

Development of a Transformative Model of Change for Mental Health Education, Research, and Service

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ABSTRACT

Background. The challenges and opportunities of the 21st century necessitate transformative change in health professions education toward a collaborative and quality-oriented culture. A transformational learning approach, facilitated by organizational support, strong change valence, and psychological safety, can promote organizational readiness to change and engagement in initiatives that yield measurable outcomes at the individual, group, and organizational levels.

Objective. The study aimed to identify factors that contribute to organizational readiness to change, describe the impact of the process of change at the individual, group and organizational levels, determine appropriate indicators to measure the intended and emergent outcomes, and describe the effect of the use of reflexivity on the researcher and the research process.

Methods. The study used an explanatory sequential mixed methods design. Data sources included structured observations, surveys, interviews, and document review, allowing for methodological triangulation. The study site is a clinical department in a national university with a total of ninety (90) participants.

Results. Quantitative results identified supportive situational factors ($\beta = 0.462-0.486$, 95% CIs excluding zero) and task demands ($\beta = 0.238-0.283$, 95% CIs excluding zero) as the only statistically significant predictors of organizational readiness to change. Change valence and psychological safety demonstrated small, non-significant effects ($|\beta| < 0.20$). Readiness was therefore strongly associated with organizational support and clarity of expectations even in the context of perceived resource constraints. The transformative learning approach was associated with enhanced leadership development, a strengthened collaborative culture, and measurable gains in education, training, research, and service. Reflexive practice contributed to methodological rigor and informed key research decisions.

Conclusion. The findings have validated and refined the conceptual framework on the process of promoting change toward desired outcomes in the clinical department under study. The insights gained have also informed the next steps in facilitating the progression of the department in becoming future-proofed and may be considered for application in organizations similarly undergoing change.

Keywords: *transformative learning, psychological safety, mental health, organizational development, organizational readiness to change*



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INTRODUCTION

The challenges presented by as well as opportunities provided in the 21st century call for changes in health professions education through a transformative, collaborative and quality culture in education, service and research.¹⁻⁴ One recommended approach is Mezirow's transformational learning, an adult learning framework that involves introducing a disorienting dilemma toward promoting the reintegration of a new perspective.⁵ It is appropriate for situations when long-held frames of reference are found to no longer be useful and therefore need to be transformed into a version that is more applicable. It is intended to facilitate the development of decision makers who can make socially responsible choices that can foster culture change.⁵

Change can be intentionally influenced in speed and direction using certain interventions.^{6,7} When individuals are prepared for change, they are more likely to initiate action on change-related activities, exhibit persistence, and display cooperative behavior. Being psychologically willing and behaviorally able to participate increases the likelihood of effective implementation. The promotion of readiness to change can therefore be considered a major prerequisite when aiming for change.⁷

As a construct, organizational readiness to change can be viewed as consisting of two subconstructs, a shared resolve to implement a change, called change commitment, and a shared belief in the collective capability to do so, called change efficacy. Organizational readiness to change varies as a function of how much organizational members value the change, called change valence, and how favorably they appraise three key determinants of implementation capability, namely, task demands, resource availability, and situational factors.^{7,8}

Psychological safety is another quality that has been recognized as an important strategy for promoting change

readiness in a group.⁹ Mistakes are inevitable on account of the complexity of work environments. Discussing these mistakes can provide valuable lessons. A sense of safety to speak up or exercise voice, especially in relation to mistakes, is called psychological safety. Its presence increases the likelihood for team members to engage in learning behaviors and for outcomes to improve.^{10,11}

When fostering change in an organization, the process of learning occurs at several levels: the individual, the group, and the organization. Crossan's 4I Framework contends that such learning is connected by four processes: intuiting, interpreting, integrating, and institutionalizing as shown in Figure 1.¹²

Considering how health professions have developed built-in mechanisms to preserve the status quo, it can be challenging for institutions tasked with the provision of health services and the development of requisite competencies in health professionals to forge responsive changes.¹³ Adding to the challenge were the resource requirements and physical restrictions imposed when the pandemic was declared in March 2020 which stretched resources to capacity and significantly disrupted operations and services in various institutions. The gradual resumption of prepandemic activities and the easing of physical restrictions in early 2022 provided an opportunity for an academic unit involved in mental health education, research and service to review department directions and consider embarking upon the changes called for.

Conceptual Framework

This study involves the development of a transformative model of change to future-proof a department involved in mental health education, research and service.¹⁴ As illustrated in Figure 2, a transformative learning approach was used to foster the development of the department toward a transformative, collaborative and quality culture at the



Figure 1. The levels of learning in an organization.

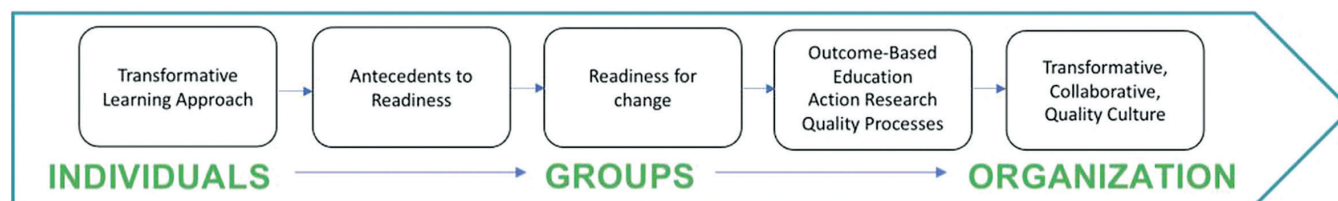


Figure 2. The conceptual framework.

individual, group and organizational levels. Organizational support for implementation capability, change valence, and psychological safety was expected to promote readiness to change thereby facilitating engagement in initiatives aimed at enhancing responsiveness.

Guided by a situational analysis which included interviews with department members, an andragogically-informed and evidence-based organizational development program was designed and implemented. Interventions focused on enhancing member competencies through relevant brief online courses, regular mentoring by experts, and targeted organizational support. Particular attention was given to the promotion of a culture of collaboration and continuous improvement in a physically and psychologically safe environment.

The multiple roles of the researcher as principal investigator, change proponent, and department chair in the study site posed methodological challenges but also provided an

opportunity to intentionally employ reflexivity.¹⁵ Subjectivity was treated as an analytic resource rather than a liability.

Given a small clinical department in a health science center, the study aimed to 1) identify factors that contribute to organizational readiness to change, 2) describe the impact of the process of change at the individual, group and organizational levels, 3) determine appropriate indicators to measure the intended and emergent outcomes, and 4) describe the effect of the use of reflexivity on the researcher and the research process.

METHODS

An explanatory sequential mixed methods design was used, in which findings from the initial quantitative phase using a survey questionnaire and observation were utilized to guide the content of the subsequent qualitative phase using a semi-structured interview (Figure 3). This approach

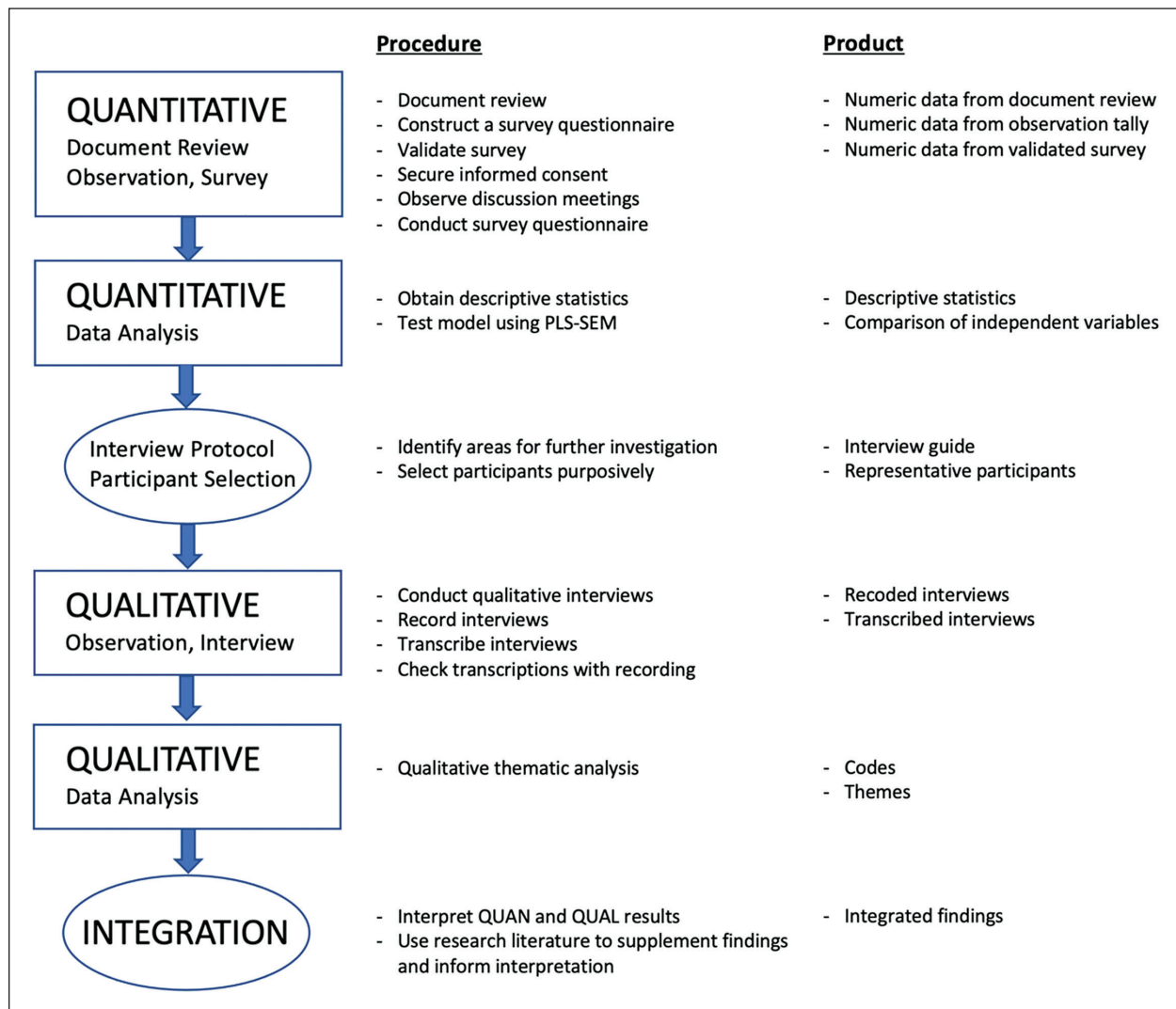


Figure 3. Conduct of explanatory sequential mixed methods design.

was intended to integrate findings from both methods and to generate a more comprehensive understanding of the phenomenon than either quantitative or qualitative methods alone.¹⁶ Observation of groups, the administration of a survey questionnaire to individuals, and interviews with members representative of various department roles were used to provide a triangulated approach. The results from the initial quantitative phase using a survey questionnaire and observation were utilized to guide the content of the subsequent qualitative phase using a semi-structured interview. Secondary data was examined to provide supporting evidence for engagement in change-related efforts and to monitor outputs of relevant units.

Population and Sampling Technique

The study site is the Department of Psychiatry and Behavioral Medicine (DPBM) of the University of the Philippines Manila. This department is involved with mental health education, research and service and had been undergoing organizational development designed specifically for the unit with the goal of addressing current and future needs.¹⁷⁻²⁰ Activities consistent with the transformative approach had been implemented for two years during the time of the study in October 2023 to February 2024. The study population consisted of all those who had been with the department for at least three months, therefore ensuring significant exposure to the department initiatives (N=92).

For observation, all group meetings among members that had been scheduled for four weeks were identified and eight meetings were chosen based on composition to include as many members as possible. For the survey, data was collected from members of the entire population who consented to participate. For interviews with a homogeneous population and narrowly defined objectives, the recommended number is 9-17 interviews.²¹ Stratified purposive sampling ensured representation across roles, exceeding the minimum recommended interview sample size for homogeneous populations to achieve saturation such that no new themes emerged.

Data Collection

Research assistants approached participants in person for consent, explained the contents of the consent form and then requested for their signatures. The observations were done first, followed by the survey questionnaires and culminating with the interview. Each data collection phase was completed before proceeding to the next.

The observation instrument was adapted from a study on psychological safety conducted on healthcare teams. It included thirty-one (31) observable behaviors under seven categories: (1) voice, (2) defensive voice, (3) silence behaviors, (4) supportive, (5) unsupportive, (6) learning or improvement-oriented and (7) familiarity type behaviors.¹¹ The observation guide was reviewed and approved by five experts which consisted of two (2) psychologists with doctorate degrees who were teaching in the academe, one (1)

physician with a Master's degree in Bioethics, and two (2) psychiatrists, one of whom had a doctorate degree. All five experts had sufficient training and experience to qualify as research instrument development and subject matter experts. Observations were conducted on 4 recorded meetings and 4 in-person meetings. All meetings observed were regularly scheduled unit meetings. The research assistants were trained in the use of the instrument, and they openly discussed their observations to facilitate inter-observer agreement.

A survey questionnaire developed for the purpose of determining the relationship between antecedents to change and organizational readiness to change was used.²² The scale questionnaire demonstrated good content, face, and construct validity. It had strong internal consistency (Cronbach's α ranging from 0.897 to 0.942), adequate convergent validity (AVE = 0.619–0.841), and acceptable discriminant validity based on HTMT criteria hence supporting the decision for its use. The items were presented as statements to be rated for agreement using a 10-point Likert scale with options ranging from 1 (strongly disagree) to 10 (strongly agree). The questionnaires were administered by research assistants to all the members of the population who consented to participate. Digital and hardcopy versions were used based on the preference of the respondent.

After the results of the observations and the survey had been encoded and analyzed, the interviews were conducted by research assistants trained for the purpose. The sequencing of the questions followed the ORID reflection approach, a process useful for facilitating discussions that is based on Kolb's Experiential Learning Theory. ORID stands for objective, reflective, interpretive and decisional.^{23,24} It ensures exploration of what the participants know, how they feel, what they learned and how they will be affected moving forward, technically providing a format for guided critical reflection. The semi-structured interview guide had a dual purpose of being a data collection instrument as well as a guided reflection tool consistent with a transformative approach. Regular processing meetings were held with the principal investigator and all three interviewers to ensure uniformity in the coverage and process of the interview, the quality of data yield, and the achievement of saturation.

Data Processing and Analysis

Descriptive statistics were used for the observations as well as for each of the constructs in the questionnaire. The partial least squares structural equation modeling (PLS-SEM) was employed to analyze the results of the survey questionnaire using SEMinR R package. A mathematical equation called the inverse square root method was used for minimum sample size estimation in PLS-SEM. In the formula, what is required is an estimate of the smallest coefficient in the resulting path diagram, called the minimum beta coefficient. For a minimum beta coefficient of 0.3, the minimum sample size is 69 participants.²⁵ PLS-SEM is appropriate for this study due to the relatively small sample

Table 1. Number of participants taking part in each data collection activity (N=90)

Participant Categories	Observation	Questionnaire	Interview	Total
<i>Consultants</i>	10	18	7	19
<i>Fellows</i>	4	10	5	10
<i>Residents</i>	12	26	8	26
<i>Nursing Staff</i>	14	22	6	22
<i>Allied Professionals</i>	3	6	3	6
<i>Project Team</i>	5	7	2	7
Total	48	89	31	90

size (n = 89), the lack of normality, and the complexity of the proposed model, which includes eight latent constructs.²⁵⁻²⁷

The interviews were transcribed by research assistants and the transcriptions were reviewed and uploaded to a qualitative analysis software called ATLAS.ti 24. Thematic analysis was chosen because it is a theoretically flexible approach to qualitative analysis which allows the combination of inductive and deductive methods. The analysis focused on themes which captured participants' experiences with the antecedents for readiness to change, organizational readiness to change, and impact of participation in department initiatives. Coding was performed by a single researcher following an iterative process of open coding, categorization, and theme development. To enhance rigor, a reflexive journal and consultation with methodological and subject-matter experts were employed. Crossan's 4I Framework was used as a guide in observing the progression among individuals over time and membership in units.¹²

Ethical Considerations

The study was approved by the Research Ethics Board of the University of the Philippines Manila with UPMREB 2023-0525-01.

RESULTS

Profile of Respondents

Ninety (90) members consented to participate while two declined representing a 97.83 percent response rate. Table 1 shows the number and category of respondents per phase while Table 2 shows the profile of those who participated in the study. The observed meetings varied in length and lasted between 30 to 120 minutes. The interviews lasted between 33 to 86 minutes with an average of 49 minutes.

Factors Contributing to Organizational Readiness to Change

Ratings on constructs defining organizational readiness to change were high (Table 3). On a scale of 1-10 with 10 representing strong agreement, the mean ratings and medians for the items for change commitment and for change efficacy were concentrated around 8 to 9 indicating a strong readiness to engage in change-related initiatives.

Among antecedents to organizational readiness to change, change valence received the highest mean ratings, followed psychological safety while resource availability was rated the lowest.

Table 4 shows the contribution of each independent variable to the dependent variables as indicated by the arrow pointed to by each independent variable. To determine which of the independent variables significantly contributed to and can thus be considered as significant predictors of organizational readiness to change, bootstrapping was done with 1000 samples. Structural relationships were evaluated using standardized bootstrap mean coefficients with 95% confidence intervals excluding zero.

The path models in Figures 4 and 5 show relationships between antecedents for readiness to change and organizational readiness to change. A significant predictor should have a corresponding bootstrapped 95% confidence interval excluding zero. The bold red lines indicate relationships with 5% level of significance. The model demonstrated substantial explanatory power, accounting for 70.4% of the variance in

Table 2. Distribution of survey respondents according to their demographic characteristics (N=89)

Demographic Characteristics	Frequency (Percent) (N=89)
Sex	
Female	45 (50.57)
Male	44 (49.44)
Age (years)	
Mean = 36.91	
Standard Deviation = 9.28	
Appointment Status	
Tenured/permanent	30 (33.71)
Temporary, full-time	34 (38.30)
Temporary, part-time	25 (28.09)
Educational Attainment	
Some college, but no degree	4 (3.26)
Associate degree (e.g., Associate in Office Administration)	2 (2.24)
Bachelor's degree (e.g., BA, BS)	23 (25.84)
Master's degree (e.g., MA, MS)	2 (2.24)
Professional degree (e.g., MD, JD)	57 (64.04)
Doctorate degree (e.g., PhD, EdD)	1 (1.12)

Table 3. Constructs and sample items

Constructs	Sample items	Mean	Standard Deviation	Median	Min	Max
<i>Change commitment</i>	We are doing all that we can to accomplish the outputs of the department project.	8.73	1.37	9	3	10
<i>Change efficacy</i>	We can handle the challenges that may arise as we work on this department project.	8.62	1.19	9	6	10
<i>Change valence</i>	The department project is aligned with our department's mission, vision and goals.	9.33	0.94	10	6	10
<i>Situational factors</i>	Our unit head has shown support for the department project.	9.04	1.22	10	6	10
<i>Task demands</i>	I understand how the department project will affect my responsibilities within the department.	8.89	1.10	9	7	10
<i>Resource availability</i>	Our department has the human resources needed to accomplish the outputs.	6.03	2.58	6	1	10
<i>Psychological safety in relation to peers</i>	If I had a question or was unsure of something in relation to work, I can ask my peers.	9.43	0.95	10	6	10
<i>Psychological safety in relation to the unit head</i>	If I had a question or was unsure of something in relation to work, I can ask my unit head.	9.27	1.18	10	4	10

Table 4. The bootstrap estimated standard error, T statistic, and confidence intervals for the path coefficients

	Bootstrap Mean (β)	Bootstrap SD	T Stat.	2.5% CI	97.5% CI
<i>CV → CC</i>	0.019	0.096	0.166	-0.160	0.217
<i>CV → CE</i>	0.046	0.109	0.449	-0.159	0.278
<i>TD → CC</i>	0.238	0.108	2.289	0.045	0.471
<i>TD → CE</i>	0.283	0.126	2.257	0.041	0.533
<i>RA → CC</i>	0.137	0.100	1.290	-0.048	0.330
<i>RA → CE</i>	0.113	0.100	1.101	-0.088	0.308
<i>SF → CC</i>	0.462	0.125	3.669	0.211	0.693
<i>SF → CE</i>	0.486	0.114	4.288	0.260	0.703
<i>PSH → CC</i>	-0.078	0.193	-0.555	-0.443	0.292
<i>PSH → CE</i>	-0.015	0.163	-0.244	-0.321	0.302
<i>PSP → CC</i>	0.189	0.165	1.270	-0.102	0.532
<i>PSP → CE</i>	0.026	0.146	0.248	-0.265	0.302

Note: CC = Change Commitment; CE = Change Efficacy; CV = Change Valence; TD = Task Demands; RA = Resource Availability; SF = Situational Factors; PSH = Psychological Safety with Head; PSP = Psychological Safety with Peers.

change commitment ($R^2 = 0.704$) and 69.5% of the variance in change efficacy ($R^2 = 0.695$).

Supportive situational factors demonstrated the largest standardized bootstrap mean effects on change commitment ($\beta = 0.462$, 95% CI [0.211, 0.693]) and change efficacy ($\beta = 0.486$, 95% CI [0.260, 0.703]). Interpreting practical significance based on their magnitude (approximately 0.10 = small, 0.20 – 0.30 = modest, ≥ 0.40 = moderate-to-large), these coefficients reflect moderate to large magnitude, indicating that higher perceived organizational support was associated with nearly half-standard deviation increases in both readiness constructs. Task demands showed smaller but still statistically significant effects ($\beta = 0.238$, 95% CI [0.045, 0.471] for commitment; $\beta = 0.283$, 95% CI [0.041, 0.533] for efficacy), suggesting a more modest contribution.

In contrast, change valence, resource availability, psychological safety with head, and psychological safety

with peers demonstrated small, standardized bootstrap mean coefficients ($\beta < 0.20$), suggesting minimal contribution.

Overall, the results indicate that readiness to change in this setting was most strongly associated with perceived organizational supports and clarity of expectations, rather than individual-level motivational or relational factors.

Impact of the Process of Change

At the time of the study two years from the introduction of the change initiatives, members demonstrated awareness about the change initiatives, with varying degrees of impact at the individual, unit and department levels.

At the individual level, members became more open to trying out new ways of working and relating (F2: “I was used to working alone but I came to realize the value of working with others who had something else to share and therefore make things easier and better”). They responded

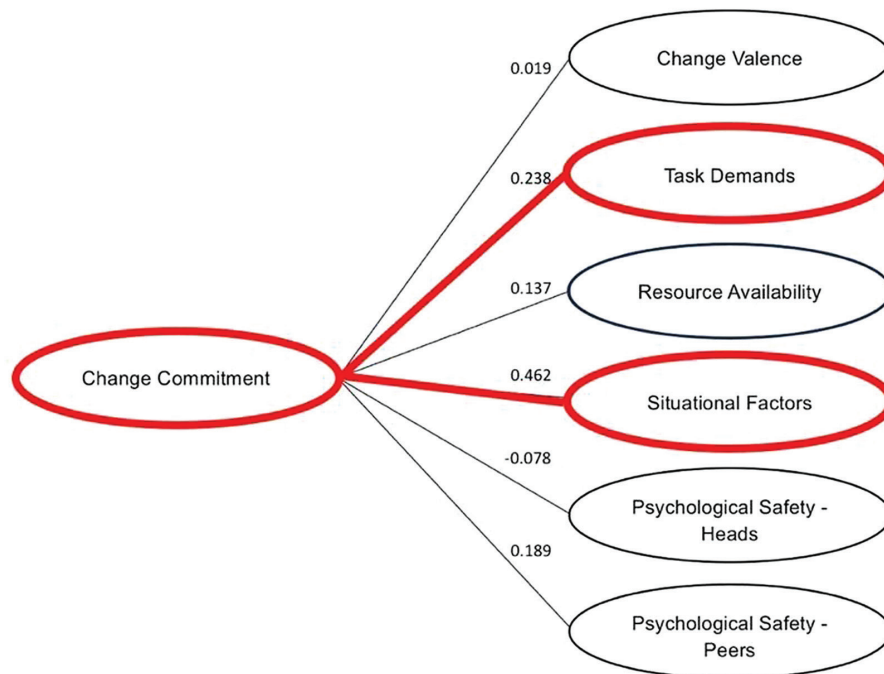


Figure 4. Resulting path model for change commitment.

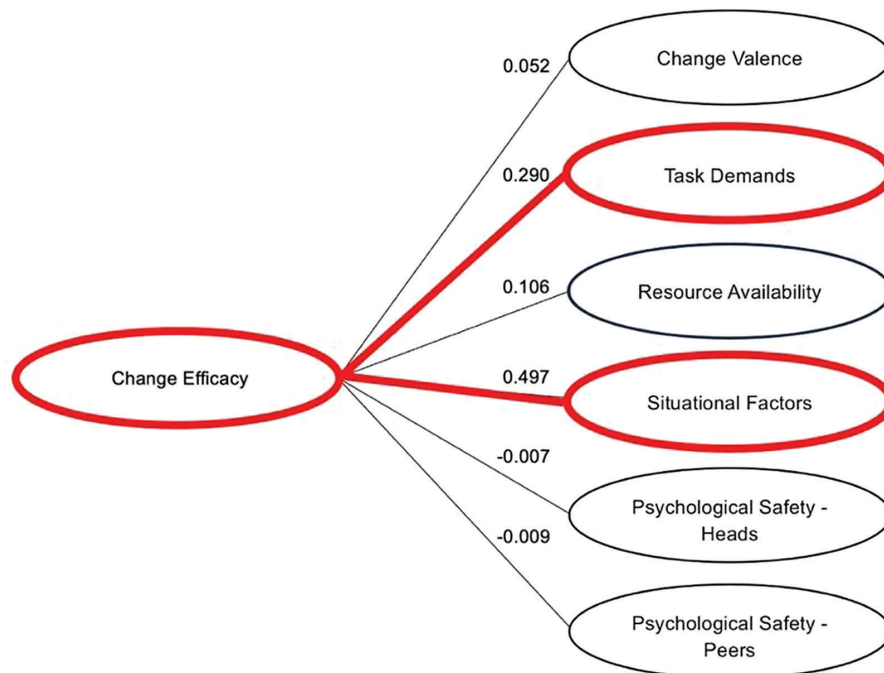


Figure 5. Resulting path model for change efficacy.

positively to being asked to speak up more, engaged more regularly with other units, and fulfilled assigned collaborative requirements. They readily participated in capacity building activities. Clearer task expectations reinforced accountability while increased transparency through shared activities highlighted the mutuality of the transformative experience

among members and units and more importantly, how everyone was doing their part toward the same vision and mission. The shared experience of working toward a shared goal strengthened motivation, coordination across units, encouraged openness to alternative perspectives, and fostered leadership and a commitment to excellence (R1: "I can be a

leader, too! I'm able to take on administrative duties and I can be assertive and speak my mind"). There was appreciable participation aligned with the intended direction of change.

A minority (n=2), however, reported no personal transformation and described their participation as a matter of compliance.

Outcomes of the Process of Change

The intended outcomes were retrospectively assessed through verifiable evidence of participation and the production of relevant outputs across education and training, research, patient care, and support services. These included but were not limited to outcome-based academic programs, outcome-based training programs, collaborative and relevant research proposals, and strengthened quality processes. The outcomes from the transformational learning approach were measured qualitatively based on documented engagement in organizational learning activities.

Outputs in Education and Post-graduate Training

Undergraduate mental health curricula and postgraduate training programs for residents and fellows were revised to align with the outcome-based framework and to integrate public health competencies.

The department was able to adequately address the increase in the number of undergraduate students and postgraduate trainees. A new postgraduate degree program was developed in alignment with a college initiative to offer parallel clinical and academic degree programs for residents-and fellows-in-training.

Outputs in Research

The research process was restructured to enhance research productivity, quality and the overall research experience. Completed research projects increased from 11 in 2021 and 8 in 2022 to 25 in 2023. There was active participation in research dissemination through poster presentations, oral presentations, and research competitions. Several members secured research grants. Notably, a member of the department led the completion of the first nationwide prevalence survey on mental health conditions.

Outputs in Patient Services

Inpatient management procedures were updated. Regular interprofessional meetings facilitated collaboration and earlier alignment in assessment and management, contributing to more holistic patient care.

Outpatient services improved substantially. Based on the appointment tracker, the waiting time for patients who signed up for consultation decreased from a high of 6 months in 2021 to a low of 2 weeks in 2022. Appointment documentation was digitalized to improve monitoring and coordination.

Outputs in Support Services

An Extension Services Unit was established to oversee extension services including community-based engagements. A Quality Assurance-Human Resource Unit was created to address human resource and quality assurance needs, resulting in the successful recruitment of much-needed personnel. Additional units, including Interprofessional Education and Collaboration, Wellness, and Physical Plant, were organized to strengthen departmental support.

The Practice of Reflexivity

Reflexivity was reinforced through regular reflective journaling and ongoing consultation with subject-matter and methodological experts. These processes promoted an awareness of how the researcher's dual role in the department may influence participant responses, given that the principal investigator would access data.

This awareness informed key methodological considerations, including the selection and training of research assistants, standardized recruitment procedures that excluded direct invitations from the principal investigator, and the rigorous development of data collection instruments to ensure neutrality, reliability, and validity. Standardized data collection protocols were implemented to promote consistency, reliability, and transparency across all phases of the study. During analysis, subject-matter and methodological experts were consulted to critique preliminary codes and themes and challenge assumptions. Disconfirming findings were actively sought from research assistants.

DISCUSSION

The magnitude of the standardized effects suggests that readiness in this context was more strongly associated with supportive situational conditions than with individual attitudinal factors, with task clarity demonstrating a secondary but meaningful contribution. Qualitative findings were consistent with this pattern: participants emphasized clear expectations, improved communication, leadership and administrative support, and opportunities for collaboration as important facilitators of engagement despite increased workload and perceived resource limitations. Recognition of the importance of the intended change, while valued, did not appear sufficient to mobilize participation in the absence of structural supports and clarity regarding required actions.

Strong organizational support appeared to mitigate the impact of perceived resource constraints. Although change valence and psychological safety were not statistically significant predictors in the structural model, their high ratings suggest they may function as contextual enablers rather than direct predictors of readiness. Similarly, lower ratings for resource availability did not correspond to reduced participation, indicating that the influence of perceived constraints may be moderated by the presence of clear expectations and supportive organizational conditions.

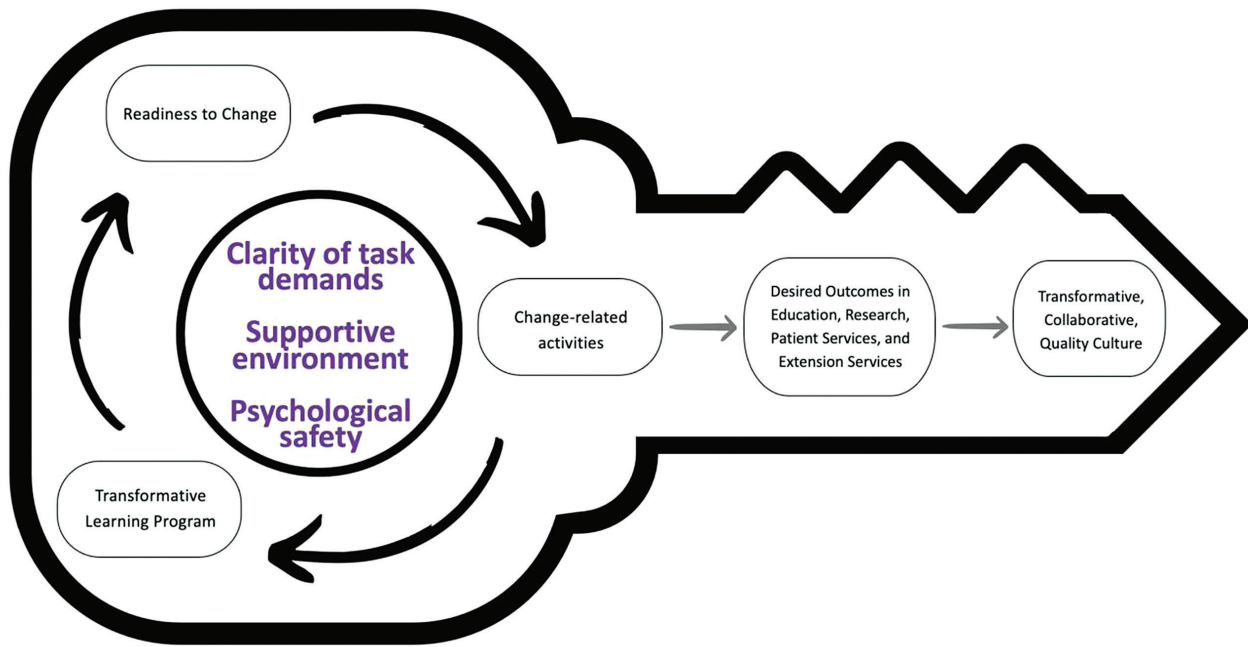


Figure 6. A transformative model of change.

The coherent, collective action observed in the study site was akin to the reflective action identified in the transformative learning approach.⁵ The developments aligned with Crossan's 4I framework on organizational learning.¹² Members moved from intuiting as individuals and then came to interpreting and integrating in groups, with emerging practices starting to get embedded into routines, rules and procedures.

Institutionalization is said to embody effective change management and is the hallmark of organizational learning.¹² Although practices consistent with transformation, interdependence and quality assurance were becoming evident among members of units, institutionalization had not yet been achieved. The challenge therefore is to further enhance and sustain these practices.

Transformative Model of Change

The theoretical framework for a theory of change consists of preconditions, interventions and indicators toward a long-term outcome.⁶ Based on the findings then, the components of the transformative model of change that is appropriate for the current purpose are organizational readiness to change (preconditions), change-related activities in a transformative learning program (interventions), desired outputs in education, research, and service (indicators) and a transformative, collaborative quality culture (long-term outcome) as shown in Figure 6. The circular arrows in the illustration serve to demonstrate the iterative nature determined to be necessary in the process to facilitate institutionalization.

Study Limitations

The small sample size and single-site design limit external generalizability, and the unique organizational

culture of the clinical department may constrain applicability to other settings. Self-reported data collected during an ongoing change process may have been influenced by Hawthorne effects and social desirability bias, particularly given hierarchical relationships and close professional ties among participants. The researcher's embedded role may have shaped responses. These limitations were mitigated through methodological triangulation, the training of research assistants, and transparent reflexive practice; nevertheless, they remain important considerations in interpreting the results. Stratified purposive sampling ensured representation across employee categories, while data collection and analysis methods were designed to optimize the depth and quality of the data. Detailed descriptions of the study site, participant characteristics, and contextual factors were provided to support readers in assessing similarity with other settings and determining applicability.

CONCLUSION

Strong change valence was necessary but not sufficient to drive organizational readiness to change. Organizational support in the form of favorable situational factors and clear task demands were statistically found to be the significant predictors. Psychological safety, though not found to have statistical significance, was reportedly experienced and favorably cited by majority of the members interviewed, suggesting an enabling role once organizational support and clarity of task demands are in place.

The findings suggest that the use of sound educational principles and approaches such as the transformative learning model, may strengthen participation in change-related

activities and support progress toward intended outcomes. At the time of the study, practices consistent with the desired changes were just beginning to take hold, underscoring the need for sustained, iterative reinforcement to achieve institutionalization.

The study validated and refined the conceptual framework guiding the process of promoting change toward desired outcomes within the clinical department. The insights gained have informed subsequent strategic steps to support the department's continued progression toward long-term adaptability and resilience. Given that similar change imperatives exist across academic units, and that the theoretical framework was derived from literature not specific to mental health, the lessons from this study may be applicable to other academic and healthcare organizations undergoing comparable transformation.

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Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

All authors declared no conflicts of interest.

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