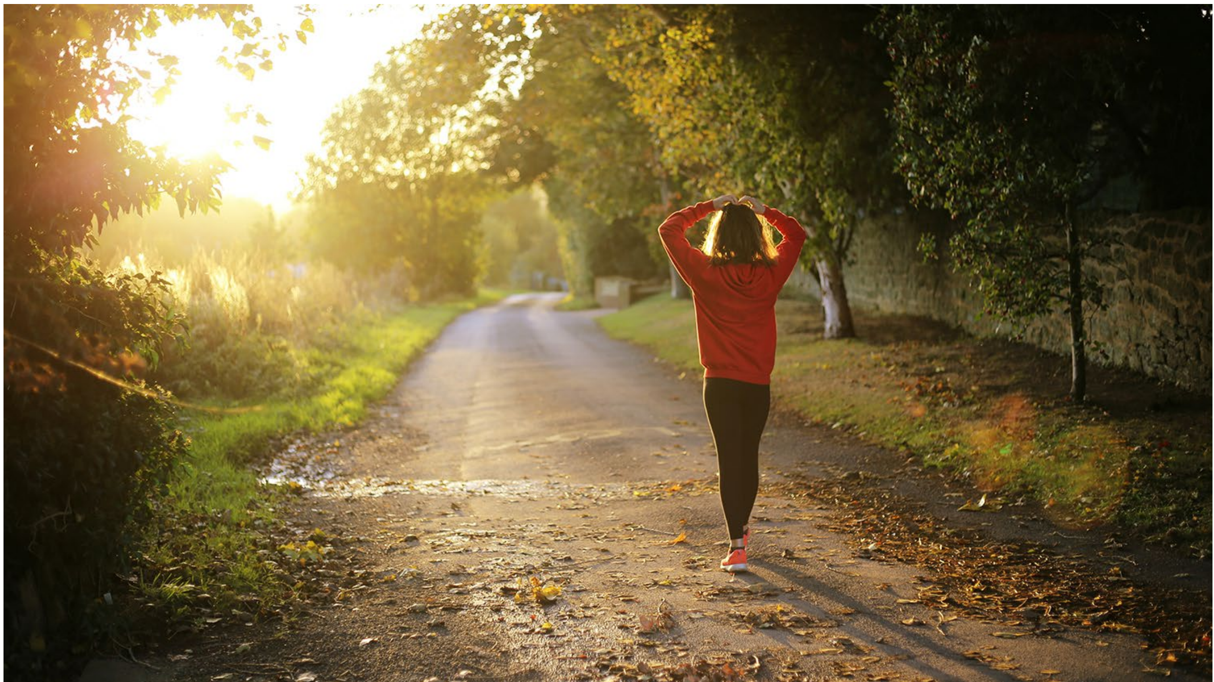

Coaching, mentoring and mental health

SHARING RESOURCES AND DEVELOPING BEST PRACTICE
FOR COACHES, MENTORS AND SUPERVISORS

DR FIONA DAY

The author

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About this resource

This information guide was prepared by EMCC UK member and volunteer Dr Fiona Day, a former senior public health doctor. The guidance is intended to support EMCC UK members to consider some of the risks and good practice in the area of mental health and wellbeing; point to definitive sources of information; and help members consider how they can best respond to possible risks to their business.

Introduction

I am delighted to introduce the resources on mental health and coaching guidance elaborated by Dr Fiona Day, an EMCC UK volunteer, who has put together a comprehensive set of guidance to help us navigate the complexities of coaching and mental health. In this resource, you will find ethical considerations, authoritative knowledge on mental health, and rich reflection points to help you improve your professional practice, as well as your own wellbeing and mental health.

Natalia de Estevan Ubeda
EMCC Knowledge Exchange Director

Work-related stress

Many coaches, mentors and supervisors will work with clients experiencing work-related stress. The symptoms of work-related stress (a reaction to events or experiences in someone's home life, work life, or both) and more serious mental health problems can be very similar, and often exist together in an adult. This means that a coach, mentor or supervisor can easily end up out of their depth with a client who is developing or has developed a mental health problem, and who needs a clinical treatment such as medication or therapy, rather than a coaching intervention, to support their recovery.

Work related stress can also trigger a previous mental health problem. The client (and their manager if relevant) is often unable to identify the difference between work-related stress and mental illness, and so will probably not be able to tell you that they no longer feel coaching is an appropriate intervention.

As a coach, mentor or supervisor, it is important to have at least a basic understanding of human psychology and mental illness, to be able to discern whether a potential client is suitable for coaching.

Mental health problems evolve over time, and the line between coaching for work related stress and treatment for mental illness can be unclear for even a skilled clinician and coach. EMCC UK members are therefore encouraged to consider their clients' mental health at every step of the client journey as part of their ethical practice.

The aims of this resource are to:

- Support EMCC UK members with their ethical practice in relation to mental health
- Provide evidence-based, authoritative knowledge on the subject of mental health
- Encourage reflection and identify actions for members to undertake to improve their professional practice
- Support EMCC UK members to prevent or take early action to improve their own wellbeing and mental health

Please note that this guidance does not constitute clinical or medical advice.

Understanding mental ill health in the adult population

No one knows exactly how many people in the population have a mental illness at any one point in time. This is for a variety of reasons, including the fact that mental illness evolves over time, and there is no 'blood test' equivalent which says that someone is definitively ill or well. Rather, there is a spectrum, ranging from good mental health, temporary mild mental health problems, through to severe and enduring mental illness.

In order to understand the changing patterns of mental ill-health in the population (also called the epidemiology), the UK Government and National Health Service undertake regular forms of 'needs assessment' to study the trends and to review all the different potential data sources. These range from measures including the number of therapy sessions attended, surveys of reasons for consultations in General Practice, and the number of different forms of medication used to treat mental illness. This also varies with the UK devolved governments.

One in four people

One in four people in the UK will have a mental health problem at some point. While mental health problems are common, most are mild, tend to be short-term and are normally successfully treated, with medication, by a GP.

Mental health is about how we think, feel and behave. Anxiety and depression are the most common mental health problems. They are often a reaction to a difficult life event, such as bereavement, but can also be caused by work-related issues.
Where (work-related) stress is prolonged it can lead to both physical and psychological damage, including anxiety and depression.

Work can also aggravate pre-existing conditions, and problems at work can bring on symptoms or make their effects worse.

Whether work is causing the health issue or aggravating it, employers have a legal responsibility to help their employees. Work-related stress risks must be assessed to measure the levels of risk to staff. Where a risk is identified, steps must be taken to remove it or reduce it as far as reasonably practicable.

Some employees will have a pre-existing physical or mental health condition when recruited or may develop one caused by factors that are not work-related factors.

Mental health conditions, work and the workplace (Health and Safety Executive)

From time to time, large population surveys are undertaken by researchers to measure the burden of mental ill-health in the population. The last time this was done in England was in the Psychiatric Morbidity Survey in 2014, which found the following trends in the population's mental health:

Adult Psychiatric Morbidity Survey: Mental Health and Wellbeing, England, 2014

For Scotland, Wales and Northern Ireland, please check your devolved national websites for the appropriate equivalent:

Mental Health in Scotland
Mental Health in Wales
Mental Health in Northern Ireland

Economic and social impact

Poor mental health has enormous economic and social impact. Mental illness is one of the largest single causes of disability (OECD 2014) and sickness absence in the UK (CMH 2010), accounting for 70 million sick days in 2007 (CMH 2007).

- In 2014, 17.5% of working-age adults had symptoms of a common mental disorder (CMD)
- Mental illness has increased in women, and remained largely stable in men
- Rates of mental illness increased in men and women aged 55-64
- Only one person in three with a CMD was in receipt of treatment, which was defined as current receipt of psychotropic medication, and/or counselling, or other psychological therapy
- 39 per cent of adults surveyed in England in 2014 aged 16-74, with conditions such as anxiety or depression, were accessing mental health treatment. This figure has increased from one in four (24 per cent) since the last survey was carried out in 2007
- Overall, around one in six adults (17%) surveyed in England in 2014 met the criteria for a CMD
- Women were more likely than men to have reported CMD symptoms. One in five women (19%) had reported CMD symptoms, compared with one in eight men (12%). Women were also more likely than men to report severe symptoms of CMD – 10% of women surveyed reported severe symptoms, compared to 6% of men

Groups at high risk

Different subsections of the population are more vulnerable to mental illness, due to a combination of their genes, age, gender, early life experiences and life events, and their wider social and environmental contexts. See this Government guidance:

Mental health: population factors

Several groups are identified as being of high risk of mental health problems. See the following two key resources:

Fundamental Facts about mental health 2016 (Mental Health Foundation)

Chief Medical Officer: annual reports (Gov.uk)

The groups at high risk of mental health problems are:

- Black and minority ethnic groups (BAME)
- People living with physical disabilities
- People living with learning disabilities and neurodevelopmental disabilities such as Asperger's Syndrome, Autistic Spectrum, ADHD
- People with alcohol and/or drug dependence
- Prison population, offenders and victims of crime
- Lesbian, gay, bisexual and transgender (LGBT) groups
- Carers
- People with sensory impairment, such as loss of sight
- Homeless people
- Refugees, asylum seekers and stateless persons

High rates of people moving home within and between areas can disrupt social ties and community networks and are related to higher levels of stress and mental health problems. See the following report:

Population turnover and area deprivation (Joseph Rowntree Foundation)

This can include people in life transitions, such as students. People who have recently arrived from abroad to live in an area may face barriers to accessing mental health services.

People who do not speak English well might need specific help to enable them to access the mental health services. Refugees are more likely to have experienced trauma and have a higher prevalence of mental health conditions, such as post-traumatic stress disorder (PTSD), depression and anxiety. See the following article:

Meeting the mental health needs of refugees and asylum seekers (The British Journal of Psychiatry)

Other examples of high risk groups are highlighted on this government page:

Mental health: environmental factors (Public Health England)

In particular, higher rates of mental health problems are associated with poverty and socio-economic disadvantage. Across the life-course, examples of groups identified as high priority are:

- Women who are pregnant or have a child aged under 12 months
- Children living at a socio-economic disadvantage
- Children with parents who have mental health or substance misuse problems

- Looked-after children
- Adults with a history of violence of abuse
- People with poor physical health
- Older people living in care homes
- Isolated older people

There are three specific populations where coaches and mentors might work with people with higher rates of mental ill health:

- Young people and students
- Unemployed
- People who experience high levels of stress at work

Mental illness in young people and young adults

Young people and specifically young women have become a key high risk group. According to the English Psychiatric Morbidity Survey, the gender gap in mental illness has become most pronounced in young people, and there is evidence that this gap has widened in recent years.

In 2014, at least one in five 16-24 year old women reported having self-harmed at some point in her life. Most of the young people who reported self-harming in the survey did not seek professional help afterwards. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping. There is a risk that the behaviour will spread to others, and also that greater engagement with the behaviour may lead in time to a higher suicide rate.

EMCC UK members who work with young people or students may benefit from additional training in working with vulnerable young people.

Mental ill health in the unemployed

The rate of common mental disorders in the economically inactive or unemployed is twice as high as those in part- or full-time employment, according to the English Psychiatric Morbidity Survey. This may be due to mental illness causing inability to work, or unemployment causing mental illness, or a combination.

EMCC UK members who work with unemployed or underemployed clients may benefit from additional training in working with people with common mental disorders.

Stress and mental illness at work

Work-related stress is the second most commonly reported cause of occupational ill health in Great Britain, accounting for 37% of all work-related ill-health cases, and 45% of all working days lost due to ill health, according to the Health and Safety Executive. It is recognised by both industry and unions as a major workplace health issue.

Workers in all industries and in all sizes of business may be affected, with significantly higher incidences seen in education, health and social care, local and central government, and finance.

In 2015/16, around 488,000 workers said they had experienced stress caused or aggravated by work, of which just under half were new cases. Some 11.7 million working days were lost due to stress, depression or anxiety. See the following Health and Safety Executive strategy document:

HSE's Health and Work strategy

Tailoring to meet individual needs

While not (yet) directly mentioning coaching, NICE guidelines do state that training programmes need to be tailored to meet employees' individual needs, learning style and ability, which could include providing:

- A training needs analysis
- Work based, practical on the job training
- Mentoring or one to one sessions
- Opportunities for reflection

The English Psychiatric Morbidity Survey found gender differences: women in full-time employment were twice as likely to have common mental disorders as full-time employed men.

Employers have a legal duty to protect employees from occupational hazards at work by doing a risk assessment and acting on it. Learn more here, with this Health and Safety Executive guidance:

Stress risk assessment

In addition, all staff who are potentially exposed to the risk of work-related stress should have a stress risk assessment undertaken using the Health and Safety Executive 'Management Standards' for work related stress. These define the characteristics, or culture, of an organisation where the risks from work related stress are being effectively managed and controlled. The six standards are: demands, control, support, relationships, role, change. Find out more here:

What are the Management Standards?

EMCC UK members are encouraged to be familiar with these legal requirements to inform their own businesses, and also to underpin their understanding of workplace stress hazards.

There is evidence on what works in terms of good management practice in the workplace, as detailed by NICE (National Institute for Health Care Excellence):

Workplace health: management practices

Coaches and mentors who support managers and leaders to develop in their roles may benefit from understanding the evidence base. The leadership style of manager is recommended to be that of mentor or coach.

Managing boundaries, coachability, and ethical issues

If you don't have a clinical background, or if you wish to update your knowledge about common mental health issues, then training in mental health first aid (MHFA) with an accredited provider would be a useful form of CPD for any coach, mentor or supervisor to undertake. There are different courses for adult, higher education, youth, and armed forces. See these online courses from MHFA England:

Online mental health training

It is necessary to consider the client's mental health at every step of contracting and working with your coaching, mentoring or supervision clients, in line with the EMCC UK Ethical Code.
This includes making it clear that while coaching, mentoring and supervision may be effective in supporting clients or supervisees with work-related stress, as well as improving wellbeing, they are not clinical interventions. Suggested areas for coaches, mentors and supervisors to consider are:

- Referral criteria for employers
- Marketing/ websites
- Consultation screening processes
- Contract
- Privacy and confidentiality policy or statement
- Intake forms to gather information
- Other information sources received, such as reports
- Raising concerns with a client during a session, including clients under the influence of substances such as alcohol, and pausing the relationship either during or after the session pending a clinical assessment or mutual review of the suitability of coaching
- Supervision and discussion to ensure the coach/mentor stays within the frame of wellbeing support, and not mental illness treatment, within ethical boundaries
- Protecting and taking action to improve the mental health and wellbeing of the coach, mentor, or supervisor themselves
- Processes to ensure that if a client is working with a therapist and a coach at the same time, that the clinician is aware, and the coach is aware, that the remits of each professional are clearly defined, and that coaching is both appropriate and manageable for the client at the time
- Escalation processes and legal issues around limits to confidentiality, such as concern about harm to self, others, fitness to practise as a coach, mentor or supervisor, as well as the client's own fitness to practise at work
- Potential for safeguarding issues

Case study: Katie

Katie was referred to a coach by her employer, who wanted her to be supported in building confidence, and managing her emotions more skilfully in the work context.

However, in a follow up session, Katie told the coach that she had recently self-harmed, after an incident where she had felt bullied by a colleague. The coach knew that the self harm was a very serious alarm bell, and that coaching was no longer likely to be a safe intervention for Katie, or for her as a coach. Bearing in mind her ethical code, as well as her contract with the client, she had a duty to maintain confidentiality to a point, and also to work only within the scope of her professional capability.

The coach paused the session. She said it must be very hard for Katie at the moment, and that she had serious concerns about whether coaching was an appropriate intervention.

She knew she needed to ensure that Katie would agree to consult her GP or attend Accident and Emergency as soon as possible. If she would not agree to this, she might have to raise with Katie the possibility of breaching her confidentiality, reminding her that this was set out in their contractual agreement.

Katie agreed to contact her GP and to let the coach know when she had booked the appointment. If Katie had been unwilling to do this, the coach would have phoned her indemnity insurer and booked an urgent supervision session to request advice on how to handle this very serious situation.

Katie voluntarily agreed to terminate the coaching relationship. The coach also suggested that Katie discuss her feelings with her employer or occupational health service, as the self harm was driven by a work related situation. The coach withdrew from the relationship and reflected on her own practice with her supervisor, and in her own reflective writing, which resulted in her making changes to her own processes.

Case study: Khalid

Khalid was referred to a coach by his employer for additional support following a short period of sickness absence for 'stress'. This had been precipitated by a period of intense work, while Khalid was covering for a colleague's absence. The coaching goals focused on developing assertiveness, rebuilding confidence, and managing low level 'stress'.

Khalid seemed quite low in the first session. He was frequently tearful not just about the recent difficulties at work, but about a number of personal difficulties outside of work. The coach said she was sorry things were so hard for Khalid, and reminded him of the areas she could help with (work-related) and the areas she could not help with (personal issues).

She then asked Khalid if he knew where he could seek further support for his personal difficulties, and said that any personal therapy or clinical support should be prioritised over the coaching relationship. At the coach's suggestion, Khalid agreed to speak to his GP between sessions.

In the second session, Khalid was tearful again, and was unable to focus on the coaching goals. The coach reminded him of their agreement that he would contact his GP, and Khalid said he had not done this. The coach reminded him of the limits of coaching and their agreement about his seeing the GP. She asked whether he felt able to continue with the session. He said that he did.

However, Khalid remained unable to focus during the session and so after further consideration, the coach said she felt they needed to pause the session and also the coaching relationship pending review by his GP. She worked with Khalid to agree a plan where he would contact the GP, and she agreed to contact him on a specific date to find out how he was, with a view to exploring whether it was appropriate to continue the coaching relationship.

She also discussed the situation with her supervisor and reflected on her learning. In light of her experience, she then made changes to her own processes.

Resources

If you are worried about your own mental health, or that of a client, an employee, a friend or family member, then services in the UK include the following:

GP, 111, or your local NHS mental health service

See this useful list of mental health helplines

For NHS information about coronavirus, mental health and other conditions:

Health A to Z

Live well – tips and tools to help you make the best choices about your health and wellbeing

Looking after your mental health during the coronavirus outbreak

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