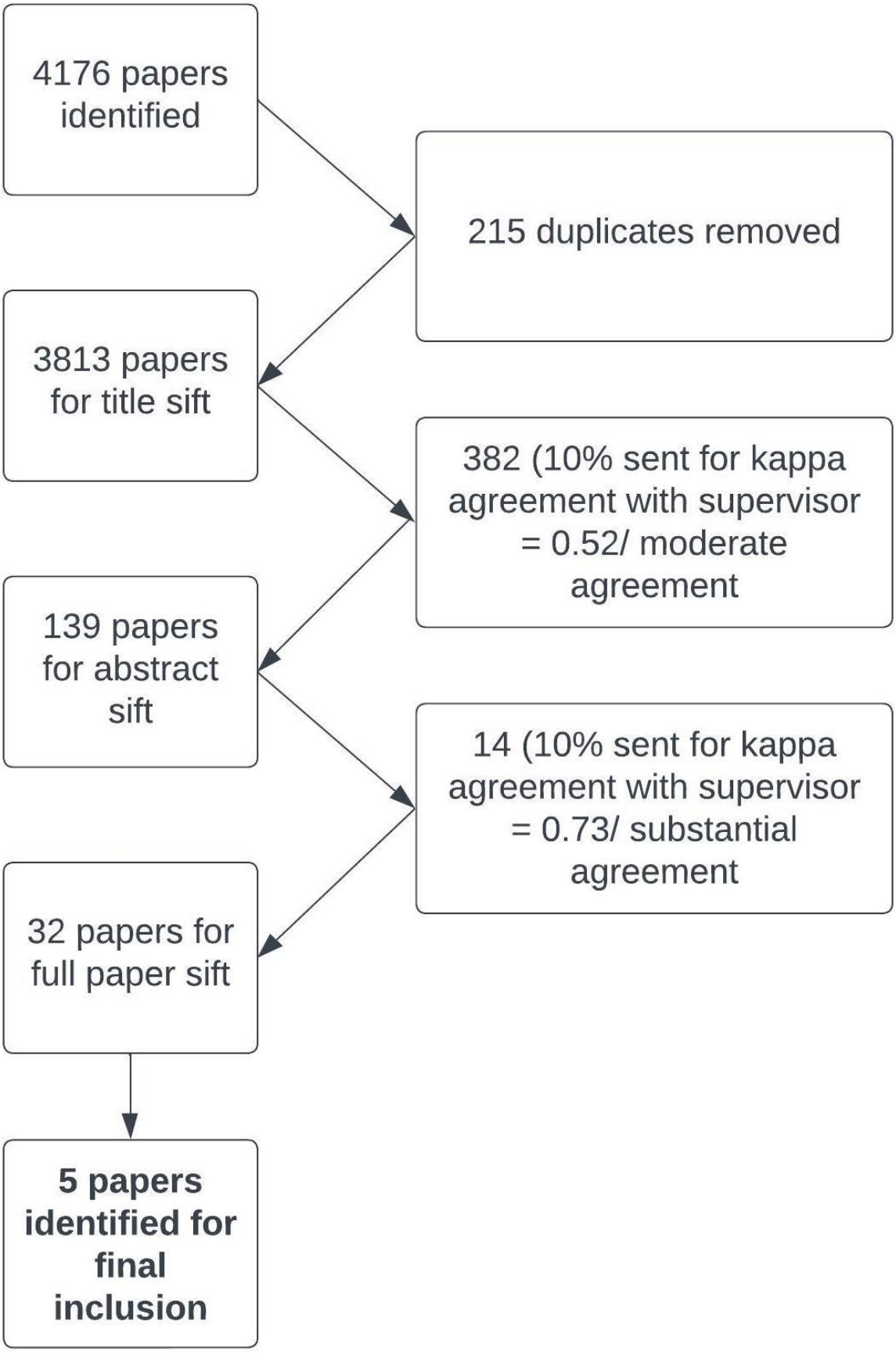

Figure 4: Flowchart of article sifting

3.3.6 Data extraction and quality assessment

Extraction of information from the papers was informed by (Garrard, 2017) whereby information relating to the core research areas, methodology, results and conclusions were collected. This process allowed for the synthesis of pertinent information relating to the SLR objective from which sense making and next steps could be identified.

With the information collated from the data extraction, the articles were quality assessed using the mixed-method assessment tool (Hong et al., 2018). The critical appraisal of the literature identified is a core step of SLRs as it is a systematic examination of the studies to determine its trustworthiness (Burls, 2009; Hong, Gonzalez-Reyes, et al., 2018). It enables researchers to determine the value of research within a particular context and its respective reliability of information whilst also identifying poor quality research, which otherwise may lead to false conclusions (Burls, 2009) . Other quality assessment tools are available (e.g., Snape et al., 2017) but the MMAT was adopted as it was particularly oriented towards SLRs which use either quantitative, qualitative or mixed methodological approaches to research. Both quality assessment tools use a 'yes/ can't tell/ no' rating (template in Appendix 2) but the MMAT has the advantage of providing further granularity as previous versions of the MMAT allows a score to be attributed to each criteria (i.e., 1- if information was present, and 0- if information was missing/ insufficient). This additional scoring is advised to be progressed with caution as, following a review of literature, it was advised not to use quantitative summaries of the scoring as the information does not help the reviewer or the reader understand which components of the reviewed article are problematic. However, the authors recognise that the quantitative quality score allows for ease of reporting and so have proposed a scoring mechanism which they recommend the to be presented alongside details and discussion as part of the wider SLR.

For this SLR, the initial scoring of 'yes/ can't tell/ no' was used. Once this step was completed, a rating of 'yes' was given 2 points, 'can't tell' was given 1 point, and 'no' was given 0 points. Using the maximum points available (which varied depending on the methodology adopted) the scores were converted to percentage and cross

referenced with the quality scoring documentation, with 1* being the lowest quality and 5* being the highest.

3.4 Results

3.4.1 Data quality

Of the five papers that were chosen all had clear research questions with appropriate methodologies to collect and analyse the respective data. Three of the papers received a quality scoring of 3*, one paper had a scoring of 4* (Moreno-Chico et al., 2021; Roy et al., 2020; Slade, Bird, Le Boutillier, et al., 2015; Swendeman et al., 2021) and one paper had a scoring of 5* (Owusu et al., 2023).

3.4.2 Study characteristics

A summary of study characteristics is displayed in Table 5.

3.4.2.1 Location

All studies took place in western countries. The majority of the studies (three) took place in the USA (Owusu et al., 2023; Roy et al., 2020; Swendeman et al., 2021), one took place in the UK (Slade, Bird, Clarke, et al., 2015) and one in Spain (Moreno-Chico et al., 2021). These may influence the findings as the way in which mental ill health is treated and the associated stigma is different to other parts of the world (Krendl & Pescosolido, 2020).

3.4.2.2 Participants

Of the five studies, two took place with physical health patients (Moreno-Chico et al., 2021; Roy et al., 2020), with the other three recruiting mental health patients. This is of note as this has a direct connection with the measures adopted by the studies and, for the two with physical health focusses, the primary intention of the intervention being around the impact of the health coaching intervention on physical health outcomes.

For study 1, 2 and 4 final participant numbers were reported as those who completed the entire programme of intervention. In study 1 (Moreno-Chico et al., 2021) 118 participants were original part of the study, however 16 individuals dropped out due

to refusal in taking part, moved out of area or due to ill health (13.5% attrition). In study 2 (Swendeman et al., 2021), 22 participants began the study but 1 participant withdrew and contact was lost with another participant (9% attrition). Study 4 (Owusu et al., 2023) began with 170 participants, but due to incomplete data sets only 121 participants were included in the final study write up (28.8% attrition rate). Study 5 (Slade et al., 2015) reported demographics for all participants from the start of the study. The study had 403 individuals at the start but reported data on 298 individuals (attrition of 26%). The attrition rate was attributed to a number of different issues including individual withdrawal, poor health, loss of contact and death. Study 3 (Roy et al., 2020) reported no attrition rate, due to the fact that this was a retrospective study and so all required data was matched and available prior to the study commencing.

3.4.2.3 Design

There was variation in research design across all five papers. Three of the papers used a quantitative methodology (Moreno-Chico et al., 2021; Owusu et al., 2023; Roy et al., 2020) and the other two used a mixed methodological approach. (Slade et al., 2015; Swendeman et al., 2021). Two studies included a control group into the design (Moreno-Chico et al., 2021; Slade et al., 2015). None of the studies declared the research epistemological stance adopted.

3.4.2.4 Health coaching intervention

There was variation in the design of the coaching sessions. This included the number of sessions participants were offered or engaged in, the modality of coaching, the coaching intervention provider (i.e., participants could have received coaching from a different coach for each session) and the amount of time between each session. Additional information related to the coaching intervention is presented in Table 6.

Study	Author/ year	Country	Design	Control group	Participants	Patient population
1	Moreno-Chico et al., 2021	Spain	Quantitative	Yes IG= 52 CG= 52	N= 104 Male= 74 Female= 30	Physical health
2	Swendeman et al., 2021	USA	Mixed methods	No	N= 20 Male= 20 Female= 0	Mental health
3	Roy et al., 2020	USA	Quantitative	No	N= 1306 Male= 260 Female= 1046	Physical health
4	Owusu et al., 2023	USA	Quantitative	No	N= 121 Male= 26 Female= 95	Mental health
5	Slade et al., 2015	UK	Mixed methods	Yes IG= 210 CG= 193	N= 403 Male= 260 Female= 143	Mental health

Table 5: Study characteristics

Study	Number of sessions	Session duration	Duration of coaching intervention	Time between sessions	Modality	Coaching provider	Coaching training
1	4-6	45 mins	6 weeks	Weekly	Face-to-face	Nurse	Not stated
2	2	30 mins	12 weeks	4 weeks	Telephone	Paraprofessionals	Not stated
3	6-14 hours	30-45 mins	12 weeks	Not stated	Not stated	Multi-disciplinary	Well Coach certified
4	3-6	45 mins	6 weeks	Weekly/ biweekly (as directed by patient)	Live messaging	Not stated	ICF adherence
5	Not stated	Not stated	12 months	Not stated	Face-to-face	Multi-disciplinary	EMCC adherence

Table 6: Health coaching intervention details

3.4.2.5 Measures and analytical approach

As part of the inclusion criteria, all studies had to incorporate validated mental health measures as a primary or secondary measure as this was an inclusion criteria. However, when analysing and consolidating the learning from the papers, the variation in the measures adopted was notable. In two papers where the primary patient population sample was in acute settings (Moreno-Chico et al., 2021; Roy et al., 2020), physical health measures were also captured. Physical health data were objective and clinical and included weight, BMI, waist circumference, and medication adherence. The exception to this is the self-reported drug use in the Swendeman et al., (2021) study which could have been biometrically ratified but was not. To note, as part of this study substance misuse was categorised as a mental health condition. Table 7 shows the different measurement tools adopted in the studies.

A number of different condition-based metrics were collected across all studies but there was limited consensus as to the validated measures to use. This can be seen in the different measures being adopted to measure anxiety (study 1, 2, 3 and 4) which all showed an improvement following the health coaching. In addition to mental health measures, all five studies used non-psychological condition-based metrics, for example study 1 collected data on perceived social support from participants. Whilst there is strong evidence of (Harandi et al., 2017) of the impact of social support on mental health status, this is not a direct condition-based assessment relevant to this literature review.

Across the five studies, quality of life, anxiety and depression were the most assessed mental health conditions and areas. Four studies (studies 1, 2, 3 and 5) collected measures on quality of life, 2 (studies 1 and 3) collected data on anxiety and depression (as a combined metric) and two (studies 3 and 4) on just anxiety. For each of these areas there was poor consistency in the tools adopted to measure the concepts, thus making consolidation of the learning challenging. The assessment of anxiety and depression across the studies reflects the high frequency with which these conditions are diagnosed in the UK and thus make it an appropriate measure to capture, despite these conditions being a primary outcome in only two of the studies (2 and 3).

Additionally, there was no consistency in the analysis methodologies of the different studies (e.g., t-tests, cluster randomised control trial etc.). This, again, poses difficulty when attempting to bring together learning from different sources as the different analysis methods will all be considering data from different perspectives.

3.4.2.6 Impact of health coaching

Studies 1, 2, 3 and 4 evidenced health coaching to have a positive impact on mental health across different measures, both psychological and physical condition based. For the purposes of this literature review, however, results only pertaining to psychological conditions were considered. Studies 1-4 demonstrated how health coaching can have a significant impact on those at sub-clinical levels on psychological conditions (e.g., anxiety from study 4) and the benefit derived more so by those who are older and have a higher educational attainment (study 1).

Study 5 showed no difference across the measures adopted and across the intervention and control groups. It is unlikely that there was spontaneous recovery in all participants within the control group, as this is an incredibly rare occurrence with limited research being available regarding this phenomenon.

3.4.2.7 Experience of health coaching

Studies 2 and 5 used a qualitative approach to understand the experience of the health coaching intervention. Study 2 used interviews to determine the feasibility and acceptability of the health coaching intervention from the perspective of the participants. From these interviews, it was deemed that health coaching was well received and enabled participants to have greater self-reflection, awareness and motivation. In study 5 interviews were conducted with patient participants as well as staff participants to determine the experience of the intervention package (which included health coaching). The analysis of the interviews identified that effective implementation of the intervention package was associated with more positive changes in recovery. The information identified through interviews from both studies provides some insights relating to the process and impact of the health coaching intervention during the research programme but requires further in-depth work.

Despite this limitation, the fact that the intervention was well received indicates the potential ease with which health coaching can be introduced into health systems.

Measure focus	Study	Measure	Measure reference
Quality of life	1	Perceived Health-Related Quality of Life	Spanish version (Vilagut et al., 2008) based on the original works of Ware et al., (1996)
	2	Short-form 12 (SF-12)	Hays et al., (1995)
	3	Dartmouth COOP Health Survey (DART)	Eaton et al.., (2005)
	5	Manchester Short Assessment of Quality of Life (MSAQL)	Priebe et al., (1999)
Anxiety & depression (combined questionnaire)	1	Goldberg Anxiety and Depression Scale (GAD)	Spanish version (Montón et al., 1993) based on the original works from Goldberg et al., (1988)
	3	Patient Health Questionnaire Mood Scale (PHQ-9)	Martin et al., (2006)
Anxiety	3 & 4	General Anxiety Disorder scale (GAD-7)	Spitzer et al., (2006)
Self-efficacy	1	General Self-efficacy scale	Spanish version (Suárez et al., 2000) based on the original works of Schwarzer (1993)
Patient activation	1	Patient Activation Measure (PAM-13)	Spanish version (Moreno-Chico et al., 2017) translated from Hibbard et al., (2005)

Social support	1	Perceived Social Support	Spanish version (Bellón Saameño et al., 1996) based on the original works of Broadhead et al., (1988)
Hope	5	Herth Hope Index	Herth (1992)
Recovery	5	Process of Recovery	Neil et al., (2009)
Well-being	5	Warwick-Edinburgh Mental Well-being Scale (WEMWBS)	Tennant et al., (2007)
Assessment of needs (patient)	5	Camberwell Assessment of Needs Short Appraisal Schedule (Patient)	Phelan et al., (1995)
Confidence	5	Mental Health Confidence Scale	Carpinello et al., (2000)
Physical health measures	1	Medication Adherence	Spanish version (Val Jiménez et al., 1992) based on the original works from Morisky (1986)
	3	Blood pressure Body composition Waist circumference Nutrition Health fitness Pain rating Exercise min/week	In line with standard physical health measurements
Assessment of needs (staff)	5	Camberwell Assessment of Needs Short Appraisal Schedule (Staff)	Phelan et al., (1995)
Global functioning (staff perspective)	5	Health of the Nation Outcome Scales (HoNOS)	Wing et al., (1998)

Assessment of functioning (staff perspective)	5	Global Assessment of Functioning (GAF)	Hall (1995)
Process and impact measures	5	INSPIRE	Williams et al., (2015)
	2	Client Satisfaction Questionnaire	Attkisson & Greenfield (1996)
	4	Satisfaction	Unvalidated satisfaction measure- additional question added to GAD regarding 'likely to recommend"

Table 7: Quantitative measures captured

A summary of study findings has been presented below in Table 8.

Study	Author/ year	Findings	Limitations	Recommendations
1	Moreno-Chico et al., 2021	Significant difference identified between intervention and control group on PAM at time point 1 (6 weeks after intervention began) but not at interim or end time points Education and age had a significant impact (positively correlated with higher activation) Inconclusive evidence relating to other measures adopted in research (e.g., self-efficacy, quality of life, etc.) Flexible and dynamic approach to intervention based on participant needs contributed to improved activation across timepoints Coaching only effective for duration of programme	Sample bias may have occurred through self-referral Small sample size Short intervention duration Sample all from one hospital source Researcher is the same individual as that providing the intervention Different health coaching approach adopted compared with other interventions so difficult to consolidate learning Adopted PAM which few other health coaching research has done and so difficult to consolidate learning	Longer intervention needed beyond the research as other longer-term programmes have shown more success Additional studies needed to understand how health coaching impacts activation Clarity/ agreement on how to best capture the impact of health coaching
2	Swendeman et al., 2021	Feasibility and acceptability of intervention is positive with an increase in self-awareness and reflection regarding drug use. Coaching helped connect drug use with Quality of Life Participants reported that they were satisfied with the intervention	Had opportunity to do quantitative analysis on data but did not Small sample No women or heterosexual individuals included in sample No control group	More representative sample needed Longer programme needed to inform ongoing impact of health coaching Need to consider what is needed to integrate health coaching as part as existing interventions

		Quality of Life measure indicated improvement but not at a statistically significant level	Self-reported measures only (not cross-referenced with biological markers of opioids in blood Financial incentive reported as motivation to continue in research	
3	Roy et al., 2020	Significantly improved lifestyle habits (exercise, eating habits and nutritional awareness) Biometric data showed significant improvement (blood pressure and body composition) Across all psychometrics there was a significant improvement (GAD, PHQ and DART) Some (but not statistical) improvement in pain, positivity and nutritional behaviours Integrating coaching into wellness programme was noted as resulting in widespread improvement. The more coaching session an individual engaged in the better the impact (i.e., those who did four or more sessions had better quality of life and were less anxious)	Pre and post measures utilised which can be reductive in analysis (though spontaneous recovery is rare) Non-random allocation of participants into different levels of intervention intensity No control group No comparison between coaches to ensure fidelity to coaching model. Whilst all coaches would have had same training, participants may have had sessions with different coaches. Coaching sessions conducted during exercise sessions causing a potential issue with patient attention and reflection	Need to look at coaching as a standalone intervention to truly determine impact

4	Owusu et al., 2023	T-test showed that pre- and post-coaching there was a significant improvement in General Anxiety Disorder (GAD) scores, with some having reduced to subclinical levels GAD reduced the more sessions participants engaged in. Those with subclinical GAD scores had the biggest reduction (i.e., the most improvement) Participants were 'likely to recommend' intervention (but this was measured using an unvalidated satisfaction measure)	High number of exclusion criteria Can't determine coach fidelity to model (but all had same training) Sample was relatively small No control group Participants self-selected modality of coaching received, but no comparison was conducted to determine any potential impact/ difference this may have made High attrition rate Whilst a greater number of sessions were associated with greater improvement the results indicated an average of 3 coaching sessions were used (of an initial offer of 6) Not possible to make causal conclusions due to absence of control group and sample randomisation	Longer term follow up needed to determine ongoing impact of health coaching
5	Slade et al., 2015	No impact of the three work practice interventions on recovery (one of which was coaching) on any measures (patient or staff) Teams with a better engagement with the interventions had better results and improvements. Intervention was associated with reduced care costs	Variable implementation of intervention (e.g., only 12 of intended 36 externally facilitated team reflections took place) Untested shorter version (12 month) used rather than the original and tested version (18 months) Control group may have already been implementing recovery principles as	Consider a different psychometric for such an intervention More work needed at team/ system level to make a bigger impact Consider organisational stability as inclusion/ exclusion criteria for team and patient inclusion (two clinical teams in intervention arm were

		Findings were determined at multi-system level (i.e., patient, staff, team and financial)	organisations had already begun to adopt principles Unsure whether the primary measure adopted was indeed the best one Difficulty in recruitment, shortfall of 39 participants and so potential in not reaching power level needed High attrition rate Blinding participants to intervention or control group was not possible thus possibility causing social desirability bias	disbanded during course of research)

Table 8: Summary of findings, limitations and recommendations

3.5 Discussion

This SLR provides an important step forward when attempting to understand the impact of health coaching. It is of particular importance as it is the first of its kind focussing specifically on mental health outcomes. This, considering the context of the current status of mental health NHS service provision and the associated challenges, is crucial if alternative impactful interventions are to be offered. However, there is still much to consider in this field. Building on the seminal works of previous SLRs in the broader area of health coaching (i.e., including physical health measure only studies) (Boehmer et al., 2023; Gray, 2019; Wolever et al., 2013; Yang et al., 2020) this SLR has identified a number of gaps in the extant literature. 3813 studies were identified through a systematic search, of which five studies met inclusion criteria. All five identified health coaching as a viable intervention to positively impact mental ill health conditions. However, the SLR has also identified some significant gaps in the extant literature relating to numerous core components of research. This review highlights that research into health coaching, which adheres to a consistent and agreed definition and intervention offer of coaching is still in its infancy.

Our current understanding of the impact of health coaching is limited in a number of ways. First, the study designs employed vary significantly across the articles reviewed. The absence of control groups limits the understanding available of the difference health coaching can offer between a group receiving the intervention and not. In studies 1 and 5 where a control group was used, study 5 data showed no discernible difference between the groups whereas study 1 did. This discrepancy, as proposed by study 5, may have been due to the fact that control group participants may have already been exposed to the principles and interventions that the intervention groups were using as a result of in-house organisation training and philosophical changes in how patient care should be delivered. Studies 2, 3 and 4 acknowledge the absence of a control group as a limitation of their study and recommended that future research to consider the involvement of control groups. The control groups would play a pivotal role in determining the impact of health coaching on a service user's health goals and outcomes. It would be necessary to clarify that long-term impact of coaching, however, would require a different research design.

Relatedly, there is a lack of clarity in why participants are not retained during the course of the research project. Only two studies (4 and 5) presented data regarding dropout rates which showed a higher than expected attrition rate (I. Wright et al., 2021). Dropouts were reported to be due to incomplete data sets (study 4) and refusal to continue/ loss of contact in study 5. This may be a reflection of the fact that health coaching as an intervention does not yet have the systemic structures needed to support mental health patients when determining the impact of health coaching. This is compounded by the lack of reporting on epistemological positions of the research and thus makes it difficult to understand the justification for research approaches and design.

Second, the broad range of measures used makes it difficult to distil findings (Table 7). The heterogenous tools adopted, even to measure the same condition, causes a challenge when attempting to consolidate and learn from findings across literature. The measures used are appropriate for the respective hypotheses but the variation in tool use may be a reflection of the absence of an agreed coaching definition across the profession (Gray, 2019; Yang et al., 2020). It is also possible that the broad range of measures used also reflects the gap in knowledge around the mechanisms of coaching and thus the specific measures to adopt remain unclear hence the broad range used to measure change/ impact.

Third, the approach to patient care within each organisation causes variation in the already existing issue of small sample sizes which all studies identified as a limitation. The approach defines the fundamental principles by which clinicians are expected to engage with and provide care to patients. All studies included in the final paper list have all taken place in western countries. This may reflect the fact that stigma, approaches, diagnostics and treatment to mental ill health vary significantly across countries (Krendl & Pescosolido, 2020). This variation results in differences in how individuals access mental health services, the criteria by which their illness is diagnosed and receive treatment (particularly in line with how mental ill health is viewed and accepted in the respective culture and country) (Gopalkrishnan, 2018; Office of the Surgeon General (US) et al., 2001). As this SLR included worldwide searches (though the literature had to be available in English) it may be,

therefore, that health coaching from non-English speaking countries has not yet been published and/or translated. It could also be that in some countries health coaching has not been researched/ utilised to support individuals with mental ill health.

Fourth, the lack of understanding of mechanisms of health coaching and on which areas of health the coaching intervention may have has resulted in a wide range of how the health coaching intervention is delivered. There is an absence of understanding how many coaching sessions make a significant impact on mental health reported status, by whom the sessions should be delivered, the appropriate tools and measures which should be adopted to determine change and session content. All studies provided a different number of health coaching sessions to their participants and so there is no knowledge of a ceiling/ plateau level where any additional coaching sessions yield no additional benefits to the patient. Similarly, the studies have not presented sufficient information relating to the coach provider and where it has, it is recognised that that the researcher and coach provider were the same individual. By not having this information it is difficult to not only assess coaching fidelity (i.e., whether all coaches providing coaching in the same way), it is also not possible to understand whether there are particular roles better suited to providing the intervention. That is to say, are clinician and patient relationships too entrenched in the medical model of care provision for there to be a sufficient shift into health coaching approaches?

Lastly, one of the biggest limitations acknowledged by all the studies was the absence of considering the impact of health coaching long term which would help to determine whether any improvements of health coaching are sustained. All studies recognised that once the respective research projects were completed the health coaching interventions ceased. Whilst this is likely to be as a result of pragmatic and ethical considerations associated with research, it is also due to the fact that the wider systemic structures that would continue the health coaching intervention has not yet been considered. Therefore, in order to determine this, and address some of the issues relating to dosing, ceiling effect, appropriate coach profession and begin some work towards the mechanisms of coaching it is important to consider the

organisational needs, readiness and factors required to establish a high quality service which is feasible, adds value and is economically justifiable.

3.5.1 Limitations and recommendations highlighted by the studies

Deeper exploration into the impact of health coaching was highlighted as a recommendation from all 5 papers. They each acknowledged that health coaching indicated positive effects on their participant sample, however they had no way of determining longer term impacts following the cessation of the project. This was in part due to the fact that the intervention was not embedded into business as usual within the health settings in which the research took place.

Additionally, echoing the existing literature reviews (Gray, 2019; Kivelä et al., 2014; Wolever et al., 2013) future studies require more explicit description of the coaching intervention and training received by those providing the intervention. There is limited information provided in articles, and whilst this literature review ensured that more detail was provided in articles or made available through article links, this does not allow for other researchers to have easily accessible information.

All studies also mentioned their sample size and/ or participant demographics as being a limited factor in their research. The implication of such being the challenge to derive generalisable results from the research into other settings and therefore being a consideration for future research to address.

3.5.2 Strengths and limitation of this SLR

This study is the first of its kind to focus primarily on the impact of health coaching on mental health outcomes. It therefore contributes to the evidence base where there is a clear gap and thus offering new insights into this area.

Despite this the current SLR is not without its limitations. Due to the pragmatic nature of this research, grey literature was excluded as this would have yielded a high number of articles and reports to be reviewed. There is an existing debate in the research field about the impact of this. The exclusion of grey literature allows for SLRs to be conducted in timely way but it may eliminate the inclusion of practice

relevant/ up to date knowledge which has not yet progressed (Adams et al., 2017; Snyder, 2019).

Despite mitigating measures taken to ensure independent decisions regarding article selection, it remains possible that bias may have occurred during this process. The primary researcher and supervisors had discussed the topic area in depth prior to conducting the SLR which may influence the decisions made in article selection. To eliminate this bias in the future it may be useful to have a fully independent and blind reviewer to assess the inclusion/ exclusion of articles.

Whilst all included studies considered mental health impact, they all had physical health/ recovery as primary outcome measure, and with some literature only using self-reported measures. This therefore compromises the possible participant priority and biases when completing measures. Further studies should look to examine different stakeholder perspectives to ensure a comprehensive understanding of the impact of health coaching in mental health settings.

3.6 Conclusion

Mental health provision in the UK has begun to shift towards more explicit demand on CMHT staff compounding the impact of already strained resources. This SLR has shown that by supporting patients to be the drivers of their own health outcomes and holding personal recovery at the heart of the work, outcomes can improve. However, the extant literature is not without flaws which continues the fracture in the research when considering health coaching. This is as a result of different factors, including variation in research design, variation in how the coaching service is established as a research project within the wider system in which it is being conducted and variation in the definition of coaching as well as the different metrics used to measure the same condition. This has created a coaching research base which cannot provide more detailed information regarding the mechanism and long-term impact of coaching. The gap identified in this SLR, particularly around understanding the longer-term establishment and impact of health coaching now requires research to progress evidence and bolster the literature base to determine the organisational considerations required to introduce a health coaching service in

health settings. This is a prerequisite step in introducing and evaluating large scale change in the NHS (Skivington et al., 2021). It is therefore necessary that future research considers the viability, practicalities and challenges associated with establishing a health coaching service in a mental health trust.

Chapter 4 – Empirical study

4.1 Abstract

Health coaching as an intervention to improve health outcomes has increased in its use over the last decade (Gray, 2019). Multiple systematic literature reviews have consolidated the research related to health coaching and has determined it to have positive effects on service user care, health and experience (Ammentorp et al., 2013b; Boehmer et al., 2023; Kivelä et al., 2014; Wolever, Moore, et al., 2016). However, much of this research has focussed on physical health as a primary outcome measure (Meetoo, 2008). Additionally, health coaching interventions which have been introduced in clinical settings have been done so as an adjunct to treatment as usual (Moreno-Chico et al., 2021; Owusu et al., 2023; Roy et al., 2020; Slade et al., 2015; Swendeman et al., 2021). Therefore, whilst we can identify the benefits of a health coaching service, there is no research of the wider considerations required to inform how best to introduce and maintain the service.

This research sought to understand the feasibility of establishing a health coaching service in a large mental health trust and the organisational considerations required in order to introduce, implement and sustain such a service to support service user health and outcomes (Reichert & Jacobs, 2018), and reduce burden on a pressured National Health Service (Buchan et al., 2017). Using a semi-structured approach, with transcripts interrogated using Template Analysis (King, 1998), five overarching themes were identified: ensuring safety, components of the service infrastructure, considering the organisation and wider system readiness, ensuring equitability in service provision and the importance of measuring effectiveness of the service. This empirical research has provided a stepping stone in developing and evaluating complex interventions (Skivington et al., 2021) and future research in this topic would benefit from additional contributions from wider stakeholders to ensure a wholly comprehensive perspective is gathered to establish a health coaching service for mental health service users.

4.2 Introduction

4.2.1 Health coaching as an approach

The use of health coaching as an intervention in healthcare is growing (Ammentorp et al., 2013b; Kivelä et al., 2014; Wolever et al., 2016) with research progressing alongside. Recent systematic literature reviews (Ammentorp et al., 2013b; Hill et al., 2015; Kivelä et al., 2014; Wolever et al., 2013) have investigated the impact of health coaching on health related outcomes and determined generally positive effects on physical health outcomes, where health coaching has predominantly focussed. It has had promising effects on many heath areas for example, cardiovascular disease, cholesterol, weight management, medication adherence, and diabetes control (Navicharern et al., 2009; Olsen & Nesbitt, 2010; Patja et al., 2012; Sacco et al., 2009; Thom et al., 2015; Wayne et al., 2015; Wolever et al., 2010; Wongpiriyayothar et al., 2011). Little research has examined the outcomes of health coaching in a purely mental health context (i.e., focussing on mental health as a primary outcome and not as a secondary measure to physical health outcomes) (Meetoo, 2008). This is a crucial distinction as physical and mental health contexts (environmental, financial, stigma, safety considerations etc.) are very different and thus require different considerations.

Even within physical health focussed coaching service, many different coaching offers have been made as there is no consistent approach (Gray, 2019). This is in part due to the absence of a universally agreed definition of coaching and informed by that, health coaching (Ammentorp et al., 2013b; Gray, 2019; Kivelä et al., 2014; Wolever et al., 2013; Wolever, et al., 2016). The implication is that research is being published under coaching as an umbrella term, but incorporates education, advice, mentoring, motivational interview and therapy (Wolever et al., 2013; Moore et al., 2016) which is not consistent with how professional coaching is defined leading to variation in who, what and how coaching is provided. Without a consensus of definition, it is difficult to understand what a health coaching service needs to offer and, in turn, an organisational challenge in the considerations it needs to make to establish, implement and provide a health coaching service.

Attempts to develop a health coaching definition have been made, but most seminally by Wolever et al., (2013) who, through their systematic literature review, consolidated the existing definitions to propose that health coaching is:

"a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The coach is a healthcare professional trained in behavior change theory, motivational strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being" (Wolever et al., 2013, p. 52).

By adopting this definition, as encouraged by Gray (2019), a commonly agreed approach to health coaching as an intervention can be offered to service users. The incorporation of health coaching as an offer in health settings has the potential to reshape service provision to be more patient-centred and enabling. This is, now more than ever, crucial considering the pervasive NHS resource depletion and low staff morale causing long waiting times and suboptimal health outcomes (Buchan et al., 2017, 2019; NHS Digital, 2023; NHS Staff Survey, 2022; Reichert & Jacobs, 2018; Taylor, 2020). That is to say, as health coaching has been evidenced to support patients towards meaningful recovery and enable independence, then this may lead to a reduction in service access and support needed. Despite the challenges around health coaching, the potential benefits of it are clear and it is now time for research to turn its attention to the feasibility from an organisational perspective of what is needed to establish a coaching service.

4.2.2 Establishing a health coaching service within the National Health Service

Establishing novel services in the NHS has proven to be a challenge historically, however this has provided the institution with rich data and information to inform future implementation plans. Barriers to introducing change include unrealistic timeframes, ambiguous goal/ vision and the exclusion of all relevant stakeholders in bringing about change (Carmichael, 2023; Katikireddi et al., 2014; Institute for Innovation and Improvement, 2017). In the absence of literature which reviews

implementation processes of a health coaching service, learning from institution wide changes is useful to consider. For example, the Improving Access to Psychological Therapies (IAPT) services highlighted the importance of change clarity, stakeholder involvement, change momentum and understanding the change within its respective context as being crucial to contributing to the success of introducing a change (Hutten et al., 2010) With the awareness of the institutional (national) and organisational (local) complexity of NHS services Fitzgerald & Biddle (2020) emphasise that a framework to introduce change which acknowledges and works with the complex system is adopted. The NHS, in this way, have published the Change Model (Sustainable Improvement Team & Horizons Team, 2017) and the National Institute for Health Research in conjunction with the Medical Research Council (Skivington et al., 2021) have provided a framework for developing and evaluating complex interventions. Despite the many similarities between the two models, for this research the Skivington et al., (2021) was adopted to inform the stepwise process of exploring the considerations necessary to introduce a health coaching service. The model, compared to the Change Model, provides more in-depth and structured steps to progressing change. They identify when one can consider a step 'completed' or indeed when a process needs to revert back to a step previously thought completed which will ensure a rigorous and comprehensive change approach. Additionally, the model is more practical and acknowledges where there may need to be 'trade-offs' where researchers consider the most important questions/ areas to consider to enable decision making rather than asking questions which provide absolute certainty. They define a complex intervention as one which requires considerations of components such as "the range of behaviours targeted; expertise and skills required by those delivering and receiving the intervention; the number of groups, settings or levels targets; or the permitted level of flexibility of the intervention or its components" (2021, p. 2). This is relevant to health coaching as the service is likely to address a variety of behaviours and would need to be flexible in order to best meet and work with the local population to provide a meaningful and beneficial service. For interventions to be suitable for real-world practice Skivington et al., (2021) state that early engagement is required with service users, practitioners and those in higher positions (e.g., policy makers or organisational leadership). This would provide comprehensive considerations of the

acceptability, feasibility, cost-effectiveness and scalability of an intervention. The core elements of developing and evaluating complex interventions is fourfold:

1. Developing the intervention – either developing a new intervention or adapting an intervention using relevant existing literature
2. Feasibility – determining feasibility and acceptability of the intervention with an agreement on evaluation design
3. Implementation – encouraging the uptake of the intervention through deliberate efforts. This includes using improvement and implementation science approaches to support the intentional and systematic approach to support progression of health care services (Nilsen et al., 2022)
4. Evaluation – using the most appropriate approach and methodology to determine intervention outcomes

Components of these core elements have been initiated by previous systematic literature reviews which have provided the structure of the health coaching intervention (i.e., step 1). Next in the stepwise progression is to determine the feasibility of such an intervention. To ensure that the intervention is deemed feasible it needs to also consider how the service will be judged, either by existing outcome measures and/ or by other metrics (e.g., practitioner/ service user feedback). Measures of a 'successful' high quality service in healthcare in the UK is determined by the Care Quality Commission five areas: safe, effective, caring, responsive and well-led (Care Quality Commission, 2024). However, the STEEEP framework proposed the Institute of Medicine (2001) provides more granularity to consider which is more useful when considering introducing a novel service. STEEEP was also adopted as the framework for this research as it is used within the organisation in which the research took place. The framework is used to provide assurances to the community, staff and the wider organisation that the care provided meets the six dimensions that are associated with high quality service provision. These dimensions were identified following service user and stakeholder involvement. STEEEP refers to:

1. Safe – avoiding harm to patients
2. Timely – reducing wait times, which may be harmful itself
3. Efficient – avoiding waste (skillset, time, supplies, etc.)
4. Effective – services which are evidence based

5. Equitable – service provision does not vary in accessibility or quality across personal characteristics
6. Patient-centred – care which meets the needs, values and preferences of the service user and incorporates the individual into decision making

Using the STEEEP framework as the evaluation outcome, feasibility of the intervention is determined against these areas and adopted as a template for exploration for this research.

In summary, there has been growing literature which presents the benefits of a health coaching service, but these have been mainly focussed on physical health outcomes. Literature to date has contributed to the initial step of establishing a health coaching service and additional work, namely feasibility of such a service, is required as the next step to appropriately consider how a complex intervention is introduced into a complex organisation, using the STEEEP framework to ensure a high quality service is provided.

4.2.3 Study aims

The study aims for this empirical research are informed by a recent SLRs (e.g., (Gray, 2019; Wolever et al., 2013; Ammentorp et al., 2013b; Gray, 2019; Kivelä et al., 2014) which reviewed the impact of health coaching on mental health outcomes. This SLR highlighted that whilst there are indications of positive health outcomes for service users, there continues to remain significant gaps in the literature. Namely:

- There is significant variation in the research design, methodology and outcome measures there are used. This impacts the ability to consolidate the findings and learnings from the research.
- There is a high attrition rate for the research which has taken place which may be an indication of broader issues with the intervention (e.g., is there stakeholder demand for the service?)
- The absence of long term outcomes for those who have taken part in research.

Arguably, the latter issue is of most importance as there is no evidence to determine whether health coaching makes a significant impact on the health outcomes that are being addressed as part of the intervention. The long-term impact has been difficult to determine to due to the fact that the intervention is often bolted on to existing health services which is then withdrawn following the cessation of the research. There seemingly is no broader consideration into the stakeholder and institutional needs and contexts which would enable the health coaching service to be sustained.

Therefore, this paper is the first of its kind to determine what the organisational considerations need to be, from the coach practitioner perspective, to establish a coaching service. Coach practitioners are individuals who are qualified to Level 7 Coach practitioner level and provide coaching to staff within the health organisation in which the research is being completed.

The main research question is:

- What are the organisational considerations required to establish a health coaching service within a mental health hospital?

Sub-questions are:

- What are the specific considerations to ensure a high quality service which is safe, timely, efficient, effective, equitable, and timely?
- What are the skills, knowledge and competencies required by coaches to provide a high quality service?

This will provide practical insights to enable health coaching services to be established in healthcare settings which meet stakeholder needs incorporating six quality indicators.

4.3 Method

4.3.1 Philosophical underpinnings

This thesis is underpinned by a social constructionism epistemology using a transformative lens. Both adopt the principle that there are multiple realities which are socially constructed (Willig, 2013; Willig & Rogers, 2017), with the transformative

paradigm emphasising the importance of the role that social, political, economic and other factors can play in defining the version of reality one experiences (Mertens, 2007; Watkins & Cooperrider, 2000). As the health service is influenced by multiple internal (e.g., executive leadership members) and external (e.g., local community stakeholders and groups, reigning governmental party) factors which create hierarchies and influence the decisions and perspectives of individuals, this lens is important in order to contextualise responses. Additionally, the establishment of a health coaching service has the potential to improve patient care and outcomes through the focus on personal recovery (Slade, 2009) and thus reduce injustice and stigma of mental ill health in society, which Mertens identifies as a cornerstone of the transformative paradigm.

Social constructionism adopts a qualitative approach (Flick, 2014) while transformative paradigms has the flexibility to be used for both qualitative and quantitative research (Mertens, 2007). As part of this research, qualitative methods have been used so as to invite the views from all participants, holding them equally as important as one another.

4.3.2 Participants

As part of this study, 11 level 7 trained coaches took part through a purposive sampling approach. Level 7 is an internationally recognised qualification which is equivalent to a post graduate certificate or diploma (depending on route). It enables the coaches to become accredited with the official coaching bodies which ensure governance, competencies and skills. Participants were identified as being trained to Practitioner Level and were, at the time, employees of the South London mental health NHS Foundation Trust in which the research took place. Coaching is an established service within this hospital with all coaches adopting the European Mentoring and Coaching Council (EMCC) definition of coaching which states that coaching *"inspires clients to maximise their personal and professional potential. It is a structured, purposeful and transformational process, helping clients to see and test alternative ways for improvement of competence, decision making and enhancement of quality of life. Coach and Mentor and client work together in a partnering relationship on strictly confidential terms. In this relationship, clients are experts on*

the content & decision making level; the coach & mentor is an expert in professionally guiding the process" (EMCC, 2017). This is an important factor of this research as it ensures that all coaches are practicing from the same foundational understanding of what coaching is and provides assurance as to the consistency of their approach to the intervention.

Whilst there are many different stakeholder perspectives to consider when determining the organisational needs to establish a health service, this study purely focussed on the views of trained coach practitioners (i.e., those who would be delivering the intervention), to determine from their experience what they anticipate is required to deliver a coaching service. Definitive sample size was not possible prior to the commencement of the research. Literature (Braun & Clarke, 2021b; Brooks et al., 2015; King, 1998, 2012) was reviewed to provide guidance which emphasised the importance of researcher reflexivity to determine when to end data collection, incorporating pragmatic considerations (e.g., time and resource limitations) in the decision making process.

Participant demographics were collected and are presented in Table 9.

Gender	2 males (Diamond and Anoush) 9 females (Cosmos, Angel, Anemone, Precious, Tag, Em, Roxanne, Dahlia, and Peach)
Age range	55 - 67
Age average	62
Ethnicity	7 – White British 1 – White – Any other background 1 – Black or Black British – Caribbean 1 – Black or Black British – African 1 – Did not disclose
Years level 7 qualified – range	3 – 16

Years level 7 qualified – average	8
Professional background	Teacher Employment Advisor Occupational Therapist Occupational Psychologist Doctor Human Resource Specialist
Current post	Organisational development consultant Doctor Service Director Employment Advisor Peer Recovery Trainer Service Users in Training & Education Manager Head of Occupational Therapy Peer trainer
Number of coaching clients in last 6 months – range	1 – 15
Number of coaching clients in last 6 months – average	7
Number of coaching clients since qualifying – range	5 – 300
Number of coaching clients since qualifying – average	81

Table 9: Participant demographics

4.3.3 Procedure

Consultation of the Health Research Authority decision making tool categorised this research as evaluation, and thus not requiring any NHS ethical approval. University ethics was secured, and the project was conducted in line with professional standards outlined as part of the authors place of work, the British Psychological Society and the Health Care and Professions Council. The ethical procedures underpinning this work was gaining informed consent (Appendix 4), confidentiality (through pseudonyms), ensuring the welfare of participants (by signposting to mental

health charities where necessary) and acting with integrity (no use of manipulation of deceit).

Participants were approached via email inviting them to take part in the research. Interested participants had an initial call with the researcher where the research protocol was outlined and any preliminary queries from participants addressed. Once satisfied, informed consent was ascertained, and participants were asked to complete a demographics form (Appendix 5). A mutually convenient one-hour meeting time was identified to conduct the semi-structured interview on Microsoft Teams which was recorded and automatically transcribed, for which participants provided written consent.

The semi-structured interview schedule (Appendix 1) was informed by STEEEP (Institute of Medicine, 2001) which provided sufficient structure to ensure exploration of required components of a high quality health service whilst also allowing for additional and more in-depth discussions on topics which emerged.

4.3.4 Analysis

Template analysis (TA) was used to interrogate the data. TA is frequently adopted within applied research, incorporating what is already known about a particular field to provide a framework for analysis (Braun & Clarke, 2021b; King, 2012; King & Brooks, 2016). A combination of deductive and inductive approaches were used to code the data. The deductive element was from a priori codes using STEEEP, which were then informed, challenged or strengthened by the inductive element by reviewing interview transcripts and adjusting the codebook.

Delve software package was used to manage the data and was in line with the main procedural steps associated with TA (Brooks et al., 2015). Initially, a priori themes were established, followed by researcher familiarisation with the data set. Through this familiarisation the data was clustered together and themed either under an existing a priori code or, where necessary, a new code following novel meaningful clusters. Three transcripts were used to initially to test the template and adjusted as needed; an additional two were used to refine the template. One further transcript

was required to be analysed before there was no data of clear relevance remaining which remained uncoded. This template was then adopted to analyse the remaining five transcripts.

Whilst the codebook was refined, proponents in qualitative research (Braun & Clarke, 2006, 2013, 2021b; King, 1998, 2012; King & Brooks, 2016) emphasise the importance in acknowledging a researchers own world view. This can happen despite having a priori codes. Different techniques were applied to quality check the analysis, including scrutiny from research supervisor and an audit trail of key decisions, though these do not eliminate bias. It is therefore possible that the understanding of participants' accounts may be subject to different interpretations by others.

4.4 Results

The themes identified through the data analysis have been presented as a mind map (Figure 5). From the interviews with participants, five overarching themes were identified. Firstly, the need for the organisation consider the elements needed to provide safe service, Secondly, the need to consider the fundamental infrastructural need to provide health coaching. Thirdly, the readiness and mindset of the organisation to provide an alternative and non-medical intervention. Fourthly, the importance of ensuring health coaching access which is inclusive to all and finally, a service which is equitable and has a measurable and positive impact on patients. This section will provide more detail relating to each theme and sub-themes identified as part of the interview analyses, and subsequently discusses the connection between themes and subthemes were they have been identified.

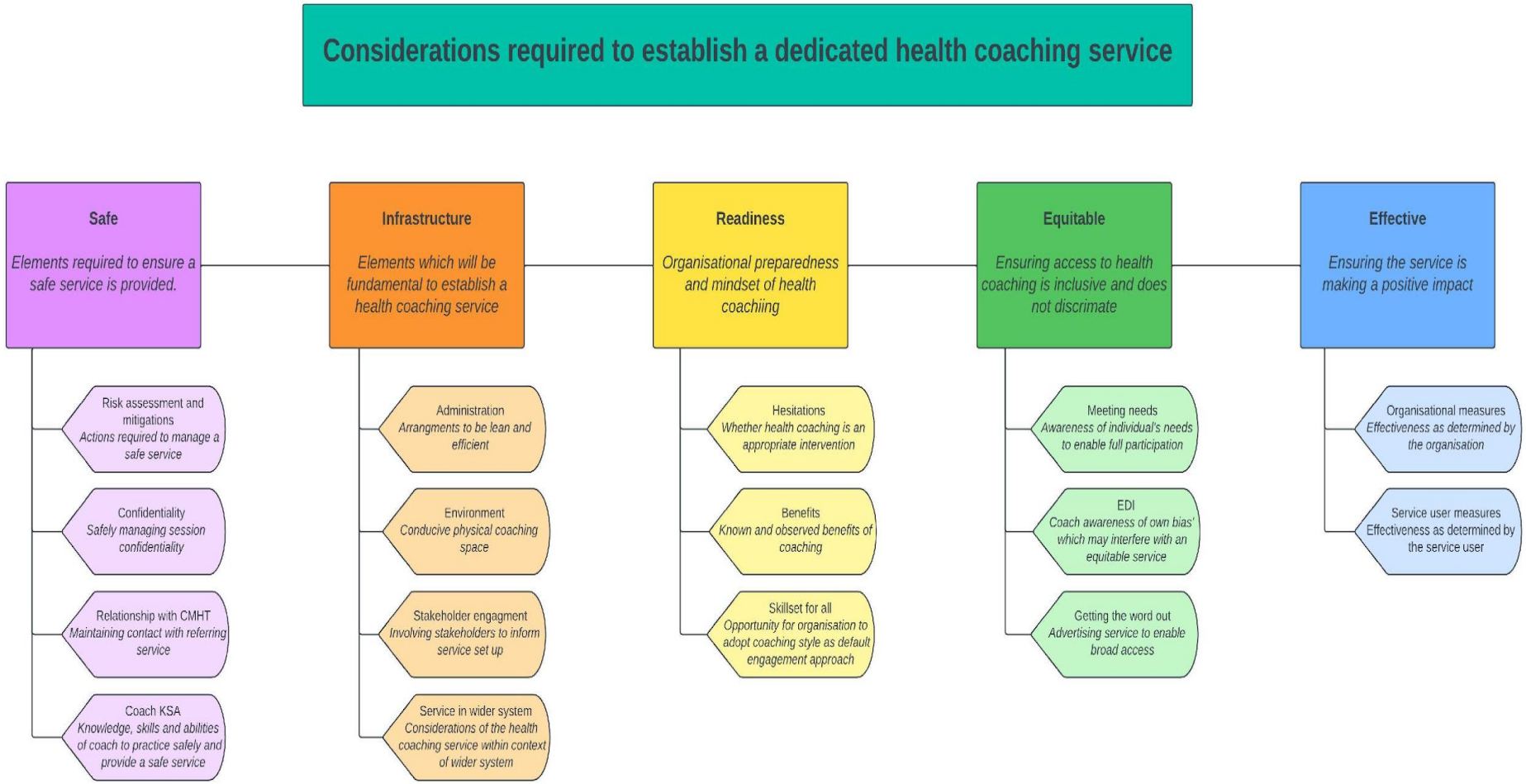

Figure 5: Considerations required to establish a dedicated health coaching service themes

4.4.1 Safe

The notion of a safe service was a prominent theme raised by participants. This is in line with the first consideration of STEEEP and is defined by the Institute of Medicine (2001) as relating to the element required to ensure a safe service is provided. Through the interviews, a number of subthemes were identified.

4.4.1.1 Risk assessment and mitigation

In order to establish a safe service, all participants noted the importance of establishing a risk assessment and related mitigations. The role of the risk assessment and respective mitigations was seen as an assurance to the service user, coach and organisation that coaching was an appropriate intervention to offer, and in the circumstance of an issue arising, sufficient safeguards were in place to manage and resolve them.

> "*Anyone working in a clinical service needs to be aware of what the potential risks are and to be able to ask about some patient safety issues and know what to do with what gets flagged up. So, if somebody [the coachee] says, 'I'm feeling so awful, I'm having suicidal thoughts', they [the coach] think, 'OK, I know how to explore this' and so we can have the session. And I also know where I need to take this information and to be able to say this to the service user." (*Dahlia)

4.4.1.2 Confidentiality

Participants' acknowledged the increased possibility of risk or concerns around service user's individual safety to arise. Whilst confidentiality is an integral component of a coaching session (International Coaching Federation, 2020) there would still be the professional obligation for the coaches to alert appropriate services to manage any risk shared.

> "*I think that you would need to contract with the service user that if there was a time that you were concerned about their safety that you would have no choice but to alert whoever is their link person or key worker. And if they don't have a key worker, then to alert their GP. And I think you'd have to have some really clear (about) that and you'd encourage the service user to do it themselves, but you'd have to set within an hour or so."* (Cosmos)

4.4.1.3 – Relationship with CMHT

An important component of offering a safe service was the need to ensure that service users were active users of the mental health services, i.e., they had not been discharged from the care of the Trust. This was to support the appropriate care provision was accessible to service users if an issue arose.

> *"Certainly, if there was any concern about somebody being able to manage the coaching, I think would probably be important that they're still linked to a team for backup and then the coach would have a link to be able to refer back to if someone has a relapse or something."* (Anoush)

4.4.1.4 – Coach knowledge, skills and abilities

A core component of providing safe care was ensuring commensurate competencies, knowledge and abilities of the coach practitioner. In this way the organisation would be assured of safe practice; the coach would be well placed to engage with the service user and appropriately escalate issues; and the service user would receive high quality health coaching intervention.

Within this theme, three subthemes were identified.

4.4.1.4a – Mental health training

Ultimately there was general consensus as to the extent of mental health training or knowledge a coach would be required to have in order to coach safely. It was clear that all coaches, regardless of their professional background would require a minimum knowledge of mental health first aid, mental health disorders (and how they present) and how to ensure risk management.

> *"But I think you do need to be [mental health aware] cause of the potential complexity of it, I think for the service to feel more, you know, secure and from a safeguarding point of view, I think people would need to have a reasonable understanding both of the different mental health presentations and conditions, and all the existing services and resources that are around and where the person is at that point in time in the system and potentially if they need to be referred somewhere else, maybe or something else they've got."* (Anoush)

"If you think about someone who's got borderline personality disorder, where there are whole issues around attachment, where you know, splitting all of those things, black and white thinking, if you don't know that and you're going in to coach them and they're coming up with solutions that are actually unhelpful in terms of the way they're behaving and their beliefs and how things have happened for them because of their trauma, etcetera., it could potentially be unhelpful. Whereas if you've got somebody, so I'll just give you a quick example - in rehab we're always wanting to skill people up, make them more independent and help them on their way. If you do that with someone with personality disorder, they would often start to really get very upset, you know, kind of it triggers, it's triggering because you're kind of that connection, that attachment and that therapeutic relationship is so key that that attachment and any transitions need to be managed very carefully so that you don't kind of retraumatise and retrigger somebody who has a very poor attachment style and if you didn't understand that you can get somebody with personality disorder to actually relapse or you know self-harm." (Dahlia)

However, the starting point of the conversations were different. Whilst those from a clinical background, emphasised the importance of mental health exposure they were clear that the health coach did not need skills beyond those mentioned above. However, those from a purely coaching/ corporate background initially stated their hesitance in providing coaching for mental health service users.

"So, one assumption that I would be battling with, and it's an anxiety, is 'oh, supposing in my engagement now with somebody who I know is a service user and there are some issues with their mental wellbeing, etcetera., supposing I start doing some stuff with them that actually triggers things and actually has an impact that, you know, potentially is negative'. You know? So, there's an anxiety there – 'oh my goodness am I, you know, exploring territory that I shouldn't be, that I shouldn't have been exploring?' And a clinician who's had really years of training and experience is better suited to do that. And then I think of all kinds of things such as the code of ethics, you

know, and the whole principles of practising within your professional, realm and comfort." (Diamond)

As the interview progressed, they challenged their initial perspectives and saw the potential of their own ability to safely provide health coaching and the advantage that not being a clinician brings to the coaching space.

"Maybe you can lay the health condition aside and just see that person. Like I'm Anemone. I might have anxiety and depression sometimes, but maybe that gets put to one side and it's just me, isn't it? Sometimes it becomes so much about their health condition and maybe that's not helpful. So maybe there isn't that need to even touch on that." (Anemone)

"I'm not working with the coachee to support them specifically with [their mental health condition]. I'm working with the coachee to support them in something that they want to achieve for themselves. So, the eating disorders is the context, it's the contextual thing. So, it's not an in-depth knowledge but just actually there's a broad awareness of working in the mental health field. It's really interesting. I'm a reflective person and just thinking 'oh, this is really interesting' cause I'm going full circle. Cause initially I was thinking oh no it's gotta be a clinician, but now I'm not." (Diamond)

4.4.1.4b Coaching skills and competencies

Through the interviews the necessity to match intervention and respective skills level of those providing the intervention was discussed. Participants noted that's as a result of coaching not being a regulated profession, there was a lack of boundaries and clarity in what the coach can and cannot provide their coachee.

"I remember supervising someone who went on a weekend course and said they were now a coach and I was horrified at some of the practise and there were absolutely no boundaries. I mean, this particular coach even went to A&E with the woman one weekend because and. And it's just like that's not coaching." (Cosmos)

It, therefore, led to a discussion about the need to adopt a coaching competencies framework to ensure that coaches were clear of their role and remit in providing coaching, and also that minimum standards and assurances were provided.

> *"I think the most important thing is to have a coaching qualification regardless of any other experience or qualifications that people have got. I don't believe you need to be a psychologist to do coaching. I think you need to be a qualified coach to do effective coaching…I think we would start with the skill and ability of the coach and just being really clear that they are working within the either the EMCC code of Conduct or the ICF -one of the professional bodies ethical code and code of conduct because there is a danger because people are helpful by nature, especially in a coaching relationship that they stray into more therapeutic approach. So being very clear what the boundaries are around the help that they're offering. So I think there's a difference between having a coaching conversation, which is what we equip people at our foundation level to have, which I think is absolutely fine in their day-to-day interactions with service users, all the rest, but I think if it's a programme of coaching then there needs to be a level of skill and experience that, well that will come, But yeah, a level of skill and a commitment to working within a code."* (Em)

4.4.1.4c Supervision/ continuous professional development

The adoption of a code of conduct also ensured alignment to ethical practices. The importance of this was emphasised as a way to ensure checks and balances were in place where coach knowledge, skills and abilities were in line with up-to-date evidence-based practice, as well as ensuring fidelity to the coaching model. Additionally, supervision and continuous professional development was also noted as being a psychologically safe space where coaches could speak to peers and seniors and seek advice, guidance and reassurance in their practice.

> *"'What? What am I doing? How am I feeling? And what's with the outcomes that that I'm having? Could I do things differently?' And needs the space to kind of unpack some of that and part of that is that kind of pastoral kind of reassurance element that sometimes comes with that supervision. And just practical reassurance. And yeah, a bit of stretching and challenging, just that*

whole thing about continuously thinking and reviewing practise. In an area that's in a slightly, it's slightly new, so you know supervision full stop anyway, but actually particularly you know delivering something in a new service you need some space to come unpack that kind of what's emerging for you." (Diamond)

"CPD and supervision, I think is a really important part of development and governance. And so in our service, we do peer supervision once a month for coaching specifically. And in that space, so we have a 2 hour space, and in that space we do a check in round and talk about our clients and then also ask for time if there's a specific client that we want to spend a bit more time on. And then colleagues ask coaching questions and explore the issues. So you do get a sense of their coaching approach, but it's also a way of getting support when you need it to try something different with a challenging clients or where you're a bit stuck or you've already made a decision and you just want to get some assurance that it was an okay thing to do. So I think it's got a number of different levels where it adds value, so partly it's the ongoing development of the coach, partly it's a governance thing, um and partly it's a supportive space and also we get a sense of one another in that and what our coaching styles are." (Em)

4.4.2 Infrastructure

This theme was established outside of the a priori themes as a result of a broader conversation with participants. This theme brought together the elements which the participants considered fundamental to establishing a health coaching service.

4.4.2.1 Administration

It was emphasised that the service be straightforward in how it is delivered and the structured. Participants wanted to ensure that the service was set up in a pragmatic and streamlined way to reduce any bureaucratic burden for coaches and service users and ensure the service was provided in a timely way. Within this there were a number of subthemes.

4.4.2.1a Package offer

One component of the service administration was the need for clarity around the package offer. Providing this clarity would enable service users and wider organisational staff to be aware of what the intervention could offer, and to whom, to ensure the appropriate use of the service by all.

> *"So part of me thinks that maybe you should have some kind of commitment from them as well, that they will do you know, maybe at least two or three sessions? Because sometimes if you just do one session, you don't really get the benefit from it. So yeah, there's lots of options I think of how you could do it. I think definitely people need to understand a little bit about what it is they're getting themselves into."* (Angel)

4.4.2.1b Patient eligibility

The package offer and streamlined service administration also needs to consider the target group of the intervention. Participants discussed how there would need to be an agreement on when a service user is most appropriate to access the service. This appropriateness is in relation to their mental health status which was important to enable them to get maximum benefit from the coaching sessions.

> *"I don't think it's about diagnosis. I think it's about the individual. It's about that where they are at that point in time about their cognitive sparing."* (Peach)

4.4.2.1c Governance

Another component of service administration was the need for the service to be appropriately governed within the system it operates and be held accountable for the service it provides.

> *"I think they the organisation would need the assurance that there is a specific skill level in the coaches providing the coaching and that there is some sort of scrutiny and check in, but whether that is through an external quality assurer, or whether it's through the processes like peer supervision and that sort of thing so the usual kind of checks and balances."* (Em)

"How do we ensure that there's good governance in relation to this. What do we have in place? It's just supposing something emerges from this, what's the steps that we have? So what's the process stuff? What's the steps that we have in the eventuality of different things happening? How do we manage things like confidentiality, you know, with the individual? I don't know where people are coming from, but the individual and their clinical team, whoever's working with them, you know what's, you know, there's some of that stuff. How does that work?" (Diamond)

4.4.2.2 Environment

Whilst coaching has been successfully delivered online, the option to deliver the service in person was discussed more fully. The discussion took place within the broader context of the NHS where funding depletion has resulted in the selling of estates and, particularly since the COVID-19 pandemic, the adoption of hot desking. However, this was recognised to not be conducive for conducting a coaching session, and thus a need to ensure that an appropriate coaching space was identified.

"If it's in person, it would be helpful if it was quite a nice confidential space rather than, you know, a broom cupboard on a ward somewhere, so something that makes people feel invested in and valued. So I know it's a real challenge for the trust at the moment with the estates the way they are, but it would be really helpful because I think environment has a huge impact on the quality of the, the interventional interaction then as well so. From a practical point of view, some way of being comfortable and confidential would be great." (Em)

4.4.2.3 Stakeholder engagement

The discussion around stakeholder engagement was a frequently raised topic. Stakeholders in the interviews related to service users, the organisation and wider community/ voluntary services. There was an acknowledgment that the coaching service required additional perspectives to be incorporated to ensure that the needs and expectations were being met for all involved.

"C*ause I'm wondering how from a service user perspective, whether it's something that 'ohh yeah, actually this, I quite like this idea. This is something that would help me'."* (Roxanne)

"*But I think then you need to get the perspective from psychologists and social workers, nurses, doctors and see where they all think it fits in, I think often as OTs ourselves, we're also often feel like we're always competing as well anyway, what everyone else and what's our little bit of the role and how do we focus on that?"* (Anoush)

4.4.2.4 Service in wider system

Participants discussed different options with how the health coaching service would operate within the context of the wider NHS system. No definitive answer was provided but it was clear that the different options suggested attempted to protect the health coaching service from being too separate, and therefore vulnerable, or being too enmeshed with mental health Trust, and therefore not being seen as providing something different than a medical intervention.

"I *was thinking, yeah, where does it sit? Where is it gonna sit in with everything else to make sure…And I can't decide. I don't know. I haven't got an answer to this, but I just want to make sure either that it's not too separated at all so that it's somehow becomes too removed and too remote and then maybe vulnerable in a way of being so separated off. But equally not being too close in either, that's just seen like by the patients as another part of the system that's, you know, if there's any paranoia of is it just gonna be more of the same. So I think it's, you know, that's a tricky thing to get that balance right. I think probably because it's a where it can sit to where it will sit."* (Anoush)

"T*he other way of doing is flipping it and not having it as part of the organisation but having a third sector organisation manage it so that there's a clear blue water between your being seen clinically or you're not being seen clinically. So that's another option would be to think about you know do you develop a partnership with Mind, just as an example, do they manage it?*

Take the requests cos it wouldn't be referral. You'd have to really think about the language, the request for health coaching would go through to them." (Cosmos)

4.4.3 Readiness

Reflections on the perceptions of coaching from an organisational perspective were shared by participants. There was discussion regarding whether there was organisational readiness and the need for it to be championed at an Executive level to ensure buy-in and support.

> *"You know who needs to be speaking at that executive leadership team level to say this is the direction of travel that this organisation wants to explore take. So, there's that kind of thing which is about getting a buy in."* (Diamond)

There was an acknowledgment that within those perceptions of health coaching, there would be both hesitations for the service being established and offered, as well as a level of excitement knowing the potential benefits of the service.

4.4.3.1 Hesitations

Hesitations were related to the containing and maintaining of any safety issues, with coaches being cognisant of the fact that there could be organisational liability if things 'went wrong'.

> *"I think from the organization's perspective, the organisation must be absolutely satisfied that the risk element is absolutely minimised, so we would need to think about ways that help reassure the organisation that we've done absolutely everything we can to minimise that risk"* (Diamond)

4.4.3.2 Benefits

Coaches identified multiple possible positive impacts of a health coaching service through the discussion. The benefits were in line with the evidence base and was informed by their own experiences of receiving and delivering coaching. There was an emphasis of the real potential that health coaching could offer service users.

"*I think it's a really good approach. I think it fits very well with the recovery approach, encouraging people to take more responsibility for their own health and wellbeing."* (Em)

Within this theme, there were three main benefits that were identified.

4.4.3.2a Awareness

Coaches reflected on the increased self-awareness that coaching leads to.

"I think people are amazed what resources they have within themselves and how they've gone on to become so much more self-aware and really came into it feeling quite stuck in their circumstances". (Anemone)

4.4.3.2b Moving forward

There was a recognition that coaching enables individuals to move thought and reflection into action, which helped people to make changes and make progresses in areas that were important to them.

"*But how things opened up and how they imagined it to be just about helping them move forward, maybe with the job choice or career or whatever, and then it's really helped them to understand themselves, you know, holistically really I think."* (Anemone)

4.4.3.2c Empowering

The opportunity for individuals to identify and prioritise areas of importance and change to them, and then determine for themselves how to go about making the changes was recognised as being empowering for the individual. This was particularly important within the context of a health setting where service users can feel 'done to' rather than being held able to make choices for themselves and take responsibility for their actions.

"*Because people who are coached as opposed to having things done for them to them, mentored, you know, have a sense of self achievement in. It gives them the hope, it gives them the confidence that someone has a belief in them as well, because when you're coached, you feel that someone is acknowledging that you have the wherewithal to work things."* (Precious)

"*I think it's power to the people, isn't it? Really enabling them to feel in control. Getting people to take responsibility for themselves and to make decisions based on that…the empowerment would mean he could move forward, maybe, with his life and do other things and feel confident in himself to do other things rather than stay still."* (Anemone)

4.4.3.3 Skillset for all

As part of the organisational readiness, a component that was discussed by the participants was the importance of coaching as a skillset being expected of all staff, regardless of role or team they were in. The participants noted that a coaching style skillset would build on staff existing skills and techniques and allow them to engage with service users in a more intentional way. This was seen as being important because it would build an organisational culture which emphasised the focus of health care on patient centred outcomes.

"It should be a dedicated separate component. But I also think that a lot of the other disciplines need to have that skill as well. So that they can bring it into their everyday conversations when it's appropriate with patients." (Peach)

4.4.4 Equitable

Equitability was another a priori code which was prominent through conversations. There was an emphasis on making the service as equitable as possible by ensuring that all service users had equal access to the service regardless of any protected characteristics (particularly around their diagnosis). This was possibly made more prominent by the organisational context at the time. Over the last two years, the organisation has instated policies which ensure equity of services and treatment to all patients and carers. This was done as a direct result of the identified discrepancies in care provision where patients from a Black and Minority Ethnic background have received sub-optimal or more harmful care, with less access to talking therapies and diagnoses compared to their white counterparts. Three main sub-themes were identified.

4.4.4.1 Meeting needs

This sub-theme identified the potential gap in service user knowledge which would potentially obstruct individuals from making a fulling informed decision. Coaches discussed the need to sometimes step out of a purely coaching mode and into a signposting role to ensure that they were supporting service users to be aware of all options available to them. However, the caveat highlighted was that even with this information input, the coach needs to ensure they maintain neutrality and not advocate for a particular option.

> *"Sometimes they don't have enough baseline knowledge to think about what some of the solutions might be for them to, and that's an important point. It's not just about that activation, but it's also about their level of education about a particular topic, because you can't help yourself if you don't know… how can you have a good nutritional diet if you don't really have an idea of what that means. Of course, through the coaching you can get them to the point where they go and do that research but if they then are kind of floundering, coming up with solutions that are just not, don't have an evidence base to them, we've got to be quite careful about that as well."* (Peach)

Meeting needs also related to the responsibility the health coaching services and coaches would have to ensure that services were made accessible to different people and individual differences. This included disability, neurodiversity, visual impairments, English as a second language and more. Additionally, this also required coaches to be aware that the timing of the coaching needed frequent reviewing to ensure that coaching was the right intervention for that individual at that time.

> *"So I had a coaching client recently and who's a senior clinician and we paused our coaching for three months because she became quite unwell and so we agreed what she needed to do is to go and seek some help. And then she contacted me to say that she had sought help and she was getting the help and actually she was taking three months off and now we've set started up again because she's recovered."* (Cosmos)

4.4.4.2 Equality, diversity and inclusion

Ensuring equality, diversity and inclusivity, in addition to the above, was considered from the coach's responsibility in keeping conscious and unconscious biases in check.

> *"And what's interesting is that it is so easy to make assumptions about people, because the person I am working with is a psychologist and I sort of thought 'well wait a minute she is a psychologist, how can she be having these anxieties, you know what I mean, how can she behave this way', so I think it's also, yeah, about us kind of being very open to work with them and not having those assumptions and judgements."* (Anemone)

It was also important to take into account a service users background and context to support them in consideration of those factors.

> *"If somebody accesses CBT who is of Indian heritage, there's a whole South Asian therapist piece now because people will say 'ohh the CBT therapist said, just cut your family off then, if they're behaving like that.' And all Indian people like, 'yeah, right that's not happening', so that's absolutely useless. And because of that they're totally disengaged from that therapist because they don't get you at all or your roots or your culture. They don't understand it and it becomes blatantly obvious and then actually anymore gains that you're gonna make may be very limited."* (Peach)

4.4.4.3 Getting the word out

To make the service equitable, there was discussion about the importance of advertising the service to all, and in different ways, to ensure that many people from different backgrounds and context could know that they could access the service.

> *"I suppose just making sure that you use different channels, as many channels as possible so people have a good understanding of it and making sure you use every possible channel and access route to make sure that everyone has fair access to the service."* (Tag)

4.4.5 Effective

This theme was an a priori code which was confirmed through the analyses. There was a clear need to ensure the service was effective, though generally participants weren't sure on how effectiveness would be demonstrated. They discussed the concepts and areas for measurement in more broad terms which allowed for consolidation of comments. They also identified the need to measure effectiveness from the organisational perspective as well as the service users, though recognising that, whilst connected, this at times may not be measuring the same construct, concept or outcomes.

4.4.5.1 Organisational measures

Organisationally, the overwhelming focus for demonstrating effectiveness was through financial measures. This may be reflective of the current financial circumstances of the organisation where it entered the new fiscal year in a multi-million-pound deficit.

> *"Everything is money. The bottom line, you know everything is all about. So, if you're able to demonstrate that, um, this health coaching has had such a profound impact that it's prevented the patient from re-entering service because things are embedded and they have a plan, they feel much more in control of their mental health. And so they're not, they're unlikely to come back into services. Then that bottom line approach that you know that I would guess that would seem quite attractive to Commissioners. That actually this is making the difference. This is so we, you know, we don't need as many beds or there's gonna be less impact on A&E or whatever it might be."* (Roxanne)

> *"I'm just thinking about the current climate in the NHS and it's the focus is all about money. And unless we can demonstrate how coaching contributes to saving money I think it's just a difficult position to be in because I don't think there are any short term money saving examples that that we could use so feasibility, I dunno, I think the NHS needs to take a breath and think about what its priorities are."* (Em)

Additionally, there was a discussion about the fact that the health coaching service needed to demonstrate its alignment to contributing to the organisational strategy and aims.

> "What's the value to the organisation?' Because it could be a whole new thing about, well, actually if we're delivering health coaching as a programme on offer, are we doing things in terms of some of our objectives?" (Diamond)

However the challenge with this was the time coaching takes to show a demonstrable change in outcomes.

> *"Because sometimes it's quite long before you see improvement and it could be the coaching sessions happen and they went quite well, but there may be steps are taken a bit further down the line. It can be quite a slow process."* (Anemone)

Regardless of the outcomes, the coaches felt that due to the different definitions people were measuring effectiveness in different ways, and there was an inherent challenge in ensuring objective and standardised measures.

> *"The 1000 flowers blooming, that everybody's measuring something different. So how do I know if I go to that place that you know the outcomes for that organisation, and their health coaches are the same? You have to be measuring apples and apples, not apples and pears."* (Peach)

> *"So for example if you are coaching someone with diabetes, the fact that their HBa1C [sugar level markers] is now amazing when before it was all over the shop or that they use less insulin, that they have lost weight, that they haven't had three admissions to hospital in the last months. All of these are objective data, hard data. In mental health what would that be? Yes, less admissions. And if they do get admitted, fewer bed days perhaps. Obviously that's a multifactorial…they're all multifactorial…But in mental health that's not helpful in a sense because you're kind of…I guess what I'm saying is it's personalised, but you have to track stuff. Otherwise, how do you know? So, what are we spending our money on? Where's the health economics? Where's the economics around…OK, is this a good use of time of doing an hour here rather than going to the gym or cooking some… planning your*

healthy meals, you know? So you need to have something that shows that it's working." (Peach)

Thus, leading to the need to use qualitative measures to determine effectiveness, despite this not always being the type of measure that organisations value.

"If you think about whole service you want to do some quantitative stuff. I mean, there's numbers, isn't there, how many people say 'yes, their objectives were met' but the real value is getting underneath that and say 'what's this experience about?' What has it done? What has it led to? What has it opened up? Whatever it is, it's qualitative stuff for me." (Diamond)

"So, we've developed an operational definition for return on investment for improvement and it's not only around reducing cost, it's about improving quality." (Cosmos)

4.4.5.2 Service user measures

Whilst acknowledging the challenge in measuring impact quantitatively, references were made to questionnaires which attempts to capture qualitative experiences through quantitative means, for instance, the Quality of Life Scale (Flanagan, 1978) or the DIALOG (Priebe et al., 2007). However, much of the considerations of measuring health coaching impact on service users was through discussions, explorations and check ins between the service user and their coach.

"It's absolutely essential as part of the coaching to be getting feedback throughout and getting feedback from the individual. So that should be a process as part of the coaching session. 'Did this cover what you wanted to cover?' and you know checking into the start of the next session 'what's happened? what's changed? What further change do you want to make?' and so on and then independent of that asking for some anonymous feedback." (Dahlia)

"I suppose you could find out from the person. You know what they think and if it's made a difference. I suppose you could get them to fill out some kind of questionnaire or something at the beginning and then fill it out at the end to

find out whether people have found it helpful, you know their goals I suppose. And then you see whether people have achieved their goals or not. As a way seeing whether it was successful. Also, I think you need to bear in mind that people might change their goals as well, cause I've had that quite often. People they say, well, actually no, it's not really that. Cause once they start exploring that they should decide this maybe something different. So obviously then you would be measuring from those goals. I can't think of anything else." (Angel)

This was built upon when thinking about how coaching can provide some insight into new areas of improvement or satisfaction then what was originally identified.

"When people do the balance wheel the first time they might be focusing on various things, but through the process of coaching, realised that the initial balance wheel wasn't actually an accurate reflection of their levels of satisfaction. So I think it's a very difficult thing to do globally. I think it would, it's more of a qualitative measure and it's the feedback again just you know, has it met your expectations?" (Em)

4.4.6 Inter-relation of themes

When conducting TA there were a number of themes which were inextricably linked with other themes. An advantage with this analysis methodology is the ability to maintain them as distinct themes and present their connectedness through written and visual representation (Figure 6) (King, 2012). The interrelations were identified when identifying the original themes and noticing that there was a possibility of themes sitting across multiple areas. Final decision around where the themes should sit was through discussion with supervisor.

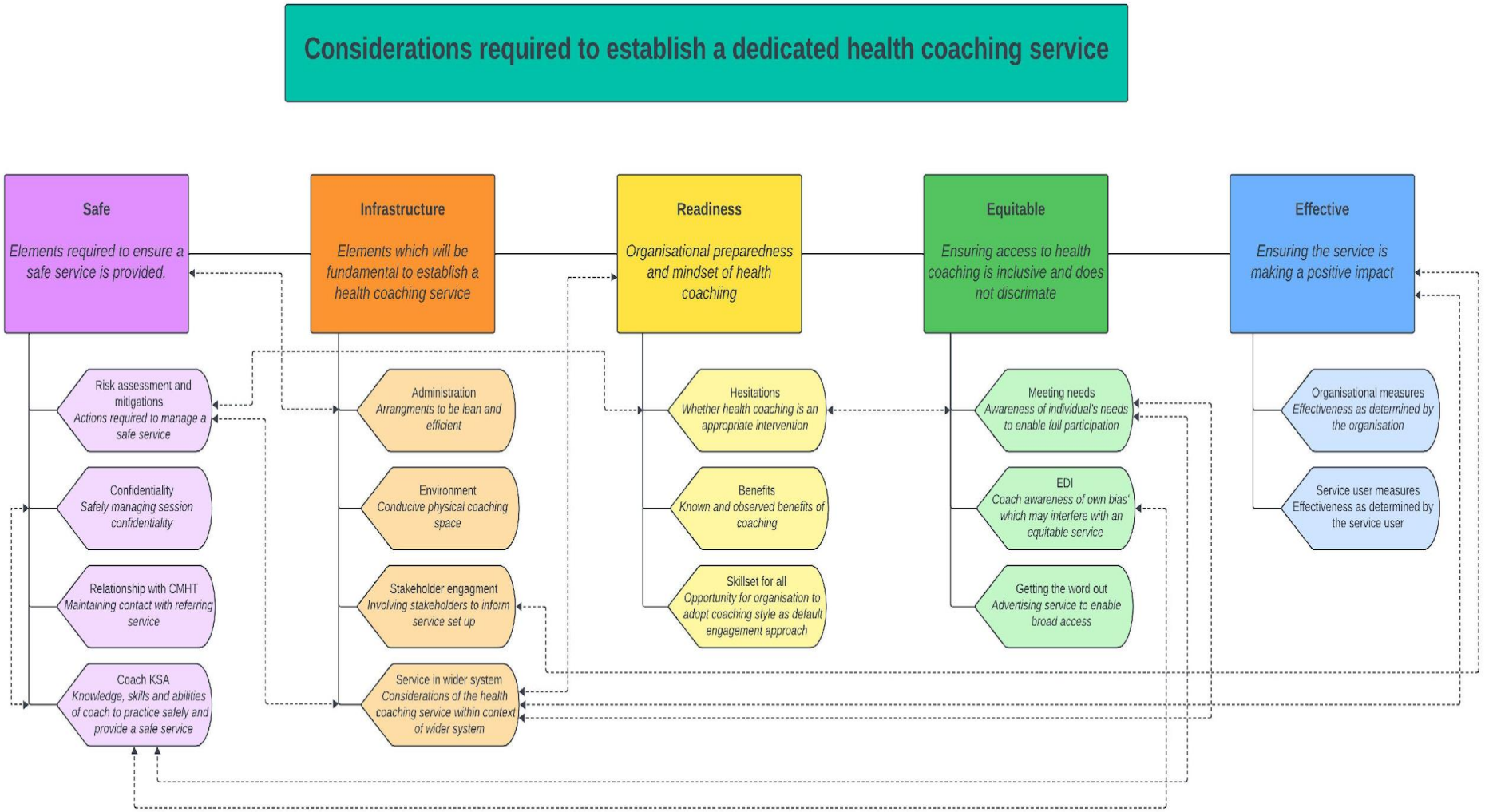

Figure 6: Considerations required to establish a dedicated health coaching service themes with interaction between themes

4.4.6.1 Safe and administration

The administration of the health coaching service had to continually incorporate safety as a core consideration of its set up. Patient eligibility, service governance, and the service offer needed to be developed in a way to ensure no harm would come to the service users. Where possible issues could arise, reasonable and proportional mitigations need to have been established. This also meant that the health coaching service needed to be very clear as to the parameters and offer of the service.

> *"I think one of the problems is the definition of coaching and people have different expectations of what it is, so confusion or lack of clarity is one of the things that might get in the way" (Em)*

More explicitly, participants discussed the importance of the service administration and its consideration of risk assessments and mitigations. It was clear that participants felt that without a service user risk assessment, the service should not be set up to ensure that the organisation, coaches and service users were protected. The risk assessment would not only act as a tool to catalogue and develop risk plans but would also be used to determine the service user's readiness to engage with coaching sessions. Participants were keen to emphasise that coaching was not an intervention to be used at any time for all people, and so a system to determine eligibility was important.

> *"It's not going to be, it's not going to be suitable for every patient. So I think a lot of care needs to be given as to what a good patient looks like for having this type of intervention, so how we set up the service and how we look after everyone is crucial." (Roxanne)*

4.4.6.2 Confidentiality and coach knowledge, skills and abilities

The participants discussed the importance of confidentiality as a core component of a coach's knowledge, skills and abilities, citing it as a core dimension of coach competencies in line with regulatory bodies. However, they noted the challenge of this when balancing the need to provide a safe service and managing risk to service users and others. The participants were clear that as part of coach knowledge, skill and ability, it was important for them to recognise when confidentiality needed to be

breached (informing the service user beforehand) to manage safety concerns and risk.

> *"Their rights to the confidentiality would be the normal rights, you know, with the provisos of course on any risk issues." (Precious)*

4.4.6.3 Risk assessment and mitigations, and hesitations

Participants were clear that part of the hesitations that staff, coaches and the organisation may have regarding the health coaching service was in relation to its ability to manage risky situations. The importance of risk assessments and mitigations has been mentioned previously but is crucial to ensure that no harm comes to service users or coaches, and also protects the organisation from any liability. Risks discussed include when patients may become overly distressed or discuss illegal or unsafe behaviours (i.e., harm to themselves or others). Regarding staff there was a discussion about how topics discussed as part of a coaching session could be a trigger to coaches, or even the possibility that a situation may arise which may have felt physically threatening. These risks are not exclusive to service users, however there would be a difference in the organisational accountability and the way in which the issues would need to be addressed.

> *"Given people's mental health condition and certainly knowing the clients who come through to our service here, they're usually in a state of mind where they might not be able to use coaching yet and actually sometimes might make it worse so we definitely need a way to make sure we are looking after them otherwise I don't think it would work for anyone." (Anoush)*

4.4.6.4 Risk assessment and mitigation, and service in wider system

One suggestion offered to manage risks and create appropriate mitigations plans was for the health coaching service maintain links with referring mental health teams or, in the least, ensure that there was a direct link back to the service from which the service user was receiving care. In this way, should a new risk be identified from the clinical team, the coach would be updated, and if a risk was identified as part of the coaching session, the coach would be able to appropriately work with the service

user to support them to raise with their clinical team (or for the coach to raise it to the clinical team – see 4.4.6.2).

> *“From the organization's perspective, the organisation must be absolutely satisfied that the risk element is absolutely minimised so which is the readiness for coaching from the service users perspective, clarity about what coaching is and what coaching isn't because that's a massive thing. (Diamond)*

4.4.6.5 Stakeholder engagement and effective

Participants were clear that the service needed to demonstrate its effectiveness, however, were unsure about a set of measures which would allow to do this. They discussed the need to include stakeholders (inc., service users, carers, other disciplines, budget holders and executive teams) to determine what their metrics of success would be. There was a recognition that different stakeholders would likely require different metrics to determine whether the health service was effective, and that data collection to cover all different metrics may impact smooth and service delivery.

> “I guess the cleaner ways is to just, yeah, speak to patients and get their evaluation in terms of how it's made a difference to them.” (Roxanne)

> “I think we'll we will need to ask their services how they feel they've been, what changes they they've observed. (Precious)

> “I don't like the notion of return on investment because again, I think it's very individual. So I suppose we need to know from the organization's point of view, what do they want to satisfy them that it's been a good use of resource.” (Em)

4.4.6.6 Service in wider system and readiness

A challenge identified was how the health coaching service would exist within a complex system. The NHS works with multiple different agencies which exist across and outside of the trust and a health coaching service would require good relationships with intra- and inter-organisational departments (e.g., community

mental health teams). There needs to be a level of readiness and preparedness from teams and wider agencies to best utilised the health coaching service to embrace and utilise the service.

> *"It needs to be set up in a way which means that other services outside of the hospital also know that we have this on offer but if they don't want it or aren't signed up to it then there's no point. We gotta get their sign up too" (Precious)*

4.4.6.7 Service in wider system and meeting needs

Appreciating the service in the wider system was recognised to better allow coaches to meet the needs of those accessing the service. Understanding service user context, what services they may already be accessing or what services they might need was seen to an important consideration to better be able to meet service users *"where they're at" (Cosmos).*

> *"You gotta think, the majority of our patients have needs that are met by other agencies outside of here so we've got a responsibility to make sure that we think about the person as a whole, you know holistically, to really help them achieve what they want "Peach"*

4.4.6.8 Service in wider system and effective

Understanding the measures for effectiveness and how the health coaching service fits with the wider system was seen as an important consideration. The necessity to appreciate the way in which other services function and measure effectiveness was explored. This was discussed for two main reasons. Firstly, where the health coaching service could learn from how other services measure effectiveness.

> "Do you know the QoL (Quality of Life)? We use that a lot in older adults but that might be something we can take and use or amend to make it more for this service" (Cosmos)

Secondly, where there may be measures of effectiveness that are already being captured elsewhere which the health coaching service may not need to duplicate.

> *"We've got the DIALOG starting to come in at the moment too which is done by the care coordinator so it might be useful to think about how we can use*

that to kinda track how the sessions are going rather than get them to fill out more questionnaires. But I think what might be a bit tricky there is that it might go up and down (patient satisfaction) so it might not always show the improvements we're trying to help with. (Tag)

4.4.6.9 Coach knowledge, skills and abilities, and meeting needs

Having the requisite coaching competencies was seen as bring crucial to understanding and being able to meet the needs of the service users. There was a recognition that coaches need to tailor the way they work appropriately to enable effective and meaningful work with the coachees. Additionally, being able to work with individuals which met their needs would enhance and contribute to coach practice and development. A frequently discussed suggestion was to ensure that coaches had basic mental health training to support them in their knowledge of different mental health conditions and the symptoms and behaviours to be aware of which may impact the content of coaching sessions.

" I think we need to make sure that people are confident and competent so that we optimise the safety aspect of it and people's ability to really understand the boundary between therapy and coaching. So I remember supervising someone who went on a weekend course and said they were now coached and I was horrified at some of the practise and there were absolutely no boundary. I mean, this particular coach even went to with to A&E with the woman one weekend because and. And it's just like that's not coaching. This, I think, would be helped by having some basic mental health first aid training or something that you can get for free on the NHS website. I think that would just really help knowing our boundaries but what the coachee needs." (Cosmos)

4.4.6.10 Coach knowledge, skills and abilities, and EDI

Similarly, coaches meeting their core competencies and engaging in professional development would contribute to the true spirit of equality, diversity and inclusivity. Through the supervisory and developmental activities of the coach they would be

supported to check and challenge their own unconscious and conscious biases which may interfere with their coaching intervention.

> *"I'm on the equality, diversity and inclusion working group and we have something called safe space where we come together as clinicians and employment advisors to talk about how we manage the needs of our service users that come in but come from different cultural backgrounds. It helps us think about how some of our own biases can impact our relationships and so there's a bit of safe challenging from colleagues in the room to make sure that we are being sensitive to our clients' needs. (Anemone).*

4.4.6.11 Hesitations and meeting needs

Being able to meet service users' needs was a concern expressed by coaches. This caused coaches to express their hesitations in providing the health coaching service. Core to this hesitation was the coach's priority in maintaining the safety and wellbeing of the service users. Whilst this was of particular concern during the beginning of the interviews, as the conversations progressed these dissipated following explorations and mitigations to these concerns (e.g., mental health training, supervision, governance, etc.

> *"If you are a clinician…you have a sense of when coaching is appropriate, when it's not in terms of you know who you're working with, how you're working, when you're going to see you utilise the coaching approach…there is that thing in me that's says 'well I'm not sure if I am the one to do (coaching) with them'…but I suppose I'm making a few assumptions there and I think, 'well, what do I need to overcome this?' well it'd be things like supervision and mental health training and doing other CPD stuff" (Diamond)*

4.5 Discussion

This study set out to establish the organisational considerations required prior to introducing a health coaching service for mental health service users. It did so by completing 11 interviews with accredited coaches who work within a mental health NHS organisation which brings robustness and awareness of contextual factors to this research. It contributes to the literature around implementing complex interventions in an NHS context and to the beginning of establishing a health

coaching service for service users which is a “patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals…” (Wolever et al., 2013, p. 52).

The themes identified through the study highlight the paramount and complex considerations (Skivington et al., 2021) required and also the inextricably linked components in setting up the service. Five overarching themes were identified through the use of TA (King, 2012); ensuring safety, components of the service infrastructure, considering the organisation and wider system readiness, ensuring equitability in service provision and the importance of measuring effectiveness of the service.

In the main, participants were supportive of a dedicated coaching service for mental health service users. They saw the potential positive impact that the service could provide i.e., enabling more person-centred recovery, holding people able and accountable and reducing demand on services, which is supported by their experience but also supported by evidence based literature reviews (Gray, 2019; Kivelä et al., 2014; Wolever et al., 2013). Concerns centred mostly on ensuring a safe practice for the service users which was multifaceted and reflected the current emphasis on providing safe care (NHS England and NHS Improvement, 2019). Providing safe care included, clinically safe (i.e., managing the safety and mitigating risks to patients), education and training of coaches to support their knowledge in mental health conditions, the use of data to help make informed decisions and ensuring the appropriate skills, knowledge and abilities strengthened by supervision and continuous professional development.

These components contributed to the shift in participant thinking during the course of the interviews. Initially, those participants with a non-clinical background expressed hesitation in providing health coaching to mental health service users. However, when reflecting on the service provision they realised that with the appropriate service set up and infrastructure, service user, coach and organisational safety could be ensured with mitigations established. Participants all coach Trust staff who may or may not have disclosed an existing mental health diagnosis. Regardless of the

disclosure, the coaches work with the individual rather than with the diagnosis they have, and so the evolution in the participants' thinking may be a reflection of their assumptions being challenged in trying to determine the difference between coaching an individual who is identified as a mental health service user and coaching an individual who is a Trust staff member with a mental health diagnosis.

Ensuring appropriate service infrastructure, which considers the organisational and wider context aligns with NHS England's (NHS England, 2023a) operational planning guidance. The components spoken about by participants comprehensively consider the needs of service infrastructure from different perspectives. However, additional input is required from other stakeholders (e.g., service users, carers, other health teams, executive leadership team, finance and contract members) to benefit from extensive system stakeholder perspectives (Skivington et al., 2021).

An additional advantage of engaging all stakeholders is the opportunity to prime and determine individual and organisation readiness to change in considering and implementing a new service. Change is comprised of structural and psychological factors (Holt et al., 2010) and is frequently framed using the transtheoretical model of change (Prochaska & DiClemente, 1982) which is comprised of five stages: precontemplation, contemplation, preparation, action and maintenance. Engaging stakeholders in feasibility discussions contributes to the pre-contemplative and contemplative processes and may progress the 'thinking' process into the 'doing'.

Stakeholder conversations were also highlighted by participants are being crucial to better understanding the measures by which effectiveness would be determined. Skivington et al.,'s (2021) work emphasised the importance of measurement to determine value and difference making. This informs decisions relating to the maintenance of services, particularly where there is resource depletion in the NHS and financial decisions undergo scrutiny and require justification. Participants noted that, whilst they were unclear themselves how to measure effectiveness, service value and difference making, it was likely that the organisational measures and service users measures of effectiveness would be different. Organisational measures were seen to be related more to objective direct and indirect financial impact (reduced number of bed days, reduced need to access health teams etc.),

whilst service user measures were more likely to be qualitative and relating to their experience, ability to achieve goals (or gain more clarity on what they wanted to do) and making meaningful personal changes. This highlighted the importance of distinguishing between the medical model definition of recovery and the concept of personal recovery (Slade, 2009).

However, with regards to providing an equitable service, participants did not distinguish between different measures that might be noted by stakeholders. At the time of the research, the Patient and Carer Race and Equality Framework (PCREF-NHS England, 2023b) was being newly adopted by the organisation. This anti-racism framework was, in part, focussed on ensuring that all people, regardless of their race, were provided with the same care and opportunities and their white counterparts. The participants were keen to ensure that specific strategies were developed to ensure fair and equitable access to the health coaching service, and that this was a proactive and continuous endeavour.

This research, having used TA to interrogate the participant interviews, has identified five overarching themes which are inter-connected reflecting the complexity in ensuring the introduction and implementation of a safe, timely, equitable, effective, efficient and timely health coaching service. The research has a number of practical implications for future work. Firstly, the results presented can be adopted by any mental health NHS organisations. Acknowledging the differences across mental health Trusts, the overall functioning, structures and governance are similar. It is therefore advantageous when introducing a novel intervention such as this. Secondly, by being explicit in the coaching definition adopted there is assurance as to the expectations of what health coaching is and the respective offer. By adopting and delivering coaching aligned to this definition it allows for a larger data set to be collected and evaluated in the longer term to determine benefits. This is benefitted by the minimum internationally recognised coaching level and qualification of the research participants. Finally, with the research following clear and recognised structures and frameworks it provides assurance of the quality and validity of the output for organisations to adopt and utilise with minimal adaptations.

4.5.1 Research strengths and limitations

The qualitative design of this research lent itself to developing a comprehensive and in-depth understanding of the considerations required before establishing a mental health coaching service. The evidence informed interview schedule by STEEEP (Institute of Medicine, 2001) provided an important starting point from which to engage participants, whilst the open questions and semi-structured interview allowed for broader and flexible curiosities to guide the discussion (Adams, 2015). This benefitted from the researcher's own experience of being a coach and working in a mental health context as prompting and follow-up questions were informed by real life experience, which otherwise might not have happened with a less familiar or experienced researcher. The adoption of STEEEP (Institute of Medicine, 2001) and the framework to develop and evaluate complex interventions (Skivington et al., 2021) were adopted over other relevant models as they provided more granularity into considerations required to establish a novel health intervention. This has been important as part of this research as there is no extant literature on which to build and provide additional insights to introduce a health coaching service. The adoption of this frameworks is further justified as there is a fracture in the coaching literature relating to definition, dosing and intervention provider (Gray, 2019). These further compounds the challenge of knowing who, how, when and what comprises a high quality intervention. The use of the frameworks on which this research is anchored provides insights into the fundamental considerations required to begin the development and the implementation of a complex health intervention.

Using an evidence informed interview schedule provided a priori themes for the initial codebook when analysing the transcripts using TA. The flexible nature of template analysis allowed the researcher to utilise the a priori themes for initial coding but did not bind them to it, inviting new codes to be incorporated following the ongoing interrogation of the different transcripts (King, 2012).

This analysis methodology was driven by the research design, question and protocol but also lent itself to an effective and efficient analysis of the transcripts. Having the a priori codes established allowed for ongoing data interrogation to build on existing codes, i.e., the researcher was not working from a blank sheet of paper, whilst not compromising the integrity of the project. This was also important due to the time

pressure of completing this research project. Whilst TA does not stipulate an exact sample size, it encourages the incorporation of the researcher reflexivity to determine when best to end data collection. This reflexivity was achieved through discussions with supervisor, as well as the researcher fully familiarising and immersing themselves in the transcripts to determine any remaining gaps in themes. To ensure there were no biases in ending or continuing data collection, ongoing input from the researcher's academic supervisor was sought.

Another consideration which required mitigation was the sampling methods. Resource and pragmatic limitations influenced the population sample which could be invited for taking part in the research. To ensure a higher sensitivity level of ethical approval wasn't required (which would have significantly affected the project timeline), only level 7 qualified coaches were invited to take part. Additionally, in the absence of a comprehensively representative stakeholder group, some perspectives shared may have been limited. For example, there was a discussion about the opportunities to coach service users virtually, however it is well documented that service users, particularly those in mental health services, are disproportionately disadvantaged when it comes to using digital solutions (Borghouts et al., 2021; Cortelyou-Ward et al., 2020). This includes digital literacy, access to hardware and the psychological comfort with engaging in another individual online. Inviting a broader and representative sample group would ensure these factors would be considered a mitigated more effectively. Additionally, whilst participants' views and opinions were sought, the reality of working as part of a large and complex organisation means that some decisions are not theirs to make. For instance, the questions seeking the participants' thoughts around measuring effectiveness could not be answered sufficiently from an organisational or a service user perspective. Having adopted a transformative paradigm, the absence of clear answers to questions may be reflective of the fact that the participants exist as a part of a greater whole in a large and complex hierarchical system (Mertens, 2008).

Whilst there were some limitations attributed to the sampling technique, the research benefitted from the fact that the sample group were from diverse professional background. With the participants being from a clinical and operational background

provided more rich insight into the organisational considerations required to establish a health coaching service.

4.5.2 Implications of research in the research site

With the researcher being a substantive member of staff within the organisation in which the research was conducted, part of the ethical (and moral) obligation was for feedback to be shared. This was done with the participants, the established coaching service staff and the Service Director. At the time of writing this thesis, arrangements have been made for the research to be shared at the Leadership Forum and the upcoming Annual General Meeting. The former would be to the organisation-wide leaders (clinical, operational and corporate) and would provide the opportunity to provide the insights shared by the potential intervention providers and also begin the conversation with wider stakeholders and gauge readiness for change. The latter would be to any organisation member of staff as well as service users, families, carers, voluntary and third sector organisations. This would have the same intended outcome as the Leadership Forum but with a wider pool of stakeholders. It could be from this that the next steps in the considerations would be informed (e.g., whether to engage with service users or senior organisational members first or even if there is an appetite for such a health coaching service).

It is also important to reiterate the implication of researching in one's own organisation. As explored in Chapter 2, the ethical considerations especially around the power dynamics was important to explore and establish checks and balances. It was necessary to ensure that participants did not feel compelled to take part and, if they did, to respond in a manner that the researcher would deem desirable. To mitigate this full disclosure as to the research aims, objectives and process was provided to the sample group. Another implication is that the researcher had prior knowledge to the complexities of the organisational structure and its current challenges and contexts. (e.g., national, financial, local service provisions and commissioning etc.). It was important, through the continued discussion with the programme directors and supervisors to ensure that no researcher bias was present when conducting the interviews or analysis. To overcome this transcript samples were coded by the supervisor to ensure consistency in the data interrogation and

coding. When presenting back to the Leadership Forum and at the Annual General Meeting it will be crucial to present and discuss these points in order to be transparent about the research.

4.5.3 Future research

It is crucial to ensure that future research follows agreed methodology and stepwise processes. There is more that can be completed as part of determining feasibility, specifically in the inclusion of wider stakeholder views. Following this, in line with the phases to establish and evaluate complex interventions in the NHS as outlined by Skivington et al., (2021) the appropriate next step is to develop an evaluation framework for the intervention. This evaluation needs to consider appropriate outcome measures and evidence of change from multiple sources. The evaluation also needs to look beyond whether the intervention 'works' (i.e., achieving the intended outcome of health coaching) and consider the broader impact of the intervention, such as the contribution it makes to system change. This next step would require a broader participant group i.e., more stakeholder engagement and perspectives, for example, the Chief Financial Officer, Head of Contracts and Performance, service user and carer representatives etc. Incorporating evaluation concepts from the implementation science field (e.g., (Proctor et al., 2009) would provide a robust framework to ensure comprehensive and multiple formats of outcome measures, such as implementation, service and client outcomes.

Following the establishment of an evaluation methodology it would then be possible to begin trials to determine the efficiency of the complex intervention. To support this, concurrent efforts need to be made to develop an agreed definition of coaching to ensure all interventions and evaluations are in relation to the same concept. This would contribute to a strong evidence base on which more reliable conclusions can be drawn.

4.6 Conclusion

This empirical research has provided a stepping stone in developing and evaluating complex interventions (Skivington et al., 2021), specifically in relation to establishing a health coaching service for mental health service users. This feasibility study has

identified the prerequisite considerations and components from the perspectives of coaching professionals to ensure comprehensive and adequate thought is given to establishing a health coaching service. The themes and the inter-connectedness identified highlight the complexity in embarking on such an endeavour emphasising the need to ensure more research is conducted to explore and unpack these components. The themes identified as part of this research will ensure that the organisational, coach and service user needs are met, whilst also ensuring the service can be evaluated in line with existing measures of high-quality service assessment. Therefore, going forward prior to establishing a mental health coaching service the organisation must consider how to ensure a safe, equitable and effective service with the appropriate infrastructure and organisational readiness.

Chapter 5 – Discussion

This chapter brings together the previous four chapters. This chapter aims to summarise and present the aims of this thesis within the context of the two studies; the SLR and the empirical study. The chapter will also highlight the strengths and limitations of this body of the works completed and identify the practical implications and its contribution to practice and knowledge base in the field. Table 10 provides a synthesis of findings from the SLR as well as the empirical study.

	Study 1 – SLR	**Study 2 – Empirical research**
Key aims	- Determine the impact of health coaching on mental health conditions	- Determine the organisational needs for a mental health Trust to introduce a high-quality health coaching service
Method	- Systematic literature review - 3 databases searched - Yielded 3182 papers	- Semi-structured interviews - Template analysis
Sample	- 5 papers met inclusion criteria - 4 papers in physical health settings with mental health as secondary outcome - 1 paper in mental health setting	- 11 Level 7 trained coaches - Employed by mental health Trust - Average years qualified= 8, range= 3-16 - Variety of professional discipline background
Key findings	- Health coaching generally has positive impact on health outcomes - Discrepancy in which tools are used to measure same construct/ condition - Coaching ceases to continue following the end of project - In order to establish health coaching to determine feasibility, impact and economic benefits, it is needed to understand the organisational needs ahead of	- 5 overarching themes identified: safety, infrastructural needs, organisational readiness, equality of service, and effectiveness - Many subthemes which were also inter-related across themes

	introducing the service. This has not yet been done as is crucial to being able to introduce the service	

Table 10: Synthesis of results from study 1 and 2

5.1 Aims and overall findings

The aim of this thesis was to understand the components necessary to establish a health coaching service for mental health service users. This was driven by the growing demand on mental health national health services (NHS Digital, 2023; Suleman et al., 2021a) against a context of dwindling staff numbers (Taylor, 2020), morale (NHS Staff Survey, 2022) and resources (Buchan et al., 2017, 2019). The implication of this is an increase in waiting times (NHS Digital, 2023) and suboptimal health outcomes (Reichert & Jacobs, 2018). The NHS Confederation (2022) declared the system unsustainable urging for the system to review and offer different interventions to yield different results. One such way is health coaching as evidence is increasing in this field (Ammentorp et al., 2013b; Boehmer et al., 2023; Kivelä et al., 2014; Wolever et al., 2013). Health coaching has been defined as *'a patient-centred process that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds. The actual coaching process entails goal-setting determined by the patient, encourages self-discovery in addition to content education, and incorporates mechanisms for developing accountability in health behaviours'* (Wolever et al., 2013, p. 52). The systematic reviews have shown the positive effects of health coaching on physical health outcomes, however no research has yet been conducted to determine the outcomes of health coaching on mental health conditions/ metrics to date.

5.1.1 Findings for study 1 – systematic literature review

To address this gap in the literature, an SLR was conducted to consolidate the extant literature and evidence base relating to health coaching with mental health outcomes. Three databases were searched of which five papers met the inclusion criteria. The results indicate that health coaching has a positive impact on anxiety and depression but no other mental health condition based measure was used. Only

one of the studies solely focussed on mental health service users (Slade et al., 2015) and this paper reported no change as part of the health coaching intervention. The other four studies looked at physical and mental health conditions in parallel as part of their research and showed generally positive changes across the metrics following health coaching. Two of the papers (Slade et al., 2015; Swendeman et al., 2021) also conducted qualitative analysis relating to the participants' perspective on the feasibility and acceptability of health coaching. Participants reported positive experiences with coaching and felt as though this was a useful intervention to be offered.

Whilst these results are positive there are significant criticisms of the evidence. There has been no universally accepted definition of health coaching. Through the systematic literature review by Wolever et al., (2013), a health coaching definition was developed which Gray (2019) recommended to be adopted for health coaching delivery and research. The acceptance of an agreed definition is of importance as currently research is measuring concepts and mental health conditions in different ways. This is a pervasive issue in all types of coaching with Wang et al, (2021) arguing that if the field is unable to agree a definition this will then create discrepancy in knowing what and how to measure mechanisms and impact of coaching. Additionally, by adopting an agreed definition of coaching, it will allow the field to consolidate learning more easily and develop a more compelling narrative of the impact of coaching.

An additional limitation of the extant literature identified by the SLR is that research regarding health coaching has often been an 'add-on' to treatment as usual and forming part of a research project, meaning that once the research project has ended the health coaching intervention has no longer been provided. It has therefore not been possible to determine the longer term impact of health coaching. This is of significance as the financial justification and sustained health benefits cannot be measured. Skivington et al., (2021) has provided a considerations required ahead of introducing and evaluating complex interventions in health context. This identifies that a component of this is to understand the necessary components to implement an intervention. This has not yet been conducted with health coaching, especially in a mental health context.

This is of significance as only one paper (Slade, Bird, Clarke, et al., 2015) was identified which was conducted in a mental health institution with mental health participants. The absence of research considering health coaching in only mental health contexts is a reflection of how mental health conditions are secondary to physical health conditions compounded by systemic discrepancy with regards to resourcing and funding (Gilburt & Mallorie, 2024; Saxena et al., 2007). Whilst this discrepancy remains a live issue in health services it can be argued that it is even more imperative to better understand the impact of health coaching on mental health service users in order to contribute to alleviating the pressures experienced by mental health institutions.

The other four papers all took place in a physical health setting where health coaching impact was measured as a secondary outcome. The context is important to note as physical health services function in a very different way and in a very different socio-political climate than mental health services (Mental Health Research, 2023). Therefore, focussed attention is required to sufficiently explore and understand the organisational considerations needed in order to establish a health coaching service in mental health settings. The SLR has shown that this work has not yet taken place.

5.1.2 Findings from study 2 – empirical study

Building on this gap in extant literature identified by the SLR, the second study invited 11 participants to take part in semi-structured interviews which sought to understand their perspectives on the organisational considerations needed prior to establishing a health coaching service for mental health service users. The participants were identified and approached due to their coach training level and the fact that they were employed by and working in a mental health Trust. The aim of the study was to determine the considerations required to establish a health coaching service for mental health service users as part of the Trust. The semi-structured interviews were informed by the STEEEP framework (Institute of Medicine, 2001) which provides the metrics by which high-quality services are

determined and followed the stepwise recommendations for developing and implementing an intervention in the NHS (Skivington et al., 2021),

The empirical study highlighted that necessity to use recognised and evidence based models which enable change to be introduced in the NHS. Whilst many are available, e.g., the Change Model (Sustainable Improvement Team & Horizons Team, 2017), the adopted framework was the product of the National Institute for Health Research in conjunction with the Medical Research Council (Skivington et al., 2021) which focusses on the requisite steps for developing and evaluating complex interventions. The Skivington et al., (2021) model was adopted as it provided more in-depth and structured steps to progressing change. This was of particular importance as this thesis was exploring the introduction of a completely novel intervention and so thorough and comprehensive consideration was required in order to enable this. The model provides instructions and guidance to determine when a step in the model is 'completed' or indeed when a process needs to revert back to a step previously thought completed which will ensure a rigorous and comprehensive change approach. The model is practical (rather than theoretical/ academic) in nature and so lends itself to being easily applicable and aligned to the authentic clinical and organisational context in which the research took place. This pragmatic approach is also reflected in the fact that it acknowledges where there may need to be 'trade-offs' where researchers consider the most important questions/ areas to consider to enable decision making rather than asking questions which provide absolute certainty. It was therefore not necessary to make any adaptations to this model before adopting it for use as part of the research. The addition of the STEEEP framework (Institute of Medicine, 2001) complemented the Skivington et al., (2021) as it provided granularity to ensure an intervention is of high quality. The STEEEP framework proposed the Institute of Medicine (2001) provides more specific areas from which to consider high quality services. The domains of provides assurances to the community, staff and the wider organisation that the care provided meets the six dimensions that are associated with high quality service provision. Using STEEEP as the coding framework from which the semi-structured interviews were established provided the research with assurance that necessary quality domains were being considered. The benefit of adopting Template Analysis (King,

1998) was the ability to introduce and disregard themes that were/weren't supported by virtue of the analysis.

From the interviews study 5 overarching themes were identified through the use of template analysis (King, 1998, 2012), namely; safe, infrastructure, readiness, equitable, and effective. Each of these themes had sub themes and were inter-related within and across the overarching themes. This highlighted the complexity of establishing a high-quality service from the perspective of those who would be delivering the service. Participants were supportive of the use of health coaching in a mental health Trust, noting the possibility the intervention has on allowing patients to become the drivers of their own care, needs and goals which is reflected in other SLRs (Gray, 2019; Kivelä et al., 2014; Wolever et al., 2013). Initially, participants without a professional background in mental health were concerned that they may do more harm than good without knowing sufficient information about mental health conditions, their respective symptoms and ways to manage. However, these perspectives evolved during the course of the interview, aligning more with the views of those with a professional background in mental health where it was suggested that a rudimentary level of knowledge would be beneficial for coach and coachee. This formed part of the safe theme, which also included patient risk assessment and mitigations, confidentiality, relationship with care providers and coach knowledge, skills and abilities and was the most pressing area which needed to be considered.

It was also noted that the organisation needed the mindset to support a novel intervention within the context of the existing infrastructure of the organisation. This, it was suggested, would be appropriately achieved through stakeholder discussions (Skivington et al., 2021). Engaging stakeholders has been identified as an important step to supporting the mindset shift from the 'thinking' to the 'doing' (Prochaska et al., 1994). By engaging with stakeholders it was also said to be easier to identify the metrics by which an effective service would be determined as well as understand the systemic enablers and barriers to providing an equitable service.

This study has contributed to the gap in literature identified in study 1 which highlighted the benefits of using a health coaching service on mental health

outcomes, but without any organisational considerations needed to establish a health coaching service.

5.1.3. Overall findings

The findings from this thesis progressed extant literature relating to the positive impact of health coaching in a mental health service with study 2 making initial strides towards determining the organisational considerations required to establish a health coaching service.

The outcome of the empirical research, i.e., the organisational considerations, will enable the identified gaps from the SLR to be addressed. Much of the literature from the SLR noted the inability to measure the long-term impact of health coaching owing to the ceasing of service following the end of research. The information identified in the empirical research would allow for an appropriate and well-considered health coaching service to be introduced which would enable long-term intervention measurement. The discussion around these considerations would also allow for a discussion, using evidence from literature, around the different measures that could be used to measure any difference or impact of health coaching.

The empirical study also explicitly employed the use of the health coaching definition proposed by Wolever et al., (2013) which was reinforced by the level 7 requirement of all participants in the sample group. This ensured consistency in what and how the coaching intervention would be conducted.

A gap from study 1 was the absence of reporting who provided the health coaching service to participants. By being more explicit about the skills, knowledge and competencies required of coaches a more safe and effective service could be offered.

5.2 Implications for research and practice

5.2.1 Future research suggestions

This thesis has built on the Skivington et al's., (2021) work which identifies the appropriate process to develop literature, evidence and interventions in the NHS. The thesis invited one stakeholder perspective to contribute towards service implementation by better understanding the organisational considerations required prior to establishing a health coaching service.

In line with this, and acknowledging, that this research invited only one of multiple stakeholders to participate, future research should be focussed on incorporating the views of service users, carers, service decision makers (e.g., chief financial officer) and wider third party and voluntary sector groups. Research has shown the importance of incorporating as many relevant stakeholder perspectives so as to develop a better, well-informed, and requested service.

Additional areas of research include the continued development of health coaching research in a mental health setting. To ensure the continuation of high quality research, recommendations by recent literature reviews (Gray, 2019; Wolever et al., 2013) should be followed which calls for health coaching research to adopt a unified definition of coaching and to incorporate the same validated outcome measure for various health conditions. In doing so, it is more possible to generate replicable studies and data which is more easily consolidated and therefore continue to build on the evidence base. This in turn would allow for longer term studies to determine the extent to which the effects of coaching last and further contribute to discussion and decisions around financial viability and return on investment of a health coaching intervention.

5.2.2 Practice and policy implications

This thesis reinforces the importance of discussions with stakeholders in establishing a service which is, in itself, complex within a complex organisation. Locally, this research provides strong evidenced information to inform policy and practice for the Trust within which it took place. Externally, this research provides a foundation for

other mental health Trusts to establish their own health coaching service, though it is recommended that an additional engagement piece is conducted with local stakeholders. This is necessitated by the fact that individual Trusts have unique structures, funding, commissioning, governance and population needs.

As mentioned previously in the thesis, a primary goal of health coaching is to reduce the burden on health practitioners and improve health outcomes for service users. The establishment of a health coaching service, using the information generated from this thesis will contribute towards this endeavour.

Knowing the positive impact of health coaching, there is also the opportunity (as also identified in the empirical study) for local coaching development programmes to be developed which would prioritise the upskilling of all health practitioners in core coaching skills. This would enable a coaching approach to be a complementary skill to clinical approaches and support mental health service users to engage with self-identified goals more routinely. This in turn can improve engagement with clinical teams and thus health outcomes. More broadly, coaching skills could be incorporated into clinical training more explicitly so to make health professionals aware of the different conversation types in their arsenal. This has already been done by other approaches e.g., motivational interviewing (Rollnick et al., 2008) and has had positive effects in socialising the approach into everyday practice.

5.2.3 Wider implications

Beyond the future research and policy implications of this research, there is also an opportunity to apply this to a much broader scope. Learning from the SLR can contribute to the field of coaching as a discipline to begin to establish a more robust, rigorous and methodologically high quality research base. The SLR identified a number of gaps, e.g., the unknown 'dosing', definition, outcome measures, mechanisms etc. to determine the impact of and how to maximise coaching interventions. These issues are not unique to coaching and apply to broader interventions. For example, Donaldson-Feilder et al., (2019) also identified these issues within the mindfulness field and similarly in self-compassion literature by Neff and Dahm (2015). Therefore, there is the potential benefit for in developing a more

coordinated approach to reporting and evaluating interventions which impact health outcomes. This will ensure that sufficient information is provided to practitioners about introducing and implementing an intervention.

The empirical research, beyond the local and national application, reinforces the utility of the Skivington (2021) model as a structured, step-wise and evidenced approach to developing and introducing a novel intervention in the NHS to ensure stakeholder satisfaction, high quality outcomes and sustainability. Additionally the STEEEP framework (Institute of Medicine, 2001) complements to the Skivington (2021) model by providing further granulation by utilising an already existing framework in the NHS which determines measures of a high quality intervention. From the empirical study, further evidence and application of these frameworks in practice are presented. Whilst acknowledging other frameworks are available to support enable the introduction of changes (e.g., Sustainable Improvement Team & Horizons Team, 2017), it can be argued that the empirical research as part of this thesis contributes to wider change models more broadly in exploring in more depth a specific step required in order to introduce change. In so doing, change models can ensure that thorough use of this step is incorporated into the model(s).

5.3 Contribution to knowledge

This thesis provides a unique contribution to the coaching body with a particular lens on mental health services. The results and outcomes from the SLR highlight that within the field of health coaching there exists gaps relating to quality variation by studies, broad range of outcome measures, context approach to mental health, lack of understanding about the mechanism of coaching, and no evidence provided related to the long term impact of coaching. From this, the empirical study informed by the Skivington et al., (2021) framework focussed on the determining on what is organisationally required to establish a long term health coaching service. In so doing the requisite steps associated with the framework would also be addressed as the research progresses through the framework. That is to say, by understanding what is needed to establish a sustainable health coaching service it is more possible to work with stakeholders to determine outcome measures and determinants of

success, understand the impact of coaching, and conduct long term research that provides insights into the mechanism of coaching. By adopting recognised and respected frameworks which are utilised in the NHS for establishing and evaluating an intervention (Skivington et al., 2021) and the measures of high quality services (STEEEP; Institute of Medicine, 2001), it has been possible to create a coherent connection between the evidence base and the appropriate next stage in bridging theory and research into practice.

Chapter 6 - Reflective Assessment

6.1 Personal reflexive context

I am a white, cisgendered, heterosexual, middle class, Christian background, atheist non-disabled woman. I am the daughter of migrants and on both sides of the family, who were brought up in poor circumstances, have experienced persecution. This has been experienced by my parents up till my great-grandparents where our records cease to exist due to the ethnic cleansing my people have been subjected to. This has left an indomitable scar on our family and the way in which we function with people around us and the world. Through the persecution of my people I have often wondered what it is that truly makes us different from one another. The colour of our skin? The place we grew up? The absence or presence of ill health? Why do any of these matter in who a person is? It has meant that my political and social perspective is one of inclusivity and egalitarianism.

6.2 Topic selection

It is for this reason I am passionate about working in health services, and more specifically in mental health. I have had family members who have experienced mental ill health and from the absence of mental health knowledge and for fear of ridicule, tainting the family name, and ostracising have not been able to engage with services that might help them. The stigma associated with a mental ill health diagnosis exists to this day. I have previously worked in a clinical capacity and saw the fear on people's faces, including family members, when a diagnosis was given. In my current role working with staff, they talk to me about the challenges they have in meeting their service users' needs because of the resource constraints, lack of funding, increasing vacancies etc., all of which means that they are having to move away from engaging with a service user in a meaningful way, to seeing as many as they can and completing necessary governance and assurance documents. This is absolutely not because they are bad at their jobs, they are in fact trying to see as many people as possible, to help as many people as possible. Paradoxically, this is stripping service users from being empowered to be the drivers of their own care, goals and future. This is the subjectivity with which I have entered this professional doctorate programme. The people I have surrounded myself with; the organisation,

my immediate colleagues, my organisational clients- we all subscribe to these similar values and principles. It is with these lenses that I have engaged with the research question, and the basis for the way the data has been interrogated and presented. All research is subjective- it is all based on the beliefs and feelings of the researcher and how it should be understood (Braun & Clarke, 2021b; Denzin & Lincoln, 2005).

6.3 Functional and disciplinary reflexive context

Working in prestigious mental health organisation which is internationally recognised for generating and contributing to cutting edge research to inform mental health evidence based practice, there is both an opportunity and implicit expectation to contribute to research. As a result, the organisation attracts and has a culture of continuous practice but also one of competition and pride. Many clinicians, practitioners and academics are drawn to the organisation to advance their professional lives. Having worked in the organisation for over a decade, and also having an interest in pracademia, I have a desire to contribute as well, however my approach is away from the traditional quantitative methodologies more associated with medicine and more towards the social science, qualitative methods. My desire to contribute to research goes beyond the theoretical and into the practical application in order to make a meaningful difference to care, experience and outcomes. This is both a professional desire to progress and also a moral need.

6.4 Scoping out the research idea

Despite always knowing that I wanted my research to focus on services for mental health users, the biggest challenge for me was to ensure that my work remained within the sphere of occupational psychology and not veer into the realm of clinical psychology. Initially the focus of this research was about providing an intervention for mental health service users, however there were two main issues with this research. Firstly, the scope of the research was too large for the purpose of the thesis, and secondly the more I engaged with this topic the more it became about clinical outcomes. These two issues were highlighted to me in the upgrade panel which needed to be addressed and resolved before being able to progress with my work. These issues were overcome by speaking with my supervisor, course directors, course colleagues and my sponsoring organisation to get to the heart of

what I was attempting to do with this thesis. Through sound boarding, discussion and reviewing the literature the research focus was refined and made more specific within the parameters of the discipline.

I had been preparing to enter the professional doctorate for some time with the initial research idea scoped and skeletal research design identified. Having to revisit the original research idea caused me some anxiety. This anxiety manifested itself as a degree of paralysis in knowing what and how to proceed. This was unexpected for me and caused delays in progressing with my work. Instead, I refocussed my energies towards my employment causing further delays in my research.

Having experienced this, in hindsight I would have practiced more objectivity when identifying my research topic. I became entrenched in the original research idea to such an extent that, following feedback and challenge, I found it difficult to pivot to a new focus. I would have taken more time at the start to really define and pinpoint my research area of interest and be able to summarise the intention of my work more concisely. In doing so, I would have been able to articulate my research and had challenging feedback from the start, allowing me to evolve my research question much sooner. I also needed to take some time to check and challenge my own working by critiquing the occupational psychology contribution my original research idea would be making. At this point I would have been able to determine the conflict in research area.

6.5 Systematic literature review (SLR)

One of the main challenges in conducting the SLR was my ability to be very clear and accurate on my search terms. Having already begun my initial review (whilst waiting for the upgrade panel feedback) my initial search results were in their millions. I struggled to sift such a large number of returned results and, having no other way forward, I spent lots of time title sifting. During this process I noticed that a vast number of articles were completed unrelated to the search terms and the research area. I spent some time trying to understand why this had happened, however, considering the lengthy process of the sifting I decided to continue with sifting so as to not lose more time. When I got to my final articles, I noticed that a

number of articles that I knew of through my own reading and work did not appear at any stage of the sifting process. This worried me as I was concerned as to what other papers were not included in my final SLR.

Through ongoing supervision and course input, I realised that I would be unable to justify and defend my SLR work at the viva stage. My primary reason for this was the number of papers that were omitted from the sifting process. I decided to completely redo the SLR work. Whilst I was concerned that the amount of time redoing of the SLR, I did benefit from the learning accumulated from the initial attempt and led me to have a more smooth, speedier and confident SLR. I reidentified the search terms against the question of my SLR. I then made contact with the discipline librarian who checked and challenged my work and encouraged me to complete an initial search so that we could determine the number of returns. Having done this, and with millions still being returned, we adapted the search terms to be far more specific. I also included key search terms from the research papers that were originally omitted from my SLR to ensure that the appropriate search terms were being used. I also used the database thesaurus to ensure that the search terms with which I refer to concepts were captured in the database. Through refining the search strings, a more manageable number of papers were returned to sift and also included relevant papers which were originally omitted.

The main issue that occurred across both my SLRs was the impact of the absence of a universally agreed definition of coaching. My application of the definition was aligned to those of the governing bodies (i.e., European Mentoring and Coaching Council) and previous health coaching papers which have proposed a definition. The absence of the definition meant that a vast majority of the papers returned had adopting mentoring, psychoeducation, motivational interviewing, or therapy. These interventions were not of relevance but nonetheless took significant time to sift out of the searches.

Having read and familiarised myself with the articles the task of consolidating learning and findings were the next steps. It became clear to me that this was going to be a complex task due to the fact that there was discrepancy in the tools used to measure the same construct/ condition. For example, multiple different tools were

used to determine the extent of anxiety in the participant sample across the studies. I found that when trying to identify themes and report on the study information I began to feel overwhelmed by the amount of detail required to be attended to. I am aware that I am not a particularly detail oriented individual and therefore struggled for a long time in completing this component of the thesis. I broke the tasks down into small and manageable chunks, and still struggled to progress. Having learnt from the other areas of thesis write up, I realised that in order to progress the SLR I could begin writing up the discussion section ahead of the results section. As I was so familiar with the articles I knew the information that needed to be reported and critically analysed. In writing the discussion section I was also able to understand the data at a higher level which played to my strengths and I was able to sift through the what information was needed to be reported on in the results section to ensure that there was a flow to my SLR write up. It is important for me, going forward, to recognise my areas of strengths and weakness and understand how to maximise by abilities to progress work.

Having completed the full write up, it became clear that perhaps 'pure' coaching might not always be the most appropriate approach to adopt with service users. In this learning, the coach participants shared that if a person doesn't have the knowledge how would they know what to act on. In one of the quotes, a participant remarked *"(If) they don't have the kind of enough baseline knowledge to think about what some of the solutions might be for them to, and that's an important point. It's not just about that activation, but it's also about their level of education about particular topic, because you can't help yourself if you don't know… how can you have a nutritional a good nutritional diet if you don't really have an idea of what that means. Of course you can say through the coach you can get them to the point where they go and do that research and there is something about that. But if they then are kind of floundering, coming up with solutions that are just not, don't have an evidence base to them, got to be quite careful about that as well."* (Peach). With this insight it may be that coaching would have to have some element of education to enable patients to fully explore the options available to them. In which case additional articles from the sifting process would have been eligible for review. Whilst this insight only came about at the end of the thesis process, in the future I would work more closely with expert groups to think about what the intervention

would be so as to better inform what the SLR inclusion and exclusion criteria could and should involve.

6.6 Research study and design

The research design was informed by having a social constructionist philosophical approach which underpinned my clear research question. The two are inextricably linked as it is argued that the type of questions a researcher asks is informed by their world view (Braun & Clarke, 2021b). My need to understand the perspective of professional coaches and their insights for an organisation to establish a health coaching service was most appropriately met through a qualitative approach where understanding and learning through depth and breadth of exploration would be most fruitful. Qualitative research is my preferred and most exercised research approach. This aligns most closely with how I want to experience and understand the world but is also where I feel most comfortable. I have had limited exposure to conducting statistical analyses since my undergraduate degree and therefore the thought of conducting quantitative analysis raises fear, anxieties and doubts in my abilities.

Reviewing the literature I became aware of a paper written for the NHS (Skivington et al., 2021) which provided a stepwise process in how complex interventions could be introduced and evaluated. This was helpful for me as it gave me a clear framework against which I could anchor my argument for the way in which I could contribute to the literature base. I also found it helpful because I am aware of my preference to have clear steps laid out for resolving complex issues. Having familiarised myself with the paper I recognised that the SLR informed the initial step of the process, and that this research would meet step 2. Through the SLR I also learnt that much research has skipped through stages and had begun to implement an intervention in isolation of the wider context and needs of the stakeholders. This meant that when the research had ended the intervention ceased to be provided as the appropriate considerations had not been made of how the intervention would exist and be sustained.

Considering the qualitative approach to the research I was aware that my analysis would adopt Thematic Analysis (TA). Upon familiarising myself to the analytic

approaches I learnt that TA was an umbrella approach to analysis (King, 1998) and one subtype was Template Analysis. This was an important learning for me as it allowed me to adopt a far more relevant and appropriate analysis methods for the research. This was due to the fact that part of the NHS paper also covered the appropriate mechanisms for evaluation, which in an NHS context is crucial to ensure return on investment for the organisation, the service provider and the service recipient. I learnt about the high quality metrics for an NHS service, STEEEP, and used these to guide my interview schedule. As part of Template Analysis, a priori codes can be used as an initial framework for the coding. Having read about Template Analysis I became acutely aware that whilst the approach provides a starting point for analysis it is crucial to remain objective and eliminate and add appropriate themes as the data becomes more interrogated. As this was my first time adopting this method, with the initial transcripts it was difficult to remain objective. This was not only because I had the a priori codes, but also because I was so familiar with the transcripts having read and reread them multiple times. In so doing, I had already begun to develop a conceptual model of the transcript contents. I overcame this challenge by giving myself time between the batches of transcript analysis to have some mental space and breakaway from the content. Once I had completed the analysis I also spoke with individuals who were completely removed from my research. Their check and challenge helped provide me with insights that refined my thinking and my work.

This was a chapter of research that was illuminating to me and my ongoing practice as an occupational psychologist. I had the opportunity to immerse myself in different qualitative methodologies and apply the most appropriate to this research in practice. I have shared this with my colleagues as I can see how its application in our work is relevant and useful. I also saw the connection more explicitly of using existing literature to inform, not only the research area, but also the research analysis approach to best suit the stage of research.

6.7 Ethical considerations

Having conducted different forms of research in the NHS I am aware of the different intensity and scrutiny of ethics committees. It was crucial for me to ensure that the

research could be completed within the timeframe of the programme duration and so needed to consider this limitation as part of the development and formulation of my research question. Using the health research council decision tool, it was determined that my study would be classed as evaluation and thus not requiring ethical approval from the national research board. Approval was still required from the organisation, and so processes were completed to achieve this. University ethics approval was completed alongside the organisational process which was beneficial as the concurrent iterations informed one another to ensure a considered, thorough and robust ethics submission.

The biggest ethical considerations which needed to be explored and mitigated against was the personal relationship I had with the study participants. I have worked with these individuals for over 5 years (and longer for other individuals). The implication of this in a study setting is the potential desire for them to provide me with the 'right' or my 'desired' answer. It was important for me to ensure that this did not occur as I didn't want to compromise the legitimacy of the research. I therefore didn't discuss the concept of health coaching and their thoughts on the service at any point until the research analysis had been completed (i.e., when they were unable to withdraw their data from the research). This helped preserve an uninfluenced perspective from the participants. This consideration was the most sensitive that I have dealt with in my professional and pracademic career. It required me to be flexible so that I could maintain my authenticity with my colleagues whilst also not influencing their thoughts or contributions to the research.

6.8 Overall reflections

This has been an enjoyable experience for a few reasons. Firstly, it allowed me to engage with a research area which is a real passion for me. I have noticed the gap in the literature at an anecdotal level but having completed the introduction it became even clearer the need to research and consider a novel intervention to support individuals take control of their mental health. Digging deeper into the literature through the SLR the anecdotal gap became evidenced and bolstered the need to investigate the area in more detail. The most enjoyable component came when I completed the empirical study. I was keen to engage with participants soon to

understand their perspective and provide the 'why and what' to my research question. Perhaps I was so keen to progress in this area that I didn't spend enough time writing up the SLR. Writing up the empirical study was exciting and helped me to think about presenting my findings in a creative way. I wouldn't describe myself as particularly creative and so this part really stretched me, though it benefitted from my preference of understanding things in a logical and simple (but not simplistic) way.

Secondly, I realised that when I have protected, dedicated and focussed time I am able to achieve a good amount of writing. It takes me a while to get into the necessary headspace but once I begin to flow, I am able to make good progress. I have been a lifelong procrastinator and dread getting started on work, but I have realised through this process that when I start with a part of the writing that engages me, I become excited to progress work. Part of the dread was the initial amount of work that I had to do- it began to feel overwhelming and not possible to surmount. The course directors were immensely helpful at this point where they showed us and gave us a template of how to approach the thesis in small, manageable chunks. Additionally, I learnt about the environment in which I need to be to sufficiently engage with writing. I realised that working from home at the start of this journey was unproductive for me, particularly when I was dreading getting started. I committed to a structured day of going to the British Library and working my normal work hours. This meant that I was getting out the house, getting some steps in but also not missing out on down time and spending time with friends and family. I know that I benefit immensely from structure and routine and so establishing that early on during the dedicated writing process was helpful.

Finally, this thesis has confirmed my need and the importance of having a soundboard. In part this is due to how overwhelming it becomes holding the thesis in my head, but also because it helps me to clarify my work and how I am trying to communicate my points. At the beginning of the thesis the course directors emphasised the importance of being able to communicate our work succinctly. By speaking with people around me the research question and the work I was doing clarify and become clearer. I have benefitted from many individuals who have given me their time and reflections so that I can progress and improve my work. Going

forward I need to ensure that I continue to engage with people around me to help refine my work.

References

Adams, R. J., Smart, P., & Huff, A. S. (2017). Shades of Grey: Guidelines for Working with the Grey Literature in Systematic Reviews for Management and Organizational Studies. *International Journal of Management Reviews*, *19*(4), 432–454. https://doi.org/10.1111/ijmr.12102

Adams, W. C. (2015). Conducting Semi-Structured Interviews. In K. E. Newcomer, H. P. Hatry, & J. S. Wholey, *Handbook of Practical Program Evaluation* (1st ed., pp. 492–505). Wiley. https://doi.org/10.1002/9781119171386.ch19

Ammentorp, J., Uhrenfeldt, L., Angel, F., Ehrensvärd, M., Carlsen, E. B., & Kofoed, P.-E. (2013a). Can life coaching improve health outcomes?—A systematic review of intervention studies. *BMC Health Services Research*, *13*, 428. https://doi.org/10.1186/1472-6963-13-428

Ammentorp, J., Uhrenfeldt, L., Angel, F., Ehrensvärd, M., Carlsen, E. B., & Kofoed, P.-E. (2013b). Can life coaching improve health outcomes?—A systematic review of intervention studies. *BMC Health Services Research*, *13*, 428. https://doi.org/10.1186/1472-6963-13-428

Andresen, R., Oades, L., & Caputi, P. (2003). The Experience of Recovery from Schizophrenia: Towards an Empirically Validated Stage Model. *Australian & New Zealand Journal of Psychiatry*, *37*(5), 586–594. https://doi.org/10.1046/j.1440-1614.2003.01234.x

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11–23. https://doi.org/10.1037/h0095655

Arnold, C. (2008). *Bedlam: London and Its Mad*. Simon & Schuster UK.

Aromataris, E., & Pearson, A. (2014). The Systematic Review: An Overview. *AJN The American Journal of Nursing*, *114*(3), 53. https://doi.org/10.1097/01.NAJ.0000444496.24228.2c

Atherton, H. (2015). *The Impact Of Performance Targets Within The NHS And Internationally*. The Health Foundation. https://www.health.org.uk/sites/default/files/TheImpactOfPerformanceTargetsWithinTheNHSAndInternationally_0.pdf

Attkisson, C., & Greenfield, T. (1996). The Client Satisfaction Questionnaire (CSQ) Scales. In *Measures for Clinical Practice: A Sourcebook*.

Ayling, R., & Mewse, A. J. (2009). Evaluating internet interviews with gay men. *Qualitative Health Research*, *19*(4), 566–576. https://doi.org/10.1177/1049732309332121

Bachkirova, T. (2023). Foreward. In W.-A. Smith, J. Passmore, E. Turner, Y.-L. Lai, & D. Clutterbuck, *The Ethical Coaches' Handbook: A Guide to Developing Ethical Maturity in Practice*. Routledge & CRC Press. https://www.routledge.com/The-Ethical-Coaches-Handbook-A-Guide-to-Developing-Ethical-Maturity-in-Practice/Smith-Passmore-Turner-Lai-Clutterbuck/p/book/9781032234632

Bachkirova, T., Jackson, P., & Clutterbuck, D. (2011). *Coaching and Mentoring Supervision: Theory and Practice*. McGraw-Hill Education (UK).

Baker, C., & Kirk-Wade, E. (2023). *Mental health statistics: Prevalence, services and funding in England*. House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Bandura, A. (1986). *Social Foundations of Thought & Action: A social cognitive theory*. Englewood Cliffs.

Baron, L., & Morin, L. (2010). The impact of executive coaching on self-efficacy related to management soft-skills. *Leadership & Organization Development Journal*, *31*(1), 18–38. https://doi.org/10.1108/01437731011010362

Bellón Saameño, J. A., Delgado Sánchez, A., Luna del Castillo, J. D., & Lardelli Claret, P. (1996). Validez y fiabilidad del cuestionario de apoyo social funcional Duke-UNC-11 [Validity and reliability of the Duke-UNC-11 questionnaire of functional social support]. *Atencion primaria*, *18*(4), 153–156, 158–163.

Bimrose, J., Barnes, S.-A., & Brown, J. (2005). *A Systematic Literature Review of Research into Career-related Interventions for Higher Education*. Manchester: HECSU. https://warwick.ac.uk/fac/soc/ier/publications/2005/jb_hecsu_literature_review_2005.pdf

Bloom, D. E., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A. B., Gaziano, T., Hamandi, A., Mowafi, M., O'Farrell, D., Ozaltin, E., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., Weinstein, C., & Weiss, J. (2012). The Global Economic Burden of Noncommunicable Diseases. *PGDA Working Papers*, Article 8712. https://ideas.repec.org//p/gdm/wpaper/8712.html

Boehmer, K. R., Álvarez-Villalobos, N. A., Barakat, S., de Leon-Gutierrez, H., Ruiz-Hernandez, F. G., Elizondo-Omaña, G. G., Vaquera-Alfaro, H., Ahn, S., Spencer-Bonilla, G., Gionfriddo, M. R., Millan-Alanis, J. M., Abdelrahim, M., Prokop, L. J., Murad, M. H., & Wang, Z. (2023). The impact of health and wellness coaching on patient-important outcomes in chronic illness care: A systematic review and meta-analysis. *Patient Education and Counseling*, *117*, 107975. https://doi.org/10.1016/j.pec.2023.107975

Boehmer, K. R., Barakat, S., Ahn, S., Prokop, L. J., Erwin, P. J., & Murad, M. H. (2016). Health coaching interventions for persons with chronic conditions: A systematic review and meta-analysis protocol. *Systematic Reviews*, *5*(1), 146. https://doi.org/10.1186/s13643-016-0316-3

Bono, J. E., Purvanova, R. K., Towler, A. J., & Peterson, D. B. (2009). A Survey of Executive Coaching Practices. *Personnel Psychology*, *62*(2), 361–404.

Borghouts, J., Eikey, E., Mark, G., De Leon, C., Schueller, S. M., Schneider, M., Stadnick, N., Zheng, K., Mukamel, D., & Sorkin, D. H. (2021). Barriers to and Facilitators of User Engagement With Digital Mental Health Interventions: Systematic Review. *Journal of Medical Internet Research*, *23*(3), e24387. https://doi.org/10.2196/24387

Bosmans, J. E., Brook, O. H., Van Hout, H. P. J., De Bruijne, M. C., Nieuwenhuyse, H., Bouter, L. M., Stalman, W. A. B., & Van Tulder, M. W. (2007). Cost Effectiveness of a Pharmacy-Based Coaching Programme to Improve Adherence to Antidepressants: *PharmacoEconomics*, *25*(1), 25–37. https://doi.org/10.2165/00019053-200725010-00004

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. SAGE.

Boyce, L. A., Jackson, R. J., & Neal, L. J. (2010). Building successful leadership coaching relationships: Examining impact of matching criteria in a leadership coaching program. *The Journal of Management Development*, *29*(10), 914–931. https://doi.org/10.1108/02621711011084231

Boyle, D., Clark, S., & Burns, S. (2006). *Hidden work: Co-production by people outside paid employment*. Joseph Rowntree Foundation.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative

analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021b). *Thematic Analysis. A practical guide*. SAGE. https://uk.sagepub.com/en-gb/eur/thematic-analysis/book248481

Briner, R., & Rousseau, D. (2011). Evidence-Based I–O Psychology: Not There Yet. *Industrial and Organizational Psychology*, *4*. https://doi.org/10.1111/j.1754-9434.2010.01287.x

British Psychological Society. (2021). *Code of Ethics and Conduct*. British Psychological Society. https://www.bps.org.uk/guideline/code-ethics-and-conduct

Broadhead, W. E., Gehlbach, S. H., de Gruy, F. V., & Kaplan, B. H. (1988). The Duke-UNC Functional Social Support Questionnaire: Measurement of Social Support in Family Medicine Patients. *Medical Care*, *26*(7), 709–723.

Brook, O. H., van Hout, H., Stalman, W., Nieuwenhuyse, H., Bakker, B., Heerdink, E., & de Haan, M. (2005). A Pharmacy-Based Coaching Program to Improve Adherence to Antidepressant Treatment Among Primary Care Patients. *Psychiatric Services*, *56*(4), 487–489. psyh. https://doi.org/10.1176/appi.ps.56.4.487

Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The Utility of Template Analysis in Qualitative Psychology Research. *Qualitative Research in Psychology*, *12*(2), 202–222. https://doi.org/10.1080/14780887.2014.955224

Brown, J. D. (2015). Characteristics of sound quantitative research. *Shiken Journal*, *19*(2), 24–28.

Buchan, J., Charlesworth, A., Gershlick, B., & Seccombe, I. (2017). *Rising Pressure: The NHS Workforce Challenge*. The Health Foundation. http://allcatsrgrey.org.uk/wp/download/management/human_resources/RisingPressureNHSWorkforceChallenge.pdf

Buchan, J., Gershlick, B., & Charlesworth, A. (2019). *Falling short: The NHS workforce challenge*. The Health Foundation.

https://allcatsrgrey.org.uk/wp/download/management/human_resources/S05_Falling-short_The-NHS-workforce-challenge.pdf

Buckley-Walker, K., Crowe, T., & Caputi, P. (2010). Exploring identity within the recovery process of people with serious mental illnesses. *Psychiatric Rehabilitation Journal*, *33*(3), 219–227. https://doi.org/10.2975/33.3.2010.219.227

Burls, A. (2009). What is Critical Appraisal? *Evidence Based Medicine*, 1–8.

Burr, V. (2003). *Social Constructionism* (Second). Routledge/Taylor & Francis Group.

Burr, V. (2015). *Social Constructionism* (Third). Routledge/Taylor & Francis Group. https://doi.org/10.1016/B978-0-08-097086-8.24049-X

Care Quality Commission. (2024). *Assessing Quality and Performance*. https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessing-quality-and-performance/reach-rating

Carmichael, S. (2023). Change is constant but change that works is optional. *Kaleidoscope Health and Care*. https://www.kscopehealth.org.uk/blog/change-is-constant-but-change-that-works-is-optional/

Carpinello, S. E., Knight, E. L., Markowitz, F. E., & Pease, E. A. (2000). The development of the Mental Health Confidence Scale: A measure of self-efficacy in individuals diagnosed with mental disorders. *Psychiatric Rehabilitation Journal*, *23*(3), 236–243. https://doi.org/10.1037/h0095162

Cassatly, M. G. (2010). Coaching the Patient-Physician Relationship: A Successful Approach to Lower Healthcare Costs with Improved Medical Outcomes - ProQuest. *Journal of Medical Practice Management*, *25*(4), 229–234.

Centre for Reviews and Dissemination. (2008). *Systematic Reviews: CRD's guidance for undertaking reviews in healthcare.* Centre for Reviews and

Dissemination. University of York. https://www.york.ac.uk/crd/SysRev/!SSL!/WebHelp/SysRev3.htm

Chalmers, I., & Glasziou, P. (2016). Systematic reviews and research waste. *The Lancet*, *387*(10014), 122–123. https://doi.org/10.1016/S0140-6736(15)01353-7

Conn, S., & Curtain, S. (2019). Health coaching as a lifestyle medicine process in primary care. *Australian Journal of General Practice*, *48*(10), 677–680. https://doi.org/10.31128/AJGP-07-19-4984

Cortelyou-Ward, K., Atkins, D. N., Noblin, A., Rotarius, T., White, P., & Carey, C. (2020). Navigating the Digital Divide: Barriers to Telehealth in Rural Areas. *Journal of Health Care for the Poor and Underserved*, *31*(4), 1546–1556.

Daniels, K., Watson, D., Nayani, R., Tregaskis, O., Hogg, M., Etuknwa, A., & Semkina, A. (2021). Implementing practices focused on workplace health and psychological wellbeing: A systematic review. *Social Science & Medicine*, *277*, 113888. https://doi.org/10.1016/j.socscimed.2021.113888

Daouk-Öyry, L., & Rosinski, P. (2010). Coaching across cultures. In S. Palmer & A. McDowall, *The Coaching Relationship* (1st ed.). Routledge.

Davis, J., Mengersen, K., Bennett, S., & Mazerolle, L. (2014). Viewing systematic reviews and meta-analysis in social research through different lenses. *SpringerPlus*, *3*(1), 511. https://doi.org/10.1186/2193-1801-3-511

de Haan, E. (2008). *Relational Coaching: Journeys Towards Mastering One-To-One Learning*. John Wiley & Sons.

de Haan, E., Duckworth, A., Birch, D., & Jones, C. (2013). Executive coaching outcome research: The contribution of common factors such as relationship, personality match, and self-efficacy. *Consulting Psychology Journal: Practice and Research*, *65*(1), 40–57. https://doi.org/10.1037/a0031635

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Denyer, D., & Tranfield, D. (2009). Producing a systematic review. In *The Sage handbook of organizational research methods* (pp. 671–689). Sage Publications Ltd.

Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research, 3rd ed* (pp. xix, 1210). Sage Publications Ltd.

Department of Health. (2002). *The journey to recovery: The Government's vision for mental health care*. https://www.scie-socialcareonline.org.uk/the-journey-to-recovery-the-governments-vision-for-mental-health-care/r/a11G000000181zOIAQ

Docherty, M., & Thornicroft, G. (2015). Specialist mental health services in England in 2014: Overview of funding, access and levels of care. *International Journal of Mental Health Systems*, *9*(1), 34. https://doi.org/10.1186/s13033-015-0023-9

Donaldson-Feilder, E., Lewis, R., & Yarker, J. (2019). What outcomes have mindfulness and meditation interventions for managers and leaders achieved? A systematic review. *European Journal of Work and Organizational Psychology, 28*(1), 11-29.

Eaton, T., Young, P., Fergusson, W., Garrett, J. E., & Kolbe, J. (2005). The Dartmouth COOP Charts: A Simple, Reliable, Valid and Responsive Quality of Life Tool for Chronic Obstructive Pulmonary Disease. *Quality of Life Research*, *14*(3), 575–585.

Eghigian, G. (2011). Deinstitutionalizing the history of contemporary psychiatry. *History of Psychiatry*, *22*(2), 201–214. https://doi.org/10.1177/0957154X11399499
Emanuel, E. J. (2000). What Makes Clinical Research Ethical? *JAMA*, *283*(20), 2701. https://doi.org/10.1001/jama.283.20.2701

EMCC. (2017). *EMCC Competence Framework* (2). https://emccpoland.org/wp-content/uploads/2018/02/EMCC-quality-glossary-v2.pdf

Farre, A., & Rapley, T. (2017). The New Old (and Old New) Medical Model: Four Decades Navigating the Biomedical and Psychosocial Understandings of Health and Illness. *Healthcare*, *5*(4), 88. https://doi.org/10.3390/healthcare5040088

Fink, P. J. (1992). *Stigma and Mental Illness*. American Psychiatric Pub.

Fitzgerald, K., & Biddle, L. (2020). Creating the conditions for change: An NHS perspective. *Journal of Health Organization and Management*, *34*(3), 345–361. https://doi.org/10.1108/JHOM-02-2019-0031

Flanagan, J. C. (1978). A research approach to improving our quality of life. *American Psychologist*, *33*(2), 138–147. https://doi.org/10.1037/0003-066X.33.2.138

Flick, U. (2014). *The SAGE Handbook of Qualitative Data Analysis*. SAGE Publications, Inc. https://doi.org/10.4135/9781446282243

Frates, E. P., Moore, M. A., Lopez, C. N., & McMahon, G. T. (2011). Coaching for behavior change in physiatry. *American Journal of Physical Medicine & Rehabilitation*, *90*(12), 1074–1082. https://doi.org/10.1097/PHM.0b013e31822dea9a

Freeman, R. E. (2010). *Strategic Management: A Stakeholder Approach*. Cambridge University Press.

Fugard, A., & Potts, H. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology*, *18*. https://doi.org/10.1080/13645579.2015.1005453

Garrard, J. (2017). *Health sciences literature review made easy: The matrix method* (Fifth edition). Jones & Bartlett Learning.

Gergen, K. J. (1973). Social Psychology as history. *Journal of Personality and Social Psychology*, *26*(2), 309–320.

Gilburt, H., & Mallorie, S. (2024). *Mental Health 360 | Funding And Costs*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-funding-costs

Gillard, S., Betton, V., Green, K., Holt, B., Lucock, M., Miller, S., Minogue, V., Simmons, L., Turner, K., & White, S. (2010). *The barriers and facilitators of supporting self care in Mental Health NHS Trusts*. National Institute for Health Research. https://eprints.kingston.ac.uk/id/eprint/17850/2/165-final-report.pdf

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research* (5. paperback print). Aldine Transaction.

Goldberg, D., Bridges, K., Duncan-Jones, P., & Grayson, D. (1988). Detecting anxiety and depression in general medical settings. *BMJ : British Medical Journal*, *297*(6653), 897–899.

Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in Public Health*, *6*. https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2018.00179

Grant, A. M., & Cavanagh, M. J. (2010). Life Coaching. In E. Cox, T. Bachkirova, & D. Clutterbuck, *The Complete Handbook of Coaching* (1st ed., pp. 297–310). SAGE.

Grant, A. M., Passmore, J., Cavanagh, M. J., & Parker, H. M. . (2010). The state of play in coaching today: A comprehensive review of the field. In G. P. Hodgkinson & J. K. Ford, *International Review of Industrial and Organizational Psychology* (pp. 125–167). Wiley Blackwell. https://doi.org/10.1002/9780470661628.ch4

Gray, H. (2019). *Recommendations for an economic evaluation of health coaching*. Institute for Employment Studies. https://www.employment-studies.co.uk/system/files/resources/files/520_0.pdf

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82.

Hadikin, R. (2004). *Effective Coaching in Healthcare*. Elsevier Health Sciences.

Hall, R. C. W. (1995). Global Assessment of Functioning: A Modified Scale. *Psychosomatics*, *36*(3), 267–275. https://doi.org/10.1016/S0033-3182(95)71666-8

Hammersley, M. (1992). *What's Wrong With Ethnography? Methodological explorations*. Routledge. https://www.taylorfrancis.com/books/mono/10.4324/9781351038027/routledge-revivals-wrong-ethnography-1992-martyn-hammersley

Hammersley, M. (2001). On 'Systematic' Reviews of Research Literatures: A 'narrative' response to Evans & Benefield. *British Educational Research Journal*, *27*(5), 543–554. https://doi.org/10.1080/01411920120095726

Hannan, R., Thompson, R., Worthington, A., & Rooney, P. (2016). *The Triangle of Care*. Royal College of Nursing. https://www.england.nhs.uk/wp-content/uploads/2017/11/case-study-supporting-well-carers-included.pdf

Harandi, T. F., Taghinasab, M. M., & Nayeri, T. D. (2017). The correlation of social support with mental health: A meta-analysis. *Electronic Physician*, *9*(9), 5212–5222. https://doi.org/10.19082/5212

Hargrove, R. A. (1995). *Masterful coaching Extraordinary results by impacting people and the way they think and work together*. Pfeiffer.

Harrison, P. L., Pope, J. E., Coberley, C. R., & Rula, E. Y. (2012). Evaluation of the Relationship Between Individual Well-Being and Future Health Care Utilization and Cost. *Population Health Management*, *15*(6), 325–330. https://doi.org/10.1089/pop.2011.0089

Hawkins, P. (2014). Coaching Supervision. In E. Cox, T. Bachkirova, & D. Clutterbuck (Eds.), *The Complete Handbook of Coaching* (pp. 381–383). SAGE.

Hayes, E., & Kalmakis, K. A. (2007). From the sidelines: Coaching as a nurse practitioner strategy for improving health outcomes. *Journal of the American Academy of Nurse Practitioners*, *19*(11), 555–562. https://doi.org/10.1111/j.1745-7599.2007.00264.x

Hayes, E., McCahon, C., Panahi, M. R., Hamre, T., & Pohlman, K. (2008). Alliance not compliance: Coaching strategies to improve type 2 diabetes outcomes. *Journal of the American Academy of Nurse Practitioners*, *20*(3), 155–162. https://doi.org/10.1111/j.1745-7599.2007.00297.x

Hays, R. D., Sherbourne, C. D., & Mazel, R. (1995). *User's Manual for the Medical Outcomes Study (MOS) Core Measures of Health-Related Quality of Life*. RAND Corporation. https://www.rand.org/pubs/monograph_reports/MR162.html

Hazen, B., & Steckler, N. A. (2010). Career Coaching. In E. Cox, T. Bachkirova, & D. Clutterbuck, *The Complete Handbook of Coaching* (1st ed., pp. 311–323). SAGE.

Health and Care Professions Council. (2016). *Standards of conduct, performance and ethics* |. Health and Care Professions Council. https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry*, *1*(6), 467–482. https://doi.org/10.1016/S2215-0366(14)00023-6

Hendriks, S., Grady, C., Chiong, W., Fins, J. J., Ford, P., Goering, S., Greely, H. T., Hutchison, K., Kelly, M. L., Kim, S. Y. H., Klein, E., Lisanby, S. H., Mayberg, H., Maslen, H., Miller, F. G., Ramos, K. M., Rommelfanger, K., Sheth, S. A., & Wexler, A. (2019). Ethical Challenges of Risk, Informed Consent, and Posttrial Responsibilities in Human Research With Neural Devices: A Review. *JAMA*

Neurology, 10.1001/jamaneurol.2019.3523. https://doi.org/10.1001/jamaneurol.2019.3523

Heney, D. B. (2022). Solving for stigma in mental health care. *Journal of Evaluation in Clinical Practice*, *28*(5), 883–889. https://doi.org/10.1111/jep.13735

Herth, K. (1992). Abbreviated Instrument to Measure Hope: Development and Psychometric Evaluation. *Journal of Advanced Nursing*, *17*, 1251–1259. https://doi.org/10.1111/j.1365-2648.1992.tb01843.x

Hess, V., & Majerus, B. (2011). Writing the history of psychiatry in the 20th century. *History of Psychiatry*, *22*(2), 139–145. https://doi.org/10.1177/0957154X11404791

Hibbard, J. H., Mahoney, E. R., Stockard, J., & Tusler, M. (2005). Development and Testing of a Short Form of the Patient Activation Measure. *Health Services Research*, *40*(6 Pt 1), 1918–1930. https://doi.org/10.1111/j.1475-6773.2005.00438.x

Hill, B., Richardson, B., & Skouteris, H. (2015). Do We Know How to Design Effective Health Coaching Interventions: A Systematic Review of the State of the Literature. *American Journal of Health Promotion*, *29*(5), e158–e168. https://doi.org/10.4278/ajhp.130510-LIT-238

Holt, D. T., Helfrich, C. D., Hall, C. G., & Weiner, B. J. (2010). Are You Ready? How Health Professionals Can Comprehensively Conceptualize Readiness for Change. *Journal of General Internal Medicine*, *25*(Suppl 1), 50–55. https://doi.org/10.1007/s11606-009-1112-8

Hong, Q. N., Gonzalez-Reyes, A., & Pluye, P. (2018). Improving the usefulness of a tool for appraising the quality of qualitative, quantitative and mixed methods studies, the Mixed Methods Appraisal Tool (MMAT). *Journal of Evaluation in Clinical Practice*, *24*(3), 459–467. https://doi.org/10.1111/jep.12884

Hong, Q. N., Pluye, P., Fabregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffits, F., Nicolau, B., O'Cathain, A., Rousseau, M.-

C., & Vedel, I. (2018). *Mixed Methods Appraisal Tool (MMAT)*. Canadian Intellectual Property Office. http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria%20manual_2018%202008%202001_ENG.pdf

Huda, A. S. (2021). The medical model and its application in mental health. *International Review of Psychiatry*, *33*(5), 463–470. https://doi.org/10.1080/09540261.2020.1845125

Hughes, R., Hayward, M., & Finlay, W. M. L. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*, *18*(2), 152–160. https://doi.org/10.1080/09638230802053326

Hulland, J., & Houston, M. B. (2020). Why systematic review papers and meta-analyses matter: An introduction to the special issue on generalizations in marketing. *Journal of the Academy of Marketing Science*, *48*(3), 351–359. https://doi.org/10.1007/s11747-020-00721-7

Hutten, R., Chambers, E., Connell, J., Hardy, G., & Parry, G. (2010). *Implementing IAPT: lessons from the demonstration sites*. https://eprints.whiterose.ac.uk/90775/1/IAPT%20Interim%20Report.pdf

Institute for Innovation and Improvement. (2017). *Improvement Leaders' Guide; Managing the human dimensions of change*. NHS Institute for Innovation and Improvement. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-3.4-Managing-the-Human-Dimensions-of-Change.pdf

Institute of Medicine. (2001). *Crossing the Quality Chasm; A new health system for the 21st Century*. National Academy Press. https://doi.org/10.1037/e317382004-001

International Coaching Federation. (2020). *Code of Ethics*. https://coachingfederation.org/ethics/code-of-ethics

Ioannidis, J. P. a. (2016). The Mass Production of Redundant, Misleading, and Conflicted Systematic Reviews and Meta-analyses. *The Milbank Quarterly*, *94*(3), 485–514. https://doi.org/10.1111/1468-0009.12210

James, N., & Busher, H. (2009). *Online Interviewing*. SAGE Publications Ltd. https://doi.org/10.4135/9780857024503

Johnson, C., Saba, G., Wolf, J., Gardner, H., & Thom, D. H. (2018). What do health coaches do? Direct observation of health coach activities during medical and patient-health coach visits at 3 federally qualified health centers. *Patient Education and Counseling*, *101*(5), 900–907. https://doi.org/10.1016/j.pec.2017.11.017

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A Review of the Quality Indicators of Rigor in Qualitative Research. *American Journal of Pharmaceutical Education*, *84*(1), 7120. https://doi.org/10.5688/ajpe7120

Jones, N., Corrigan, P. W., James, D., Parker, J., & Larson, N. (2013). Peer support, self-determination, and treatment engagement: A qualitative investigation. *Psychiatric Rehabilitation Journal*, *36*(3), 209–214. https://doi.org/10.1037/prj0000008

Jones, R. J., Woods, S. A., & Guillaume, Y. R. F. (2016a). The effectiveness of workplace coaching: A meta-analysis of learning and performance outcomes from coaching. *Journal of Occupational and Organizational Psychology*, *89*(2), 249–277. https://doi.org/10.1111/joop.12119

Jones, R. J., Woods, S. A., & Guillaume, Y. R. F. (2016b). The effectiveness of workplace coaching: A meta-analysis of learning and performance outcomes from coaching. *Journal of Occupational and Organizational Psychology*, *89*(2), 249–277. https://doi.org/10.1111/joop.12119

Jones, R. J., Woods, S. A., & Zhou, Y. (2018). Boundary conditions of workplace coaching outcomes. *Journal of Managerial Psychology*, *33*(7/8), 475–496. https://doi.org/10.1108/JMP-11-2017-0390

Jowett, A., Peel, E., & Shaw, R. (2011). Online Interviewing in Psychology: Reflections on the Process. *Qualitative Research in Psychology*, *8*(4), 354–369. https://doi.org/10.1080/14780887.2010.500352

Katikireddi, S. V., McKee, M., Craig, P., & Stuckler, D. (2014). The NHS reforms in England: Four challenges to evaluating success and failure. *Journal of the Royal Society of Medicine*, *107*(10), 387–392. https://doi.org/10.1177/0141076814550358

Kelly, G. (1955). *The Psychology of Personal Constructs*. Norton.

Kielhofner, G., & Burke, J. P. (1980). A Model of Human ccupation, Part 1. Conceptual Franlework and Content. *American Journal of Occupational Therapy*, *34*(9), 572–582.

Kierkegaard, S. (1992). *Either/Or: A Fragment of Life* (A. Hannay, Ed. & Trans.). Penguin Books.

King, N. (1998). Template analysis. In Gi. Symon & C. Cassell, *Qualitative methods and analysis in organizational research: A practical guide* (pp. 118–134). SAGE.
King, N. (2012). Doing Template Analysis. In G. Symon & C. Cassell, *Qualitative Organizational Research: Core Methods and Current Challenges* (pp. 426–450). SAGE.

King, N., & Brooks, J. M. (2016). *Template Analysis for Business and Management Students*. SAGE. https://us.sagepub.com/en-us/nam/template-analysis-for-business-and-management-students/book244282

Kirkham, J. J., Altman, D. G., & Williamson, P. R. (2010). Bias Due to Changes in Specified Outcomes during the Systematic Review Process. *PLOS ONE*, *5*(3), e9810. https://doi.org/10.1371/journal.pone.0009810

Kivelä, K., Elo, S., Kyngäs, H., & Kääriäinen, M. (2014). The effects of health coaching on adult patients with chronic diseases: A systematic review. *Patient*

Education and Counseling, *97*(2), 147–157. https://doi.org/10.1016/j.pec.2014.07.026

Koenigsberg, M. R., Bartlett, D., & Cramer, J. S. (2004). Facilitating Treatment Adherence with Lifestyle Changes in Diabetes. *American Family Physician*, *69*(2), 309–316.

Krendl, A. C., & Pescosolido, B. A. (2020). Countries and Cultural Differences in the Stigma of Mental Illness: The East–West Divide. *Journal of Cross-Cultural Psychology*, *51*(2), 149–167. https://doi.org/10.1177/0022022119901297

Kroeze, J. H. (2012). Postmodernism, Interpretivism, and Formal Ontologies. In *Research Methodologies, Innovations and Philosophies in Software Systems Engineering and Information Systems* (pp. 43–62). IGI Global. https://doi.org/10.4018/978-1-4666-0179-6.ch003

Kumar, A., Paul, J., & Unnithan, A. B. (2020). 'Masstige' marketing: A review, synthesis and research agenda. *Journal of Business Research*, *113*, 384–398. https://doi.org/10.1016/j.jbusres.2019.09.030

Kvale, S., & Brinkmann, S. (2009). *InterViews: Learning the Craft of Qualitative Research Interviewing*. SAGE.

Lai, Y.-L., & McDowall, A. (2016). Coachee Satisfaction and Beyond: A Systematic Review of the Coaching Relationship. *Coaching Psykologi - The Danish Journal of Coaching Psychology*, *5*(1), Article 1. https://doi.org/10.5278/ojs.cp.v5i1.1685

Leech, B. L. (2002). Asking Questions: Techniques for Semistructured Interviews. *Political Science & Politics*, *35*(4), 665–668. https://doi.org/10.1017/S1049096502001129

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA

Publications and Communications Board task force report. *American Psychologist*, *73*(1), 26–46. https://doi.org/10.1037/amp0000151

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*, *57*(9), 705–717. https://doi.org/10.1037/0003-066X.57.9.705

Mancini, M. A. (2007). The Role of Self–efficacy in Recovery from Serious Psychiatric Disabilities: A Qualitative Study with Fifteen Psychiatric Survivors. *Qualitative Social Work*, *6*(1), 49–74. https://doi.org/10.1177/1473325007074166

Martin, A., Rief, W., Klaiberg, A., & Braehler, E. (2006). Validity of the Brief Patient Health Questionnaire Mood Scale (PHQ-9) in the general population. *General Hospital Psychiatry*, *28*(1), 71–77. https://doi.org/10.1016/j.genhosppsych.2005.07.003

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, *50*(4), 370–396. http://dx.doi.org.ezproxy.lib.bbk.ac.uk/10.1037/h0054346

Maxwell, J. A. (2013). *Qualitative Research Design: An Interactive Approach* (3rd ed.). SAGE.

McIntosh, M. J., & Morse, J. M. (2015). Situating and Constructing Diversity in Semi-Structured Interviews. *Global Qualitative Nursing Research*, *2*, 2333393615597674. https://doi.org/10.1177/2333393615597674

Meetoo, D. (2008). Chronic diseases: The silent global epidemic. *British Journal of Nursing (Mark Allen Publishing)*, *17*, 1320–1325. https://doi.org/10.12968/bjon.2008.17.21.31731

Mental Health Foundation. (2016). *The most common diagnosed mental health problems: Statistics*. https://www.mentalhealth.org.uk/explore-mental-health/statistics/most-common-diagnosed-mental-health-problems-statistics

Mental Health Research. (2023, October 7). *Inequality of Mental Health—World Mental Health Day 2023*. https://www.mqmentalhealth.org/inequality-of-mental-health/

Mertens, D. M. (2007). Transformative Paradigm: Mixed Methods and Social Justice. *Journal of Mixed Methods Research*, *1*(3), 212–225. https://doi.org/10.1177/1558689807302811

Mertens, D. M. (2008). *Transformative Research and Evaluation*. Guilford Press.
Merton, R. K., & Kendall, P. L. (1946). The Focused Interview. *American Journal of Sociology*, *51*(6), 541–557.

Miller, D. (2001). Successful change leaders: What makes them? What do they do that is different? *Journal of Change Management*, *2*(4), 359–368. https://doi.org/10.1080/714042515

Moher, D., Liberati, A., Tetzlaff, J., Altman, D., & Prisma Group*. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement | Annals of Internal Medicine. *Annals of Internal Medicine*, *151*(4), 264–269.

Montón, C., Pérez Echeverría, M. J., Campos, R., García Campayo, J., & Lobo, A. (1993). [Anxiety scales and Goldberg's depression: An efficient interview guide for the detection of psychologic distress]. *Atencion Primaria*, *12*(6), 345–349.

Moreno-Chico, C., González-de Paz, L., Monforte-Royo, C., Arrighi, E., Navarro-Rubio, M. D., & Gallart Fernández-Puebla, A. (2017). Adaptation to European Spanish and psychometric properties of the Patient Activation Measure 13 in patients with chronic diseases. *Family Practice*, *34*(5), 627–634. https://doi.org/10.1093/fampra/cmx022

Moreno-Chico, C., Roy, C., Monforte-Royo, C., González-De Paz, L., Navarro-Rubio, M. D., & Gallart Fernández-Puebla, A. (2021). Effectiveness of a nurse-led, face-to-face health coaching intervention in enhancing activation and secondary outcomes

of primary care users with chronic conditions. *Research in Nursing & Health*, *44*(3), 458–472. psyh. https://doi.org/10.1002/nur.22132

Morisky, D. E., Green, L. W., & Levine, D. M. (1986). Concurrent and Predictive Validity of a Self-Reported Measure of Medication Adherence. *Medical Care*, *24*(1), 67–74.

Morse, J. M., & Field, P. A. (1995). *Qualitative Research Methods for Health Professionals*. SAGE Publications.

Nakanishi, M., Kurokawa, G., Niimura, J., Nishida, A., Shepherd, G., & Yamasaki, S. (2021). System-level barriers to personal recovery in mental health: Qualitative analysis of co-productive narrative dialogues between users and professionals. *BJPsych Open*, *7*(1), e25. https://doi.org/10.1192/bjo.2020.156

Navicharern, R. N., Aungsuroch, Y., & Thanasilp, S. (2009). *Effects of Multifaceted Nurse-Coaching Intervention on Diabetic Complications and Satisfaction of Persons with Type 2 Diabetes*. *92*(8).

Neff, K. D., & Dahm, K. A. (2015). Self-compassion: What it is, what it does, and how it relates to mindfulness. *Handbook of mindfulness and self-regulation,* 121-137.

Neil, S. T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W., & Morrison, A. P. (2009). The questionnaire about the process of recovery (QPR): A measurement tool developed in collaboration with service users. *Psychosis*, *1*(2), 145–155. https://doi.org/10.1080/17522430902913450

NHS. (2019). *The NHS Long Term Plan*. NHS. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS Confederation. (2022, December 2). *NHS mental health services are under unsustainable pressure health service leaders warn*. https://www.nhsconfed.org/news/nhs-mental-health-services-are-under-unsustainable-pressure-health-service-leaders-warn

NHS Digital. (2023). *Mental Health Services Monthly Statistics*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics

NHS England. (2023a). *2023/24 priorities and operational planning guidance*. https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

NHS England. (2023b). *Co-production*. https://www.england.nhs.uk/always-events/co-production/

NHS England. (2023c). *Patient and carer race equality framework*. https://www.england.nhs.uk/publication/patient-and-carer-race-equality-framework/

NHS England and NHS Improvement. (2019). *The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England and NHS Improvement and the National Collaborating Centre for Mental Health. (2019). *Community Mental Health Framework for Adults and Older Adults* (1). https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

NHS Staff Survey. (2022). *National results across the NHS in England | NHS Staff Survey*. NHS. https://www.nhsstaffsurveys.com/results/national-results/

Nilsen, P., Thor, J., Bender, M., Leeman, J., Andersson-Gäre, B., & Sevdalis, N. (2022). Bridging the Silos: A Comparative Analysis of Implementation Science and Improvement Science. *Frontiers in Health Services*, *1*. https://www.frontiersin.org/articles/10.3389/frhs.2021.817750

Nolan, C., & Garavan, T. (2015). Human Resource Development in SMEs: A Systematic Review of the Literature: Human Resource Development in SMEs. *International Journal of Management Reviews*, *18*. https://doi.org/10.1111/ijmr.12062

Nolan, C. T., & Garavan, T. N. (2016). Human Resource Development in SMEs: A Systematic Review of the Literature. *International Journal of Management Reviews*, *18*(1), 85–107. https://doi.org/10.1111/ijmr.12062

Office of the Surgeon General (US), Center for Mental Health Services (US), & National Institute of Mental Health (US). (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. http://www.ncbi.nlm.nih.gov/books/NBK44243/

Olsen, J. M., & Nesbitt, B. J. (2010). Health Coaching to Improve Healthy Lifestyle Behaviors: An Integrative Review—Jeanette M. Olsen, Bonnie J. Nesbitt, 2010. *American Journal of Health Promotion*, *25*(1), e1–e12. https://doi.org/10.4278/ajhp.090313-LIT-101

Owusu, J. T., Wang, P., Wickham, R. E., Smith, S. F., Lee, J. L., Chen, C., & Lungu, A. (2023). Outcomes of a Live Messaging, Blended Care Coaching Program Among Adults With Symptoms of Anxiety: Pragmatic Retrospective Cohort Study. *JMIR Formative Research*, *7*, e44138. https://doi.org/10.2196/44138

Pae, C.-U. (2015). Why Systematic Review rather than Narrative Review? *Psychiatry Investigation*, *12*(3), 417–419. https://doi.org/10.4306/pi.2015.12.3.417

Page, M. J., Altman, D. G., Shamseer, L., McKenzie, J. E., Ahmadzai, N., Wolfe, D., Yazdi, F., Catalá-López, F., Tricco, A. C., & Moher, D. (2018). Reproducible research practices are underused in systematic reviews of biomedical interventions. *Journal of Clinical Epidemiology*, *94*, 8–18. https://doi.org/10.1016/j.jclinepi.2017.10.017

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *British Medical Journal*, *372*, n71. https://doi.org/10.1136/bmj.n71

Palmatier, R. W., Houston, M. B., & Hulland, J. (2018). Review articles: Purpose, process, and structure. *Journal of the Academy of Marketing Science*, *46*(1), 1–5. https://doi.org/10.1007/s11747-017-0563-4

Palmer, S., & McDowall, A. (2010). The Coaching Relationship: Putting People First. An introduction. In *The Coaching Relationship* (1st ed., pp. 19–26). Routledge.
Park, Y. S., Konge, L., & Artino, A. R. J. (2020). The Positivism Paradigm of Research. *Academic Medicine*, *95*(5), 690–694. https://doi.org/10.1097/ACM.0000000000003093

Passmore, J., & Fillery-Travis, A. (2011). A critical review of executive coaching research: A decade of progress and what's to come. *Coaching: An International Journal of Theory, Research and Practice*, *4*(2), 70–88. https://doi.org/10.1080/17521882.2011.596484

Passmore, J., & Tee, D. (2020). *Coaching Researched: A Coaching Psychology Reader for Practitioners and Researchers*. John Wiley & Sons.

Passmore, J., & Theeboom, T. (2016). Coaching Psychology Research: A Journey of Development in Research. In L. E. Van Zyl, M. W. Stander, & A. Odendaal, *Coaching Psychology: Meta-Theoretical Perspectives and Applications in Multicultural Contexts* (pp. 27–46). Springer. https://doi.org/10.1007/978-3-319-31012-1_2

Patja, K., Absetz, P., Auvinen, A., Tokola, K., Kytö, J., Oksman, E., Kuronen, R., Ovaska, T., Harno, K., Nenonen, M., Wiklund, T., Kettunen, R., & Talja, M. (2012). Health coaching by telephony to support self-care in chronic diseases: Clinical

outcomes from The TERVA randomized controlled trial. *BMC Health Services Research*, *12*(1), 147. https://doi.org/10.1186/1472-6963-12-147

Paul, J., & Criado, A. R. (2020). The art of writing literature review: What do we know and what do we need to know? *International Business Review*, *29*(4), 101717. https://doi.org/10.1016/j.ibusrev.2020.101717

Perkins, R. (2012). UK Mental Health Policy Development: A Counter-Argument Deriving from User's Experience. In P. Phillips, T. Sandford, & C. Johnston, *Working in Mental Health: Practice and Policy in Changing Environment* (1st ed.). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780203120910-3/uk-mental-health-policy-development-rachel-perkins

Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward, P. (1995). The Camberwell Assessment of Need: The Validity and Reliability of an Instrument to Assess the Needs of People with Severe Mental Illness. *The British Journal of Psychiatry*, *167*(5), 589–595. https://doi.org/10.1192/bjp.167.5.589

Pietroni, P. (2003). Cultural revolution. *British Medical Journal*, *326*(7402), 1304–1306. https://doi.org/10.1136/bmj.326.7402.1304

Priebe, S., Huxley, P., Knight, S., & Evans, S. (1999). Application and Results of the Manchester Short Assessment of Quality of Life (Mansa). *International Journal of Social Psychiatry*, *45*(1), 7–12. https://doi.org/10.1177/002076409904500102

Priebe, S., McCabe, R., Bullenkamp, J., Hansson, L., Lauber, C., Martinez-Leal, R., Rössler, W., Salize, H., Svensson, B., Torres-Gonzales, F., Van Den Brink, R., Wiersma, D., & Wright, D. J. (2007). Structured patient–clinician communication and 1-year outcome in community mental healthcare: Cluster randomised controlled trial. *British Journal of Psychiatry*, *191*(5), 420–426. https://doi.org/10.1192/bjp.bp.107.036939

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, *19*(3), 276–288. https://doi.org/10.1037/h0088437

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). *Changing for Good: The Revolutionary Program that Explains the Six Stages of Change and Teaches You how to Free Yourself from Bad Habits*. W. Morrow.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation Research in Mental Health Services: An Emerging Science with Conceptual, Methodological, and Training challenges. *Administration and Policy in Mental Health*, *36*(1), 10.1007/s10488-008-0197–4. https://doi.org/10.1007/s10488-008-0197-4

Rahman, M. S. (2016). The Advantages and Disadvantages of Using Qualitative and Quantitative Approaches and Methods in Language “Testing and Assessment” Research: A Literature Review. *Journal of Education and Learning*, *6*(1), 102. https://doi.org/10.5539/jel.v6n1p102

Reichert, A., & Jacobs, R. (2018). The impact of waiting time on patient outcomes: Evidence from early intervention in psychosis services in England. *Health Economics*, *27*(11), 1772–1787. https://doi.org/10.1002/hec.3800
Richards, V., & Lloyd, K. (2017). *Core values for psychiatrists* (p. 17). Royal College of Psychiatrists.

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12–A13.

Roberts, K., Dowell, A., & Nie, J.-B. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology*, *19*(1), 66. https://doi.org/10.1186/s12874-019-0707-y

Robson, C. (2002). *Real World Research: A Resource for Social Scientists and Practitioner-Researchers*. Wiley.

Rogers, C. R. (1959). *A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-centered Framework*. McGraw-Hill.

Rojon, C., & McDowall, A. (2010). Cultural Orientations Framework (COF) Assessment Questionnaire in Cross-Cultural Coaching: A Cross-Validation with Wave Focus Styles. *International Journal of Evidence Based Coaching and Mentoring*, *8*(2), 1–26. https://doi.org/10.24384/IJEBCM

Rojon, C., McDowall, A., & Saunders, M. N. K. (2011). On the Experience of Conducting a Systematic Review in Industrial, Work, and Organizational Psychology. *Journal of Personnel Psychology*, *10*(3), 133–138. https://doi.org/10.1027/1866-5888/a000041

Rojon, C., Okupe, A., & McDowall, A. (2021). Utilization and development of systematic reviews in management research: What do we know and where do we go from here? *International Journal of Management Reviews*, *23*(2), 191–223. https://doi.org/10.1111/ijmr.12245

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. (2008). Motivational Interviewing in Health Care: Helping Patients Change Behavior. *COPD: Journal of Chronic Obstructive Pulmonary Disease*, *5*(3), 203–203. https://doi.org/10.1080/15412550802093108

Roy, B., Roberts, P., Lisowski, C., Kaye, M. P., & Sforzo, G. A. (2020). Integrating Health Coaching With a Medical Fitness Program to Treat Chronic Health Conditions. *American Journal of Lifestyle Medicine*, *14*(3), 326–334. https://doi.org/10.1177/1559827617728025

Royal College of Psychiatry. (2022, October 10). *Hidden waits force more than three quarters of mental health patients to seek help from emergency services*. Www.Rcpsych.Ac.Uk. https://www.rcpsych.ac.uk/news-and-features/latest-

news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services

Ryan, R. M., & Deci, E. L. (2000). Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being. *American Psychologist*, *55*(1), 68–78.

Sacco, W. P., Malone, J. I., Morrison, A. D., Friedman, A., & Wells, K. (2009). Effect of a brief, regular telephone intervention by paraprofessionals for type 2 diabetes. *Journal of Behavioral Medicine*, *32*(4), 349–359. https://doi.org/10.1007/s10865-009-9209-4

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet*, *370*(9590), 878–889. https://doi.org/10.1016/S0140-6736(07)61239-2

Schein, E. H. (1980). *Organizational Psychology*. Prentice-Hall.

Schneider, M., McDowall, A., & Tee, D. (2022). The barriers to a scientific and evidence-based coaching evaluation practice. *Philosophy of Coaching: An International Journal*, *7*(1), Article 1.

Schwarzer, R. (1993). *Measurement of perceived self-efficacy. Psychometric scales for crosscultural research*. Freie Universitat Berlin.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5–14. https://doi.org/10.1037/0003-066X.55.1.5

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive Psychology Progress: Empirical Validation of Interventions. *American Psychologist*, *60*(5), 410–421. https://doi.org/10.1037/0003-066X.60.5.410

Senneseth, M., Pollak, C., Urheim, R., Logan, C., & Palmstierna, T. (2022). Personal recovery and its challenges in forensic mental health: Systematic review and thematic synthesis of the qualitative literature. *BJPsych Open*, *8*(1), e17. https://doi.org/10.1192/bjo.2021.1068

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. John Wiley & Sons. http://catdir.loc.gov/catdir/toc/onix05/96015292.html

Siontis, K. C., & Ioannidis, J. P. A. (2018). Replication, Duplication, and Waste in a Quarter Million Systematic Reviews and Meta-Analyses. *Circulation: Cardiovascular Quality and Outcomes*, *11*(12), e005212. https://doi.org/10.1161/CIRCOUTCOMES.118.005212

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *British Medical Journal*, *374*, 1–11. https://doi.org/10.1136/bmj.n2061

Slade, M. (Ed.). (2009). What is recovery? In *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals* (pp. 35–44). Cambridge University Press. https://doi.org/10.1017/CBO9780511581649.003

Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research*, *10*(1), 26. https://doi.org/10.1186/1472-6963-10-26

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Slade, M., Bird, V., Clarke, E., Boutillier, C. L., McCrone, P., Macpherson, R., Pesola, F., Wallace, G., Williams, J., & Leamy, M. (2015). Supporting recovery in

patients with psychosis through care by community-based adult mental health teams (REFOCUS): A multisite, cluster, randomised, controlled trial. *The Lancet Psychiatry*, *2*(6), 503–514. https://doi.org/10.1016/S2215-0366(15)00086-3

Slade, M., Bird, V., Le Boutillier, C., Farkas, M., Grey, B., Larsen, J., Leamy, M., Oades, L., & Williams, J. (2015). Development of the REFOCUS intervention to increase mental health team support for personal recovery. *The British Journal of Psychiatry: The Journal of Mental Science*, *207*(6), 544–550. https://doi.org/10.1192/bjp.bp.114.155978

Smither, J. W. (2011). Can Psychotherapy Research Serve as a Guide for Research About Executive Coaching? An Agenda for the Next Decade. *Journal of Business and Psychology*, *26*(2), 135–145. https://doi.org/10.1007/s10869-011-9216-7

Snape, D., Meads, C., Bagnall, A.-M., Tregaskis, O., Mansfield, L., & MacLennan, S. (2017). *What Works Wellbeing: A guide to our evidence review methods* (pp. 1–37). What Works Centre for Wellbeing, London, UK.

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, *104*, 333–339. https://doi.org/10.1016/j.jbusres.2019.07.039

Sonesh, S. C., Coultas, C. W., Lacerenza, C. N., Marlow, S. L., Benishek, L. E., & Salas, E. (2015a). The power of coaching: A meta-analytic investigation. *Coaching: An International Journal of Theory, Research and Practice*, *8*(2), 73–95. https://doi.org/10.1080/17521882.2015.1071418

Sonesh, S. C., Coultas, C. W., Lacerenza, C. N., Marlow, S. L., Benishek, L. E., & Salas, E. (2015b). The power of coaching: A meta-analytic investigation. *Coaching: An International Journal of Theory, Research and Practice*, *8*(2), 73–95. https://doi.org/10.1080/17521882.2015.1071418

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Stokes, J., & Jolly, R. (2010). Executive and Leadership Coaching. In E. Cox, T. Bachkirova, & D. Clutterbuck, *The Complete Handbook of Coaching* (1st ed., pp. 245–256). SAGE.

Strauss, A. L., & Corbin. (1990). *Basics of qualitative research: Grounded theory procedures and techniques /*. Sage Publications,.

Suárez, P. S., Perez Garcua, A. M., & Bermudez Moreno, J. (2000). Escala de autoeficacia general: Datos psicométricos de la adaptación para población española. *Psicothema*, *12*(2), 509–513.

Suleman, M., Sonthalia, S., Webb, C., Tinson, A., Kane, M., Bunbury, S., Finch, D., & Bibby, J. (2021a). *Unequal pandemic, fairer recovery*. Health Foundation. https://reader.health.org.uk/unequal-pandemic-fairer-recovery/foreword

Suleman, M., Sonthalia, S., Webb, C., Tinson, A., Kane, M., Bunbury, S., Finch, D., & Bibby, J. (2021b). *Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report*. The Health Foundation. https://doi.org/10.37829/HF-2021-HL12

Sustainable Improvement Team, & Horizons Team. (2017). *Leading Large Scale Change: A practical guide*. NHS England.

Swendeman, D., Sumstine, S., Aguilar, E., Gorbach, P. M., Comulada, W. S., & Gelberg, L. (2021). Feasibility and Acceptability of Mobile Phone Self-monitoring and Automated Feedback to Enhance Telephone Coaching for People With Risky Substance Use: The QUIT-Mobile Pilot Study. *Journal of Addiction Medicine*, *15*(2), 120–129. https://doi.org/10.1097/ADM.0000000000000707

Taylor, M. (2020). Why is there a shortage of doctors in the UK? *The Bulletin of the Royal College of Surgeons of England*, *102*(3), 78–81. https://doi.org/10.1308/rcsbull.2020.78

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, *5*(1), 63. https://doi.org/10.1186/1477-7525-5-63

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *The British Journal of Social Work*, *42*(3), 443–460.

The 1774 Madhouses Act, 14 George 3, c.49 (1774).

Theeboom, T., Beersma, B., & van Vianen, A. E. M. (2014). Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context. *The Journal of Positive Psychology*, *9*(1), 1–18. https://doi.org/10.1080/17439760.2013.837499

Thom, D. H., Willard-Grace, R., Hessler, D., DeVore, D., Prado, C., Bodenheimer, T., & Chen, E. (2015). The Impact of Health Coaching on Medication Adherence in Patients With Poorly Controlled Diabetes, Hypertension, and/or Hyperlipidemia: A Randomized Controlled Trial. *The Journal of the American Board of Family Medicine*, *28*(1), 38–45. https://doi.org/10.3122/jabfm.2015.01.140123

Tolman, C. W. (2012). *Positivism in Psychology: Historical and Contemporary Problems*. Springer Science & Business Media.

Topp, L. (2018). Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838–1844. *Social History of Medicine*, *31*(4), 754–773. https://doi.org/10.1093/shm/hky015

Tranfield, D., Denyer, D., & Smart, P. (2003). Towards a Methodology for Developing Evidence-Informed Management Knowledge by Means of Systematic Review. *British Journal of Management*, *14*(3), 207–222. https://doi.org/10.1111/1467-8551.00375

Tuke, W. (1855). William Tuke, the Founder of the York Retreat. *Journal of Psychological Medicine and Mental Pathology*, *8*(32), 507–512.

Turner, J., Hayward, R., Angel, K., Fulford, B., Hall, J., Millard, C., & Thomson, M. (2015). The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research. *Medical History*, *59*(4), 599–624. https://doi.org/10.1017/mdh.2015.48

Turpin, G., Clarke, J., Duffy, R., & Hope, R. (2009). A new workforce to deliver IAPT: A case study. *The Journal of Mental Health Training, Education and Practice*, *4*(2), 37–46. https://doi.org/10.1108/17556228200900017

United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral. (1978). *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research : Appendix*. Department of Health, Education, and Welfare, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Uttley, L., & Montgomery, P. (2017). The influence of the team in conducting a systematic review. *Systematic Reviews*, *6*(1), 149. https://doi.org/10.1186/s13643-017-0548-x

Val Jiménez, A., Amorós Ballestero, G., Martínez Visa, P., Fernández Ferré, M. L., & León Sanromà, M. (1992). Estudio descriptivo del cumplimiento del tratamiento farmacológico antihipertensivo y validación del test de Morisky y Green. *Atención primaria: Publicación oficial de la Sociedad Española de Familia y Comunitaria*, *10*(5), 767–770.

Vilagut, G., María Valderas, J., Ferrer, M., Garin, O., López-García, E., & Alonso, J. (2008). Interpretación de los cuestionarios de salud SF-36 y SF-12 en España: Componentes físico y mental. *Medicina Clínica*, *130*(19), 726–735. https://doi.org/10.1157/13121076

Villagonzalo, K.-A., Leitan, N., Farhall, J., Foley, F., McLeod, B., & Thomas, N. (2018). Development and validation of a scale for self-efficacy for personal recovery in persisting mental illness. *Psychiatry Research*, *269*, 354–360. https://doi.org/10.1016/j.psychres.2018.08.093

Voida, A., Mynatt, E. D., Erickson, T., & Kellogg, W. A. (2004). Interviewing over instant messaging. *CHI '04 Extended Abstracts on Human Factors in Computing Systems*, 1344–1347. https://doi.org/10.1145/985921.986060

Wang, Q., Lai, Y.-L., Xu, X., & McDowall, A. (2021). The effectiveness of workplace coaching: A meta-analysis of contemporary psychologically informed coaching approaches. *Journal of Work-Applied Management*, *14*(1), 77–101. https://doi.org/10.1108/JWAM-04-2021-0030

Wang, Q., Lai, Y.-L., Xu, X., & McDowall, A. (2022). The effectiveness of workplace coaching: A meta-analysis of contemporary psychologically informed coaching approaches. *Journal of Work-Applied Management*, *14*(1), 77–101. https://doi.org/10.1108/JWAM-04-2021-0030

Ware, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: Construction of Scales and Preliminary Tests of Reliability and Validity. *Medical Care*, *34*(3), 220–233.

Watkins, J., & Cooperrider, D. (2000). Appreciative Inquiry: A Transformative Paradigm. *OD Practitioner*, *32*, 6–12.

Wayne, N., Perez, D. F., Kaplan, D. M., & Ritvo, P. (2015). Health Coaching Reduces HbA1c in Type 2 Diabetic Patients From a Lower-Socioeconomic Status Community: A Randomized Controlled Trial. *Journal of Medical Internet Research*, *17*(10), e224. https://doi.org/10.2196/jmir.4871

Wenzl, M., McCuskee, S., & Mossialos, E. (2015). Commissioning for equity in the NHS: Rhetoric and practice. *British Medical Bulletin*, *115*(1), 5–17. https://doi.org/10.1093/bmb/ldv031

Whitmore, J. (1992). *Coaching for Performance: A Practical Guide to Growing Your Own Skills*. Nicholas Brealey Publishing.

Whitmore, J. (2002). *Coaching for Performance: GROWing People, Performance and Purpose*. Nicholas Brealey.

Williams, J., Leamy, M., Bird, V., Le Boutillier, C., Norton, S., Pesola, F., & Slade, M. (2015). Development and evaluation of the INSPIRE measure of staff support for personal recovery. *Social Psychiatry and Psychiatric Epidemiology*, *50*, 776–786.

Williams, K., Kiel, F., Doyle, M., & Sinagra, L. (2002). Breaking the boundaries: Leveraging the personal in executive coaching. In C. Fitzgerald & G. J. Berger, *Executive Coaching: Practices and Perspectives* (Eds, pp. 227–249). Davies-Black Publishing.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (Third). McGraw-Hill Education (UK).

Willig, C., & Rogers, W. S. (2017). *The SAGE Handbook of Qualitative Research in Psychology*. SAGE.

Wilson, T., Buck, D., & Ham, C. (2005). Rising to the challenge: Will the NHS support people with long term conditions? *British Medical Journal*, *330*(7492), 657–661.

Wing, J. K., Beevor, A. S., Curtis, R. H., Park, S. G. B., Hadden, J., & Burns, A. (1998). Health of the Nation Outcome Scales (HoNOS): Research and development. *The British Journal of Psychiatry*, *172*(1), 11–18. https://doi.org/10.1192/bjp.172.1.11

Wolever, R. Q., Dreusicke, M., Fikkan, J., Hawkins, T. V., Yeung, S., Wakefield, J., Duda, L., Flowers, P., Cook, C., & Skinner, E. (2010). Integrative Health Coaching for Patients With Type 2 Diabetes. *The Diabetes Educator*, *36*(4), 629–639. https://doi.org/10.1177/0145721710371523

Wolever, R. Q., Jordan, M., Lawson, K., & Moore, M. (2016). Advancing a new evidence-based professional in health care: Job task analysis for health and wellness coaches. *BMC Health Services Research*, *16*(1), 205. https://doi.org/10.1186/s12913-016-1465-8

Wolever, R. Q., Moore, M. A., & Jordan, M. (2016). Coaching in healthcare. In T. Bachkirova, D. Drake, & G. Spencer, *The SAGE Handbook of Coaching*. SAGE Publications Ltd. https://www.torrossa.com/en/resources/an/5018357

Wolever, R. Q., Simmons, L. A., Sforzo, G. A., Dill, D., Kaye, M., Bechard, E. M., Southard, M. E., Kennedy, M., Vosloo, J., & Yang, N. (2013). A Systematic Review of the Literature on Health and Wellness Coaching: Defining a Key Behavioral Intervention in Healthcare. *Global Advances in Health and Medicine*, *2*(4), 38–57. https://doi.org/10.7453/gahmj.2013.042

Wongpiriyayothar, A., Piamjariyakul, U., & Williams, P. D. (2011). Effects of patient teaching, educational materials, and coaching using telephone on dyspnea and physical functioning among persons with heart failure. *Applied Nursing Research*, *24*(4), e59–e66. https://doi.org/10.1016/j.apnr.2010.02.007

World Health Organization. (2003). *Investing in mental health*. World Health Organization. https://apps.who.int/iris/handle/10665/42823

World Health Organization. (2013). *Investing in mental health: Evidence for action*. World Health Organization. https://apps.who.int/iris/handle/10665/87232

Wright, A., Maloney, F. L., & Feblowitz, J. C. (2011). Clinician attitudes toward and use of electronic problem lists: A thematic analysis. *BMC Medical Informatics and Decision Making*, *11*, 36. https://doi.org/10.1186/1472-6947-11-36

Wright, I., Mughal, F., Bowers, G., & Meiser-Stedman, R. (2021). Dropout from randomised controlled trials of psychological treatments for depression in children

and youth: A systematic review and meta-analyses. *Journal of Affective Disorders*, *281*, 880–890. https://doi.org/10.1016/j.jad.2020.11.039

Wu, I., Bathje, G., Kalibatseva, Z., Sung, D., Leong, F., & Collins-Eaglin, J. (2017). Stigma, mental health, and counseling service use: A person-centered approach to mental health stigma profiles. *Psychological Services*, *14*, 490–501. https://doi.org/10.1037/ser0000165

Yang, J., Bauer, B. A., Lindeen, S. A., Perlman, A. I., Abu Dabrh, A. M., Boehmer, K. R., Salinas, M., & Cutshall, S. M. (2020). Current trends in health coaching for chronic conditions: A systematic review and meta-analysis of randomized controlled trials. *Medicine*, *99*(30), e21080. https://doi.org/10.1097/MD.0000000000021080

Appendix 1: Interview schedule

Organisational feasibility of a Health Coaching service in a mental health Trust

1. What are your thoughts on a dedicated provision of health coaching for mental health service users?
    a. What informs your thoughts?
2. What would be needed to ensure the service was safe?
    a. For service user
    b. For coach
    c. For organisation
3. What would be needed for it to be offered in a timely way?
4. What would be needed for it to be offered in an equitable way?
    a. Any diagnosis that this wouldn't work for?
    b. How would it work alongside the care they receive, treatment as usual plus health coaching, or should there be criteria?
5. What would be needed for it to be offered in an efficient way?
6. What would be needed for it to be offered in that makes a meaningful impact?
7. What would be needed for it to be offered in patient-centered way?
8. Who would be best placed to offer the coaching service?
9. What skills, knowledge and competencies would be needed for the service to be delivered to a high quality?
10. What measures/ outcomes would be best to measure the impact of health coaching?
    a. From service user perspective
    b. From organisation perspective

Appendix 2: MMAT template

Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix 3: Consent sheet

Organisational feasibility of a Health Coaching service in a mental health Trust

Please read the following items and tick the appropriate boxes to indicate whether you agree to take part in this study. Please retain a copy of the form for your own reference.

- I have read the information sheet in full; I understand the purpose of this research is to understand more about the feasibility of providing health coaching for mental health service users.
- Any questions I had have been answered, and I understand I may ask further questions at any time.
- I understand what is involved in participating, that it is voluntary, and that I may refuse to answer any questions. I also understand that I may withdraw without consequences and penalty by until data analysis begins, i.e., by [31/09/2023], by contacting the researcher.
- I understand only the student, the supervisor and the examiners will have access to the raw data I provide. All data will be stored on password-protected encrypted computers. All personally identifying information will be deleted at the end of the assessment period.
- I understand that a fully anonymised version of the dataset may be shared with other researchers through the Open Science Framework, an online research data repository.
- I agree to the interview being recorded.
- I agree to the interview being video-taped.
- I understand that I have the right to ask for the audio/video recording to be turned off at any time during the interview.
- I understand the data will be transcribed word-by-word by Microsoft Teams, whilst the interview is taking place. The researcher will also review and make corrections where necessary. The data will then be analysed and aggregated by the researcher in order to identify general patterns and trends.

- I understand that a summary report without demographics will be shared with South London & Maudsley NHS Foundation Trust.
- I recognise that my identity may become apparent unintentionally. Even though no personally identifiable information will be included in the reporting, particularly close contacts may still recognise individual participants due to the presence of indirect identifiers. The researcher will take reasonable care to reduce this risk
- I understand the results will be used for a dissertation and may also be used for academic publications, such as conference presentations or journal articles.
- I agree to take part in this study under the conditions set out above.

Signed _____ Dated: _____

Appendix 4: Demographics capture sheet

Thank you for expressing an interest in taking part in this research project, Organisational feasibility of a Health Coaching service in a mental health Trust. Please take some time to complete the following questionnaire.

Age	
Ethnicity	A. White – British
	B. White – Irish
	C. White – Any other background
	D. Mixed – White and Black Caribbean
	E. Mixed – White and Black African
	F. Mixed – White and Asia
	G. Mixed – Any other mixed background
	H. Asian or Asian British – Indian
	I. Asian or Asian British – Pakistani
	J. Asian or Asian British – Bangladeshi
	K. Asian or Asian British – Any other Asian background
	L. Black or Black British – Caribbean
	M. Black or Black British – African
	N. Black or Black British – Any other Black background
	O. Other Ethnic Groups – Chinese
	P. Other Ethnic Groups – Any other ethnic group
	Q. Do not wish to disclose
Gender	1. Male (including trans man)
	2. Female (including trans woman)
	3. Non-binary
	4. Other (not listed)
	5. Do not wish to disclose
Length of time coaching (from end of qualification)	
Professional background	

Current post	
Length of time in current post	
Number of coaching clients in last 6 months	
Number of coaching clients since qualifying as coach	