Canadian Psychiatric Association
Association des psychiatres du Canada

Original Research

The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie
2018, Vol. 63(12) 834-841

DOI: 10.1177/0706743718762100
TheCJP.ca | LaRCP.ca
SAGE

Workplace Mental Health Training in Health Care: Key Ingredients of Implementation

La formation en santé mentale en milieu de travail dans les soins de santé : principaux ingrédients de la mise en œuvre

Sandra E. Moll, MSc(OT), PhD[1], Jessica VandenBussche, MSc(OT), OT Reg(Ont)[1], Katelyn Brooks, MSc(OT), OT Reg(Ont)[2], Bonnie Kirsh, PhD[3], Heather Stuart, PhD[4], Scott Patten, MD, PhD[5,6], and Joy C. MacDermid, BScPT, PhD[7,8,9]

Abstract

Objectives: Despite growing awareness of the importance of workplace mental health training and an increasing number of educational resources, there is a gap in knowledge regarding what shapes training effectiveness. The purpose of this study was to compare and describe the active ingredients of 2 workplace mental health education programs for health care workers.

Methods: Within the context of a randomized clinical trial, a multimethod process evaluation was conducted to explore key process elements shaping implementation outcomes: the innovation, service recipients, service providers, and the organizational context. Data collection included descriptive statistics regarding program participation, postprogram interviews with a purposive sample of 18 service recipients, 182 responses to open-ended questions on postgroup and follow-up surveys, and field journal reflections on the process of implementation. Data analysis was informed by an interpretive description approach, using a process evaluation framework to categorize responses from all data sources, followed by within and cross-case comparison of data from both programs.

Results: Five key forces shaped the implementation and perceived outcomes of both programs: a contact-based education approach, information tailored to the workplace context, varied stakeholder perspectives, sufficient time to integrate and apply learning, and organizational support. The Beyond Silence program provided more opportunity for contact-based education, health care–specific content, and in-depth discussion of diverse perspectives.

Conclusions: To increase mental health literacy and reduce stigma, workplace training should be based on best practice principles of contact-based education, with contextually relevant examples and support from all levels of the organization.

[1] School of Rehabilitation Science, McMaster University, Hamilton, Ontario, Canada
[2] Windsor, Ontario, Canada
[3] Department of Occupational Science and Occupational Therapy, Rehabilitation Sciences Institute, and Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada
[4] Bell Canada Mental Health and Anti-Stigma Research Chair, Department of Public Health Sciences, Queen's University, Kingston, Ontario, Canada
[5] Departments of Community Health Sciences and Psychiatry, University of Calgary, Calgary, Alberta, Canada
[6] Member, Mathison Centre for Research & Education in Mental Health, Hotchkiss Brain Institute, University of Calgary, Calgary, Alberta, Canada
[7] Physical Therapy and Surgery, Western University, London, Ontario, Canada
[8] Clinical Research Lab, Hand and Upper Limb Centre, St. Joseph's Health Centre, London, Ontario, Canada
[9] Rehabilitation Science, McMaster University, Hamilton, Ontario, Canada

Corresponding Author:
Sandra E. Moll, MSc(OT), PhD, Institute for Applied Health Science, School of Rehabilitation Science, McMaster University, 4th Floor, 1400 Main St. W, Hamilton, Ontario, L8S 1C7, Canada.
Email: molls@mcmaster.ca

Abrégé

Objectif : Malgré une sensibilisation croissante à l'importance de la formation en santé mentale en milieu de travail, et un nombre croissant de ressources éducatives, les connaissances accusent des lacunes concernant ce qui constitue l'efficacité de la formation. Le but de cette étude était de comparer et de décrire les ingrédients actifs de deux programmes de formation en santé mentale en milieu de travail pour des travailleurs de la santé.

Méthodes : Dans le contexte d'un essai clinique randomisé, une évaluation d'un processus à multi-méthodes a été menée afin d'explorer les principaux éléments du processus qui façonnent les résultats de la mise en œuvre : l'innovation, les bénéficiaires de services, les prestataires de services, et le contexte organisationnel. La collecte de données comprenait des statistiques descriptives sur la participation au programme, des entrevues post-programme avec un échantillon choisi de 18 bénéficiaires de services, 182 réponses à des questions ouvertes sur le post-groupe et des sondages de suivi, et des réflexions sur le terrain du processus de mise en œuvre. L'analyse de données a été éclairée par une approche de description interprétative, à l'aide d'un cadre d'évaluation de processus pour catégoriser les réponses de toutes les sources de données, suivie par une comparaison à l'intérieur et croisée des données des 2 programmes.

Résultats : Cinq forces clés ont donné forme à la mise en œuvre et aux résultats perçus des deux programmes, soit une approche éducative sur place, de l'information taillée pour le contexte d'un milieu de travail, les perspectives variées des intervenants, suffisamment de temps pour intégrer et appliquer l'apprentissage, et le soutien organisationnel. Le programme Beyond Silence offrait plus de possibilités d'éducation sur place, de contenu propre aux soins de santé, et une discussion approfondie des diverses perspectives.

Conclusions : Afin d'accroître la littératie en santé mentale et de réduire les stigmates, la formation en milieu de travail devrait être fondée sur les principes des pratiques exemplaires de l'éducation sur place, avec des exemples contextuellement pertinents, et le soutien de tous les paliers de l'organisation.

Keywords

qualitative, health services research, stigma, mental health literacy, process evaluation

Background

The business case for addressing the mental health of health care workers is well established, and there is a growing demand for programs and tools to promote psychological health and safety.[1] Despite recent increases in the number of available resources, very few have been systematically evaluated.[2] In addition, many are generic and do not consider the unique educational needs of health care workers who may have higher levels of mental health literacy yet higher levels of stigma and silence surrounding mental ill health at work.[3,4]

"Beyond Silence" is a new workplace mental health education program customized for health care organizations. The curriculum was informed by the findings of several qualitative research studies exploring the mental health experiences of health care workers.[4,5] It incorporates best-practice principles of contact-based education to address the stigma associated with mental illnesses and help seeking.[6] The program is designed to be led by 2 peer educators: employees within the organization who have personal experience with mental health recovery and are trained to facilitate a respectful dialogue regarding workplace mental illness, substance use, and psychological health and safety. The program includes 12 hours of in-person training plus online discussions to complement each in-person session. Topics include understanding how common mental disorders present in the workplace, recognizing when help is needed, reaching out to colleagues, knowing what works, and building on success. There is an emphasis not only on information sharing but also on discussion, problem solving, and skill development, including examples that are specific to health care workplaces. The program is designed for a closed group of 8 to 12 participants.

To evaluate the impact of the Beyond Silence program, a randomized, parallel-group trial was conducted comparing Beyond Silence and Mental Health First Aid training (MHFA) on mental health literacy, stigmatized beliefs, and help-seeking/help-outreach behaviors.[7] MHFA was selected as a "gold standard" comparator as it also involves 12 hours of mental health literacy training and has a good base of evidence regarding its effectiveness.[8] MHFA is a standardized, module-based program that focuses on the signs and symptoms of a range of mental disorders, and a standard approach to providing "mental health first aid."[8] It was developed for the general public and has been implemented in many settings, including workplaces,[8,9] but its relevance and impact within health care has not been established.

There is growing recognition of the importance of process evaluation within the context of a clinical trial, particularly with complex health service interventions that include many active ingredients.[10] Process evaluations "explore the implementation, receipt, and setting of an intervention and help in the interpretation of the outcome results."[11(p413)] Exploring the nuances of program implementation can help to expand, extend, and complement the outcome evaluation. Process evaluations include an exploration of the social context, components of the intervention itself, and how it is received

Table 1. Interview Participants.

	Mental Health First Aid	Beyond Silence
Gender		
Male	1	2
Female	8	7
Age (years)		
25-35	1	1
35-45	2	2
45-55	4	2
55-65	2	4
Role in organization		
Clinical	5	4
Nonclinical	3	4
Both	1	1

Table 2. Key Program Characteristics.

Program Element	Mental Health First Aid	Beyond Silence
Target audience	Designed for the general public	Customized for health care workers
Content/ format	Standardized, module based Focused on recognizing the signs and symptoms of mental health problems, providing initial help and guiding a person toward appropriate professional help	Scenarios, videos, role-play, online discussion 35% mental health literacy, 35% stigma-reduction contact-based education, 30% skill development
Leadership	One Mental Health First Aid–certified trainer	Co-led by 2 "peer educators" (employees with lived experience of mental illness and recovery)
Schedule	12 hours over 2 full days	12 hours: six 2-hour sessions + 5 online sessions

by various subgroups of participants.[11,12] This study is a process evaluation of mental health literacy training with health care workers, documenting and comparing active ingredients of the Beyond Silence and the MHFA programs. Two key questions guided the research are (1) What is the perceived impact of the program, from the perspective of participants? and (2) How is the program impact influenced by (a) the content and format of the program itself, (b) actions of program facilitators, (c) characteristics of the program participants, and (d) the organizational context?

Methods

A multilevel implementation science framework informed the study design using a multimethods approach to data collection. The implementation science framework proposed by Chaudoir et al.[13] focuses on 4 implementation variables: the innovation, the service recipients, the service providers, and the organizational context. Initial comparisons were based on quantitative descriptive data, followed by a focus on qualitative data from the participant interviews and surveys. Details regarding the methodology have been noted in the study protocol.[7] Ethics approval was obtained from both participating hospitals.

Participants

Participants in the overall clinical trial were hospital employees in 2 multisite hospitals in a mid-sized urban city in southern Ontario. Employees could participate if they were (1) full, part-time, or casual employees; (2) agreeable to being randomly assigned to either of the 2 programs; (3) committed to attending 12 hours of mental health education outside of paid work time; (4) able to communicate in English; and (5) had no prior training in either program. Approximately 59% of the study participants were in clinical positions, 20% were support staff, and 21% were in a management role.

Data were collected from 182 employees who completed postgroup and/or 3-month follow-up surveys. A subgroup of 18 participants was also recruited to participate in in-depth individual interviews about their experience. We used purposive sampling to recruit key informant volunteers who were participants in the first 3 intake periods. To include participants who varied in in gender, age, organizational role, and program experience, the project coordinator identified 3 participants from programs in each of the 3 cohorts (representing approximately one-third of the total number of participants at the time) and invited them to participate in a follow-up interview about their experience. All who were invited agreed to participate. The final sample of interviewees included 9 participants from each of the 2 programs. As noted in Table 1, the majority of participants were female and older than 45 years, with a mix of clinical and nonclinical roles.

Intervention Approach

There were 8 intakes over the course of 1 year (September 2014–October 2015). In each intake, employees were randomly assigned to one of two 12-hour educational interventions (Beyond Silence or MHFA). Table 2 outlines the key characteristics of each program.

Data Collection

An online survey was distributed to all participants immediately following completion of the program and again at a 3 months. The survey included demographic data (age, gender, occupational role), as well as 3 open-ended questions asking for general feedback about the program, identification of what they gained from attending, and suggestions for improvement. Survey completion rates postgroup and at the

Table 3. Comparing Perspectives on Program Characteristics.

Program Element	Mental Health First Aid	Beyond Silence
Content	I felt that the Mental Health First Aid program was very good, although a little simplistic and repetitive for people who are health care providers.	I felt that we were reenacting what it should look like in the workplace, that availability of one another to be able to talk freely, openly about what they've experienced. And I feel like that is how ideally that would look in the workplace.
	I was hoping for more relevant hospital examples to apply because that was kind of my bias, my motivation for taking the course was [to focus on] hospital employees and some of the things that they go through and how to support them.	. . . this perfect person that I would idealize and somebody that seemed like they had [it] together. And then to hear her speak about this extreme moment in her life and really realize that "Wow, this doesn't have a face. Mental illness doesn't have a face." . . . That person can look completely happy and yet they're suffering—you don't know and I think that was a real eye opener for me.
	The real, the richest learning for me came when people shared their personal experiences.	
Schedule	Breaking out the course into . . . shorter classes would help with retention of information, as well as some follow up after the course.	I liked going every other week and felt that I had a chance to review the discussions, even put them to use over the "off" week. I am not sure if I would have been overwhelmed with info on the 2 day course.
Participants	I liked that clinical staff were mixed with nonclinical staff, therefore providing different perspectives.	I found the group very interesting in terms of the mix . . . there were people who had obviously had a great deal of experience with mental health issues within their own personal situations, whether it was at work or in their personal lives. It was very interesting to hear their viewpoints.
		Managers don't always tend to be vulnerable with the workers. . . . So seeing that they struggle with some things as well, was kind of nice . . . to see that, okay they're human as well.
Leaders	. . . have an experienced mental health provider and perhaps a person who has experienced a mental health problem co-facilitate to challenge stigma and misinformation more directly.	The facilitators were nonjudgmental people who both had experience with mental/addictions issues. This allowed for their own personal experiences to be shared and created an environment that fostered honesty and trust regarding a sensitive subject.

3-month follow-up were 87% and 78%, respectively, with comments from more than 92% of the survey respondents. There were 73 postgroup plus 68 follow-up comments from Beyond Silence participants and 83 postgroup plus 79 follow-up comments from the MHFA participants.

In-depth semistructured interviews were conducted with 18 participants approximately 3 months after they completed the program. Interviews explored their perceptions of the program, including how they became involved, their impressions of the experience, what they gained from participating, and suggestions for improvement. The interviewers were students who were not involved in development or implementation of the program. A field journal was also maintained to track the implementation process, from recruitment through data collection and analysis.

Data Analysis

An interpretive description approach was used to analyze qualitative survey responses, interview transcripts, and data regarding program implementation. Interpretive description involves identifying themes and patterns within subjective data to generate findings that inform clinical understanding and application.[14] Dedoose software[15] was used to manage the data. Data were initially coded in an iterative process of categorizing comments that reflected each of the 4 process factors. Double coding of initial interviews was completed by members of the research team to ensure consistency in coding practices. Comments within each category were then reviewed to identify key experiences for participants in each program and the similarities and differences across programs.

Findings

Findings from all data sources were compiled to explore the impact of 4 key dimensions of program implementation: (1) the innovation itself (i.e., content and format), (2) the program participants, (3) the program leaders, and (4) the organizational context. A summary of quotes from participants in each program is provided in Table 3.

Innovation Content and Format

Both programs provided 12 hours of education related to mental health and mental illnesses; however, as noted on Table 2, there were differences in content, format, and scheduling. Many MHFA survey respondents indicated that the course content met their expectations of a basic introduction to mental health and illness. Some liked the structure of reviewing each type of illness or "disease process"; others, particularly those with a clinical background, indicated that the information was a "refresher" about various mental health conditions. A few clinicians complained that the

information was too basic with limited opportunity for new learning. Another consistent comment from the MHFA participants was that they would like more examples and case scenarios that were relevant to their workplace. In contrast, the Beyond Silence participants talked about how much they valued the opportunity to reflect on and discuss issues and scenarios that were directly relevant to their day-to-day work.

Sharing personal stories was emphasized by all participants as having the greatest impact on their learning. Even though it was not a formal part of the MHFA program, it was something that participants sought out. Many of the Beyond Silence participants referred to the personal stories they heard (this was a core element of the program), including opportunities for discussion on a weekly basis. The personal stories reportedly increased their insight into what colleagues may be experiencing and also helped to combat the stigma associated with the condition. This process challenged their preconceived ideas about mental illness and had a lasting emotional impact on them. Although the opportunity for sharing stories was typically identified as a valued part of the program, it is important to note that there were a few exceptions. For example, one male survey respondent noted, "For the introverts, [it was] a little too much required participation." Since the information was deeply personal at times, it was not necessarily easy for them to hear about or share experiences.

In addition to the content, there were comments about the program schedules, including both benefits and challenges of the 2-day format (MHFA) versus the 6 biweekly sessions (Beyond Silence). Dropout rates were higher for the Beyond Silence program (34% as opposed to 20% in MHFA), since it was difficult to commit to evening meetings over a 3-month period. On the other hand, some reported that they valued the time to reflect upon the information and apply it in their work life. There were many requests for additional sessions once the training program was complete. They felt that "refresher" sessions could provide an opportunity to "try out" different strategies and maintain their motivation to apply the principles in their day-to-day work.

Program Participants

Participants in both programs came from all areas of the organization, including clinical and nonclinical positions, as well as both managers and front-line workers. The heterogeneity of participants, including age, position in the organization, work and personal experiences, was noted by all of the interviewees. Many reported an appreciation of this diversity; it led to enhanced learning from multiple perspectives. The different roles and experiences reportedly facilitated a rich conversation and exchange of ideas, and they valued the opportunity to connect with staff from across the organization. The Beyond Silence participants, in particular, had more opportunity for dialogue about workplace mental health issues, noting the value of exchanging ideas between front-line workers and managers. One of the managers indicated that it was valuable to hear the viewpoint of front-line staff as well as the union/nonunion points of view. In addition, front-line workers found it valuable to hear the perspective of managers.

Service Providers

Facilitators in both programs were employees with specialized training to deliver the program. One key difference is that the Beyond Silence program was co-led by 2 peer educators, whereas MHFA was led by 1 trained facilitator who did not share personal experiences. Crossover in leadership and small numbers in each group prevented quantitative comparison of outcomes based on program facilitators; however, comments from the survey and interview data highlighted important similarities and differences.

Facilitators in both programs reportedly played an important role in sharing information, as well as creating a positive, engaging learning environment. One notable difference was that the Beyond Silence participants talked about the significant impact of leaders who were able to share their personal experiences in an honest and authentic way. They noted the leaders' ability to use these personal experiences to create an open dialogue about mental health issues in a supportive, nonjudgmental way and that their advice had more impact since "they've been there." In contrast, several MHFA participants suggested that the program could be enriched by including leaders or speakers with personal experiences, noting it "makes a difference to have some personal knowledge . . . 'cause then you're more passionate about it."

The Beyond Silence co-leader model was set up so they had complementary areas of expertise and personal characteristics (e.g., male/female, manager/front-line worker). We trained 5 co-leaders, so they could fill in for each other in the case of vacation or illness. We also held monthly meetings to proactively support them in their role.

Social/Organizational Context

The programs were offered in 2 different health care organizations. Quantitative analysis noted no differences in outcomes between the 2 organizations (publication forthcoming). From a qualitative perspective, however, there were important differences in implementation. In the first organization, there was a history of collaboration with leaders in Health Safety and Wellness, support from senior leadership, and an advisory team of union representatives, managers, and front-line workers from both clinical and nonclinical areas. This level of engagement facilitated communication for recruitment, implementation and evaluation. In the second organization, time was needed to establish new relationships, channels of communication, awareness, and trust, as well as a positive reputation for the educational initiatives. Information was shared at senior leadership

meetings to promote awareness and managerial support (e.g., flexible scheduling) for their employees to attend.

Although participants in this study volunteered to attend sessions outside of working hours, many participants suggested mandatory attendance, particularly for employees in formal or informal leadership positions. They emphasized the importance of training to address the challenges of reaching out to provide support and suggested inclusion in employee orientation. Although some participants were proactive in sharing resources and information with their team, others found it more difficult and discussed the importance of leadership "buy-in" for real change to occur. One participant, for example, noted that she had changed but that broader system change is still needed.

> This is a stigma that needs to be broken by our corporation when it comes to staff. We are quick to help patients who may be suffering for these issues but are not as compassionate with our own coworkers when they are suffering from the same sort of issues.

Discussion

The ultimate goal of both training programs was to promote early intervention and support for health care employees who may be struggling with mental health issues. Based on the study findings, 5 key design principles appeared to shape the perceived impact of the programs: (1) contact-based education, (2) contextually relevant information, (3) an opportunity to explore varied perspectives, (4) sufficient time to integrate and apply learning, and (5) organizational readiness/support.

Our findings are congruent with current research on the value of contact-based education as a best practice approach in changing attitudes about mental illness.[16] Many studies have documented the value of positive, voluntary, prolonged, personal contact with a respected peer who has a mental illness on reducing stigma.[6,16,17] In workplace training, the nature of "contact" could range from videos to in-person stories about mental illness and recovery. In our study, the Beyond Silence peer educators were intentionally hired to facilitate opportunities for contact-based education, and there was clearly a positive response to their role. Participants valued the leaders' ability to share authentic, relevant experiences in a way that created an open, safe space for discussion and learning. The other, more unexpected response was the personal sharing that happened between participants; many shared stories about themselves, family members, and colleagues. By creating time and space for these conversations to happen, the boundaries between "us and them" were challenged, and a deeper understanding emerged regarding workplace mental health as a universal, important issue for all employees to understand and address. The impact of this approach led not only to a change in knowledge but also to significant changes in attitudes and beliefs, as noted in both quantitative and qualitative findings.

Another key finding relates to the value of contextually-relevant content. This finding is consistent with principles of adult education, which stipulates that learners are interested in learning about subjects that have immediate relevance and impact to their job and that experience provides that basis for learning.[18] Many current training approaches such as MHFA are designed to be implemented across many contexts, including the workplace.[2] Although some issues may be relevant across a range of sectors and settings, our findings suggest there is value in identifying unique issues in particular workplace settings. Beyond Silence was designed for health care; a publicly funded, service-oriented sector with a female-dominated workforce. It may not be relevant in the manufacturing sector, which has a private, for-profit orientation and predominantly male workforce. In designing and implementing training, it is important to consider how the terminology, examples, leaders, and even the amount of time spent on specific issues should be tailored to the specific learning needs of employees. The workplace culture, as well as cultural and educational backgrounds of employees, can affect their training needs.

An opportunity to explore varied perspectives was another active ingredient of both training programs. Many training programs are designed exclusively for managers since they are responsible for managing performance when employees are struggling.[2] There is increasing attention, however, on the important role of colleagues in identifying and responding to mental ill health at work.[19,20] Workplace are social spaces with many different personalities and relationships that can shape responses to employees who may be struggling. In our study, diversity in roles and personal mental health experience provided an opportunity to explore the diversity of perspectives regarding the nature of the issues and perceived responsibilities for action. As noted by our Beyond Silence participants, the opportunity to exchange diverse perspectives enhanced understanding and empathy.

Sufficient time to integrate and apply learning was another key finding. Many training programs are typically a few hours up to 2 days in length[2]; this format is efficient but may not be sufficient to sustain learning over time. Knowledge can be transmitted fairly quickly, but attitude and behavior change takes time. The Beyond Silence participants brought real workplace examples to the session for discussion and appreciated time between sessions to integrate and apply the information they were learning. Unfortunately, busy work and personal lives can interfere with a long-term training commitment, and missing sessions detracts from optimal learning. Additional research is needed regarding the value of periodic "refresher" sessions or technology-based support for continued application of the ideas. In addition, further study is needed to track behavior change over time.

The final critical ingredient for successful implementation is organizational readiness and support. In both programs, support at all levels of the organization, including high-level executives, front-line managers, union

representatives, and health and safety providers, was important in promoting participation and integration of ideas into day-to-day work practice. This finding is congruent with findings of a national case study project on implementation of standards of psychological health and safety.[21] Their keys to successful implementation included ongoing leadership support and involvement, adequate structure and resources, and commitment throughout the organization. It is not only the program itself but also how information is shared with and interpreted by employees. Support and/or incentives may be needed for coworkers to reach out to others, particularly since it is not a required part of their role. "Organizational citizenship" literature highlights strategies to engage employees in voluntary, positive action that supports coworkers and benefits the overall organization.[22]

Overall, the active ingredients for workplace mental health training are relevant to design and implementation beyond the 2 programs in this study. In comparing the 2 programs, however, the Beyond Silence participants received more contact-based, contextually relevant information and had more time to integrate and apply learning. As such, the Beyond Silence program appeared to provide added value to participants.

Study Limitations

Generalizability is limited by the small sample of participants who were likely the early adopters and motivated to participate in workplace mental health training. Most participants were female clinicians, which is not unusual in health care; however, learning needs might be different for male respondents and those in nonclinical positions. The study was conducted in 1 medium and 1 large hospital in the same urban center. Since the organizational context can affect implementation and outcomes, further research is needed to explore application in other health care settings. Strengths of the study include high survey completion rates, as well as triangulation of data sources and methods, which enhanced depth of understanding and credibility of the findings.

Conclusion

The "active ingredients" of implementation noted in this study complement the randomized controlled trial outcome data. General principles for implementation have been identified, including the importance of participant composition, scheduling, and organizational commitment. In addition, specific elements of Beyond Silence, including contact-based education, contextually-relevant content, and prolonged contact, reportedly enhanced integration and application of information. Additional research is needed to explore application in other settings and how this training should be embedded within broader organizational initiatives to address psychological health and safety.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: this research study was funded by the Ontario Mental Health Foundation.

ORCID iD

Sandra E. Moll, MSc(OT), PhD http://orcid.org/0000-0002-1937-0103
Scott Patten, MD, PhD http://orcid.org/0000-0001-9871-4041

References

1. HealthcareCAN and Mental Health Commission of Canada. Declaration of commitment to psychological health and safety in healthcare. Ottawa (ON): Mental Health Commission of Canada; June 2017 [accessed 2017 Aug 18]. https://www.mentalhealthcommission.ca/English/workplace-healthcare-declaration.
2. Canadian Mental Health Association. Workplace mental health in Canada: findings from a Pan Canadian Survey. Toronto (ON); 2016 [accessed 2017 Oct 26]. http://www.bottomlineconference.ca.php56-24.dfw3-1.websitetestlink.com/wp-content/uploads/2016/02/Workplace-Mental-Health-in-Canada_CMHA_Feb2016.pdf.
3. Bourget B, Chenier R. Mental health literacy in Canada: phase 1 draft report mental health literacy project. Ottawa (ON): Canadian Alliance on Mental Illness and Mental Health; 2007.
4. Moll S. The web of silence: a qualitative case study of early intervention and support for healthcare workers with mental ill-health. BMC Public Health. 2014;14:138.
5. Moll S, Eakin J, Franche RL, et al. When health care workers experience mental ill health: institutional practices of silence. Qual Health Res. 2013;23(2):167-179.
6. Couture S, Penn DI. Interpersonal contact and the stigma of mental illness: a review of the literature. J Ment Health. 2003; 12(3):291-305.
7. Moll S, Patten S, Stuart H, et al. Beyond silence: protocol for a randomized, parallel-group trial comparing two approaches to workplace mental health education for healthcare employees. BMC Med Educ. 2015;15:78.
8. Kitchener BA, Jorm AF. Mental health first aid training in a workplace setting: a randomized controlled trial. BMC Psychiatry. 2004;4:23.
9. Ganshorn H, Michaud N. Mental Health First Aid: an evidence review. Ottawa (ON): Mental Health Commission of Canada; 2012 [accessed 2017 Oct 26]. https://www.mentalhealthcommission.ca/English/document/5207/mental-health-first-aid-evidence-review.
10. Moore GF, Audrey S, Barker M, et al. Process evaluation of complex interventions: medical research council guidance. BMJ. 2015;350:h1258.

11. Oakley A, Strange V, Bonell C, et al. Process evaluation in randomised controlled trials of complex interventions. BMJ. 2006;332(7538):413-416.
12. Meyers DC, Durlak JA, Wandersman A. The quality implementation framework: a synthesis of critical steps in the implementation process. Am J Commun Psychol. 2012;50: 462-480.
13. Chaudoir SR, Dugan AG, Barr CH. Measuring factors affecting implementation of health innovations: a systematic review of structural, organizational, provider, patient, and innovation level measures. Implement Sci. 2013;8:22.
14. Thorne S, Reimer Kirkham S, O'Flynn-Magee K. The analytic challenge in interpretive description. Int J Qual Methods. 2004; 3(1):Article 1.
15. Dedoose Version 7.0.23. Web application for managing, analyzing, and presenting qualitative and mixed method research data. Los Angeles (CA): SocioCultural Research Consultants LLC; 2016.
16. Stuart H, Koller M, Christie R, et al. Reducing mental health stigma: a case study. Healthc Q. 2011;14(Spec No 2):40-49.
17. Patten SB, Remillard A, Phillips L, et al. Effectiveness of contact-based education for reducing mental illness related stigma in pharmacy students. BMC Med Educ. 2012;12:120.
18. Smith MK. Malcolm Knowles, informal adult education, self-direction and andragogy. Canning Town (UK): The Encyclopedia of Informal Education; 2002 [accessed 26 Oct 2017]. http://www.infed.org/thinkers/et-knowl.htm.
19. Chiaburu DS, Harrison DA. Do peers make the place? Conceptual synthesis and meta-analysis of coworker effects on perceptions, attitudes, OCBs, and performance. J Appl Psychol. 2008;93(5):1082-1103.
20. Dunstan DA, MacEachen E. Workplace managers' views on the role of co-workers in return-to-work. Disabil Rehabil. 2016;38(23):2324-2333.
21. Mental Health Commission of Canada. Case study research project findings. Ottawa (ON): Mental Health Commission of Canada; 2017 [accessed 28 August 2017]. http://www.mentalhealthcommission.ca.
22. Ilies R, Nahrgang JD, Morgeson FP. Leader-member exchange and citizenship behaviors: a meta-analysis. J Appl Psychol. 2007;92(1):269-277.