MJA
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Supporting Information

Supplementary methods

Appendix to: Gayed A, Strudwick J, Kugenthiran N, et al. Mental health training for physicians supervising resident physicians: a cluster randomised controlled trial. *Med J Aust* 2024; doi: 10.5694/mja2.52407.

Questionnaire

To be completed electronically.

Responsive Behaviour

Please indicate your level of agreement with the following statements:	**Strongly disagree**	**Disagree**	**Slightly agree**	**Agree**	**Strongly agree**
1. I can identify the difference between a mental health issue and a performance issue in my trainees.	1	2	3	4	5
2. I initiate a conversation with individuals I supervise about their mental health and well being.	1	2	3	4	5
3. I always speak with trainees within the first 2 weeks of them being away on sick leave.	1	2	3	4	5
4. I engage in regular one-on-one catch ups with my trainees to monitor work and well being.	1	2	3	4	5
5. When my trainees are experiencing mental health problems I provide them with appropriate contact details of mental health support resources within and external to our organisation.	1	2	3	4	5
6. I implement possible workplace adjustments or appropriate staged return to work plans for trainees experiencing mental health. problems	1	2	3	4	5

Preventive Behaviour

Below are some statements about managerial strategies to prevent and reduce stress at work. Please indicate your level of agreement with each statement. Please answer these questions as honestly as possible (remember your answers for all questions will remain anonymous).	**Strongly disagree**	**Disagree**	**Slightly agree**	**Agree**	**Strongly agree**
1. I do what I say I will do	1	2	3	4	5
2. I don't pass on my stress to my trainees	1	2	3	4	5
3. I give more positive than negative feedback	1	2	3	4	5
4. I monitor my trainee's workload on an ongoing basis	1	2	3	4	5
5. I give trainees the right level of job responsibility	1	2	3	4	5
6. I provide regular opportunities for my trainee to speak one to one	1	2	3	4	5
7. I try to see things from my trainees' point of view	1	2	3	4	5
8. I deal objectively with trainee conflicts	1	2	3	4	5
9. I seek advice from other physician supervisors when necessary	1	2	3	4	5

Confidence

Please indicate your current level of **CONFIDENCE** with the following:	Not at all confident	Not really confident	Slightly confident	Confident	Extremely confident
1. Initiating contact with trainees on sickness absence leave that you believe might be due to mental illness	1	2	3	4	5
2. Discussing rehabilitation/return to work plans with the trainee on sickness absence	1	2	3	4	5
3. Identifying barriers preventing a trainee returning to work and coming up with solutions to those barriers	1	2	3	4	5
4. Initiating a conversation with a trainee who is not on sickness absence but who you think may be suffering from mental illness	1	2	3	4	5
5. Initiating a conversation with trainees who have recently been exposed to a potentially traumatic event and enquiring about their well-being	1	2	3	4	5
6. Creating a work environment that prevents and reduces stress within the team	1	2	3	4	5

Mental Health Knowledge

Adapted version of Mental health knowledge schedule: Evans-Lacko, S., Little, K., Meltzer, H., Rose, D., Rhydderch, D., Henderson , C., and Thornicroft, G. Development and Psychometric Properties of the Mental Health Knowledge Schedule. (2010). *Can J Psychiatry.* 55: 440-448.

- assess stigma-related mental health knowledge among the general public
- Scored on a 5-point scale (1-5) with 'don't know' coded as neutral (ie: 3).

	Disagree strongly	Disagree slightly	Neither agree nor disagree	Agree slightly	Agree strongly	Don't know
Most people with mental health problems want to have paid employment.	1	2	3	4	5	0
If a friend had a mental health problem, I know what advice to give them to get professional help.	1	2	3	4	5	0
Medication can be an effective treatment for people with mental health problems.	1	2	3	4	5	0
Psychotherapy (eg talking therapy or counselling) can be an effective treatment for people with mental health problems.	1	2	3	4	5	0
People with severe mental health problems can fully recover.	1	2	3	4	5	0
Most people with mental health problems go to a healthcare professional to get help.	1	2	3	4	5	0

Attitudes/stigma towards mental health

Below are some statements on general attitudes towards mental illness. Please indicate your level of agreement.		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1.	Mental health problems are different to other medical problems because they are caused by peoples' own behaviour and decisions	5	4	3	2	1
2.	Anxiety disorders often resolve once people get some extra attention	5	4	3	2	1
3.	Depression often doesn't need medical help and can usually be resolved by people focusing on positive thoughts	5	4	3	2	1
4.	The majority of people who go off work due to mental health problems are just looking for financial compensation	5	4	3	2	1
5.	Post-traumatic stress disorder (PTSD) is not a true medical disorder	5	4	3	2	1
6.	If someone discloses their mental problems, they will lose most of their friends	5	4	3	2	1
7.	Once someone has suffered from depression, their memory is never as good as it was before they got unwell	5	4	3	2	1
8.	Studies have shown that people with mental health problems are much more likely to be violent towards strangers	5	4	3	2	1
9.	Depression can be considered a shameful and stigmatising disease	5	4	3	2	1
10.	It is difficult to talk to a person who is currently suffering from mental illness	5	4	3	2	1

6-item Kessler Psychological Distress Scale (K6)

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please select the number that best describes how often you had this feeling.

During the last 30 days, about how often did you feel…	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
a. …nervous?	1	2	3	4	5
b. …hopeless?	1	2	3	4	5
c. …restless or fidgety?	1	2	3	4	5
d. ...so depressed that nothing could cheer you up?	1	2	3	4	5
e. …that everything was an effort?	1	2	3	4	5
f. …worthless?	1	2	3	4	5

Table 1. Mean scores for recommended supervisor behaviours, by trial allocation group and assessment

	Model mean (standard deviation)	
Assessment	**Waitlist**	**Intervention**
Baseline	29.6 (3.2)	29.6 (3.3)
3 week follow-up	30.0 (3.2)	31.5 (3.2)
3 month follow-up	30.5 (2.8)	31.3 (2.7)
6 month follow-up	29.9 (2.7)	31.7 (2.5)

CONSORT 2010 checklist of information to include when reporting a randomised trial* (the page numbers refer to the submitted manuscript, not those of the published article or its Supporting Information file)

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	1
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)	1
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	3
	2b	Specific objectives or hypotheses	3-4
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	4
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	n/a
Participants	4a	Eligibility criteria for participants	4
	4b	Settings and locations where the data were collected	4
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	5
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	5-6
	6b	Any changes to trial outcomes after the trial commenced, with reasons	n/a
Sample size	7a	How sample size was determined	6
	7b	When applicable, explanation of any interim analyses and stopping guidelines	n/a
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequence	4
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	4
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	4
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	4
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how	7
	11b	If relevant, description of the similarity of interventions	5

Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	6-7
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	7
Results			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	8
	13b	For each group, losses and exclusions after randomisation, together with reasons	8
Recruitment	14a	Dates defining the periods of recruitment and follow-up	5
	14b	Why the trial ended or was stopped	n/a
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	16
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	8
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	8-9
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory	9
Harms	19	All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)	9
Discussion			
Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses	11
Generalisability	21	Generalisability (external validity, applicability) of the trial findings	11
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	10
Other information			
Registration	23	Registration number and name of trial registry	4
Protocol	24	Where the full trial protocol can be accessed, if available	4
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	7

Citation: Schulz KF, Altman DG, Moher D, for the CONSORT Group. CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. BMC Medicine. 2010;8:18.

*We strongly recommend reading this statement in conjunction with the CONSORT 2010 Explanation and Elaboration for important clarifications on all the items. If relevant, we also recommend reading CONSORT extensions for cluster randomised trials, non-inferiority and equivalence trials, non-pharmacological treatments, herbal interventions, and pragmatic trials. Additional extensions are forthcoming: for those and for up-to-date references relevant to this checklist, see www.consort-statement.org.