Structural Stigma, Mental Health Problems and Labour Market Participation in the Netherlands:

Evaluating policies and strategies aimed at reducing structural stigma and increasing sustainable employment for people with mental health problems

Sociology Master Thesis

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Abstract

Structural stigma plays an important, but underacknowledged, role in barring people with mental health problems from the labour market. This qualitative study among 10 employees from four different organizations intended to gain a better understanding of the ways in which people with mental health problems have experienced structural stigma in their past, and whether this has negatively contributed to feelings of self-stigma. Additionally, the study focused on evaluating which factors have positively contributed to the ability of the same people to return to and/or remain in the labour market. In doing so, it also took the perspectives of their current employers into consideration. Thematic analysis results revealed that the employees did encounter structural stigma through experiences with resufal to hire, failure to accommodate, disincentive to work and occurrences of unintentional structural stigma. Indications were also found among part of the respondents of an association between structural stigma and self-stigma. Regardless of their encounters with structural exclusion, several factors were identified by both the employers and the employees that have contributed to their ability to return to and/or remain in work. Investing in both individual level- and employer level factors, i.e., seeking treatment, Employee Assistance Programs and a supportive work environment, plays an important role in accommodating people with mental health problems at work, and may thus help to negate structural stigma in the labour market.

Keywords: mental health problems, structural stigma, self-stigma, labour market participation

1. Introduction

In 2015, the Dutch government introduced the Participation Act. It was rooted in an ideology of an inclusive society which allows everyone, including people with limited labour capacities, to participate in- and contribute to society through work. The Participation Act was specifically aimed at people who are capable of working, but who require support in obtaining employment due to physical disabilities and/or mental health problems. The objective was to help these people find work based on what they *can* do, preferably with regular employers, and to reduce their reliance on social assistance. With the introduction of the Participation Act, Dutch municipalities became responsible for its execution, and were given the reins to decide which resources they would utilize to help navigate people towards employment[1].

In 2019, a critical evaluation by The Netherlands Institute for Social Research (SCP) revealed that the Participation Act had failed to achieve its envisioned goal of a more inclusive society (Van Echtelt, et al., 2019). On the contrary, it had achieved the opposite. This was particularly the case for people with mental health problems, who form the largest target group of the Participation Act. Their chances of finding work under the new legislation had in fact decreased with 16%, whilst their dependency on social assistance had increased between 5-12%. The objectives of the Participation Act strongly relied on the willingness of employers to hire people with mental health problems. Yet, this is precisely where the Participation Act appears to be flawed, because even though 61% of employers expressed that they want to be inclusive, in reality fewer than 5% actively pursue this goal (Van Echtelt, et al., 2019).
A recent study among Dutch managers revealed that 64% are less inclined to hire someone with known mental health problems and close to 30% remains reluctant when it concerns someone who has experienced mental health problems in the past. This happened even though

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the majority of managers had positive personal experiences with people with mental health problems and only 7% had negative experiences (Janssens, et al., 2021). It is critical to consider stigma as an explanation for such behaviour, as stigma on mental health problems plays an important, but underestimated, role in barring people from working (Brouwers, 2016; Janssens, et al., 2021; Link & Phelan, 2001).

Stigma, following the definition by Link and Phelan (2001), is "a phenomenon that exists only when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold" (p.367). It refers to the labelling of differences, which are linked to undesirable characteristics based upon society's cultural beliefs (stereotyping), followed by a separation from the labelled person, resulting in status loss and discrimination for the people who are being stigmatized. An important notion is that stigmatization refers to the process of labelling and stereotyping, whereas discrimination is the behavioural component that accompanies stigma, resulting in rejection and exclusion (Link & Phelan, 2001).

For the purposes of this study, mental health problems are defined as mental conditions that can range from mild to severe, cause (emotional) distress and *can* cause difficulties with day-to-day functioning, depending on the severity of the issue (American Psychiatric Association, 2018, para.1; Zimmerman, Morgan, & Stanton, 2018). People with mental health problems frequently experience labour market discrimination, as the stereotypes that accompany mental health problems deem people as less worthy compared to those without mental health problems (Brouwers, 2020; Stuart, 2004). Even though most people with mental health problems are willing and able to partake in work (Shankar, et al., 2014; Stuart, 2004), they are commonly underemployed, performing tasks below their skillsets, receive lower salaries and

they are more often demoted or overlooked for positions (Baldwin & Marcus, 2006; Hipes, Lucas, Phelan, & White, 2016; Stuart, 2006). Additionally, the unemployment rates are between 3 and 7 times higher for people with both mild and/or severe mental health problems (Brouwers, 2020). This is problematic because work is "a normalizing factor that provides daily structure and routine, meaningful goals, improves self-esteem and self-image, increases finances, alleviates poverty, provides opportunities to make friendships and obtain social support, enriches quality of life and decreases disability" (Stuart, 2006, p.522). Furthermore, 43% of all Dutch people will experience mental health problems at some point in their lives (de Graaf, ten Have, van Gool, & van Dorsselaer, 2012). Yet, despite these numbers, stigma regarding mental health problems continues to make it difficult for people to find and/or remain in work (Brouwers, 2016).

Although several studies have concerned themselves with stigma in the labour market, its precise effects remain understudied (Brouwers, 2016; Brouwers, 2020; Janssens, et al., 2021; Link & Phelan, 2001). Additionally, the discrimination people with mental health problems have encountered has mostly been studied on an interpersonal level, not on a structural level, which refers to the interactions between institutions and stigmatized groups (Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015). This leaves a particular knowledge gap in the literature regarding the relationship between structural stigma and mental health problems in the labour market (Brouwers, 2020; Corrigan & Bink, 2016; Corrigan & Kleinlein, 2005; Corrigan, Markowitz, & Watson, 2004; Henderson, et al., 2014; Krupa, Kirsh, Cockburn, & Gewurtz, 2009; Tyler & Slater, 2018). Link and Phelan (2001) already emphasized the importance of taking structural stigma into account when they conceptualized their influential definition of stigma. It is surprising that whilst the concept itself has been acknowledged for some time, it has been continuously undermined within research (Corrigan & Bink, 2016;

Tyler & Slater, 2018). However, one cannot even begin to abate the effects of stigma, without paying mind to structural stigma, as it refers to the ways in which injustices are interwoven within institutional practices and policies, including the labour market (Livingston, 2013). As Corrigan and Watson (2002) describe it: "Stigma is inherent in the social structures that make up society. It is evident in the way laws, social serivces and the justice system are structured, as well as in the ways in which resources are allocated" (p.18). Increasing knowledge on an understudied topic like structural stigma, and the ways in which it can be combatted, is critical because it shines a light upon the (un)intentional role organizations have been playing in preventing people with mental health problems from working (Corrigan & Bink, 2016; Livingston, 2013; Tyler & Slater, 2018).

Apart from needing a better understanding on how structural stigma appears in the labour market and effective ways to diminish it; it is also important to increase knowledge on the deeper impact of structural stigma on people with mental health problems. It is widely reported that stigma on mental health problems can have adverse consequences for individuals, as it can negatively influence their health outcomes and feelings of self-confidence (Link, Cullen, Stuening, Shrout, & Dohrenqend, 1989; Pugh, Hatzenbuehler, & Link, 2015). They may even become at risk for additional mental health problems (Link, Cullen, Stuening, Shrout, & Dohrenqend, 1989). However, the interrelated structures of stigma, i.e., the relationship between structural stigma and self-stigma, have also been understudied (Hatzenbuehler & Link, 2014; Pugh, Hatzenbuehler, & Link, 2015). This leaves a gap with questions on how structural discrimination affects feelings of self-stigma in people with mental health problems (Corrigan, Markowitz, & Watson, 2004; Pugh, Hatzenbuehler, & Link, 2015).

In April 2021, the Association of Dutch Municipalities (VNG) issued a proposition towards the new Dutch government and important stakeholders and urged them to change the Participation Act in order to achieve social security, equal opportunities, and a healthy life for all (Vereniging van Nederlandse Gemeenten, 2021). This proposition, against the background of the SCP evaluation of the Participation Act, and a new Dutch government, has caused a momentum for change in policies and laws. Now would be the time to offer better insights into what strategies and policies *can* work within organizations, so that more people with mental health problems will be able to work in the future.

From this perspective and with the identified gaps in the literature, this study proposes to gain a better understanding of not only the impact of structural stigma on people with mental health problems in the Dutch labour market, but to also identify strategies within organizations that help to combat it. In doing so, this study hopes to offer valuable insights which may help in developing future strategies and policies for a more inclusive labour market in the Netherlands.

To that end, this study intends to answer the following research questions through a qualitative research approach:

- *In what ways have people with mental health problems experienced structural stigma in the Dutch labour market?*
- *How are structural stigma in the labour market and self-stigma for people with mental health problems interrelated?*
- *What are contributing factors to reducing structural stigma in the labour market for people with mental health problems which allow them to return to and/or remain in work?*

2. Theoretical framework

As this study is of a qualitative nature, the theoretical framework does not serve to develop hypotheses, nor should it produce theoretical positions that are too fixed. Rather, the theoretical framework focuses on clarifying the different concepts and associations within the literature to gain a better sense of the issue at hand. This helps in forming a clear direction and structure for the further development of the study, whilst leaving room for a sense of openness and flexibility towards the emergence of new concepts and themes as the study evolves (Lewis & McNaughton Nicholls, 2014).

2.1 Conceptualizing Structural Stigma

Following previous conceptualizations, structural stigma can be defined as the cultural norms, rules, policies and practices of social institutions, governments, and corporations which (un)intentionally restrict opportunities for stigmatized people and constrain their wellbeing (Corrigan, Markowitz, & Watson, 2004; Follmer & Jones, 2018; Hatzenbuehler & Link, 2014; Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015). Structural stigma occurs when the dominant cultural ideology within a society has manifested itself inside institutional systems, resulting in an unjust, but legitimated, power balance that preserves social disadvantages (Livingston, 2013). In practice, it means that our societies and its structures are both defined and designed by people without mental health problems, *for* people without any mental health problems. Ultimately, inherently stigmatizing policies and practices become the standard through which society operates. As time goes by, stigma is no longer merely an individual or public practice, but a phenomenon of detriment and exclusion towards people with mental health problems, that is consistently being executed by the institutional systems that make up our society, including the justice system, public and private institutions, the

media, the economy and the labour market, and the health care system (Livingston, 2013; McCrudden, 1982; Pugh, Hatzenbuehler, & Link, 2015).

Structural stigma can be both intentional and unintentional (Corrigan, Markowitz, & Watson, 2004; Livingston, 2013). When it is intentional, there is a calculated and purposeful effort behind the rules, policies, and practices of institutions, to constrain the opportunities of people with mental health problems (Corrigan, Kerr, & Knudsen, 2005; Corrigan, Markowitz, & Watson, 2004; Livingston, 2013). Perhaps the most notorious case of intentional structural stigma are the 19th and 20th century Jim Crow laws in the United States, which created racial segregation between Black people and White people (Corrigan, Kerr, & Knudsen, 2005; Corrigan, Markowitz, & Watson, 2004; Edwards & Thomson, 2010). Regarding mental health problems, there are also policies that intentionally bar people with mental health problems from obtaining better health insurance coverage, reducing their parental rights, prevent them from holding office and even from voting (Corrigan, Markowitz, & Watson, 2004; Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015). A more hidden form of intentional structural stigma takes place when institutions associate certain elements with mental health problems and use them to discriminate. This can happen when people have gaps in their resume, which are associated with mental health problems and seen as a reason not to hire someone (Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015).

Unintentional structural stigma, on the other hand, is more difficult to expose because it is usually hidden in the built-up layers of institutions. It is a representation of our historical patterns of intentional behaviour and practices towards minority groups. These practices have been reproduced over time and throughout generations, and created consistent disadvantages and inequalities, even as laws and policies have since changed (Corrigan & Lam, 2007;

Hatzenbuehler, 2017; Hatzenbuehler, Phelan, & Link, 2013). Systemic racism continues to exist even though racism is illegal, because Western society has, throughout history, adopted a white racial frame that has shaped our worldviews, beliefs and stereotypes. As a result, society continues to favor White people over others in all aspects of life even when it is unintentional (Elias & Faegin, 2020; Faegin, 2006). Similarly, this happens to people with mental health problems. Historically, these people were often separated from society and placed in mental care institutions. Segragation still exists today, as people with mental health problems continue to be barred from fully participating in society due to the stigma they cannot seem to shake (Livingston, 2013). This happens despite increased knowledge on the subject and a global prevalence of mental health problems of 29% (Brouwers, 2020; Steel, et al., 2014). Unintentional structural stigma can therefore turn into intentional structural stigma, as the damaging effects become evident but institutions fail to recognize them nor do they amend their policies and practices (Livingston, 2013).

2.2 Structural stigma and mental health problems in the labour market

2.2.1 Assumptions about mental health problems

People with mental health problems are regularly faced with barriers to find and maintain a position of employment on the grounds of stigma (Brouwers, 2016; Brouwers, 2020; Corrigan, Markowitz, & Watson, 2004; Janssens, et al., 2021; Livingston, 2013; Stuart, 2006). Several stigmatizing assumptions exist in the context of employment, that underly the discrimination they face (Krupa, Kirsh, Cockburn, & Gewurtz, 2009). The first being that people with mental health problems do not possess sufficient competence and social skills to keep up with the requirements of the job, even though many people with mental health problems are willing and able to work (Brouwers, et al., 2016; Janssens, et al., 2021; Shankar, et al., 2014; Stuart, 2004). Additionally, some assume that people with mental health

problems can be dangerous and unpredictable, and the pressure of work might trigger such behaviour. Others might view mental health problems as a way of avoiding certain tasks and obtaining privileges that other employees do not receive. Moreover, an assumption exists that partaking in work is unhealthy for people with mental health problems because it can be too stressful. The final assumption is the idea that offering a job to someone with mental health problems is merely a form of charity and does not contribute to the goals of the workplace (Krupa, Kirsh, Cockburn, & Gewurtz, 2009).

These assumptions coincide with several problematic areas identified by Brouwers (2020), which strengthen the belief that stigma contributes to the high unemployment rates and other disadvantageous consequences for people with mental health problems. Similar to the study by Krupa, Kirsh, Cockurn and Gewurtz (2009), Brouwers confirms that employers and other stakeholders uphold negative attitudes towards mental health problems. Second, there is a paradox of disclosing versus not disclosing of mental health problems to an employer, as disclosure puts the employee at risk of losing their job due to any negative assumptions that employers may uphold. Third, any anticipated discrimination and self-stigma can cause people to withdraw from working altogether (Brouwers, et al., 2016; Lasalvia, et al., 2013). Additionally, self-stigma (the internalization of stigmatizing beliefs) can lead to a "Why Try" effect, which causes people with mental health problems to question their own worthiness and capacities to work. As a consequence they stop trying to find or maintain their employment (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016).

2.2.2 Considering structural stigma

The paragraph above offers insights into several stigmatizing assumptions and consequences that go alongside stigma, which can all result in employment discrimination. The question

arises, however, when is discrimination based on mental health problems a form of structural stigma? Livingston (2013) offers a well-rounded answer to this question that should be considered when studying the phenomenon of structural stigma:

> If the unfair practices of professionals in any institutional system are recurring (i.e., not isolated events), symptomatic of problems within organizational culture, tolerated or condoned by organizational leaders, and/or not rectified despite known problems, then they are indicative of structural stigma. (p.11)

The important notion that is being made here is that structural stigma does not refer an isolated incident. Discrimination needs to happen routinely and be able to go unchecked within institutions for it to be defined as structural stigma.

2.2.3 Operationalizing structural stigma in the labour market

Considering the employment context, three ways have been identified through which structural stigma emerges and through which it can be operationalized during research (Corrigan, Roe, & Tsang, 2011; Livingston, 2013).

1. Refusal to hire. Even though employers are not allowed to inquire about any mental health problems during interviews (Rijksoverheid, n.d.), they will often use other indicators to uncover them. They may ask about gaps in resumes or check any criminal records, which are both strongly associated with mental health problems and give employers a reason for refusal to hire (Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015). A study by Hipes and colleagues (2016) also revealed that when people are open on their job applications about a gap in their resume due to a mental health condition, they receive significant fewer call-backs compared to people who have a gap due to a physical injury. Unfortunately, even though discrimination is illegal by law, in practice it remains a near impossible feat to prove that

someone was not hired because of mental health problems (Hipes, Lucas, Phelan, & White, 2016); allowing the system to continue as is.

2. Failure to accommodate. When someone has a mental health problem, they may need some accommodations at work to perform their tasks. Among others, these include flexible working hours, extra personal feedback moments, and a working environment with fewer distractions. Employers are required to offer help, but many fail to do so accordingly and oftentimes employees are unaware that an employer is even supposed to accommodate them. As a result, it can become very difficult to maintain employment (Livingston, 2013). Many employees with mental health problems that have had to quit working believe they would have been able to continue, had they been offered the proper accommodations (Brouwers, 2016; Follmer & Jones, 2018).

3. Disincentive to work. This does not pertain to the employer, but rather to the employee and the social security system. People who receive unemployment benefits can become disinclined to work because the benefits they receive may be lowered or even stopped completely once they go back to work. This can be a scary step for many, as this leaves them with uncertainty because of their mental health problems and the accompanying stigmatization and discrimination in the labour market. The benefits offer them a financial safety net which they are at risk of losing when going back to a competitive labour market, where they have yet to find out whether they will be able to succeed or not. This is a seen as a form of structural stigma because the way the system is shaped can force people with mental health problems to stay dependent on their benefits (Barnes, 1992; Livingston, 2013).

2.3 Macro-micro links

Research on stigma tends to be level-by-level (public-, self-, and structural stigma). This leads to an underrepresentation of information on how the different types of stigmas interrelate (Corrigan, Markowitz, & Watson, 2004; Hatzenbuehler & Link, 2014; Pugh, Hatzenbuehler, & Link, 2015).

The modified labelling theory by Link and colleagues (1989) suggests that once people start to internalize the public stigma surrounding their mental health problems (self-stigma), this can lead to self-discrimination in the form of withdrawing themselves from the public, and feelings of low self-competence and low self-esteem. They will also cease to take opportunities that can advance them in life, for example, in employment. Eventually, this renders a person so vulnerable, that their mental health symptoms will continue to persist, and new mental health problems can arise. This is a clear example of the harms that can come from self-stigma due to an interpersonal stigma process (Corrigan & Rao, 2012).

Particularly little remains known, however, on the potentially harmful effects of structural stigma (macro-level) on feelings self-stigma (micro-level), as studies tend to focus on the consequences of interpersonal discrimination, as mentioned in modified labelling theory (Corrigan, Markowitz, & Watson, 2004; Hatzenbuehler & Link, 2014; Pugh, Hatzenbuehler, & Link, 2015). There is a desire for more reports on the structural context in which interpersonal stigma and discrimination can take place and how it interacts with self-stigma (Livingston, 2013; Pugh, Hatzenbuehler, & Link, 2015). This may have been difficult to assess, because it is easier to attribute inequalities and unfavourable outcomes to the direct personal interactions that people with mental health issues can observe, rather than detecting the (invisible) influence of structural stigma on behavioural outcomes (Livingston, 2013).

2.3 Addressing structural stigma

Structural stigma has mostly been addressed in surveys and policy- and law evaluations. These studies have used surveys to evaluate the willingness of people to support social policies that would benefit those with mental health problems (Schomerus, Matschinger, & Angermeyer, 2006), or in contrast, for support in policies that would further restrict the rights of people with mental health problems (Lauber, Nordt, Sartorius, Falcato, & Rossler, 2000). Policy analysis intends to uncover whether certain policies invoke structural stigma (Corrigan, et al., 2005). A weakness of this type of evaluation, however, is that structural stigma is more likely to occur within institutions through unofficial protocols and practices, rather than through official policies and laws (Livingston, 2013; Yang, Zhang, Chan, & Reidpath, 2005). Therefore, another approach to uncovering structural stigma has been through interviews and surveys with the people who have the mental health problems and those close to them, to evaluate their personal experiences (Angermeyer, Schulze, & Dietrich, 2003). Such studies have found that up to half of the people who use mental health services were treated disadvantageously or even had their rights restricted due to their mental health condition (Stuart, Milev, & Koller, 2005). Comparably, another survey reported that up to 52% of people had experienced discrimination based on their mental health in the context of employment (Corrigan, et al., 2003).

2.4 Mitigating structural stigma

Knowledge on reducing structural stigma remains limited (Livingston, 2013). Some suggestions for structural stigma interventions include improving the communication on the added value of diversity, introducing more policies, or influencing the media and educational systems who often portray people with mental illnesses in a bad light (Cook, Purdie-Vaughns, Meyer, & Busch, 2014). One of the main challenges regarding mental health problems and the

labour market, is not only to help people find work but to also gain a better understanding of what helps them maintain their position of employment (Van Hees, et al., 2021; Jarman, Hancock, & Newton Scanlan, 2016). Studies often focus on employers' attitudes regarding people with mental health problems (Janssens, et al., 2021; Kalfa, Branicki, & Brammer, 2021; Shankar, et al., 2014), but limited emphasis has been placed on the people *with* mental health problems, which limits their potential in identifying elements that have improved their chances of remaining in work (Jarman, Hancock, & Newton Scanlan, 2016). Such elements, however, may contribute to the future mitigation of structural stigma in the labour market and advance employment opportunities for people with mental health problems.

Employers tend to ascribe mental health problems to personal determinants, thus placing the responsibility for the problems, as well as solving the issues, onto the individual. Even though this absolves them from improving their own work climate, it is an obstructing factor in trying to accommodate employees with mental health problems (Shankar, et al., 2014). The responsibility, however, for improving work outcomes for people with mental health problems, should not be the sole burden of an individual but that of the employer as well (Follmer & Jones, 2018; Krupa, 2007; Shankar, et al., 2014).

In this regard, Follmer and Jones (2018) identified several moderating factors, on both the individual (micro) and employer (macro) level, that can be helpful in improving employment outcomes for people with mental health problems. First, individuals may benefit from seeking treatment for their mental health problems. They could also make use of governmental or non-profit supported employment programs, which provide job coaching or offer help with transitioning between jobs. Lastly, they may benefit from partaking in skills training which can improve their work outcomes. Employers are required to offer work accommodations to

people with mental health problems, but often fail to do so accordingly. Among the accommodations are adjusting the workload and expectations, offer flexible hours, creating a quiet workplace, provide coaching, as well as offering training to supervisors in detecting and supporting people with mental health problems at work. Second, creating a work culture that is supportive of people with mental health problems plays an important role. Having compassionate and supportive co-workers and staying in contact with an employee whilst they are on sick leave, can improve their chances of returning to- and remaining in work. Lastly, offering Employee Assistance Programs (EAPs) may be beneficial to employees with mental health problems. Such programs are aimed at people with mental health problems offer employees (short-term) psychological and/or medical services, including counselling and medical screenings.

The study by Follmer and Jones (2018) emphasizes the importance of not only focusing on employees with mental health problem when targeting stigma, but on the employers as well. Indeed, anti-stigma interventions should aim to target the individual and the structural level, as well as the social level (Link, 2001; Livingston, 2013).

However, due to the shortage of empirical evidence on how to reduce structural stigma (Livingston, 2013), more knowledge is required on how to implement such measures, how they are experienced by people with mental health problems and what effects they have on feelings of self-stigma and health outcomes (Pugh, Hatzenbuehler, & Link, 2015). Field studies can prove useful to this extent to explore the experiences of both the employers and the employees with mental health problems (Follmer & Jones, 2018). Such studies can actively include people with mental health problems in the process of creating future anti-structural stigma strategies (Jarman, Hancock, & Newton Scanlan, 2016). In the process, this

can help to increase their sense of empowerment and improve their sense of social inclusion, and potentially even their health outcomes (Schneider, Livingston, & Misurelli, 2012; Livingston, 2013).

Van Hees and colleagues (2021), emphasize that when evaluating the effectiveness of certain interventions that help people with mental health problems remain in work, it is essential to to not only wonder if an intervention works, but to also take into consideration why and under what circumstances. In doing so they make use a context-mechanism-outcome structure. The context in this regard refers to the (changing) setting in which interventions take place. Mechanisms commonly refer to the interventions themselves. Lastly, the outcome focuses on the measurable qualitative and/or quantitative impact (i.e., being able to remain in work, less sick leave, etc.). In taking these three elements into account, it becomes possible to offer some causal explanations regarding effective interventions.

As mental health problems are so prevalent in society, organizations will need to continue to develop effective and inclusive strategies regarding mental health problems in the workplace (Follmer & Jones, 2018). Based on the current knowledge, this study intends to make a valuable contribution to the existing literature and the societal urgency for change. First by retrospectively studying *how* people with mental health problems have experienced structural stigma in the labour market and whether this has impacted feelings of self-stigma. Second, this study has an intention to shift the discourse regarding stigma from negative to positive by focusing on what *does* work within organizations and how people with mental health problems can be a valuable contribution to an organization, so that it may contribute to identifying successful strategies for future policies. In a sense, the research can become a form of “positive sociology”.

3. Data and methodology

3.1 Research design

The aim of this study is to gain a better understanding of the prevalence of structural stigma on the Dutch labour market against people with mental health problems; whether it has influenced feelings of self-stigma; and to evaluate strategies that are potentially effective in reducing structural stigma. The exploratory character of the research questions lends itself best to a qualitative research approach. This approach can be especially helpful when exploring an understudied topic, such as structural stigma. The study is both contextual and evaluative in its nature, as contextual research focuses on the ways in which certain phenomena manifest themselves and the experiences a target population has had with them, whereas evaluative research concentrates on the outcomes of different policies and practices (Ritchie & Ormston, 2014).

As such, this study consists of two parts. First, it takes a retrospective stance in gaining an understanding of the past experiences people with mental health problems have had with structural stigma in the labour market and its consequences on self-stigma. Second, it follows the same group of people with mental health problems who have been able to return to and/or remain in work and evaluates their experiences at their current employer, by assessing the effectiveness of inclusive policies and practices that are being incorporated by their different organizations. For this second part, it will do so by taking both the employers' and employees' perspectives into account. Taking this double-sided approach is considered necessary because in trying to reduce structural stigma, one ought to gain a better understanding on *how* structural stigma has been experienced in the first place by the respondents, before uncovering the effective elements that have allowed them to return to and/or remain in work at their current place of employment. Both parts of the story have the

potential to be equally important in uncovering factors that future policies could take into consideration to better incorporate this target group into the labour market.

Semi-structured interviews were used to obtain the necessary in-depth evaluations. This method of interviewing is often used in qualitative studies as it allows room for probing when topics emerge during the conversation with a respondent about which the interviewer wishes to know more and it also does not restrict the respondents in their answers (Arthur & Nazroo, 2003).

The design and research methods of this study were approved by the Tilburg University Ethics Review Board of the Tilburg School of Social and Behavioral Sciences under reference number TSB_RP110.

3.2 Sample

Qualitative research methods mostly use non-probability sampling methods, meaning the selection of respondents is based on the characteristics of the population, and by no means a statistical representation (Ritchie, Lewis, Elam, Tennant, & Rahim, 2014). This study used purposive sampling in its selection of respondents. With this method, respondents are chosen based on their particular features and/or characteristics (Ritchie, Lewis, Elam, Tennant, & Rahim, 2014). The sample for this study is twofold. First, it includes a sample of employees who have (had) mental health problems. This refers to both mild and more severe problems, i.e., a burn-out, a depression or a personality disorder. The inclusion criteria for these respondents were that they had to be employed at the time of the interview and that they have (had) mental health problems. It is important to note that they were not required to disclose their mental health diagnoses, as the focus of the study is not on the mental health diagnoses

themselves, but rather on their experiences in the labour market and the ways in which they have or have not been facilitated by employers. It was up to the respondents whether or not they wished to disclose that information. They were asked, however, if they are in the target group register of the Participation Act. Second, the study also includes a sample of the employers at which the respondents with mental health problems were employed at the time of the interview. Inclusion criteria for this sample were that the organization must have an inclusive policy towards working with people with mental health problems and the respondents in this sample had to either be directors or representatives from HR in order to be able to explain their company policy.

The final samples of this study consisted of 10 employees with (past) mental health problems from four different organizations: a knowledge institute, a university, a logistics company and a facility management organization and four HR representatives: one from each organization. This sample size was sufficient for data saturation. Table 1 presents an overview of the respondents.

Table 1 Characteristics of respondents

Respondent	Function	Sector	In target group register
1	Project employee / Experience knowledge expert	Knowledge institute	-
2	PhD student	University	Yes
3	Receptionist	University	Yes
4	Project employee	Knowledge institute	Yes
5	Communication & marketing	Facility management	-
6	Cleanroom manager	Facility management	-
7	Project employee	Knowledge institute	-
8	Product owner	Facility management	-
9	Warehouse worker	Logistics	Yes
10	Warehouse team leader	Logistics	-

Respondent	Function	Sector	Number of employees
1	Coordinator / HR policy advisor	University	2400
2	HR manager / Organizational development	Facility management	220
3	HR manager	Logistics	85
4	Interim HR professional	Knowledge institute	150

3.3 Method of recruitment

Recruitment of the respondents took place through personal connections and through the platform Brabants Besten; a platform consisting of innovative and inclusive organizations in the province of Brabant, the Netherlands (Innovatief Werkgeverschap, n.d.).

The organizations were approached through e-mail and sent an information letter regarding the study and asked if they were willing to participate. If they expressed an interest, a phone call or Microsoft Teams meeting was set up to discuss further details and to see if it was indeed a good match. Out of 33 approached organizations, five fit the inclusion criteria and were willing to participate in the study. However, one of these organizations decided to withdraw from the study, which resulted in the final four organizations that ended up participating. These employers were asked to hand out the information letter to their employees. The information letter specified that the study was looking for employees who have (had) mental health problems and were willing to talk about their experiences in the labour market with their past and current employer(s). Based on this letter, employees were able to decide if they fit the criteria and express to their employer if they were willing to participate in the study or contact the researcher directly. Through this method, the researcher was able to include 10 respondents who fit the requirements, without having to directly ask them about their mental health diagnosis/diagnoses (which is not allowed under the Dutch Privacy law).

3.4 Data collection

Prior to the commencement of interviews, all respondents were given an opportunity to ask any questions they may have had after reading the information letter. Subsequently, they were asked to sign a letter of informed consent and return this to the researcher. By signing the consent form, the respondents declared that they participated in the study voluntarily and that

their data would be pseudo-anonymised and stored for a period of 10 years. At the start of each interview, the respondents were reminded that their interview would be audio-recorded, and they were asked for their permission to record. The interviews took place between November 2021 and January 2022. Out of the 14 interviews, two took place face-to-face, whilst the other 12 were held online through Microsoft Teams as a consequence of Covid-19 restrictions. The duration of the interviews ranged between 29 and 110 minutes, with an average duration of 56 minutes. All interviews were performed in Dutch, the native language of all respondents, which minimized the risk of any misconceptions (Winchatz, 2006).

To function as an aide-mémoire during the interviews, two topic guides were designed: one for the employees and one for the employers (Appendix A). The use of a topic guide in semi-structured interviews ensures that the researcher can maintain a level of consistency across the interviews by asking respondents about the same themes and subtopics, whilst still leaving room for probing based on the respondents' replies. (Arthur, Mitchell, Lewis, & McNaughton Nicholls, 2014). The selected topics were modelled after the theoretical framework. A test interview took place with a peer to ensure that the questions were clear and covered the topics accordingly (McGrath, Palmgren, & Liljedahl, 2019). The topic guide was reviewed after each interview to see if questions needed to be readjusted or added to the guide. Interviews without the revised/added questions did not need to be excluded from the data, as standardisation of the data is not a necessary requirement in qualitative research (Arthur, Mitchell, Lewis, & McNaughton Nicholls, 2014; McGrath, Palmgren, & Liljedahl, 2019).

Employers were asked questions about the policy of their organization in regard to hiring people with mental health problems, the effectiveness of their policy in practice, and about their needs to (better) accommodate people with mental health problems in the long run.

Some of these questions included “How does the company accommodate people with mental health problems? What type of facilities are offered?”, “Does HR look at the ‘target group register’ when you hire someone?”, and “Do employees/supervisors receive coaching or training regarding working with people with mental health problems?”.

Employees received questions about their experiences with past employers in relation to structural stigma and feelings of self-stigma, as well as questions about their current place of employment, the accommodations they had been offered, and any improvements their employer could make to better accommodate people with mental health problems. Questions about structural stigma were operationalized according to the theoretical framework as experiences with refusal to hire, failure to accommodate and disincentive to work. Regarding the association between structural stigma and self-stigma in particular, the questions pertained to the structural influence (past) employers have had on feelings of self-stigma. To not emphasize the mental health problems of the respondents, the questions were formulated regarding their “personal situation”. It was up to the respondents if they wished to open up about their diagnoses in detail or not. Their questions included, among others, “Have you ever been denied a job because of your personal situation?”, “Have you ever not applied for a job out of fear of losing your social welfare benefits?”, “Do you think you would be able to continue your job if (not) offered accommodations?”, and “Has your current employer contributed to your level of confidence to work?”.

3.5 Data analysis

The chosen method of analysis was thematic analysis; an alternative to the commonly used grounded theory method in qualitative studies. Although they share some commonalities, grounded theory is a rigorous inductive process concerned with generating new theories based

on the different categories that emerge within the data. The process of developing a grounded theory is considered very time-consuming and comes with a set of challenging rules, even for the most advanced qualitative researchers (Spencer, et al., 2014 ; Timonen, Foley, & Conlon, 2018; Verhoeven, 2020). Therefore, this method lies outside of the scope of this study. Thematic analysis, as a practical derivant from grounded theory, was deemed a more suitable method. By coding the data, thematic analysis enables the researcher to identify common themes and patterns and rank them among higher-order key themes that help to answer the research questions (Spencer, et al., 2014 ; Verhoeven, 2020). An epistemological debate exists about the use of inductive and deductive logic with qualitative data (Ormston, Spencer, Barnard, & Snape, 2014). However, thematic analysis is flexible in that it offers researchers the possibility to use both. Deductive logic can be used to find data that corresponds with the previously established theoretical framework, whilst inductive logic can be used simultaneously to uncover potential other emerging themes (Verhoeven, 2020).

Upon completion of the data collection, the audio-recordings were used to transcribe the interviews non-verbatim. To abide by the European General Data Protection Regulation, the data from each respondent was pseudo-anonymized. The first step in the analyzing process was concerned with the familiarisation of the data by reading all of the transcripts to get an initial idea of potential recurring codes (Spencer, Ritchie, Ormston, O'Connor, & Barnard, 2014). Subsequently, the coding process of the data was done with the use of the compute software program ATLAS.ti 8. Two separate coding processes took place: one for the transcripts of the employers and one for the transcripts of the employees. Three levels of coding were applied: open-, axial-, and selective coding (Friese, 2019; Verhoeven, 2020). Open coding enabled the researcher to analyze the data phrase-by-phrase with scrutiny to explore all potential factors. During the axial coding stage, the open codes were organized

into groups based on their commonalities. In the final stage of selective coding, the focal core codes (the central themes) were determined which enabled the researcher to answer the research questions. For the employers, the open coding stage resulted in 84 codes. During the axial coding stage, these were reduced to 6 groups and with selective coding 1 focal core code with 2 subthemes was defined. For the employees, the open coding resulted in 105 codes and axial coding led to 17 different code groups. Finally, for the employees, 2 focal core codes with 5 subthemes were determined. Combined, this led to 3 focal core codes, or themes, and 7 subthemes on which the results chapter will further elaborate.

The final step in the thematic analysis process was creating a hierarchal network to summarize the themes and subthemes (Friese, 2019; Verhoeven, 2020). Although they can look similar, networks are not to be confused with quantitative models which can offer insights into causal relationships that can be generalised to the larger population. Networks are also not necessarily created with the purpose of presenting them in research reports, although they often are included, but rather they help the researcher to get a visual overview of the discovered themes and their connections to each other. Networks are a useful visual representation of the data that can help to stimulate the thought process better at times than reading through the endless gathered pages of text (Friese, 2019).

3.6 Reliability and validity

There is a discussion among scholars whether the concepts of reliability and validity as used in quantitative science can be applied to qualitative research as well (Lewis, Ritchie, Ormston, & Morrell, 2014). Regarding the reliability of a qualitative study, it can be questioned if replicability is a realistic goal. Although an exact replication in outcomes is difficult to achieve, Lewis and colleagues (2014) argue that qualitative researchers should at the very

least feel confident that the main factors found in the data would recur if the study was performed again elsewhere. Another element to take into consideration is the concept of inter-rater reliability. In quantitative studies, this refers to the idea that with an accurately developed question, different researchers would code the answers in a comparable way. In qualitative studies, creating such a consistent data set is not the objective but researchers can work together to code independently from each other to sort out any differences in coding. However, this may not be an available option to everyone. Therefore, at the very least, other scholars should be able to see how the researcher got to their outcomes. That is why offering insights into the code book, which entails the used codes in the analysis, is useful (Spencer, et al., 2014). As the researcher acted alone in this study, it was not possible to resolve any coding differences with another scholar. This may potentially affect the reliability of the study. However, the code book that was used during data analysis can be supplied.

As with reliability, opinions differ on whether the concept of validity, the extent to which a study has been able to measure the concepts it originally intended to measure, can be applied to qualitative research. An important consideration regarding the achievement of validity is the concept of internal validity, which refers to how the statements that are being made in the study are being supported by the data. With qualitative studies, the researcher tries to achieve validity by carefully examining any links between what was found in the data and how they connect to the previously established theoretical framework. The main strength of qualitative studies, particularly in relation to internal validity, is that it is rich in data and can offer extensive substantions to the claims that are being made about the phenomena that were found. The degree to which the researcher is able to achieve this, is the central component through which a researcher can establish validity in qualitative research (Lewis, Ritchie,

Ormston, & Morrell, 2014). For this reason, this was the main focus of achieving validity in this study.

Regarding any biases that can obstruct the validity of the research: the aim has always been to remain objective during the interviews and the analysis process, and research biases were taken into consideration. To try and prevent participant bias during the interviews, the respondents were given follow-up questions and open ended questions, to prevent the respondents from only giving answers they thought the researcher would want to hear. Regarding researcher confirmation bias, the data was studied as objectively as possible by using all of the data, not just the data that initially seemed relevant, and coding it in three different ways.

4. Results

To present the results along the lines of the research questions, first, a retrospective part will focus on previously experienced structural stigma by employees with mental health problems, and whether or not this has had any consequences on experiencing self-stigma. Next, a present-day section focuses on how people with mental health problems have been able to return to and/or remain in work, and which factors have contributed to their success in being able to do so in comparison to their past experiences. Here, attention will also be paid to the employers' perspective on their policies in regard to the employment of people with mental health problems. Room will also be dedicated towards recommendations for future improvements that can be made so that organizations may better accommodate people with mental health problems in the labour market.

The three focal themes and subthemes that emerged during the analysis are:

- *Experienced structural stigma:* refusal to hire, failure to accommodate, disincentive to work, unintentional structural stigma
- *Self-stigma:* employers' negative influence on self-confidence
- *People with mental health problems able to return to and/or remain in work:* individual level factors, employer level factors.

This chapter is structured along the lines of these themes. The hierarchal network of themes that was created to display an overview of the themes and subthemes is presented at the end of the results chapter to summarize the findings.

The decision was made to avoid quantification of the results, as quantifying qualitative data can lead to confusion. Presenting statements about the number of respondents who have commented on certain phenomena leads to questions about the significance of such numbers

as qualitative results from (usually small) samples cannot be generalised towards the population and therefore quantified results are best avoided, as they have a tendency to be misleading (White, Woodfield, Ritchie, & Ormston, 2014).

4.1 Retrospective findings - Experienced structural stigma

In order to evaluate whether respondents have experienced structural stigma on the account of their mental health problems in the past, they were asked questions about their encounters with refusal to hire, failure to accommodate and disincentive to work.

4.1.1 Refusal to hire

When asked about their experiences with not acquiring a job as a result of their mental health problems in the past, respondents were able to identify three reasons as to why they may have been refused for a position. The first included having a gap in one's resume due to (years) long periods of sick leave.

> *I have not gotten positions before because I have a gap in my resume. […] I was applying for an internship at a well-known consultancy agency. They look very closely at your resume. If you don't have an 8 average and you have a gap in your resume, then you really stand no chance.*

Respondents also mentioned that they suspected that they may have been refused for a job position because they had been upfront about having mental health problems during the application process. Employers did not directly tell them this was the reason to refuse them, but it did lead to suspisions. One respondent who was honest about his mental health situation on applications suspected that it played a part in being refused, but also said that it is difficult to pinpoint if that was the specific reason.*"Because I did send out letters a few times. And I do not know why they said no. They often do not say why"*. The third reason that was mentioned

by the respondents is experiencing job loss as a consequence of their mental health problems. Although these cases were not an example of refusal to hire during the application process, they are in a sense an example of refusal to re-hire due to mental health related issues and therefore also included in this section.

4.1.2 Failure to accommodate

Respondents were asked about the extent to which past employers have been able to accommodate them in their needs that stem from their mental health problems, so that they would be able to continue working at their best. Criticism was expressed on the different ways in which employers had failed to accommodate the employees in the past, which in some cases even led to having to stop working altogether. Regarding a previous employer who did not make the time for personal guidance, a respondent pointed out that *"It was also usually quite busy, and as a result they did not really have space for me. Sometimes even literally, physically. And then they said they were going to quit working with me"*. Another respondent mentioned that it is really important for them to only work on one task at a time, but that their previous employer disregarded their inability to multitask. *"You see, if you give me one task, I will finish that one first and then I can move on to the next one. But were they really considerate of that? No, not really. At least, that is how I feel about it"*. Further comments were also made about employers who failed to offer workplace adjustments. One instance was concerned with a respondent who required a quiet workplace with fewer stimuli, but who was obstructed by their employer at the time:

> *I thought to myself, I am just going to tape off my window. And then my supervisor stormed in and he was really angry. He said 'You cannot do that here because our policy is to be approachable. We want to be open for questions'. And in that regard I totally did not feel seen or heard.*

One prominent issue that was pointed out by the respondents refers to the Participation Act itself. They brought up that they were not always made aware of the Participation Act and its faciliations by their employers and/or even their social workers, even if they belonged to the target group of the Participation Act themselves and were therefore entitled to specific accommodations. In the case of one particular respondent, they had no idea that they were even registered in the target group register of the Participation Act. As a result, they also were unaware that they were entitled to a no-risk policy when they started their new job. Neither the Employee Insurance Agency (UWV) or their employer had mentioned it from the start. Of their experience at their current employer the repsondent stated

> *In the beginning I did not take sick leave but I would take up vacation days whenever I had to drop out. […] About a year after I started working here they sent me an email stating 'Oh, you belong to the Participation Act' […] and I just thought, the Participation Act? Never heard of that.*

When asked how they feel about that experience they said *"It is a bit strange if you think about it. But my employer also only seemed to discover it after a year. And then it was like 'Oh by the way'. Then all of a sudden a lot became possible"*. Although this particular respondent was very pleased with their current employer after this situation had resulted in better accommodations, the situation does point out that there are knowledge gaps regarding the accommodations that the Participation Act is supposed to be able offer at the start of one's employment, for both employers and employees.

Another instance that emphasized the problems with the knowledge regarding the Participation Act and who is entitled to certain benefits, involved a respondent who had been a non-beneficiary (nugger). They said that they did not recognize themselves in the

description of those who belong to the Participation Act target group register and was therefore also hesitant to apply for a meeting with the UWV to have their labour capacities evaluated. They also thought that they might not be acknowledged as someone who has limited labour capacities due to the way they come across and speak, even though mentally they were struggling with their ability to work. In the end, they did go through with the evaluation after a coach had motivated them to do so, and the respondent was eventually registered in the target group database. The respondent said they spoke to their previous social workers afterwards and stated "*They acknowledged 'Yes, we did not see that this could have been a solution for you. We did not recognize you as a potential person for the target group register'*".

4.1.3 Disincentive to work

During the interviews, the respondents were also asked if there had ever been moments where they did not apply for a job out of fear of losing their social assistance (if they received any). Although not all respondents have (received) social assistance, those who did mentioned that they felt that the social assistance system does not stimulate working at all.

> *It did obstruct me, especially in the beginning when I wanted to start again. Then the question is, what will you do? There is volunteer work, but then there is also a limit to how much volunteering compensation you can receive with your social assistance. So, those kind of things are obstructing. It does not motivate picking up where you left off and starting over again.*

The respondents who did not apply for jobs in the past, pointed out that social assistance offers them a sense of security and applying for a job puts that in jeopardy.

I am afraid that when it does not go well… this was for a few separate writing jobs, so purely to earn something extra. But even if it was a fulltime job, if I would lose that then I would also have a problem because then I no longer have a safety net.

4.1.4 Unintentional structural stigma

Although respondents were not explicitly asked about unintentional structural stigma, as it was not operationalized for the analysis, the respondents brought up instances where they had been restricted in their work as a result of their mental health problems, as well as being ignored in decision making processes that concerned them. One respondent mentioned

What I find very difficult about all of this is that they never asked me 'do you think you can handle it?'. They kind of decided for me and even cited it as a reason: 'The work environment is too unstable, so we do not think you would be able to function well there'.

Another respondent mentioned that when a past employer found out that the respondent received social assistance because of their mental health situation, the employer started to treat them differently: *"Because I received assistance they said 'Well, you should not do that task because you have this or that'"*. When asked about the consequences of such behaviour the respondent said *"It was not nice for me. Because you know what? You could also just try to teach me those things. Because I can do it too"*. One respondent pointed out that they were not allowed to operate certain machinery at a past place of employment and said *"But interns would come in and would be allowed to do that. Subconsciously, you then start to wonder 'What is wrong with me?'. But they were playing it safe: 'Oh he has something, so do not let him do that'"*. These examples corresponded with the theory on unintentional structural stigma; that people with mental health problems are sometimes still segregated from society to an extent, and barred from fully participating as a result of the stigma on their mental health

problems. These findings, where people were barred from participating in their work in a way that they would have preferred, support the idea that these people may have, unbeknownst to them, experienced unintentional structural stigma and therefore it was included in this section.

4.2 Retrospective findings - The relationship between structural stigma and self-stigma

The respondents were also questioned about experiences with self-stigma. This led to two opposing outcomes. One group of respondents did not show any indications of self-stigma and felt very confident in their abilities, despite having (had) mental health problems. For example, one respondent said *"I have learnt that there is nothing that I cannot do. I just do it, and if I cannot make it work, I can notice it myself and just ask for help"*. Another respondent said *"One way or another, I know that I am very good at certain things. I may not fit into a specific mold, but that is often the case with creative jobs like mine anyway"*.

4.2.1 Employers' negative influence on self-confidence

Among the group of respondents who did show signs of self-stigma, a common experience was that people started to doubt themselves as a result of their mental health problems and they had often experienced negative self-thoughts: *"The moment you get a burn-out, it dents your self-confidence and you start to think 'I am weak, I have failed'"*. With difficulties at work, another respondent said *"I thought to myself, 'See, you cannot do it. You cannot function'"*. However, the main question remained whether structural stigma in the labour market and self-stigma are interrelated and not whether having a mental health problem has the potential to influence feelings of self-stigma. Therefore, the respondents were also asked specifically about the negative influence of previous employers on feelings of self-stigma. A shared view that was pointed out was that past employers do have the ability to negatively influence self-confidence, to a point where some respondents had even started to internalize

the negative views of their employers and some were even discouraged to work at all. These indications were suggestive of a relationship between structural stigma exhibited by employers and self-stigma. One respondent elaborated on this issue and said *"I have had difficulties with working in the past, and many employers have said that it did not go well. So, then you do start to think 'There must be some truth to what they are saying'"*. When asked about the consequences they had endured as a result of those comments by employers, the respondent said *"What I mentioned earlier, that you start to think 'Can I not do anything right at all?'. After a while I started to dread work completely"*.

4.3 Present day perspective - People with mental health problems are able to return to and/or remain in work

In order to evaluate the factors that have had a positive influence on the employees' ability to work, they answered questions regarding the beneficial accommodations that their current employers has offered them, as well as questions on the influence of their work environment and their relationship with co-workers and their employer on being able to remain in work. The following section first elaborates on the statements of the employees on what has helped them to return to and/or remain in work. Next, a section will focus on their employers' side of the story and their views on working with people with mental health problems and how their policies and practices try to include these employees to the best of their ability.

4.3.1 Employees' perspective

During the interviews, the employees identified several factors that have contributed to their succes in participating in the labour market. These determinants were divided into two categories: individual level factors and employer level factors.

4.3.2 Individual level factors

On the individual level, three types of factors were identified by the employees with mental health problems that have helped them in their abilities to participate in the labour market. The first factor was seeking treatment outside of work. Treatments varied from participating in different types of therapy, including speaking with psychologists, or having to take medication. One respondent said *"I am aware that 'it' is there and I take my medication on time. I have undergone the necessary therapies in my life to learn how to deal with it"*. Another respondent spoke on how they are able to combine their treatments with working. Of their agreement with their current employer they said

> *I now have one set day to have treatments. I technically work five days a week, but on one of those day I am always registered sick in order to undergo treatment. On that day I do not do anything else… a conversation like that takes only one hour, but it can upset me for the rest of the day. So, I consciously choose to have a sick day.*

Another factor connected to this, is achieving acceptance of having a mental health problem. For some, it is a temporary obstacle, whilst others have to find a way to deal with it their entire lives. It is difficult to change what you cannot acknowledge, so, learning to accept that you have "something" and how to navigate life with it can help to improve functioning.

> *I think I started to improve when I got a bit of acceptance. I started to acknowledge 'This will never go away a 100%'. Because in the first few years I was in a mode of 'This has to go away, this has to go away, this has to go away'. Because I did not accept that I had it"*.

Another respondent who had also struggled with coming to terms with their situation said *"Lately I have come to the realization 'Ok, I have limitations and I just need to deal with it, and it is possible to do that. I too can function if I remain considerate of it"*.

The final individual level factor that was identified was concerned with participating in supported employment programs before fully returning to the labour market. One respondent who participated in such a program said *"I was matched with a mentor from the business field. And she has really…well, the reflecting and mirroring process really helped me further along"*. In this particular instance, the respondent was able to participate in an internship and gain work experience. It is through that program that the respondent even met their current employer, who quickly recognized the value of their experience knowledge after meeting with them.

4.3.3 Employer level factors

Aside from the influence of individual level factors on positive work outcomes, the respondents also identified three employer level factors that have been beneficial to their ability to work.

To begin with, the employees acknowledged the wide array of accommodations that they have been offered by their employer in order to be able to work. These accommodations have ranged from being offered flexible working hours, adjustments of their workplace, being offered a different function, paying transport, helping out with practical issues, and in particular, offering plenty of time and space for the employee to undergo treatment (and in some instances recover). One case, for example, involved a respondent for whom it was highly unfavorable to work from home during the Covid-19 pandemic: *"The advice is to 'work from home, unless'. […] But personal circumstances also count. I am allowed to come to the university two times by week because working from home simply is not possible"*. In the situation of another respondent, who had experienced a burn-out, they said

What I found most special was that they completely let me be. It was not a case where the HR manager said 'Ok, you belong in this category and these are the things we are going to do'. It was more a situation of 'You are going to rest, and if you want to lie down, then you lie down. If you want to go to lunch, you go out to lunch'. That is very difficult because you feel so guilty. But they really let me do my thing, and every few days she would check on me to see how I was doing.

The second identified factor, that was highly appreciated by respondents, was being offered to participate in an Employee Assistance Program, which included different types of coaching. This ranged from receiving coaching from the CEO himself, to job coaching, a vitality coach and lastly, being offered EMDR sessions. One of the respondents who underwent EMDR said of the outcome *"Now whenever my thoughts start to bother me, I can turn it into something positive, so that I start to think about it less"*. Of speaking with a vitality coach, who focuses on improving one's feelings of selfworthiness, one respondent stated

In a few sessions she taught me that when you have a full 'barrel of selfworth', you will start to act more according to your own worth, and you will better understand how you feel and you will become better at being able to say 'No' or 'I think this is acceptable' or 'It is not perfect but it is ok'. And it teaches you that you actually are doing a lot of things really well already.

The final factor that was identified, is the importance of the role of the workplace atmosphere in allowing people with mental health problems to work. Respondents mentioned several elements that have contributed to a positive workplace environment for them. Among the most important is having a supportive and open culture within the organization, where co-workers and supervisors are understanding of their situation, where HR and directors are also

actively involved, where the goal is to try to help the employee as best as they can, and where the employees feel safe enough to open up and ask for help when they need it.

> *I think my employer is very open to a lot of things and tries to help the employees where needed. That can be about health, with coaching and support. But also the personal development of employees. They do a lot for that as well. To me it feels like you can very easily talk about things because it is very open here.*

An employee from another organization emphasized the importance of a supportive and open workplace culture for remaining in work:

> *If there is something going on, I can always go to my boss. Even if it is a private matter, I can approach him and ask for help. That is actually also why I still work here. Just because I feel so at home that I can come to them for anything.*

Another important element here is that the current employers have tended to focus on the qualities and skills of the employee: what they can do instead of what they cannot do. *"I think it shows how my employer is. They really focus on the qualities of the person and a job position usually forms around that. That is really how it happened for me"*. One respondent whose current job is a so-called "Participatiebaan" (Participation job) mentioned how beneficial it has been to have a job created around their skills and how nice it was that the employer came to them with suggestions on how to make it work, instead of always having to be the one to approach an employer and ask if they could possibly fit in there. One respondent also pointed out how important the role of an employers' attitude can be in sustaining employment for employees with mental health problems

> *When you feel that there is too much pressure being put on you and they ask you to do things that you cannot do… Well, then at some point that person will have to end up quitting their job at that employer.*

When asked how their employers had influenced them with the offered accommodations, coaching and a supportive work environment, the overall consensus among the respondents was that their current employers have positively contributed to their feelings of self-confidence in regard to being able to work. When one respondent considered leaving their job due to their mental health situation at the time, their employer actively tried to convince them otherwise:

> *It gives you so much self-confidence when a company… despite the fact that you feel like you have failed because you got a burn-out and did not deliver what was expected of you… With those feelings of failure, it was really nice that they said 'But that is not the case at all. You are of added value here. We want you to stay!'.*

Being valued, receiving compliments, having supportive co-workers, staying in touch during sick-leave, room for personal development and being offered help; these were all examples that were mentioned that have contributed to the employees' abilities to remain in work at their current employer, despite their mental health problems.

4.3.4 Future improvements from the employees' perspective

Although the aim of this study was to look at positive factors that contribute to the work opporunities of people with mental health problems, the respondents also identified several future improvements that can be made to even better accommodate people like them. The first thing that was pointed out is that HR should look at the target group register from the start. They have access to the database and should be aware if an employee has the right to certain accommodations. That way, help can be offered straight away. Second, employers could focus on more attention regarding mental health problems at work in general. Third, there is a desire for more training for supervisors and co-workers regarding mental health problems: *"You need to be able to recognize the signals before someone drops out"*. It was

mentioned that it is important that there are people in every layer of the organization who are trained in recognizing and dealing with mental health problems, and who can offer more personal guidance: *"The HR manager or the directors are very high up in the organization for someone who works in production. So, you need to have a supervisor who can also spot the signals. Because HR and the directors cannot see everything"*. Lastly, it was mentioned that it can sometimes be very difficult to "fit in" with a system that is designed for people without mental health problems. For example, when you are less billable due to your mental health problems, but your organization relies on billable hours. Such situations can be difficult to navigate for both the employees and employers. It is therefore only fitting to conclude this section with a notion that the system should adapt more towards the people, instead of the other way around: *"I do not recognize myself in the term 'distanced from the labour market'. But that is because I think the labour market has a distance towards people"*.

4.4 Employers' perspective

Albeit, the main focus of this study has been on the perspective of the employees with mental health problems on employment, their current employers have also been interviewed. This has led to some results from their perspective on what factors they find important when it comes to working with, and facilitating, people with mental health problems.

The interviewed employers have different types of policies within their organizations, i.e., objective hiring, open hiring, regular job application processes, actively working with the Participation jobs and municipalities, or hiring people with experience knowledge. However, what connects these organizations is that they are all actively focusing on inclusion and diversity within their organizations, which appears to stem from an intrinsic motivation: *"We think that everyone in society should be given the opportunity to participate in the labour*

market". It is that sense of duty towards including an excluded group of people that is becoming ingrained within their company cultures. In regard to succesfully working with people with mental health problems, the common denominator that stood out is on customizing help for people and to work together with other parties in order to facilitate employees in the best ways possible.

> *We want to be an employer for people with all kinds of labour capacities. Therefore, we try to create customized jobs, and where possible we offer extra support, so that they can be sustainably deployed. In that way we try to offer people better opportunities to participate within our community.*

An important mention is that HR, supervisors and management should receive training in working with people with mental health problems, in order to better recognize obstacles and offer help as soon as possible. The employers that were interviewed offered a wide aray of accommodations to their employees in order to help them, from work(place) adjustments, coaching, flexible hours, to help with practical things. The employers additionally expressed the importance of making employees feel safe and that communication is key when working with people with mental health problems. Employers should also learn to be alert on signals that an employee might be struggling. This can all help to prevent people from having to drop out of work. *"We mainly start with communication. We try to uncover why something is happening. And then oftentimes it means we need to make some adjustments"*. One employer emphasized the importance of taking a small amount of time out of your day, during coffee breaks for example, to dedicate towards the mental health of employees:*"I think that we should all be more aware about the wellbeing of our colleagues. To simply say 'Take a seat, how are you really doing?'"*. Also, during sick leave, it remains important to stay in touch with employees so that they remain connected with their work

What you see with people who stay home for a longer time, for them work itself becomes so big; it is an obstacle in their way that is only becoming bigger. At a certain point, they are afraid to even come and have coffee with us. So, even if they only come twice a week for a cup of coffee. We want to stay in touch".

To conclude this section, the overal consensus among employers was that it is meaningful for people with mental health problems to be able to participate in work, not only for the person themselves, but also because they are able to add value to the organization. Lastly, it was stated that successes within organizations regarding working with people with mental health problems leads to more openness towards it in general.

4.4.1 Future improvements from employers' perspective

Among the improvements that can be made by and/or for employers, to better accommodate their employees with mental health problems, a few stood out. The first being that there is a need for more for more training among supervisors so that they can offer the best possible support*"I think, as this issue is becoming more prominent, that it would be good to offer training"*. The second, most prominent area for improvement, is that there is a dire need for more financing from the government. In one specific case, an organization had hired a woman through open hiring, but they had to let her go because she was not entitled to a no-risk policy as she was not in the target group register. The woman in question very frequently had to take sick leave, to a point where it started to become an issue for the company, financially. They struggled with the social aspect of wanting to help her, versus the financial aspect. In the end, regrettably, they had to let her go. Sadly, if the company would have received some compensation for the employee, they would have been able to keep her on and continue to support her. And it likely would have cost less to offer compensation towards the

organization, compared to the costs associated with having someone go back into the system, with all sorts of additional consequences.

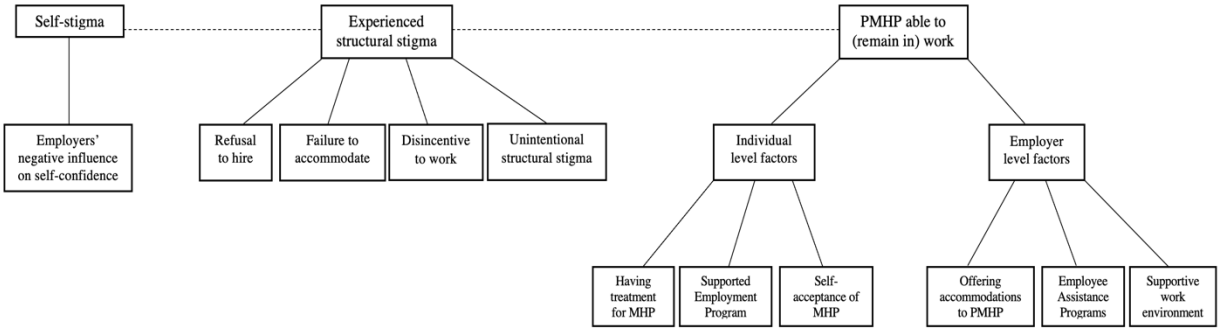
> *It is not her fault, but it is not ours either as we tried everything. And indeed, it will cost more when someone goes back into the system. But it also comes at the expense of that person you know? Because I think that if someone goes back home, deteriorates, etc. that the situation only becomes worse. There should be a safety net so that, one way or another, she could have gotten a no-risk policy and be in the target group register. That way, you would be able to continue what you have started instead of having to go all the way back to the beginning.*

4.5 Hierarchal network of themes

To recap this chapter, the illustration of the network below in Figure 1 serves as a overview of the results and the themes that have been discussed. Experienced structural stigma was recognized among the employees through incidents with resufal to hire, failure to accommodate, disincentive to work and occurrences of unintentional structural stigma. Although not all respondents experienced self-stigma as a result of their experiences with structural stigma, among those respondents who did, the negative influence of their past employees on their self-confidence, and consequently, on their feelings of self-stigma was identified; thus insinuating an association between structural stigma and self-stigma. Despite encounters with structural exclusion, they were able to identify several positive factors that have contributed to their ability to return to and/or remain in work. They pointed out that investing in both individual level- and employer level factors, has played an important role in accommodating people with mental health problems at work, and may thus help to negate structural stigma in the labour market.

Figure 1.

Hierarchal network of themes



5. Conclusion and discussion

In light of the reveal on the apparent shortcomings of the Dutch Participation Act in trying to create a more inclusive labour market (Van Echtelt, et al., 2019), and the urgent call by municipalities for policy changes (Vereniging van Nederlandse Gemeenten, 2021), this study set out to gain a better understanding on how the underacknowledged topic of structural stigma potentially prohibits labour market inclusion, and which organizational policies and strategies *can* work to increase labour market participation among people with mental health problems. In doing so, this study took a twofold approach. First, it set out to comprehend whether people with mental health problems have actually had experiences with structural stigma in the labour market and whether experiences with structural stigma had any impact on the presence of self-stigma. Second, the study tried to uncover which factors had contributed to the ability of these people to successfully return to and/or remain in the labour market, despite having (had) mental health problems. Interviews took place with 10 respondents from four different organizations to reveal both their past and present experiences with work. From each organization, an HR representative was also interviewed to describe their company's policy on working with people with mental health problems.

Through thematic analysis, the study was able to uncover that structural stigma had previously been experienced by respondents, namely through refusal to hire, failure to accommodate, a disincentive to work. These outcomes corresponded well with the theories by Livingston (2013) and Corrigan and colleagues (2011) on how to operationalize structural stigma. This study appears to be among the first to study structural stigma in practice along those lines. Although not specifically operationalized for this analysis, the study was also able to uncover signs of unintentional structural stigma among respondents who had been barred from fully participating at their previous jobs. These findings were conform with the theories

on unintentional structural stigma (Corrigan, Markowitz, & Watson, 2004; Livingston, 2013). Second, in regard to the relationship between structural stigma and self-stigma, the results showed two opposing outcomes. The first being that a group of respondents had no experiences with self-stigma, whilst the other group did experience self-stigma and found that their previous employers had negatively influenced their feelings of self-confidence, and had subsequently influenced their feelings of self-stigma. Lastly, several factors were identified as being beneficial for people with mental health problems in returning to work. On an individual level, people have benefitted from seeking treatment, participating in supported employment programs, and learning to accept that they have a mental health problem. On the employer level, receiving accommodations and coaching through Employee Assistance Programs were appreciated among the respondents. Finally, the importance of a supportive workplace environment stood out tremendously during the interviews. These findings coincide with several scholars who have previously emphasized that improving labour market outcomes for people with mental health problems should happen on both the individual level as well as the employer level (Follmer & Jones, 2018; Link, 2001; Livingston, 2013).

Van Hees and colleagues (2021), stressed the importance of taking a context-mechanism-outcome approach when evaluating the effectiveness of interventions that aim to keep people with mental health problems in work. In order to measure the effectiveness of any intervention, scholars should not only take the intervention itself into consideration, but also the context in which it is performed and whether or not it influences the outcomes. It cannot simply be assumed that offering accommodations alone will solve the obstacles people encounter. Indeed, the results of this study have revealed that the context is very important if any type of intervention is to work, as respondents repeatedly emphasized the influence of

their current workplace culture and the personal involvement of their employer in their successes to participate in the labour market.

The evaluation of the Participation Act revealed that 61% of employers say thay want to be more inclusive, but that in reality less than 5% of employers is actively trying to include more people with mental health problems within their organizations (Van Echtelt, et al., 2019). This study focused precisely on those organizations who *do* try to make it work. By creating supportive work environments, with involved employers and co-workers, plenty of accommodations, coaching and adjustmens where necessary, combined with individual level efforts, these organizations and employees have revealed from a personal point of view what can be effective in integrating people with mental health problems in the labour market. It is not merely a "one size fits all", but rather a "my size fits me" type of situation that can lead to positive outcomes. This coincides well with the notion by the Dutch Foundation for Psychotechnique (NSvP) that work should be adapted towards the people, and not the other way around (Nauta, 2016). This is where the organizations that were involved in this study can become exemplary to others.

Such examples are a necessity, because currently a large group of people with mental health problems is still being excluded from the Dutch labour market. This can be traced back to the way our labour market is designed. Much of its focus is on efficiency, and only those who can keep up with its high demands and are a low risk to employers are allowed to enter. Yet, because of this, a tremendous amount of valuable labour capacity is being overlooked. The curious thing about the Dutch labour market is that employers say they want to be inclusive, but not a lot of them actually are (Van Echtelt, et al., 2019). As Wilthagen and Stolp (2021) describe it, maybe the Netherlands uphold a so-called "giro 555" attitude, in the sense that

they might say they want to help achieve change, but would rather not be confronted with the obstacles and hard work that go along with it. Naturally, this begs the question if they are only saying they want to help as it is the socially desirable thing to say? Because in reality, being exclusionary towards specific groups is structurally embedded in our society and its systems. That is already evident in the ways in which the respondents in this study have encountered structural stigma, meaning structural exclusion. That is also where this study has delivered an important contribution to the body of literature; as it was able to uncover specific ways in which structural stigma is actually present in the labour market, this contributes to our understanding on how structural stigma works outside of formal law and policy evaluations. It is also among one of the first studies to approach structural stigma in this way by emphasizing the personal experiences of employees above all else. Lastly, it has contributed to the need for more knowledge on whether or not structural stigma can impact self-stigma. Of course, as this study was qualitative in nature, it is difficult to assess the full extent to which structural stigma takes place. Due to the size and nature of this study, it leads to further questions about the scale of the issue and what differences there are in outcomes between individuals, the types of mental health problems, sectors and the types of organizations people work for, when the subject is studied on a larger scale. However, now that there is a better understanding on the areas in which structural stigma has been detected, combining these insights with larger scale quantitative studies could help bring a better perspective on the scope of the problem.

Still, the prevalence of experiences with structural stigma among the respondents, in a relatively small sample, hints at the notion that our system is tainted: tainted by systemic exclusion. And it calls for a remedy, because institutionalized stigma is robbing us from the necessary labour capacity we need. The emphasis here is on need, because the Dutch labour

market is dealing with substantive shortages. If nothing changes, this structural shortage not only continues to exclude people who can and want to work, but it will also threaten the welfare of the country in the decades to follow (Stigter & Wilthagen, 2022). That scenario would not be in anyone's best interest. Therefore, the labour market no longer has the luxury to be picky when it comes to who is hired and who is not. The system urgently needs to change and this study can offer a helping hand in its modification by revealing some of the specific areas where change is needed. It is a contribution towards a cure for the labour market as it were.

Even though the organizations in this study have helped to gain better insights into what works when trying to include people with mental health problems in the labour market, it does not yet solve the bigger question: how do we address structural stigma system wide? Additionally, even if structural stigma was an easy feat to erase, it remains important to be considerate of context. Simply pressing "stop" on structural exclusion and welcoming everyone to participate would not solve the entire equation. Because it leaves questions on how to make it sustainable for people with mental health problems to remain in work long term. This study focused on organizations that already had an intrinsic motivation to be more inclusive, and as a result has shown that the whole organizational culture matters when trying to offer sustainable employment. So, what do other employers need to make the same changes, whilst also taking the needs of the employees with mental health problems into consideration? Would it be a question of more knowledge on what facilities are out there, provided by the Participation Act? Or is it a question of more knowledge on mental health in general? Or perhaps other elements are at play, such as concerns about financial gains and the fears that people with mental health problems will cost an organization more than they contribute to it. As with any other organization, the ones included in this study will likely also

care about their financial wellbeing, yet, they still *choose* to invest in people with mental health problems. So, rather than looking at why some organizations do work with people with mental health problems, future studies could also present other employers with the question: In this day and age, why would you not work with them?

Regarding the Participation Act itself, this study has uncovered some of the difficulties that both employers and employees have struggled with in regard to the Act. These examples have made it clear that the system that was developed to make it easier to help people towards and in work, is not always nearly as efficient as desired, as people are sometimes still unaware of the available possibilities. Additionally, it could also be argued that there is a paradox that surrounds the Participation Act as a whole. It was designed to help people, but what it simultaneously does is causing more stigmatization as it categorizes people into boxes. In that sense, the Participation Act itself could become an example of structural stigma, as it systematically excludes people from the "regular" folk.

With the momentum for change, the Participation Act is likely to receive adjustments in the nearby future. Policy makers certainly have their work cut out for them. Wilthagen and Stolp (2021) endorse the importance of contributive justice, which is the idea that everyone should be allowed to participate in productive activities for the common good. Indeed, people should be treated like people and not as a commodity. Everyone has their own value and skills to contribute to the labour market, despite their personal obstacles, and should be allowed to do so. That train of thought appears to have been the common thread within the organizations that have participated in this study, and it is precisely the type of mindset that offers the potential to become the antidote against structural stigma.

5.1 Limitations

There were some limitations in this study. The interviews were mostly done online due to Covid-19 measures. With qualitative research, a face-to-face approach is preferred as personal contact can help to establish a better rapport. Additionally, as interviews were online, sometimes problems with the internet connection would interrupt the conversation. Respondents were always asked to repeat what they had said, but some information may have been lost as a consequence of the interruptions. Another limitation is that some of the respondents had no experience with prior employers, as this was their first place of employment. So, it was not possible to measure past experiences with structural stigma for every respondent. Additionally, as a lot of people are currently working from home, there is a lack of day-to-day interactional experiences in the workplace. As some of the respondents only started working for their current employer during the pandemic, their experiences at their current workplace may have been different if they had been allowed to work at the office.

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Appendix A

Topic guide for employees (EN)

Topic	Concepts	Questions/talking points
Introduction	- Welcome - Introduce yourself - Aim of the interview - Information about confidentiality - General information (gender, age) - Questions beforehand	- Welcoming the respondent & explain the aim of the study - Asking for permission to record the interview - Anonymity in participating - Going over general information of the respondent: age, function at current organization, is this a Participation Job, do you receive social assistance? - Answering questions before the start of the interview
Current workplace	- Hiring process - Experiences in the workplace - Personal situation affecting work capacities	- How did you get this job (interview process)? - Can you tell me something about your experiences at this workplace? - Do you think something in your personal situation has made it harder for you to execute your work properly?
Structural stigma	- Workplace accommodations - Company culture - Past experiences → Refusal to hire/disincentive to work: fear of losing benefits	- Have you been offered accommodations (alterations, flexible work schedule) in order to be able to execute your work tasks better? If yes, what kind of accommodations and how have they helped you? If no, do you feel like you would need some accommodations and what kinds? - Do you think you would be able to continue your job if (not) offered accommodations? - What is the relationship like with your colleagues? How do they treat you? - What is the relationship like with your employer? How do they treat you? - Can you tell me something about your past work experiences? Have you ever been denied a job based on your personal situation? Have you ever struggled with disclosing vs not disclosing your personal situation? - If applicable: have you ever not applied for a job out of fear of losing your social welfare benefits?

Self-stigma	- 'why try' effect - Self-esteem - Influence current workplace situation	- Have you ever not applied for a job because of your personal situation? - Have you ever experienced stigma because of your personal situation? - How confident do you feel in your own abilities to work? If confident, has this always been the case? If not confident, what causes this lack of confidence and how does this affect your abilities to work? - Have your colleagues and/or employer ever made you feel like you were not capable to perform certain tasks? - Have past experiences affected your belief in your own abilities to work? - Has your current workplace contributed to your level of confidence to work?
Information not previously mentioned	- Important information not mentioned before - Ending the interview	- Are there things your employer could improve when it comes to an inclusive workplace? - Did we leave anything out / Would you like to add something? - End of the interview – thanking respondent

Topic guide for employees (NL)

Topic	Concepten	Vragen/punten ter bespreking
Introductie	- Welkom - Voorstellen - Doel van het onderzoek - Informatie vertrouwelijkheid - Algemene informatie (gender, leeftijd, functie) - Vragen vooraf	- Welkom heten van respondent en doel van het onderzoek toelichten - Toestemming vragen voor het opnemen van het interview - Anonimiteit van de respondent benadrukken - Algemene informatie respondent bespreken: leeftijd, functie bij organisatie, sprake van participatiebaan, sprake van uitkering - Eventuele vragen vooraf bespreken
Huidige werk	- Sollicitatieprocedure - Ervaringen op het werk - Invloed van persoonlijke situatie op werk capaciteiten	- Hoe ben je aan deze baan gekomen (kun je wat meer vertellen over de sollicitatieprocedure)? - Kun je me wat vertellen over je ervaringen bij deze baan? - Is of was er iets in je persoonlijke situatie waardoor het moeilijker is (geworden) om je werkzaamheden uit te voeren? Zo ja, op welke manieren beperkt dit jou? Is dat altijd/wisselend?

Structureel stigma	- Accommodaties/faciliteiten op het werk - Organisatiecultuur - Ervaringen uit het verleden → Niet worden aangenomen/geen motivatie om te solliciteren (uitkering)	- Heb je accommodaties/faciliteiten aangeboden gekregen (aanpassing werkzaamheden/flexibele uren) om je werkzaamheden beter uit te voeren. Zo ja, wat voor soort accommodaties en hoe helpen deze jou? Zo nee, heb je het gevoel dat je dit nodig zou hebben en zo ja wat dan? - Denk je dat jij je werkzaamheden kan blijven uitvoeren als je (geen) accommodaties aangeboden krijgt? - Hoe is de relatie met je collega's? Hoe behandelen zij je? - Hoe is de relatie met je werkgever? Hoe behandelen zij je? - Kun je me iets vertellen over je ervaringen met werk uit het verleden? Heb je ooit een baan niet aangeboden gekregen vanwege je persoonlijke situatie? - Heb je ooit geworsteld met wel/niet vertellen van persoonlijke problemen aan een werkgever? - Indien relevant: Heb je ooit niet gesolliciteerd uit angst om een uitkering kwijt te raken?
Zelfstigma	- 'why try' effect - Zelfvertrouwen - Invloed huidige werk	- In hoeverre ziet de buitenwereld jou als iemand met een beperking en in hoeverre ervaar jij dat ook zo? - Heb je weleens stigma ervaren vanwege je persoonlijke situatie? - Heb je ooit niet voor een baan gesolliciteerd vanwege je persoonlijke situatie? Waarom wel/niet? - Hoe zeker ben je van je vermogen om te werken? Indien zeker, is dit altijd zo geweest? Indien niet zeker, waardoor komt dit en heeft het invloed op hoe je je werkzaamheden uitvoert? - Hebben je collega's of werkgever (uit het verleden) je ooit het gevoel gegeven dat je bepaalde taken niet kon uitvoeren? - Hoe hebben ervaringen met werkgevers uit het verleden je zelfvertrouwen om te werken beïnvloed? - Heeft je huidige werkgever eraan bijgedragen dat jij je

		zelfverzekerder voelt om te werken?
Informatie die nog niet eerder is benoemd	- Bespreken van belangrijke informatie die nog niet eerder is benoemd - Einde interview	- Zijn er dingen die jouw werkgever nog zou kunnen verbeteren als het gaat om inclusiever werken? - Zijn we nog belangrijke zaken vergeten? Wil je nog iets toevoegen? - Einde van het interview – bedanken van respondent

Topic guide for employer (EN)

Topic	Concepts	Questions / Talking points
Introduction	- Welcome - Introduce yourself - Aim of the interview - Information about confidentiality - General information (gender, age) - General information company - Questions beforehand	- Welcoming the respondent & explain the aim of the study - Asking for permission to record the interview - Anonymity in participating - Going over general information of the respondent - Going over general information of the company: type of business, number of employees - Answering questions before the start of the interview
Company policy	Hiring people with mental health problems (MHP) Policy: - Hiring processes - Accommodations - Official policy - Past policy - Changes in policy	- What is the company's policy when it comes to hiring people with MHP? Is there a difference between job positions? - Do you work with Participation Jobs? - Do you look in the target group register when you hire someone? - If relevant: you work with open hiring. Can you tell me more about this? How does it work? - How does the company accommodate people with MHP? What type of facilities are offered? - Are these official policies, if not why? - Has the company policy always been like this? Why (not)? - What changes have you made and why?

Policy in practice	Effectiveness of policy - Working with people with MHP in daily life - Obstacles in hiring process - Obstacles in work - Positive contributions of people with MHP - Company culture	- How does work with people with MHP look like in the daily workplace? - What are the obstacles you come across in the hiring process? - What are the obstacles you come across in working with people with MHP? (Financial, personal, company culture) - To what extent do you come across stigma regarding MHP in the workplace? - Do employees/supervisors receive coaching/training in working with PMHP? - What are some positive contributions of working with people with MHP? Has it affected the company culture, if so, how?
Future	- Sustainable employment people with MHP	- Do you think the way the company operates ensures that people with MHP will be able to remain in work in the long run? - If not: Are there things your company needs in order to accommodate people with MHP in a better way? (i.e., from the government)
Information not previously mentioned	- Important information not mentioned before - Ending the interview	- Did we leave anything out / Would you like to add something? - End of the interview – thanking respondent

Topic guide for employer (NL)

Topic	**Concepten**	**Vragen / punten ter bespreking**
Introductie	- Welkom - Voorstellen - Doel van het onderzoek - Informatie vertrouwelijkheid - Algemene informatie (gender, leeftijd, functie) - Algemene informatie over organisatie - Vragen vooraf	- Welkom heten van respondent en doel van het onderzoek toelichten - Anonimiteit van de respondent benadrukken - Toestemming vragen voor het opnemen van het interview - Algemene informatie respondent bespreken - Algemene informatie over organisatie bespreken (soort organisatie, aantal werknemers) - Eventuele vragen vooraf bespreken

Organisatie beleid mentale gezondheid	Aannemen van mensen met mentale gezondheidsproblemen (MG) Beleid: - Aannemen/sollicitaties - Accommodaties/faciliteiten - Officieel beleid - Verleden beleid - Veranderingen in beleid	- Wat is het beleid van de organisatie omtrent het aannemen van mensen met MG? Zit daar verschil in per functie? - Werken jullie ook met Participatiebanen? - Kijkt HR ook naar het doelgroepenregister als jullie iemand aannemen? - Indien relevant: Jullie doen mee/hebben meegedaan aan open hiring, kan je daar wat meer over vertellen. Hoe gaat dat in zijn werking? - Op welke manier(en) biedt de organisatie accommodaties/faciliteiten aan mensen met MG? - Is er hier sprake van een officieel beleid omtrent werken met mensen met MG? Waarom niet? - Is het beleid van de organisatie altijd al zo geweest? Waarom (niet)? - Welke aanpassingen zijn er gemaakt aan het beleid en waarom?
Beleid in de praktijk	Effectiviteit van het beleid - Werken met mensen met MG in het dagelijks leven - Obstakels in sollicitatieprocedure - Obstakels op de werkvloer - Positieve bijdrage van mensen met MG op de werkvloer? - Organisatiecultuur	- Hoe ziet werken met mensen met MG eruit op de dagelijkse werkvloer? - Zijn er obstakels tijdens de sollicitatieprocedures als het gaat om MG en zo ja, welke? - Zijn er obstakels tijdens het werken met mensen met MG en zo ja, welke? (Financieel, persoonlijk, organisatiecultuur) - In welke mate zie je stigma op de werkvloer bij MG? - Krijgen medewerkers/leidinggevenden coaching/training als het gaat om het werken met mensen met MG? - Op welke manieren leveren mensen met MG positieve bijdragen? Heeft dit invloed gehad op de organisatiecultuur, en zo ja, op welke manier?
Toekomst	- Duurzaam werken voor mensen met MG	- Denk je dat de manier waarop de organisatie nu werkt ervoor zorgt dat mensen met MG langdurig kunnen blijven werken? - Zo niet, zijn er dingen die de organisatie nodig heeft om ervoor te zorgen dat ze mensen met MG

		beter kunnen faciliteren? (e.g., vanuit de overheid, of organisatie zelf)
Informatie die nog niet eerder is benoemd	- Bespreken van belangrijke informatie die nog niet eerder is benoemd - Einde interview	- Zijn we nog belangrijke zaken vergeten? Wil je nog iets toevoegen? - Einde van het interview – bedanken van respondent