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Evaluation of a stigma awareness intervention for unemployed people with mental illness

Kim Janssens

DECISIONS ON DISCLOSURE OF MENTAL ILLNESS IN THE WORKPLACE

Evaluation of a stigma awareness intervention for unemployed people with mental illness

Kim Maria Elisabeth Janssens

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CONTENT

CHAPTER 1

General introduction

INTRODUCTION

Work participation rates of people with mental illness are considerably lower compared to those for people without mental illness (1). As globally around one in three people will develop a mental illness at least once in their life (2, 3), this poses a public health inequality problem (4). In OECD countries, people with mental illness are three to seven times more often unemployed than people without mental illness (5). Lower employment rates are found in various mental health conditions, such as anxiety, depression (5), autism spectrum disorders (6-8) and schizophrenia spectrum disorders (9). These lower employment rates are all the more problematic because most people with mental illness are able *and* willing to work (10, 11). This means that a huge amount of work capital is left behind, and is therefore associated with high societal and economic costs (12).

Employment – under favorable conditions – is beneficial for people with mental illness as it contributes to social participation and inclusion (11, 13). In addition, employment is associated with better health, recovery, self-esteem, mastery and happiness (11, 14-17). In contrast, unemployment is associated with factors such as stress, shame and poverty (18, 19). Because employment contributes to better health and recovery of people with mental illness (14), vocational rehabilitation is an important intervention in mental health treatment (17).

The group studied in this thesis concerns unemployed people who have, or have had, mental health issues or illness and who receive social benefits. In the Netherlands, people who are (long-term) unemployed, have insufficient income or capital and are unable to make use of other provisions or benefits (such as disability benefits), are entitled to social benefits. Mental health issues or illness could be diagnosed, i.e. a (common or severe) mental disorder, but can also concern self-reported (undiagnosed) mental health issues. For consistency, in this thesis, the term mental illness will be used, unless specified otherwise. Furthermore, it should be emphasized that not all mental illnesses are the same. There is a wide variety and diversity of mental health issues, illnesses, disorders, and conditions can be experienced differently per person and over time. This will be also discussed in more detail in various sections later in this thesis.

Stigma: an underestimated barrier for work participation

An underestimated yet important factor of influence on the work participation of people with (mental) illness is workplace stigma and discrimination (20, 21). For decades the biomedical perspective prevailed in (mental) health care and research, where it was thought that because of the illness, people could not function well (22). However, nowadays there is growing evidence that also other factors (i.e. psychosocial aspects such as stigma and discrimination) than the disease play an important role in the

well-being and functioning of people with (mental) illness. Stigma and discrimination frequently occur in the work context (23-25) and can have major impact on the health and well-being of people with mental illness (21).

The word *stigma* has its origin in the old Greek language and means *burn*. It refers to specific people being burned to show others that this person was of lower status, for example a slave or criminal (26). An influential theory on social stigma was developed by Link and Phelan (27). Here they argue that 'stigma exists when elements of labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them'. This means that stigma occurs when the people who stigmatize have social, cultural, economic and/or political power, and therefore have the power to separate groups from each other. In Link and Phelan's theory (27), stigma is conceptualized in four different components: 1) Distinguishing and labeling human differences; 2) Cultural beliefs link these labels to undesirable characteristics and negative stereotypes; 3) Labels are placed in distinct categories to accomplish separation of 'us' from 'them'; and 4) Because of labels, status loss and discrimination is experienced.

An additional influential theory on stigma and discrimination comes from Thornicroft and colleagues (28), here they argue that stigma refers to problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behavior (discrimination). Stigma researchers have shown that stigma can manifest itself at different levels. First, *public stigma* involves reactions of the general public towards a group because of the stigma on that group. This presents itself in stereotypes, prejudices and discriminatory behavior. Second, *self-stigma* refers to behavior of individuals who belong to a stigmatized group, turning the stigmatizing stereotypes, prejudices and discriminatory behavior towards themselves (29). See figure 1 for an overview of the components of public stigma and self-stigma. Finally, *structural stigma* is discrimination because of rules or regulations that (un)intentionally are disadvantageous for individuals with mental illness (30).

Components of Public and Self-Stigma

Public stigma	**Self-stigma**
Stereotype:	*Stereotype:*
Negative belief about a group such as	Negative belief about a group such as
Incompetence	Incompetence
Character weakness	Character weakness
Dangerousness	Dangerousness
Prejudice:	*Prejudice:*
Agreement with belief and/or	Agreement with belief and/or
Negative emotional reaction such as	Negative emotional reaction such as
Anger or	Low self-esteem or
Fear	Low self-efficacy
Discrimination:	*Discrimination:*
Behavior response to prejudice such as	Behavior response to prejudice such as
Avoidance of work and housing opportunities	Fails to pursue work and housing opportunities
Withholding help	Does not seek help

Figure 1. Presentation of the concepts public stigma and self-stigma from Rusch and colleagues (29) .

Mental illness stigma and discrimination occur in different life domains, such as in personal relationships, communities and employment (31-34). Lasalvia and colleagues (31) and Thornicroft and colleagues (32) have found that the work context is one of the areas in which discrimination occurs most frequently. In addition, Oudejans and colleagues (33) found that an employed person with mental illness elicited less stigmatizing attitudes than an unemployed person with mental illness.

Stigma in the work context is problematic in several ways. Brouwers (21) identified four problem areas in which mental illness related stigma can be of influence on unemployment or other disadvantageous occupational outcomes:

1. Negative attitudes of employers and other stakeholders towards people with mental illness. Several studies (35-38) have found concerns among managers about employees with mental illness. These include concerns about reduced productivity or a need for work adjustments, long-term sick leave, strange behavior, the risk of relapse and symptom severity.
2. Both disclosure and non-disclosure of mental illness can lead to job loss. Studies found that both disclosure as well as non-disclosure of mental illness can have positive as well as adverse occupational outcomes (39, 40). Rüsch and colleagues (41) found that, among unemployed people with mental illness, greater reluctance to disclose mental illness was a predictor for finding employment after six months. Furthermore, disclosure can lead to a variety of positive outcomes that can enhance wellbeing and sustainable employability, such as improved relationships, improved employee wellbeing as a result of being able to be authentic, emotional support from the work environment, work adjustments and a friendly work culture (39). However, disclosure can also lead to stigma and discrimination, such as being perceived as less capable and being denied future career progress. Non-disclosure can also have both positive outcomes (avoiding stigma during the hiring period) as well as negative consequences (not getting available support) (39).
3. Anticipated discrimination, self-stigma and the 'why try'-effect may withdraw people with mental illness from actively finding paid employment. The so-called 'why try'-effect arises when people with mental illness stop trying themselves to, for example, apply for work because of anticipated discrimination (e.g. no longer participating in situations because of fear of discrimination) and self-stigma (e.g. having negative believes about themselves because of the public stigma on mental illness) (42). Several studies (23, 31, 43) have illustrated that previous discrimination experiences and anticipated discrimination can stop people with mental illness from searching and/or applying for work.
4. Stigma is a barrier to seeking healthcare. Most people with mental illness do not receive mental health treatment (44-46), which could lead to absenteeism and loss in production (47). Stigma and discrimination is associated with treatment avoidance. For example, people can stop themselves from seeking mental health care because of the expectation to be discriminated when receiving treatment (48, 49). Research among high risk professions such as the military found that military personnel is hesitant to seek professional help form mental illness because of stigma related factors such as fear of career consequences or fear of social rejection (50-52).

The problem areas mentioned above were also identified in a recent systematic review (20) that investigated studies that addressed (directly or indirectly) how stigma affects sustainable employment and well-being at work for people with disabilities (both physical and mental). In the past six years the number of publications on illness related stigma within the work context has doubled. Studies focused mainly on the role of employers. However, other stakeholders such as co-workers, employment specialists and health care professionals also seem to have an important role in finding and retaining employment for people with mental illness. These stakeholders' attitudes and behaviors and the mechanisms involved on the employment opportunities and wellbeing of people with mental illness are still understudied (20, 21).

These studies illustrate that in order to reduce stigma, multiple areas need attention. First, more research is needed on how to destigmatize the work environment. For instance, research on stigmatizing attitudes and discrimination behavior among managers, but also in other stakeholders such as HR professionals and employment specialists, is scarce. Second, it is important to investigate how people with mental illness can protect themselves against stigma, and how they can learn to deal with its consequences. For instance, research on how people with mental illness can make more deliberate disclosure decisions in the workplace can provide insights into its importance on employment outcomes.

The disclosure dilemma: whether to disclose mental illness or not

As a result of stigma, whether or not to disclose mental illness in the workplace is a major dilemma for many people with mental illness. The decision whether or not to disclose is often perceived as a stressful process (53, 54), because both disclosure and non-disclosure can have advantages and disadvantages (39). Therefore, decisional stress can be experienced, which refers to uncertainty and dissatisfaction when trying to make a decision (55, 56).

Interestingly, in the Netherlands, there is a preference among employees to disclose mental illness in the workplace. Two recent Dutch studies on workplace mental illness disclosure found that 75% of employees without mental illness indicated they *would* disclose their mental illness to their managers (57), and that 73% of employees with

mental illness *actually did* disclose to their managers (58). However, earlier studies in other countries have found that managers are reluctant to hire employees with mental illness (35, 37, 41). This willingness to disclose mental illness may be because in the Netherlands, employees with disabilities are protected by legislation such as the *Wet Verbetering Poortwachter* (Gatekeeper Improvement Act, 2002), the U.N. Convention on the Rights of Persons with Disabilities (59) and the Disability Discrimination Act (60), giving employees the idea that it is safe to disclose. Through this legislation, Dutch employers have a significant responsibility for funding sick pay, i.e. they must pay at least 70% of the salary during the first two years of sickness absence, regardless the reason of sickness (60, 61). In addition, they need to ensure that employees with disabilities have access to reasonable accommodations at work (59).

In 2010, the Conceal or reveal (CORAL) decision aid was developed, a tool to support people in their decision about whether to disclose mental illness in the work context or not (62, 63). The decision aid is based on the principle that people know their own situation best. Therefore they can make the best choices themselves, but can still benefit from help with making a choice. Health related decision aids are aimed to provide more knowledge, to facilitate more active participation in decision making and to reduce levels of decisional conflict (55). Several follow-up studies (56, 64) investigated the effect of the intervention on finding paid employment, as well as experiencing decisional conflict about whether to disclose mental illness or not. These studies found that people who used CORAL were significantly more often working full time than people who did not use the decision aid after three months. Using CORAL also resulted in less decision-making stress (56). Studies investigating similar decision aids, such as the online READY disclosure decision aid for employed people with mental illness (65) and the Plan for Managing Personal Information (66) found similar successful outcomes on employment and less decisional conflict.

As workplace stigma is increasingly being acknowledged to be a major barrier to sustainable work participation of people with mental illness, this thesis aimed to get more insight in managers' views and concerns regarding hiring a job applicant with mental illness. Moreover, this thesis aimed to study the effects of a stigma awareness intervention, that may protect people against the harmful effects of stigma. Therefore, we conducted a cluster randomized controlled trial in which the effects of a Dutch version of the CORAL decision aid tool (i.e. CORAL.NL), combined with a stigma awareness training for employment specialists are examined on finding and retaining paid employment, and on decisional conflict. In addition, a cross-sectional study was conducted, investigating managers' attitudes and hiring intentions towards hiring people with mental illness, and their concerns and reasons (not) to hire a job applicant with past or current mental illness.

AIM AND OUTLINE OF THIS THESIS

Specifically, this thesis has several objectives, which can be divided in two main aims.

1. To gain more insight into the attitudes and hiring intentions of Dutch managers towards persons who have or have had mental illness,
   and
2. To evaluate the effectiveness of a stigma awareness intervention for unemployed people with mental illness and their employment specialists, compared to usual vocational rehabilitation.

Therefore, this thesis is divided in following chapters. Current **Chapter 1**, provides a general introduction to the topics of the thesis. In **Chapter 2**, a cross-sectional study will be discussed which examines Dutch managers' knowledge of mental illness. In addition, it investigated managers' attitudes, hiring intentions, concerns and reasons (not) to hire a job applicant with past or current mental illness.

The following chapters are about the stigma awareness intervention.

Chapter 3 describes the study design and methods of a two-armed cluster randomized controlled trial. The RCT consists of an intervention and control group (care as usual) and a follow-up period of 12 months.

In **Chapter 4**, the effects of a stigma awareness intervention on finding paid employment, retaining paid employment and on decisional conflict about disclosing mental illness, compared to usual vocational rehabilitation in municipal practice is described. Furthermore, the effects of the stigma awareness intervention on secondary outcomes (i.e. mental health, positive wellbeing, stigma, experienced discrimination, work-related factors and quality of support from the employment specialist) compared to usual vocational rehabilitation will be discussed.

In **Chapter 5**, the cost-effectiveness of the intervention is discussed. In this study, the effects, costs and benefits that belong to implementing a stigma awareness intervention into vocational rehabilitation, compared to vocational rehabilitation as usual will be examined with a societal perspective.

In **chapter 6** the results of a process evaluation using quantitative and qualitative data are discussed. Here the feasibility of the stigma awareness intervention is evaluated. This includes participants' experiences and recommendations for further implementation of the stigma awareness intervention.

Finally, **Chapter 7** consists of a general discussion placing the finding in a broader context. Strengths and limitations will be discussed, and clinical implications and recommendations for future research will be given.

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CHAPTER 2

Line managers' hiring intentions regarding people with mental health problems: a cross-sectional study on workplace stigma

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ABSTRACT

Objectives

Stigma may negatively affect line managers' intention to hire people with mental health problems (MHP). This study aims to evaluate line managers' knowledge and attitudes concerning job applicants with MHP, and to assess which factors are associated with the intention (not) to hire an applicant with MHP.

Methods

A sample of Dutch line managers (N=670) filled out a questionnaire on their knowledge, attitudes and experiences concerning applicants/employees with MHP. Descriptive analyses and multiple regression analyses were used.

Results

The majority (64%) was reluctant to hire a job applicant with MHP, despite the fact that only 7% had negative and 52% had positive personal experiences with such employees. Thirty percent were reluctant to hire an applicant if they knew the applicant had past MHP. Associated with higher reluctance to hire an applicant with MHP were the concerns that it will lead to long-term sickness absence (β(95%CI)=0.39(0.23 to 0.55)), that the employee cannot handle the work (β(95%CI)=0.16(0.00 to 0.33)) that one cannot count on the employee (β(95%CI)=0.41(0.23 to 0.58)) and higher manager education level (β(95%CI)=0.25(0.05 to 0.44)). Conversely, associated with positive hiring intentions was being in favour of diversity and/or inclusive enterprise (β(95%CI)=-0.64(-0.87 to -0.41)).

Conclusions

As the majority of managers were reluctant to hire applicants with MHP, and even 30% were reluctant to hire applicants who had past MHP, these findings have major implications for social inclusion in the Netherlands, where about 75% of employees would disclose MHP at work.

INTRODUCTION

Several studies investigating social inclusion and employer behavior have shown that people with mental health problems (MHP) are less often invited for job interviews or offered a job (1, 2). This occurs despite the fact that there are (international) policy goals such as the *Convention on the Rights of Persons with Disabilities (CRPD)* of the United Nations (3) and interventions such as the international program *Mental Health First Aid* (4) to reduce (workplace) stigma and improve inclusion of people with MHP. Because unemployment rates are 3-7 times higher among people with MHP (5) and line managers (i.e. those responsible for managing employees and operations to achieve specific organizational goals, hereafter 'manager') have an important role in their employment opportunities (6), managers' negative attitudes may be barriers to employment for job applicants with MHP.

One of the factors that can hamper integration of people with MHP into the labor market is workplace stigma and discrimination (7). Stigma can be considered as comprising problems of knowledge (such as lack of knowledge and misinformation) and attitudes that can lead to negative discrimination (8), and has various forms. *Interpersonal stigma*, i.e. the interaction between the non-stigmatized and the stigmatized (9), can manifest itself in managers having concerns about employees with MHP, notably about reduced productivity, strange and dangerous behavior, symptom severity, the risk of relapse, and the need for work adjustments (10-12). *Structural stigma* may be present in institutional policies and practices (13). Several studies have found that stigma in the workplace is greater towards people with MHP than the stigma attached to people with physical disabilities (14, 15) and that managers are least willing to hire job applicants with MHP compared to people without disabilities or with physical disabilities (16).

In the Netherlands, legislation is in place to protect employees with disabilities (i.e. the *Gatekeeper Improvement Act* introduced in 2002 and *Extended Payment of Income Act* introduced in 2004). Employers, employees and occupational physicians became jointly responsible for disability benefits and reintegration to work when an employee drops out due to sickness (17). Through this act, Dutch employers have a significant responsibility for funding sick pay, in that they must pay at least 70% of the salary during the first two years of sickness absence, regardless of the cause of sickness (17, 18). Furthermore, employers are not allowed to ask about health problems (e.g. diagnosis) of a job applicant or employee and need to ensure that employees with disabilities have access to reasonable accommodations at work, as stated in the *CRPD* (3). The responsibilities and risks (including financial risks) associated with the legislation may cause higher reluctance of managers towards hiring job applicants with health problems such as MHP.

As stigma in the work context is an understudied and underestimated factor contributing to unemployment (7), the aim of this study was to examine managers' hiring intentions towards employees with past or current MHP, using a cross-sectional design. As previous research has emphasized that stigma is processed in three steps (i.e. inadequate knowledge, subsequent negative attitudes, and discrimination (8)), the research questions are as follows: 1. What is managers' knowledge of MHP?, 2. What are their attitudes, including intentions, concerns and reasons to hire a job applicant with past or current MHP?, and 3. Which factors are associated with the intention (not) to hire a job applicant with past or current MHP?.

METHOD

Data were collected in February 2018 using the Longitudinal Internet Studies for the Social Sciences (LISS) panel (19) that was administered by CentERdata. The LISS panel is a Dutch representative, random sample of 5,000 households , i.e. 8,280 panel members, who participate in monthly internet surveys, covering a large variety of domains including work, education, income, housing, time use, political views, values and personalities. The panel is based on a true probability sample of households in the Netherlands drawn from the population register. Households are provided with a computer and internet connection if needed to participate. LISS panel members have given informed consent to participate in monthly questionnaires. More information about the LISS panel can be found at http://lissdata.nl.

For the present cross-sectional study, an online questionnaire was sent to all members of the LISS panel who held a position of manager in February 2018 (N=976). After one month, a reminder was sent to members who had not filled out the questionnaire. The Ethics Review Board of Tilburg University approved the study design, protocol, and data management plan (registration number: RP193). The STROBE guidelines were followed during reporting of this cross-sectional study (20).

Measures

Because of the explorative design of this study, a new questionnaire was developed fitting the purpose of this study, using several steps. First, scientific literature about stigma, discrimination and mental health in the workplace was explored. Second, the main topics in the questionnaire were identified, i.e. knowledge about MHP, attitudes towards MHP including potential concerns and positive reasons and hiring intentions based on the theoretical stigma model proposed by Thornicroft and colleagues (8). Third, consultation and discussion took place with senior researchers and international experts in the field of stigma and mental health. Finally, the questionnaire was pilot tested within the researchers' network (N=18) and adjustments such as on the clarity of questions were based on feedback. The final version of the questionnaire addressed the following topics:

- Questions on knowledge and attitudes regarding employees and job applicants with past or current MHP, including personal experiences, e.g. '*What are your overall personal experiences with coworkers with MHP in the workplace?*' (1=very negative to 5=very positive). These questions were based on the literature of workplace stakeholders' knowledge and attitudes (e.g. (12, 15)). Because addiction problems are a highly prevalent common mental disorder (21) and one of the most stigmatized MHP (22), participants were asked in two statements: *'I would be reluctant to hire a job applicant, if I were to know that (s)he currently has alcohol addiction problems'* and *'I would be reluctant to hire a job applicant, if I were to know that (s)he has had alcohol addiction problems'* (1=strongly disagree to 5=strongly agree).
- Potential concerns about having an employee with MHP for managers were asked using 17 statements, e.g. '*it will have a negative impact on workplace atmosphere*' (including the statements *'something else, namely …'* and *'I have no concerns about this*'). Managers could indicate per statement with yes/no whether this was a concern for them. The statements were based on literature (11, 23) and feedback received in the pilot version.
- Positive reasons to hire a job applicant while knowing that he/she has MHP, for example '*if I think that the applicant will do a good job*', were asked using seven statements, to be answered with 'yes' or 'no'. Statements were based on findings of a qualitative study on disclosure (24).
- Socio-demographics (i.e. sex, age, number of household members, marital status, domestic situation and education) and work characteristics (i.e. company size, sector and personal net monthly income in euros), were collected by CentERdata.

Statistical analyses

Descriptive analyses were carried out to illustrate the socio-demographics and work characteristics of managers and to explore managers' knowledge and attitudes about employees or job applicants with MHP. For the descriptive analyses of personal experiences with coworkers with MHP the response categories 'very negative/positive' and 'fairly negative/positive' were merged into 'very to fairly negative/positive'. Furthermore, for the descriptive analyses of the intention (not) to hire someone with past or current MHP, the response categories 'strongly disagree/agree' and 'slightly disagree/agree' were merged into 'strongly to slightly disagree/agree'. Separate descriptive analyses were conducted about the intention towards hiring someone who has (had) alcohol addiction problems.

Two multiple regression analyses were conducted to examine which factors were associated with the dependent variables *intention to hire someone with past/current MHP*, on the 5-point Likert scale. Included were background characteristics, workplace characteristics, (personal) experiences with people with MHP, concerns about having an employee with MHP and positive reasons to hire a job applicant with MHP. For the multiple regression analyses, marital status was merged into the categories 'married' and 'unmarried', and education was merged into 'high school or less' and 'more than high school'. Concerning potential concerns and positive reasons, 'Something else' was left out the analyses because this item covers a variety of self-invented concerns/reasons. Because workplace characteristics 'company size' and 'personal net monthly income in euros' had many missing values, (31% and 7% respectively), these missing data were imputed in the model via multiple imputation. In both models, five imputations were conducted and pooled regression coefficients were reported.

Data analyses were performed with IBM SPSS Statistics for Windows, Version 22.0. All p-values were two-tailed with an accepted significance level of 0.05.

RESULTS

The questionnaire was filled out by 670 managers (response rate=68.8%). Responders and non-responders did not differ significantly in gender, education and personal net monthly income in euros. Responders had a significantly higher age (respectively M(SD)=46.10(11.92) and 41.27(11.00); t(637)=-6.20, 95%CI -6.36 to -3.30) and were more often married (respectively N(%)=374(55.8%) and 135(44.1%); t(974)=3.41, 95%CI 0.05 to 0.18) than non-responders. Fifty managers (7.5%) were excluded from the sample because they did not hold a position of manager at that moment. Therefore, N=620 managers were included in the analyses. Most managers were men (67.6%, N=419), married (56.0%, N=347) and working in a small company (55.0%, N=234). Concerning personal MHP, 15.4% of managers (N=94) had current or previous experience of a MHP themselves (see Table 1).

Research question 1: What is managers' knowledge of employees with MHP?

Most managers knew someone with MHP in either their work environment (58.3%, N=356) or outside the work environment (57.9%, N=354). The majority of managers had very to fairly positive personal experiences with coworkers with MHP in the workplace (52.1%, N=323), whereas 7.4% (N=46) of managers had very to fairly negative personal experiences with coworkers with MHP. Managers estimated that 20.9% (Min=0%, Max=100%) of employees in their organization would be affected by MHP during their working life. Finally, managers were asked what MHP they thought of when they heard or read about 'an employee with MHP'. The majority of managers mentioned depression, burnout, stress, and mental/emotional exhaustion (see Table 2).

Table 1. Characteristics of the sample

	%	M (SD)
Sociodemographic characteristics		
Sex (N = 620)		
Male	67.6%	
Female	32.4%	
Age (N = 620)		46.2 (11.9)
Number of household members (N = 620)		2.8 (1.3)
Marital status (N = 620)		
Married	56.0%	
Separated, divorced or widowed	11.9%	
Never married	32.1%	
Domestic situation (N = 620)		
Single, with or without child(ren)	47.6%	
(Un)married co-habitation, with or without child(ren)	50.0%	
Other situation	2.4%	
Education (N = 618*)		
Primary school	2.1%	
Intermediate secondary education	9.5%	
Higher secondary education	7.6%	
Intermediate vocational education	23.3%	
Higher vocational education	35.0%	
University	22.3%	
Workplace characteristics		
Company size (N = 428*)		
Small (up to 50 employees)	55.0%	
Medium (51 to 250 employees)	23.1%	
Large (more than 250 employees)	22.0%	
Company size as M (SD)		371.0 (1,134.9)
Sector (N = 483)		
Agriculture, forestry, fishery and hunting	3.3%	
Mining	0.2%	
Industrial production	14.1%	
Utilities production, distribution and/or trade	1.2%	
Construction	6.2%	
Retail trade	10.6%	
Catering	2.3%	
Transportation, storage and communication	5.0%	
Financial	3.5%	
Business services (including real estate, rental)	7.5%	
Government services, public administration and mandatory social insurances	10.6%	
Education	6.4%	
Health and welfare	13.0%	
Environmental services, culture, recreation and other services	2.5%	
Other	13.7%	
Personal net monthly income in euros (N = 581*)		2,576.6 (1,104.7)
Mental health characteristics		
Do you have MHP or have you had them? (N = 611*)		
Yes	15.4%	
No	84.6%	

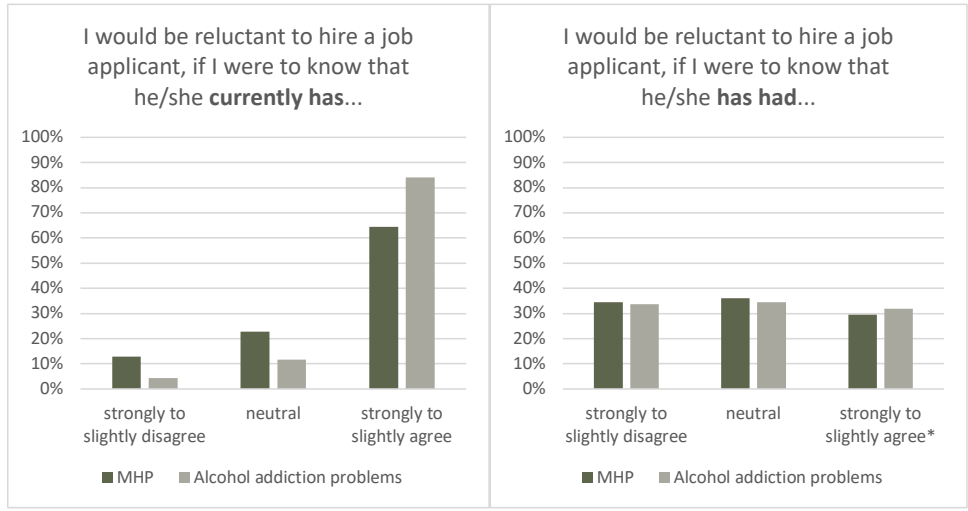
Table 2. Knowledge and attitudes regarding (future) employees with MHP

	% (N) / M (Min, Max)
Knowledge about employees with MHP	
Do you know anyone who has (had) MHP? *(could choose either 'knows someone in work environment' and/or 'outside work environment', or 'does not know anybody'))*	
Knows someone in work environment	58.3% (356)
Knows someone outside work environment	57.9% (354)
Does not know anybody who has (had) MHP	17.2% (105)
What percentage of employees in your organization/company will be affected by MHP during their working life, do you think? (0-100%)	M = 20.9% (Min=0%, Max=100%)
What do you think of when you hear or read about 'an employee with MHP'? *(more than one response is possible)*	
Depression	80.0% (496)
Burnout	76.9% (477)
Stress	71.0% (440)
Mental/emotional exhaustion	70.8% (439)
Anxiety	42.9% (266)
Manic depressive/bipolar disorder	35.5% (220)
Post-traumatic stress disorder	30.0% (186)
Psychosis	28.4% (176)
Addiction	27.1% (168)
Obsessive-compulsive disorder	26.0% (161)
Borderline disorder	24.2% (150)
Schizophrenia	23.9% (148)
Autism spectrum disorder	23.2% (144)
Eating disorder	16.5% (102)
Something else	1.8% (11)
*Experiences with **employees or colleagues with MHP***	
What are your overall personal experiences with coworkers with MHP in the workplace?	
Very to fairly negative	7.4% (46)
Neutral	21.5% (133)
Very to fairly positive	52.1% (323)
Not applicable / no personal experiences with coworkers with MHP	19.0% (118)

Research question 2: 'What are managers' attitudes, including intentions, concerns and reasons to hire a job applicant with past or current MHP?'

Concerning attitudes, 64.4% (N=398) of managers were reluctant to hire a job applicant who currently has MHP. Moreover, 29.5% (N=182) were reluctant to hire a job applicant if they knew the applicant had past MHP. Regarding alcohol addiction problems, respectively 84.0% (N=519) and 31.9% (N=197) of managers were reluctant to hire a job applicant with a current or past alcohol addiction (see Figure 1).

Figure 1. Intention to hire someone with past or current MHP.



** The response categories 'strongly disagree' and 'slightly disagree' were merged into 'strongly to slightly disagree' and the response categories 'strongly agree' and 'slightly agree' were merged into 'strongly to slightly agree'.*

No concerns were reported by 8.8% of managers; the great majority of managers (91.2%) did have one or more concerns regarding hiring employees with MHP. As can be seen from Table 3, the most frequently reported concerns were that the employee could not handle the work (55.4%, N=343), that the MHP will lead to long-term sickness absence (43.1%, N=267), that one cannot count on the employee (41.3%, N=256), employees with MHP will have a negative impact on the workplace atmosphere (39.8%, N=247) and not being sure how to help the employee (39.3%, N=244). The most frequently reported positive reason to hire a job applicant with MHP was thinking that the applicant will do a good job (75.1%, N=466, see Table 3).

Table 3. Percentages of potential concerns and positive reasons for hiring, and multiple regression analyses between demographics, workplace characteristics, experiences with people with MHP, potential concerns regarding employees with MHP and dependent variables intention not to hire someone with current/ past MHP.

	Yes (%)	Intention not to hire someone with current MHP		Intention not to hire someone with past MHP	
		Beta*	95% CI	Beta*	95% CI
Constant					
Age		0.01	[-0.00, 0.01]	0.00	[-0.00, 0.01]
Gender (0 = male)		-0.09	[-0.26, 0.08]	-0.20	**[-0.39, -0.01]**
Education (0 = high school degree or less)		0.25	**[0.05, 0.44]**	0.13	[-0.09, 0.35]
Marital status (0 = married)		-0.07	[-0.23, 0.09]	-0.08	[-0.25, 0.10]
Company size		0.00	[0.00, 0.00]	0.00	[0.00, 0.00]
Personal net monthly income		0.00	[0.00, 0.00]	0.00	[0.00, 0.00]
Personally (have) had MHP (0 = no)		-0.13	[-0.34, 0.08]	-0.41	**[-0.65, -0.18]**
Knows someone outside work environment (0 = no)		0.09	[-0.10, 0.28]	-0.14	[-0.34, 0.07]
Knows someone in work environment (0 = no)		0.15	[-0.04, 0.34]	0.03	[-0.18, 0.24]
Does not know anybody who has (had) MHP (0 = no)		0.24	[-0.06; 0.53]	0.10	[-0.22, 0.43]
What are your potential **concerns**, as a manager, about having an employee with MHP?**					
The employee cannot handle the work	**55.4%**	0.16	**[0.00, 0.33]**	-0.11	[-0.29, 0.07]
It will lead to long-term sickness absence	**43.1%**	0.39	**[0.23, 0.55]**	0.19	**[0.01, 0.37]**
You cannot count on this employee	**41.3%**	0.41	**[0.23, 0.58]**	0.21	**[0.02, 0.41]**
It will have a negative impact on the workplace atmosphere	**39.8%**	0.07	[-0.11, 0.24]	0.05	[-0.14, 0.24]
I'm not sure how to help this employee	**39.3%**	-0.01	[-0.17, 0.15]	-0.08	[-0.26, 0.10]
The employee will make mistakes	**33.8%**	0.07	[-0.10, 0.25]	0.18	[-0.02, 0.37]
The employee poses a danger to him or herself or to others in the workplace	**31.5%**	-0.05	[-0.22, 0.12]	-0.06	[-0.25, 0.13]
It will lead to conflicts	**30.4%**	-0.16	[-0.34, 0.02]	-0.08	[-0.28, 0.12]
The employee will cause damage to relationships that are important to me/the organization (such as company customers, or students at a school)	**27.0%**	0.13	[-0.06, 0.32]	0.08	[-0.13, 0.29]
I need to take over his/her duties	**26.3%**	0.02	[-0.16, 0.21]	0.09	[-0.11, 0.29]
I'm not sure how to deal with this employee	**19.2%**	-0.06	[-0.26, 0.15]	0.07	[-0.16, 0.30]
The employee has a lower work tempo	**15.3%**	-0.13	[-0.36, 0.10]	-0.03	[-0.28, 0.22]

Table 3. Continued

	Yes (%)	Intention not to hire someone with current MHP		Intention not to hire someone with past MHP	
		Beta*	95% CI	Beta*	95% CI
He/she can damage my or the organization's reputation	**11.7%**	-0.03	[-0.29, 0.24]	-0.05	[-0.34, 0.25]
Talking about the problems will take up a lot of the other employees' time	**11.7%**	0.19	[-0.57, 0.44]	0.06	[-0.22, 0.34]
I don't feel like talking about the employee's personal problems	**4.1%**	-0.06	[-0.46, 0.34]	0.03	[-0.41, 0.47]
Something else	**1.3%**				
What could be **positive reasons** for you to hire a job applicant while knowing that he/she has significant MHP?**					
If I think that the applicant will do a good job	**75.1%**	-0.09	[-0.27, 0.09]	-0.36	**[-0.56, -0.16]**
If the applicant has relevant work experience	**41.3%**	-0.15	[-0.31, 0.00]	-0.16	[-0.33, 0.01]
If there is no financial risk involved, for instance through a wage subsidy	**28.9%**	0.07	[-0.10, 0.24]	0.02	[-0.17, 0.21]
If someone I like recommends this applicant to me	**14.8%**	-0.03	[-0.24, 0.19]	-0.07	[-0.31, 0.17]
Because I am in favour of diversity and/or inclusive enterprise, out of principle	**13.0%**	-0.64	**[-0.87, -0.41]**	-0.29	**[-0.54, -0.04]**
If I like the applicant as a person	**11.9%**	0.03	[-0.21, 0.27]	0.14	[-0.13, 0.40]
Something else	**1.3%**				
Adjusted R^2			0.187		0.103

**A higher Beta (β) on the dependent variable means a lower intention to hire someone with current/past MHP. **For each statement: 0=no, 1=yes.*

Research question 3: Which factors are associated with the intention (not) to hire job applicants with past or current MHP?

Two multiple regression analyses were conducted with socio-demographic and workplace characteristics, (personal) experiences with people with MHP, concerns and positive reasons as independent variables and the dependent variables *intention to hire someone with current MHP* and *intention to hire someone with past MHP.*

Concerning hiring intentions towards an applicant with *current MHP*, significantly related to higher reluctance to hire an applicant with MHP were concerns that it would lead to long-term sickness absence (β(95%CI)=0.39(0.23 to 0.55)), that the employee would not be able to handle the work (β(95%CI)=0.16(0.00 to 0.33)), that one would not be able to count on the employee (β(95%CI)=0.41(0.23 to 0.58)) and higher manager education level (β(95%CI)=0.25(0.05 to 0.44)). In contrast, being in favour of diversity and/or inclusive enterprise (β(95%CI)=-0.64(-0.87 to -0.41)) was associated with a significantly higher intention to hire someone with MHP. The overall fit of the model was adjusted R^2=0.187 (see Table 3).

Regarding the hiring intentions towards an applicant with *past MHP*, significantly associated with higher reluctance to hire someone with past MHP were male gender (β(95%CI)=-0.20(-0.39 to -0.01)) concerns that it would lead to long-term sickness absence (β(95%CI)=0.19(0.01 to 0.37)), that one would not be able to count on the employee (β(95%CI)=0.21(0.02 to 0.41)), and having had no MHPs themselves (β(95%CI)=-0.41(-0.65 to -0.18)). Believing that the applicant will do a good job (β(95%CI)=-0.36(-0.56 to -0.16)) and being in favour of diversity and/or inclusive enterprise (β(955%CI)=-0.29(-0.54 to -0.04)) was associated with a significant higher intention to hire someone with past MHP. The overall fit of the model was adjusted R^2=0.103 (see Table 3).

DISCUSSION

This study examined managers' knowledge, concerns and positive reasons to hire a job applicant with past or current MHP, and examined factors associated with the intention (not) to hire a job applicant with past or current MHP. Whereas only 7 percent of managers had negative personal experiences with employees with MHP, the majority of managers were reluctant to hire someone with current MHP or alcohol addiction problems (respectively 64% and 82%). Moreover, about one third of managers were reluctant to hire someone with past MHP or alcohol addiction problems (respectively 30% and 32%). The great majority (91%) of managers had one or more concerns regarding hiring employees with MHP. Strongest predictors for being reluctant to hire an applicant with current MHP were concerns about long-term sickness absence,

concerns that the employee would not be able to handle the work, the concern of not being able to count on the employee and higher manager education level. In contrast, significant predictors for *positive* hiring intentions was managers' being in favor of social inclusion out of principle.

Despite the fact that managers had an accurate understanding of prevalence of MHP in the work environment and that most managers had positive personal experiences with people with MHP in private or at work, the majority was reluctant to hire an applicant with MHP. Previous studies have also found many managers to have concerns about e.g. absenteeism and the reliability of employees with MHP (10-12). However, managers' views may be too pessimistic due to a well-known phenomenon in social psychology called the negativity bias (25). This phenomenon refers to the fact that negative instances tend to be more influential than comparably positive ones. For instance, it could well be that employees with MHP who display 'negative behavior' in the workplace (e.g. conflict, crying, absenteeism) are perceived more often than those who display 'positive behavior', i.e. continue doing their work despite their health problems. Moreover, as a substantial part of employees with MHP does not disclose, managers may not even be aware of their health problems and be blind to those 'positive examples'. The point prevalence of MHP in the working age population about 20% (5), which implies that many employees with MHP must do their work well despite their health problems, and remain unnoticed. Furthermore, concerns may be a result of limited or biased knowledge of mental illness (26) because managers are -like everyone else- exposed to the typically negative societal stereotypes created by e.g. entertainment and news media, often emphasizing unreliability and dangerousness (27, 28). Providing more accurate knowledge and a representative presentation of people with MHP, for example through *intergroup contact* with an *unbiased* group of employees with MHP can have destigmatizing effects (29). However, currently non-disclosing employees will need to feel safe enough to share their MHP with their supervisor to do so (30).

According to Dutch legislation employers cannot fire a sick listed employee for 2 years, during which they need to pay for at least 70% of the sick employee's salary (17). This may explain managers' fears for long-term absenteeism when hiring an employee with MHP found in the present study. In the Netherlands, absenteeism costs are annually more than 11 billion euros for employers in continued payment of wages, and 22% of absenteeism is associated with MHP, with an average absence duration of 56 days in a year (31). Therefore managers' worries about long-term sick leave is understandable. However, we found that being protected against financial risk, for instance by wage subsidy, was not a significant predictor of positive hiring intentions, which suggests the influence of costs on managers' reluctance should not be overestimated. Moreover, MHP are highly prevalent in our society (the lifetime prevalence of mental disorders in

the global population is 29% (32)) and we should not exclude these employees from the labor market. Improving a realistic view, i.e. that MHPs do not always lead to adverse occupational outcomes, promoting positive attitudes about e.g. social inclusion in the work environment and improving manager skills in how to guide employees with MHP may have a positive influence on the hiring intentions of managers.

The finding that the majority of managers was reluctant to hire applicants with MHP, seems to contrast with the high percentage (75%) of Dutch employees that indicated they would disclose MHP to their managers in a recent study (30). Although the latter finding comes from a study on employees who already were employed this area needs further study. A possible explanation is that Dutch employers cannot fire sick listed employees for two years (17) which may create a false sense of security and a higher willingness in employees with MHP to disclose. This urges the importance of making disclosure decisions deliberately and to prepare them well to enhance the possibility of a positive outcome. More studies are needed on how to support job applicants with MHP in when and what to communicate. Strategic disclosure and preparing who to disclose to, how to disclose and the content of the message (24) may have a positive influence on the hiring outcomes (33, 34).

The fact that as many as 30% of managers were reluctant to hire someone with past MHP, suggests that even after recovery of MHP, stigma remains and may form an important barrier to the employment opportunities of people with MHP. This calls for the development of destigmatizing interventions and manager training (24, 35), but research on workplace stigma and especially on destigmatizing interventions is still in its infancy. Work related anti-stigma interventions could improve managers' knowledge, skills and supportive behavior (36) which can be important positive facilitators for sustainable return to work for people with MHP (37). Also, studies have shown that the work context itself plays a critical role in (sustainable) employment of people with MHP (37, 38). Finally, a new view on sustainable employability, based on the *capability approach* (39, 40), may be of added value in designing future anti-stigma interventions for managers. This promising non-medical approach, which is becoming increasingly popular in Dutch occupational health practice, stresses diversity, and therefore is destigmatizing by nature. Here, emphasis is placed on what employee's value in work, and how they are *able* and *enabled* to realize these values, and on employees' wellbeing (39, 40). Workplace stigma is an important disabler of employees' values.

Strengths and limitations

The strengths of this study are the use of a large sample of managers from the representative LISS-panel. The LISS-panel recruits participants on a true probability sample drawn from population registers. Because the questionnaire is filled out by

managers working in practice, and not as a vignette study, the study provides a reliable insight into the attitudes of managers. Managers participate monthly in this panel, online and anonymously, which may reduce the influence of social desirability. Limitations of this study are the cross-sectional design of the study, for which no causality can be presumed. Because this study is one of the first studies to examine managers' attitudes towards people with MHP in the Netherlands, the topics in the questionnaire are broad and explorative. Finally, managers were asked about their intention to hire someone with MHP instead of their actual hiring behavior. Future studies may want to take a longitudinal approach, investigating actual hiring behavior of managers over time and other topics related to workplace stigma, such as structural stigma.

Conclusion

In conclusion, as almost one third of managers were reluctant to hire job applicants with past MHP, and 64% were reluctant to hire applicants with current MHP, these findings have major implications for social inclusion in the Netherlands, where about 75% of employees would disclose MHP at work. Further research on mental health disclosure and workplace stigma is urgently needed to improve social inclusion of people with MHP. Moreover, relevant work experience should be gained, including unpaid work experience such as internships/traineeships and work experience programs to increase job seekers' knowledge and skills. Importantly, this work experience must be communicated and highlighted during job interviews by job applicants.

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CHAPTER 3

Evaluation of an intervention to support decisions on disclosure in the employment setting (DECIDES): study protocol of a longitudinal cluster-randomized controlled trial

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ABSTRACT

Background

Unemployment rates are higher among people with mental health issues/illness (MHI) than in the general working population, and many of them face the dilemma of whether or not to disclose their MHI when searching for employment. Disclosure can lead to rejection and discrimination, but alternatively can also have important advantages that may be necessary to retain employment. Whether disclosure decisions lead to sustainable employment depends on many factors, of which unemployed people themselves can only influence their decision to disclose or not and the way in which they communicate. This study evaluates the cost-effectiveness of an intervention to support unemployed people with MHI in their disclosure decision and communication.

Methods

This is a two-armed clustered randomized controlled trial with longitudinal design and randomization at organization level. An intervention will be examined, which exists of a disclosure decision aid tool (CORAL.NL) for unemployed people and a workplace stigma awareness training especially designed for employment specialists which focusses on how to support unemployed people in their disclosure decisions. Participants in the intervention group are unemployed people who receive support from trained employment specialists working at organizations in the intervention group and receive the CORAL.NL decision aid after baseline. The control group consists of unemployed people who receive support as usual from employment specialists working at organizations in the control group. Primary outcomes are: cost-effectiveness of the intervention, e.g. health care costs, having employment, days until start employment, independency of social security, having other forms of employment; and decision making about disclosing MHI. Secondary outcomes are mental health and wellbeing, stigma and discrimination and work related factors. Financial income data are collected via the registration systems of Dutch municipalities and Statistics Netherlands, and by questionnaires at baseline, and at 3, 6 and 12 months.

Discussion

If using a decision aid about disclosure of MHI leads to more often finding and retaining employment, this study will contribute to lowering healthcare and societal costs.

Trial registration

NL7798 (Registered 04 June 2019 - retrospectively registered;
https://www.trialregister.nl/trial/7798)

INTRODUCTION

People with mental health issues/illness (MHI) are more often unemployed than people without MHI (1-4). In addition, people with MHI who are employed have higher risk of losing their employment (3, 5) and increased risk of dropping out of work, due to unemployment, work disability, long-term absenteeism or early retirement (6). Studies have shown that unemployment exacerbates MHI (7) and that when people with MHI start working again, this positively affects their mental health (8).

One of the barriers for people with MHI to find and retain employment, are negative attitudes towards MHI. Multiple studies have shown that the stigma attached to MHI is a risk for not entering the job market or not returning to existing employment (9, 10). There are several reasons why stigma is a problem for employment: e.g., many employers have negative attitudes towards people with MHI (11-13), which often has negative effects for people with MHI in job applications, contract extensions, job promotions and other career opportunities. Moreover, anticipated discrimination (e.g. avoiding situations or activities because of the fear of being discriminated) and self-stigma (e.g. having negative ideas about oneself because of the MHI) can lead to feeling one is not performing well and therefore had better not try anything (14). This so-called 'why try-effect' discourages people from engaging in relevant activities, such as applying for jobs (15). International studies have shown that large numbers of people (39-64%) with depression, addiction problems or schizophrenia refrain from applying for jobs or receiving training or education because of possible reactions of others (9, 15, 16). Furthermore, employees with MHI often do not feel comfortable to talk about their MHI. As a result, employers and employees miss out the opportunity of talking about the need for support and (temporary) work adjustments. This is unfavorable, because work accommodations, such as adjustments of working hours, can prevent and reduce absenteeism (17).

As a result of stigma, whether or not to disclose MHI in the workplace is a major dilemma for many people with MHI of working age. Disclosure can lead to better work outcomes (i.e. due to appropriate work adjustments), but also to not being hired (18). The decision whether or not to disclose is often perceived as stressful (19, 20) in which advantages and disadvantages are weighed against each other. In 2010, the CORAL (Conceal Or ReveAL) decision aid was developed by researchers at the Institute of Psychiatry at King's College London (21). The purpose of this decision aid is to support decision making about disclosure in the work context (22). The principle of this decision aid is that people know their own situation best and therefore can make the best choices themselves, but still benefit from help with making a choice. In several follow-up studies (23, 24), using the decision aid was found to be promising: people who used CORAL

had less decision-making stress and were significantly more often working fulltime after three months than people who did not use the decision aid (24). Recently, a RCT was conducted a web-based decision aid tool (READY) to help facilitate disclosure decisions about mental health conditions for people in current employment (25). Participants who used READY had significantly less decisional conflict regarding disclosure of a mental health condition and were at a later stage of decision making. These results are very promising for disclosure decision in the employment setting and would potentially be relevant to implement and evaluate a similar decision aid tool for unemployed people with MHI in a different context in the Netherlands.

Objective and research questions

A randomized controlled trial (RCT) is conducted to examine the effects of an innovative intervention based on the English CORAL decision aid (23), which has been adapted to the Dutch context and embedded in an intervention for unemployed people with MHI and a workplace stigma awareness training especially designed for employment specialists. Furthermore, factors that facilitate finding employment and factors that hamper this will be studied. The primary research questions of this study are:

1. Does the intervention lead more often to finding and retaining paid employment for unemployed people with mental health problems, compared to usual guidance in municipal practice, controlled for other factors (e.g. mental health and stigma and discrimination)?
2. Is the intervention cost-effective from a societal perspective (including reintegration costs and healthcare costs)?
3. For whom, under which circumstances and in what way does the intervention work best, or less well, and why?

METHODS

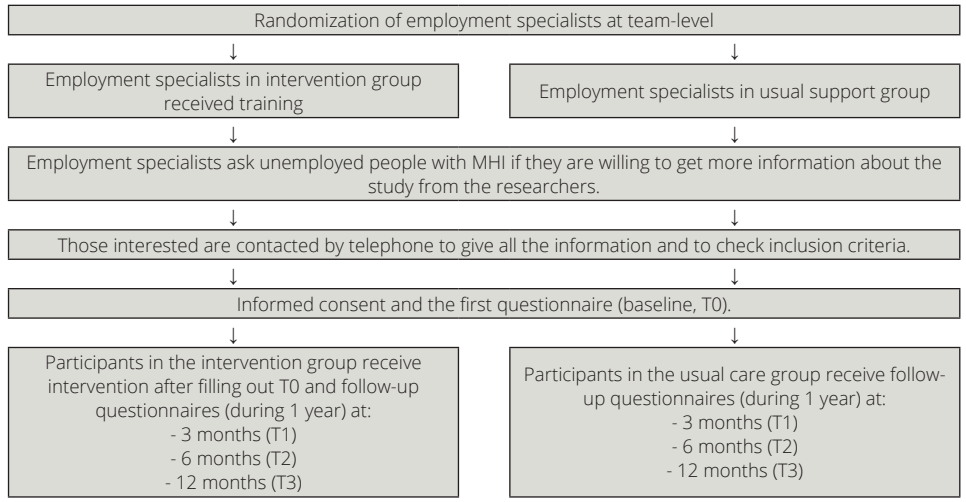
The CONSORT 2010 statement and SPIRIT 2013 statement were followed in describing the design of the study (26, 27). The study is funded by The Netherlands Organization for Health Research and Development (project code: 535001003). The Ethic Review Board of Tilburg University approved the study design, protocol, information letter, informed consent form and the questionnaires (EC-2018.06t). The study is registered under trial registration number NL7798.

Study design

The DECIDES study is a longitudinal two-armed clustered randomized controlled trial (RCT) of unemployed people with MHI who receive social benefits and/or reintegration

support from Dutch municipalities. In this RCT the effects of an intervention that consists of a decision aid for unemployed people (CORAL.NL) and a training for employment specialists who guide them in their job seeking process are evaluated. Randomization took place at organization level (see Figure 1). Participants are assessed at baseline (T0), and at three months (T1), six months (T2) and twelve months (T3). In addition, data on employment history (e.g. having employment, income, working hours per week and employment characteristics such as contract and employment type) and social benefits (e.g. having social benefits, duration social benefits and the amount of social benefits) is extracted anonymously from the registration systems of the municipalities and Statistics Netherlands from T0 till T3 of participants who give consent for this. Collecting data from registration systems is more reliable and is less burdensome for participants. Participation in the study is voluntary and all participants sign an informed consent for participation, and a separate consent for the retrieval of their personal data from Statistics Netherlands. Measurements take place in one-by-one appointments with a researcher of the project. Participants can fill out the questionnaire digitally or by paper-and-pencil. If necessary, the researcher gives support by filling out the questionnaire, e.g. by explaining or reading out loud the questions for illiterate participants. Participants were stimulated to complete follow up by handing out a financial remuneration of 10 euros and by asking several contact options (mobile phone, email) to maintain contact during the participation period. If participants give consent to collect their data from Statistics Netherlands these data will be collected, also if they discontinue to fill out the questionnaires.

Figure 1. Flow diagram of the study protocol



Setting

In the Netherlands, people above 18 years are entitled to social benefits if they have insufficient income or capital and are unable to make use of another provision or benefits, such as disability benefits. In order to receive social benefits, (re)integration obligations must be met, such as cooperating in the support that the municipality offers aimed at entering the job market or returning to existing employment. This support is offered per municipality, and is often organized differently per municipality. Regarding disabilities and employment, the Netherlands has confirmed the U.N. Convention on the Rights of Persons with Disabilities (28) and has its own Disability Discrimination Act. The convention and act includes that organizations and employers need to ensure that employees with disabilities have access to reasonable accommodations at work (29). This anti-discrimination legislation may influence the employment status of people with disabilities in various ways. Employees do not have legal obligations to inform the employer about a disability as long as the impairment does not result in any endangerments at the workplace. However, disclosure of a health problem may be necessary to get access to accommodations whereby this only can be implemented if the employer has knowledge of the disability; especially when natural supports in the workplace are not available. Organizations commonly perceive such legislation and policies as a burden, e.g. because Dutch employers must pay at least 70% of the salary of a sick employee during the first two years of sickness absence (30). This in fact might lead employers to try to avoid hiring a person with a disability (29).

Intervention

The CORAL decision aid was originally developed in the United Kingdom (21, 23, 24) and first tested in 2013. In that RCT, using CORAL among unemployed people with MHI lead to more often full-time employment and less decisional conflict than the control group (24). The current study examines the effects of the CORAL decision aid in the Netherlands. For this study, CORAL has been developed to a newer version for the Dutch context: CORAL.NL and has been extended with two infographics and a newly developed training targeted at employment specialists.

CORAL.NL

In 2017, prior to this study, the CORAL decision aid was translated and developed further to fit into the Dutch practice. To attain this, focus groups were held with: 1) people with MHI, 2) employers, 3) human resource managers, 4) mental health advocates and 5) employment specialists (18). In pilot-tests, the new CORAL.NL decision aid was tested and implemented. Contrary to the original UK CORAL decision aid, which is designed for independently use, the Dutch CORAL.NL decision aid is a comprehensive module in which people with MHI and their employment specialists are able to discuss disclosure of MHI in the work context, so that informed decisions can be made and implement.

CORAL.NL consists of four parts with several paragraphs: Part one deals with choices about disclosure and contains the pros and cons about disclosure and the personal disclosure needs and values. Part two is about one's personal situation and deals with questions about when and whom to disclose to. Part three and four summarizes previous sections to make a plan about whether to disclose or not, and if so, to whom, when and what to disclose. In addition to CORAL.NL, for this study two one page infographics have been developed that summarize the most important information from CORAL.NL: one version about disclosure during the job application process and one version about disclosure in the work context for people who already have employment. These infographics provide an easy to read one page summary of the CORAL.NL booklet and was designed as during a pilot test some respondents found it difficult to use the CORAL.NL booklet itself because they had trouble reading or concentrating.

Intervention/training-based care

Employment specialists who are allocated to the intervention group receive a workplace stigma awareness training about disclosure of MHI in the work context from the start of this study. This training is specifically designed for the purpose of this study and consists of three meetings within six months. Each meeting has a duration of two hours and is provided in groups of 4-12 employments specialists under guidance of two to three trainers. The aim of the training is to enhance awareness of stigma, discrimination and the disclosure dilemma and to introduce the CORAL.NL tools (including the booklet and infographics). Factors that contribute to reducing stigma and discrimination using training interventions are education and social contact between people with and without MHI (31). Therefore, during the training sessions informative presentations are given, people with lived experiences are present, a film is shown in which people with lived experienced share their experiences and feelings about stigma and discrimination in the work context, discussions take place and using role-plays, employment specialists have the opportunity to practice what they learn. After the first meeting, employment specialists have the skills to use the CORAL.NL tools. Several aims are worked on: 1) Creating awareness of stigma and discrimination in the work environment by providing insight into what stigma is, how it works and how it can be experienced and what the effects of stigma are; and increasing insight into stigma and discrimination by employers and managers, the effects of employment specialists' own attitudes, personal prejudices and actions and to increase insight into the negative effects of disclosure in job applications; 2) increasing understanding of how the disclosure dilemma can be experienced by people with MHI, how it affects people and how the conversation can be started about disclosure, without influencing the outcome; and 3) learning to work with the CORAL.NL tools, including how they can be used in daily practice and experiences of working with the tools. Employment specialists are stimulated and reminded to use CORAL.NL after participants participated at T0 (baseline).

Support as usual

Participants in the control group receive support as usual from their employment specialists. Neither participants nor employment specialists are introduced to CORAL. NL. In the Netherlands, people who receive social benefits from their municipality, have the responsibility to (re-)integrate into employment. Municipalities offer various facilities such as guidance from employment specialists, education and training.

Procedure

Randomization of employment specialists

All 72 participating employment specialists were recruited between November 2017 and March 2018 from eight participating organizations. Two researchers presented the study during meetings at the local organizations, provided written information about the study, and provided a registration form and informed consent. After including all employment specialists, the organizations were randomly allocated to either the intervention or control condition, using SPSS software. Cluster randomization is chosen as individual randomization would have higher risk of contamination between the intervention and control group, because employment specialists within organizations work together on a daily basis. Due to the nature of the intervention, both the employment specialists and researchers cannot be masked to the allocation to the conditions.

Recruitment of participants

Participants are recruited via the employment specialists working at eight different organizations, and via newspapers and personal letters from the organizations. Inclusion criteria for the study are: 1) being unemployed, 2) having sought any treatment (currently or in the past) for MHI, including addiction, by a health professional (e.g. GP, psychologist), and 3) adequate command of the Dutch language because the intervention and questionnaires are in Dutch. Employment specialists are asked to inform people who meet the inclusion criteria about the research and ask if they are willing to get more information about the research. If participants give permission to share their contact details with the researchers, they are informed about the research by telephone and the inclusion criteria will be checked.

Outcomes

Table 1 presents an overview of the collected data and the study time path.

Primary outcomes

The primary outcomes of this study are: 1) Cost-effectiveness which will be measured from a societal perspective comparing the intervention with usual care. Healthcare utilization and production loss will be measured with the TiC-P, which is a reliable instrument with satisfactory validation (32). The primary cost-effectiveness outcomes are having employment

(yes/no), days from baseline until start employment, receiving social benefits (yes/no) and/or having other forms of employment (i.e. voluntary work, internship). Secondary cost-effectiveness outcome is EuroQol-5D-5L, which measures health-related quality of life (33); and 2) Decision making about disclosing MHI, measured with the Decisional Conflict Scale, which has adequate test-retest reliability (34), and Stage of Decision Making (35).

Secondary outcomes

- Mental health is measured with the Dutch version of the Patient Health Questionnaire (36-38), which is used to measure the most common psychological diagnoses (mood disorders, anxiety disorders, alcohol abuse, somatoform disorders and eating disorders), and has good diagnostic validity (36).
- Wellbeing is measured with the Warwick-Edinburgh Mental Wellbeing Scale (39), which measures positive mental wellbeing and has good content validity and test-retest reliability.
- Stigma is measured with the brief Internalized Stigma of Mental Illness Scale-10 (40), which measures self-stigma among people with MHI and has good internal consistency.
- Discrimination is measured using two items of the Discrimination and Stigma Scale (15), which focuses on discrimination when finding and keeping employment.
- Work related factors such as job seeking activities is measured with 4 items, e.g. 'Have you applied to a job vacancy in the last four weeks?'; personal fears about getting to work is measured with 5 items using a 5-point Likert scale, e.g. 'Because of my mental health issues/illness, I have less opportunities finding employment'; work-related self-efficacy is measured with the Return to Work Self-Efficacy scale (41), which has good internal consistency and adequate test-retest reliability; and finally the quality of guidance from employment specialists is measured with three items of the Patient Satisfaction With Occupational Health Professionals scale (42).

Prognostic measures

- Personal characteristics such as age, gender, nationality, marital status, level of education and history of mental and physical ill-health.

Additional measures

A variety of factors which can be influenced by the intervention or can affect the chances to find employment are also measured.

- Core capabilities is measured with the Core Capability Set (43), which measures which capabilities are important for individuals (what they value) concerning employment and is a valid measurement. For participants without employment, an adapted version of the Core Capability Set is used.
- Employment specialists receive two short questionnaires, i.e. at the beginning of the

research and after including all participants, which contains questions about their demographics (age, education, years of work experience), experiences with people with MHI and attitudes towards people with MHI, measured with the Opening Minds Scale for Health Care Providers (44), which has good internal consistency and satisfactory test-retest reliability.

- Process evaluation: experiences with the intervention are measured for participants in the intervention group. Questions focus on whether the decision aid is used in the past months and participants' opinion on the decision aid. Participants in the control group are asked at measurement T3 if they are familiar with the decision aid and if so, how they know the decision aid and what their experiences are with the decision aid. Additionally individual one hour interviews are held with employment specialists and participants of the intervention group after the quantitative data collection. The interviews focus on for whom, under which circumstances and in what way the CORAL.NL decision aid work best, or less well and why.

Sample size

The power calculation is based on data from a recent international study on Individual Placement and Support, which is an evidence-based reintegration model that is also used for people with MHI who want to have regular employment (45) and has the same primary outcome measure, i.e. obtaining employment. In this study, the average percentage of employment was 50% for the intervention group and 20% for the control group (45). Keeping 50% and 20% as possible percentages, 36 unemployed people are needed in each group to find a statistically significant difference (with a 5% significance level and a power of 80%). In case of using a power of 90%, 47 participants per group would be needed. However, in this study any cluster effects and the expected dropout of participants over the four measurements must be considered. Considering a dropout of approximately 40% because of the vulnerable population, a safe assumption is to have 75 participants per group, which means a total of 150 participants.

Statistical analysis

Data will be processed with the statistical software SPSS. Analyses of this trial will be done on the basis of the statistical principle 'intention to treat', i.e. participants will be analyzed in the arms to which they are assigned. Descriptive analyses will be used to detect significant differences in the baseline characteristics between the intervention group and control group. Longitudinal multilevel analysis will be used to analyze the outcomes. Subgroup analyses will be performed on baseline characteristics and decisional stress at baseline to test if groups based on baseline characteristics differ from each other. No additional adjusted analyses will be performed. Baseline characteristics of participants with and without missing values will be examined to test for bias due to missing data. Classical methods of multiple imputations will be used for missing data.

Table 1. Data collection of data and time path

Topic	Instrument	Baseline	Follow up		
		T0	T1	T2	T3
			3 months	6 months	12 months
Primary outcomes					
Cost-effectiveness of the intervention	TiC-P EQ-5D-5L	X	X	X	X
Having employment (yes/no)	Data from Statistics Netherlands* Municipal administration Questions about work, income and benefits.	X	X	X	X
Days from baseline until start employment		X	X	X	X
Receives social benefits (yes/no)		X	X	X	X
Having other forms of employment (i.e. voluntary work)		X	X	X	X
Decision making about disclosing MHI	DCS Stage of Decision Making	X	X	X	X
Secondary outcomes					
Mental health	PHQ	X	X	X	X
Wellbeing	WEMWS	X	X	X	X
Stigma	ISMI-10	X	X	X	X
Discrimination	DISC (shortened version)	X	X	X	X
Work related factors	Job seeking activities Personal fears about getting to work RTW-SE PSWOHP (shortened version)	X	X	X	X
Prognostic measures					
Age, gender, nationality, marital status, level of education		X			

Table 1. Continued

Topic	Instrument	Baseline	Follow up		
		T0	T1	T2	T3
			3 months	6 months	12 months
History of mental ill-health		X	X	X	X
Characteristics of work and/or social benefits		X	X	X	X
Additional measures					
Work values/Core capabilities	Core Capability Set	X	X	X	X
Characteristics of employment specialists	Age, education, years of work experience of employment specialists OMS-HCP	X			X
Personal experiences and satisfaction with CORAL.NL**	Questions about the use of the decision aid Interviews with employment specialists and participants in intervention group	X	X	X	X

* If participants agree with access into personal data from Statistics Netherlands, data is collected from baseline till T3, also if they discontinue to fill out the questionnaire.
** Only for participants in the intervention group

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DISCUSSION

In the past, the biomedical model was predominant in research in the field of medicine and healthcare, and psychosocial factors were underexposed (46). Nowadays, there is more evidence that psychosocial factors such as stigma and discrimination are of major influence concerning employment for people with MHI (9, 18, 46, 47). This study provides insight into the effects of unemployment and finding employment on the health and wellbeing of people with MHI and is one of the first studies to investigate cost effectiveness of an innovative decision aid tool about disclosure of MHI in the workplace. Previous research has shown promising effects on finding and obtaining work using a decision aid about disclosure of MHI (24, 48). Besides that, evidence suggests that adequate preparation of MHI disclosure decisions is of crucial importance in finding and keeping employment (18). The societal relevance of this study consists of substantial healthcare and societal savings if using the CORAL.NL decision aid leads to more often finding and retaining employment for unemployed people with MHI.

Strengths and limitations

A strength of this study is the collaboration with eight field organizations, mostly municipalities, in the Netherlands. Because each municipality organizes their employment services differently, this study is a representation of the actual Dutch practice, yielding a heterogeneous population which allows generalization of the results to a larger population. Also, data from the questionnaires is combined with data from the register data from the Dutch municipalities and Statistics Netherlands, which gives the opportunity to collect very objective, reliable and detailed data. Limitations of the study are that participants are recruited via employment specialists, which may cause selection bias from the individual employment specialists and participants are entirely voluntary to participate in the study, which gives the risk of early dropout.

Impact of study results

This study will show whether using the intervention leads to more often finding and retaining employment for unemployed people with MHI, and to less decisional stress about disclosing MHI. If the intervention is cost effective, this study will also contribute to lower healthcare and societal costs and fewer people with MHI who remain unemployed. Findings will be disseminated through peer-reviewed international and national publications and international and national conference presentations. Publications will be actively disseminated to all relevant groups via social media and through the sponsor. At the end of the research project, a national symposium will be organized. Results of this study will become available in 2021.

Trial status

The study is registered under trial registration number NL7798 (Registered 04 June 2019 - retrospectively registered; https://www.trialregister.nl/trial/7798). Participant recruitment started April 2018 and ended July 2019. Data collection will end July 2020. The data gathering is in progress. According to the municipalities, the target group was difficult to engage in research and schedule appointments with, this delayed the submission of the study protocol paper. Priority was given to the hundreds of face-to-face meetings that need to be scheduled for data gathering. However, the researchers have no access to the primary outcome measures of the study until 3 months after the final measurement, as the primary outcome data will be retrieved from a different organization (i.e. Statistics Netherlands, an organization that secures its data very strictly) three months after the ending of the data gathering process.

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CHAPTER 4

Effectiveness of a stigma awareness intervention on reemployment of people with mental illness: a cluster randomised controlled trial

Submitted as
Janssens KM, Joosen MC, Henderson C, Bakker M, van Weeghel J, Brouwers EP. Effectiveness of a stigma awareness intervention on reemployment of people with mental illness: a cluster randomised controlled trial.

ABSTRACT

Objectives

People with mental illness are 3-7 times more likely to be unemployed than people without mental illness, which has negative impact on recovery and wellbeing. A major barrier for reemployment is workplace stigma and discrimination. In this randomised controlled trial the effectiveness of a stigma awareness intervention addressing finding work, retaining work and decisional stress were evaluated.

Methods

A cluster randomised controlled trial was conducted in Dutch municipal practice at 8 sites, with 3, 6 and 12 months follow-up. Randomisation took place at practice level. Participants were unemployed people with mental illness, receiving social benefits. The intervention consisted of a decision aid and two infographics with written information on advantages and disadvantages of workplace disclosure for participants and a 3x2hrs stigma awareness training for employment specialists. Primary outcomes were finding work, retaining work and decisional stress, i.e. decisional conflict and stage of decision making. Data were analysed by intention to treat.

Results

N=153 participants were recruited (experimental group: N=76, control group: N=77). After twelve months, significantly more experimental group participants (N=35, 53.8%) found paid work compared to the control group (N=22, 34.4%; OR=2.227, 95%CI=1.095-4.530). Also, significantly more experimental group participants (N=32, 49.2%) retained paid work compared to controls (N=15, 23.4%; OR=3.168, 95%CI=1.488-6.744). The experimental and control groups did not differ in decisional conflict (Mean difference (95%CI)=-1.173(-7.319-4.972)) or stage of decision making (Mean difference (95%CI)=-0.172(-0.853-0.510)).

Conclusions

Implementing a stigma awareness intervention in vocational rehabilitation is highly effective for finding and retaining paid work.

INTRODUCTION

People with mental illness are three to seven times more likely to be unemployed than people without mental illness (1). This is problematic, because being employed contributes to health and recovery (2). Also, being unemployed is associated with poorer (mental) health (3, 4), poverty (4) and higher risk of suicide (5). These negative effects of unemployment may be underlain by unmet psychological needs with regard to work, such as time structure, purpose and having a daily activity, and financial problems because of insufficient income (3). Contrarily, (re-)employment, provided under favourable conditions, improves health, as well as self-esteem, mastery and happiness (6), and enhances recovery of mental illness on several dimensions, such as functional, existential and social recovery (7).

A major barrier for people with mental illness is workplace stigma and discrimination (8, 9). Both (negative) attitudes and behaviours of employers, as well as anticipated stigma and self-stigma in people with mental illness are obstacles in finding and keeping employment (10). For instance, a recent representative study found that 64% of Dutch managers were reluctant to hire a job applicant with mental illness, and 30% were even reluctant to hire an applicant who has recovered from mental illness (11). Moreover, having experienced discrimination because of mental illness has shown to negatively influence job searching activities (12). Recent studies have highlighted the importance of disclosure decisions for re-employment success in people with mental illness (8, 13-15).

The decision whether or not to disclose a mental illness in the work context is a very personal and complex decision. Despite its importance for recovery, quality of life and social inclusion, workplace disclosure is highly understudied. Disclosure can have beneficial outcomes, e.g. co-worker support and work adjustments, that may help retain employment during difficult times (15). In contrast, disclosure can also have adverse outcomes such as stigma and discrimination, which may damage careers and lead to job loss. Non-disclosure can also have positive effects (the avoidance of stigma and discrimination) as well as negative effects (not receiving support and work adjustments that are needed) (15). Several recent studies have suggested that the decision regarding disclosure can impact the reemployment success of people with mental illness. A pilot randomised controlled trial (RCT) showed that people who used the CORAL (Conceal or Reveal) decision aid (16) were more often working full time after 3 months than people who did not use the decision aid and experienced less decision-making stress (14). Although there are strong indications that stigma and discrimination negatively impact employment opportunities (8, 11) and disclosure decision aids seem promising (14, 17), longitudinal research on the long-term employment outcomes for people with mental illness is lacking (8).

Therefore, in this RCT the effectiveness of a stigma awareness intervention on reemployment and decisional stress was evaluated in unemployed people with mental illness. This intervention aimed to increase awareness about stigma and the importance of a deliberate disclosure process in both unemployed people with mental illness and the employment specialists who support them in their vocational rehabilitation trajectory. The primary aim of this study is to evaluate whether this stigma awareness intervention leads to 1) finding paid employment more often; 2) retaining paid employment more often; and 3) less decisional conflict about disclosing mental illness, compared to usual vocational rehabilitation in municipal practice and controlled for other factors (e.g. mental health and stigma and discrimination). An additional aim was to gain insight into the (long-term) effects of the intervention compared to usual vocational rehabilitation on secondary outcomes, such as mental health and stigma.

METHOD

Study design

The DECIDES (DECIsions on Disclosure in the Employment Setting) study is a longitudinal, two-armed, clustered RCT among unemployed people with mental illness who receive social benefits and reintegration support from Dutch municipalities. More details of the RCT have been reported in a study protocol (https://doi.org/10.1186/s13063-020-04376-1) (18). The Ethics Review Board of Tilburg University evaluated and approved the study design, protocol, information letter, informed consent form and questionnaires (EC-2018.06t). The study was registered at the Dutch Trial Register under trial registration number NL7798.

Setting

The current study took place in the southern part of the Netherlands (Noord-Brabant). At the time of conducting the study, unemployment rates were around 3.2% for Noord-Brabant compared to around 3.5% of the working population for the Netherlands (19). People who have insufficient income or capital and have no rights on other provisions or benefits (such as unemployment benefits) are entitled to social benefits. These social benefits are paid out by municipalities and in order to receive those several obligations must be met, such as putting in enough effort to try to enter the job market. Municipalities organise their own vocational rehabilitation services and this consists of various facilities, such as support from employment specialists, education facilities and training. In case income is received, e.g. by finding paid employment, this will be deducted from the social benefits.

Participants

Participants were recruited by employment specialists on eight locations in the southern part of The Netherlands, i.e. municipalities and organisations commissioned by municipalities during personal contacts with clients, via newsletters, and personal letters to potential participants. Inclusion criteria were 1) being unemployed, i.e. an income below minimum income and receiving social benefits, 2) having sought any treatment (currently or in the past) for mental illness, including addiction, from a health professional (e.g. general practitioner, psychologist) and 3) adequate command of the Dutch language, as the intervention and questionnaires were in Dutch. Employment specialists were asked to provide information about the research to people who met the inclusion criteria. People who were willing to receive more information about the research and gave permission for their contact details to be shared with the researchers were contacted. Here, inclusion criteria were also checked. Participation in the study was voluntary. All participants signed an informed consent form prior to participation.

Randomisation and masking

This study consists of the conditions (a) vocational rehabilitation as usual (i.e. control group) and (b) vocational rehabilitation as usual combined with the intervention (i.e. experimental group). Within the participating organisations, employment specialists (N=72) were recruited between November 2017 and March 2018. Cluster randomisation to one of the conditions took place on practice level. Randomisation into a control group and an experimental group was conducted by a researcher who was not involved in the research project, by computer allocation using SPSS-software. As employment specialists work intensively together in teams, cluster randomisation was chosen to avoid contamination between the experimental and control group. Due to the cluster design of the study and the nature of the intervention, neither the employment specialists nor the researchers could be masked to the allocation to the conditions, However, employment specialists and participants of the control group were not informed about the content of the intervention. Figure 1 gives an overview of the randomisation process.

Procedures

Measurements took place at baseline (T0), after 3 months (T1), 6 months (T2) and 12 months (T3). Participants could start at any moment during the recruitment period and were followed from then on until 12 months later. As participants included people with literacy and concentration difficulties who may drop out of a longitudinal study, extra efforts were made to recruit and retain them, e.g. by gathering the data during face-to-face appointments. Also participants received a financial remuneration of 10 euros (8.5GBP) after filling out each questionnaire.

The intervention consisted of three parts: 1) a 3x2 hours workplace stigma-awareness training for employment specialists, provided by the researchers, and partly by a mental health advocate; 2) a printed version of the CORAL.NL for to the participants, together with 3) two infographics providing a brief and simplified version of the CORAL.NL tool, designed for participants with literacy or concentration problems.

The workplace stigma-awareness training for employment specialists was developed for the purpose of this study, using input from a focus group study (15), and had several aims: 1) creating awareness of stigma and discrimination in the work environment and creating insight into the effects of employment specialists' own attitudes, personal prejudices and actions; 2) increasing understanding of how the disclosure dilemma can be experienced by people with mental illness and how it affects them, and 3) learning to work with the CORAL.NL decision aid and infographics, including how they can be implemented in daily practice.

The CORAL.NL decision aid is based on the Conceal Or ReveAL (CORAL) decision aid, developed and tested in the UK (14). Subsequently, CORAL was translated and developed further into the CORAL.NL for the Dutch practice by conducting a focus group study (15). Similar to the English version, the CORAL.NL decision aid consists of a 14-pages booklet containing four parts. Part 1 deals with choices about disclosure, the pros and cons of disclosure, and personal disclosure needs and values. Part 2 is about one's personal situation and deals with questions about to whom and when to disclose. Parts 3 and 4 summarize previous sections to make a plan about whether to disclose or not, and if so, to whom and when and what to disclose. As participants included people with concentration and literacy problems, for whom a 14-page booklet may not be suitable, two very brief infographics were developed, summarizing pros, cons and tips regarding disclosure during the job application process and during employment, respectively. Participants of the experimental group received the CORAL.NL decision aid and infographic from the researcher after filling out the baseline questionnaire (T0) (see appendix 1).

Outcomes

Primary outcomes were a) finding paid employment (yes/no), defined as a minimum of one hour a week for a minimum of one month; b) retaining paid employment (yes/no), i.e. at least 12h a week, for a minimum of three months and c) decisional conflict, measured with the Decisional Conflict Scale (20), and the one-item Stage of Decision Making Scale (21), which measures the individuals' readiness to engage in decision making. Primary outcomes were measured at each measurement.

Secondary outcomes were a) self-reported current mental health, measured with the Patient Health Questionnaire (22), a screening tool for mental health disorders of

somatoform, depression, anxiety, alcohol, and eating disorders; b) positive wellbeing, which is measured with the 14-item Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (23); c) internalized stigma, using the 10-item Internalized Stigma of Mental Illness Scale (ISMI-10) (24); d) experienced discrimination, measured with two specific items from the Discrimination and Stigma Scale (DISC-12) (25) about finding and keeping a job; e) work-related factors, i.e. active in searching and applying for jobs and five statements on a 5-point Likert scale about personal fears about reemployment; and f) the quality of support from employment specialists, using three items of the Patient Satisfaction with Occupational Health Professionals scale (26). Secondary outcomes were measured at each data collection point.

Statistical analysis

The power calculation was based on data from a recent international study on individual placement and support (27) with a similar primary outcome measure, i.e. obtaining employment. Here, the average percentage employment was 50% in the experimental group and 20% in the control group. Considering these percentages in combination with a 5% significance level and power of 80%, 36 unemployed people would be needed in each group to find a statistically significant difference. For a power of 90%, 47 participants per group would be needed. Expecting a high dropout rate over four measurements, a safe assumption was to have 75 participants per group, which meant a total of 150 participants.

Descriptive statistics of sociodemographic and health characteristics for both experimental and control group, as well as for participants who dropped out compared to participants who fully participated, were computed separately and differences were tested using independent sample *t*-tests for scale and X^2-tests for nominal variables. Descriptive statistics of primary and secondary outcomes were conducted separately for the experimental and control group, and differences were tested using independent sample t-tests for scale and X^2-tests for nominal variables.

All data had a hierarchical structure, with repeated measurements (level 1) nested within individuals (level 2). Multilevel analyses were conducted to take into account that intra-individual observations are more similar than inter-individual observations. However, logistic multilevel regression analyses for the outcomes 'finding work' and 'retaining work' did not converge. Therefore, for the outcomes 'finding work' and 'retaining work', logistic regression analyses were conducted for each measurement. For decisional conflict and stage of decision making, linear multilevel regression analyses were conducted. Here, various covariance structures were tested and the best covariance structure was based on the lowest BIC/AIC. All data were analysed by intention to treat. The intervention effect was established with the group by time interaction.

In all regression analyses, sociodemographic and health characteristics were included as covariates, together with baseline levels of self-reported number of PHQ diagnoses, positive wellbeing, internalized stigma, experienced discrimination, timing of disclosure and job search activities. Two variables of experienced discrimination (i.e. experienced discrimination during *finding* work and experienced discrimination in *keeping* work) were merged to one variable (i.e. experienced discrimination during finding and/or keeping work) for the regression analyses. Dummy variables were created for educational level (reference=low educated), experienced discrimination (reference='not applicable') and timing of disclosure (reference='do not know').

Statistical analyses were performed using the Statistical Package for the Social Sciences version 24.0 (IBM). Logistic multilevel analyses were first conducted in lme4 package of R but the presented logistic regression analyses were conducted in SPSS 24.0.

The study was registered within the Netherlands Trial Register under trial registration number NL7798.

RESULTS

Participants were recruited between April 10, 2018 and July 8, 2019. Of the 233 people screened, N=153 participants met the inclusion criteria and were willing to participate (see Figure 1). Sociodemographic characteristics and health characteristics were well balanced between the control and experimental group (see Table 1).

Participants who dropped out during the study did not differ significantly from participants who completed all measures (data not shown). At baseline, participants of the experimental group and control group did not significantly differ from each other in primary outcomes. For secondary outcomes, participants did differ from each other on self-reported mental health (i.e. somatoform disorders and alcohol abuse) and internalized stigma at baseline (see Table 2).

Figure 1. Overview of the randomisation process (CONSORT diagram)

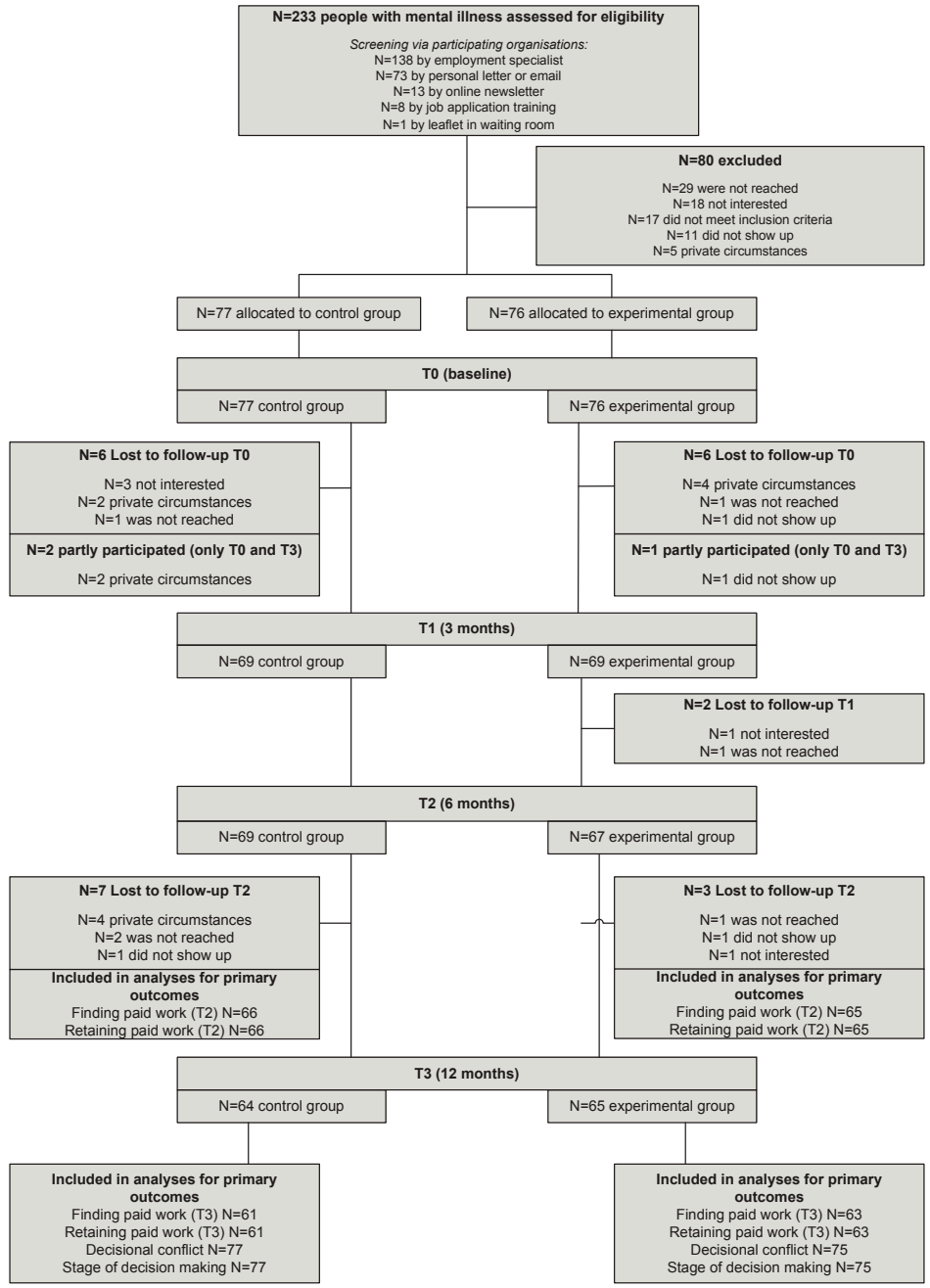

Table 1. Characteristics sample (M (SD); MIN-MAX / N (%))

	Control Group (N=77)	Experimental Group (N=76)
Age	40.0 (12.5); 19.0-62.4	37.4 (11.9); 20.0-63.1
Gender: male	40 (51.9%)	32 (42.1%)
Nationality: Dutch	71 (92.2%)	73 (96.1%)
Marital status		
No relationship (single, divorced or widowed)	65 (84.4%)	62 (81.6%)
Relationship (married, relationship living apart or co-habitation)	12 (15.6%)	14 (18.4%)
Educational status		
Lower educated or no education	31 (40.3%)	39 (51.3%)
Medium educated (MBO)	28 (36.4%)	24 (31.6%)
Higher educated (HBO of WO)	18 (23.4%)	6 (7.9%)
Self-report diagnosis*		
Anxiety	13 (16.9%)	6 (7.9%)
Attention deficit (hyperactivity) disorder	12 (15.6%)	11 (14.5%)
Autism spectrum disorder (including asperger and PDD-NOS)	8 (10.4%)	14 (18.4%)
Bipolar disorder	1 (1.3%)	2 (2.6%)
Burnout, stress, overload	9 (11.7%)	12 (15.8%)
Depression	23 (29.9%)	20 (26.3%)
Personality disorder	14 (18.2%)	11 (14.5%)
Psychotic disorder	2 (2.6%)	3 (3.9%)
PTSD	11 (14.3%)	12 (15.8%)
Schizophrenia	1 (1.3%)	0 (0.0%)
Other	8 (10.4%)	7 (9.2%)
Don't know	7 (9.1%)	7 (9.2%)
No diagnosis	8 (10.4%)	11 (14.5%)
Percentage ever admitted to psychiatric hospital	15 (19.5%)	11 (14.5%)
Percentage ever had chronic diseases (such as heart complaints, epilepsy)	33 (44.0%)	38 (50.0%)
Percentage length of time out of employment ≥ 12 months**	49 (64.5%)	48 (64.9%)

* Percentage is above 100% because of comorbidity; **Item has 9 missings

Table 2. Descriptives of primary and secondary outcomes (M (SD); MIN-MAX / N (% yes)) (continues on next page)

	T0			T1			T2			T3		
	CG (N=77)	EG (N=76)	p	CG (N=69)	EG (N=69)	p	CG (N=69)	EG (N=67)	p	CG (N=64)	EG (N=65)	p
Primary outcomes												
Finding paid work	7 (9.1%)	10 (13.2%)	0.424	18 (26.1%)	23 (33.3%)	0.352	18 (26.1%)	34 (50.7%)	**0.003**	22 (34.4%)	35 (53.8%)	**0.026**
Retaining paid work (12h/w, 3 m)	0 (0.0%)	0 (0.0%)	n/a	4 (5.8%)	9 (13.0%)	0.145	15 (21.7%)	16 (23.9%)	0.766	15 (23.4%)	32 (49.2%)	**0.002**
Decisional conflict (DCS)	33.1 (17.3); 0.0-92.2	38.8 (20.3); 0.0-87.5	0.066	32.2 (16.0); 0.0-79.7	35.1 (21.1); 0.0-100.0	0.369	31.8 (18.3); 0.0-75.0	33.1 (17.6); 0.0-100.0	0.697	31.7 (15.8); 0.0-64.1	32.9 (19.1); 0.0-95.3	0.706
Stage of Decision Making	4.3 (1.9); 1.0-6.0	4.3 (1.8); 1.0-6.0	0.875	4.5 (1.8); 1.0-6.0	4.2 (1.8); 1.0-6.0	0.390	4.4 (1.7); 1.0-6.0	4.6 (1.8); 1.0-6.0	0.737	4.2 (2.0); 1.0-6.0	4.4 (1.9); 1.0-6.0	0.619
Secondary outcomes												
Mental health problems (PHQ)												
Somatoform disorder	0 (0.0%)	21 (27.6%)	**<0.001**	17 (24.6%)	21 (30.4%)	0.446	14 (20.3%)	20 (29.9%)	0.198	17 (26.6%)	19 (29.2%)	0.736
Depressive disorder	15 (19.5%)	23 (30.3%)	0.123	27 (39.1%)	27 (39.1%)	1.000	21 (30.4%)	22 (32.8%)	0.763	24 (37.5%)	17 (26.1%)	0.166
Anxiety disorder	23 (30.3%)	17 (22.4%)	0.269	16 (23.2%)	15 (22.1%)	0.874	19 (27.5%)	20 (29.9%)	0.765	12 (19.0%)	13 (20.0%)	0.892
Eating disorder	0 (0.0%)	3 (4.1%)	0.101	5 (8.1%)	2 (3.1%)	0.218	1 (1.6%)	2 (3.3%)	0.540	4 (7.1%)	5 (8.1%)	0.851
Alcohol abuse	13 (16.9%)	5 (6.6%)	**0.048**	6 (8.7%)	6 (8.8%)	0.979	6 (8.7%)	4 (6.0%)	0.543	8 (12.5%)	5 (7.8%)	0.380
Total number of positive indications	0.7 (0.8); 0.0-3.0	0.9 (1.0); 0.0-3.0	0.108	1.0 (1.0); 0.0-3.0	1.0 (1.1); 0.0-4.0	1.000	0.9 (1.1); 0.0-3.0	1.0 (1.0); 0.0-3.0	0.463	1.0 (1.1); 0.0-4.0	0.9 (1.1); 0.0-5.0	0.582
Positive wellbeing (WEM-WBS)	47.2 (21.4); 21.0-70.0	47.3 (9.8); 14.0-70.0	0.945	48.2 (8.7); 31.0-70.0	47.7 (10.0); 15.0-70.0	0.751	47.9 (10.0); 28.0-67.0	47.6 (10.2); 14.0-70.0	0.853	47.1 (8.1); 30.0-66.0	47.8 (11.1); 14.0-70.0	0.673
Internalized stigma (ISMI)	2.1 (1.4); 1.2-3.2	1.9 (0.5); 1.0-3.0	**0.023**	2.0 (0.4); 1.1-3.1	2.0 (0.4); 1.1-3.1	0.746	2.1 (0.4); 1.0-3.0	1.9 (0.4); 1.1-3.4	0.137	2.1 (0.4); 1.0-3.0	2.0 (0.4); 1.0-3.0	0.351
Experienced discrimination finding work (DISC)			0.079			0.979			0.902			0.927
Did experience discrimination	26 (33.8%)	14 (18.4%)		21 (30.4%)	22 (31.9%)		21 (30.4%)	18 (27.3%)		18 (28.1%)	20 (31.3%)	
Did not experience discrimination	22 (28.6%)	23 (30.3%)		20 (29.0%)	20 (29.0%)		21 (30.4%)	20 (30.3%)		18 (28.1%)	17 (26.6%)	
N/a (did not searched for work yet)	29 (37.7%)	39 (51.3%)		28 (40.6%)	27 (39.1%)		27 (39.1%)	28 (42.4%)		28 (43.8%)	27 (42.2%)	

Table 2. Continued

	T0			T1			T2			T3		
	CG (N=77)	EG (N=76)	p	CG (N=69)	EG (N=69)	p	CG (N=69)	EG (N=67)	p	CG (N=64)	EG (N=65)	p
Experienced discrimination keeping work (DISC)			0.457			0.158			0.984			0.763
Did experience discrimination	33 (42.9%)	27 (35.5%)		25 (36.2%)	34 (49.3%)		27 (39.1%)	26 (39.4%)		23 (35.9%)	25 (39.1%)	
Did not experience discrimination	19 (24.7%)	17 (22.4%)		22 (31.9%)	13 (18.8%)		16 (23.2%)	16 (24.2%)		15 (23.4%)	17 (26.6%)	
N/a (did not had a job yet)	25 (32.5%)	32 (42.1%)		22 (31.9%)	22 (31.9%)		26 (37.7%)	24 (36.4%)		26 (40.6%)	22 (34.4%)	
Timing of disclosure			0.686			0.571			0.518			0.879
Preferably disclosing MHP during application process	27 (35.1%)	27 (36.0%)		31 (44.9%)	24 (35.3%)		28 (40.6%)	30 (44.8%)		28 (43.8%)	25 (39.1%)	
Preferably disclosing MHP at work (after application process)	10 (13.0%)	8 (10.7%)		9 (13.0%)	12 (17.6%)		8 (11.6%)	12 (17.9%)		9 (14.1%)	12 (18.8%)	
Preferably not disclosing MHP at work	26 (33.8%)	21 (28.0%)		19 (27.5%)	18 (26.5%)		20 (29.0%)	17 (25.4%)		17 (26.6%)	16 (25.0%)	
Don't know	14 (18.2%)	19 (25.3%)		10 (14.5%)	14 (20.6%)		13 (18.8%)	8 (11.9%)		10 (15.6%)	11 (17.2%)	
Searched or applied for a job in the past four weeks	41 (53.2%)	51 (67.1%)	0.080	32 (46.4%)	32 (46.4%)	1.000	33 (47.8%)	31 (46.3%)	0.856	22 (34.4%)	21 (32.3%)	0.803
Received support from your employment specialist in the past 3 months (6m for T3)	62 (80.5%)	67 (88.2%)	0.194	51 (73.9%)	44 (63.8%)	0.198	40 (58.0%)	40 (59.7%)	0.838	31 (48.4%)	25 (38.5%)	0.253
If yes:												
What grade would you give the support?	6.9 (1.3); 1.0-10.0	7.3 (2.3); 1.0-10.0	0.245	6.5 (2.8); 1.0-10.0	7.2 (2.2); 1.0-10.0	0.180	6.4 (2.5); 1.0-10.0	7.1 (2.4); 1.0-10.0	0.179	6.7 (2.4); 1.0-10.0	6.9 (2.8); 1.0-10.0	0.728
The employment specialist treated me in a pleasant manner (based on PSO-HP)	4.4 (1.2); 1.0-5.0	4.5 (0.9); 1.0-5.0	0.421	4.3 (1.2); 1.0-5.0	4.6 (0.9); 1.0-5.0	0.168	4.0 (1.4); 1.0-5.0	4.6 (1.0); 1.0-5.0	**0.037**	4.0 (1.4); 1.0-5.0	4.0 (1.5); 1.0-5.0	0.858
The employment specialist seemed professional (based on PSO-HP)	4.3 (1.2); 1.0-5.0	4.3 (1.1); 1.0-5.0	0.752	4.1 (1.3); 1.0-5.0	4.4 (1.0); 1.0-5.0	0.217	3.8 (1.3); 1.0-5.0	4.4 (1.0); 1.0-5.0	**0.035**	3.8 (1.4); 1.0-5.0	4.0 (1.4); 1.0-5.0	0.667

Table 2. Continued

	T0			T1			T2			T3		
	CG (N=77)	EG (N=76)	p	CG (N=69)	EG (N=69)	p	CG (N=69)	EG (N=67)	p	CG (N=64)	EG (N=65)	p
Overall, I am satisfied with the support of the employment specialist (based on PSO-HP)	4.1 (1.4); 1.0-5.0	4.3 (1.1); 1.0-5.0	0.514	3.9 (1.5); 1.0-5.0	4.3 (1.2); 1.0-5.0	0.211	3.7 (1.5); 1.0-5.0	4.4 (1.1); 1.0-5.0	**0.026**	3.8 (1.4); 1.0-5.0	3.9 (1.5); 1.0-5.0	0.847
Questions only answered by people who did not have a job at that measurement; (1=totally disagree, 5=totally agree)												
Return to work self-efficacy (RTW-SE)	3.8 (1.1); 1.1-6.0	4.1 (1.0); 1.0-6.0	0.168	3.7 (1.2); 1.1-5.8	4.1 (1.1); 1.0-6.0	0.125	3.6 (1.1); 1.1-5.8	3.9 (1.1); 1.0-6.0	0.195	3.5 (1.2); 1.1-5.8	3.8 (1.1); 1.0-5.8	0.197
I feel stressed to find a job	3.4 (1.5); 1.0-5.0	3.4 (1.4); 1.0-5.0	0.757	3.1 (1.5); 1.0-5.0	3.4 (1.4); 1.0-5.0	0.352	3.3 (1.4); 1.0-5.0	3.3 (1.3); 1.0-5.0	0.841	3.2 (1.2); 1.0-5.0	3.2 (1.4); 1.0-5.0	0.851
It is exciting to find a job	3.9 (1.0); 1.0-5.0	3.9 (1.1); 1.0-5.0	0.789	3.6 (1.4); 1.0-5.0	3.7 (1.1); 1.0-5.0	0.796	3.7 (1.1); 1.0-5.0	3.8 (1.2); 1.0-5.0	0.568	3.6 (0.9); 1.0-5.0	3.5 (1.3); 1.0-5.0	0.703
I will succeed to find a job	3.7 (1.2); 1.0-5.0	3.9 (0.9); 1.0-5.0	0.328	3.3 (1.3); 1.0-5.0	3.7 (1.1); 1.0-5.0	0.125	3.3 (1.3); 1.0-5.0	3.6 (1.1); 1.0-5.0	0.289	3.1 (1.0); 1.0-5.0	3.3 (1.0); 1.0-5.0	0.585
Because of my MHP, I have less opportunities to find a job	3.1 (1.3); 1.0-5.0	3.0 (1.3); 1.0-5.0	0.562	3.2 (1.4); 1.0-5.0	3.0 (1.2); 1.0-5.0	0.453	3.3 (1.3); 1.0-5.0	3.1 (1.3); 1.0-5.0	0.381	3.1 (1.2); 1.0-5.0	2.8 (1.4); 1.0-5.0	0.372
I think my MHP affect my job performance	3.3 (1.3); 1.0-5.0	3.1 (1.3); 1.0-5.0	0.311	3.3 (1.2); 1.0-5.0	3.0 (1.2); 1.0-5.0	0.286	3.2 (1.4); 1.0-5.0	3.2 (1.1); 1.0-5.0	0.941	3.2 (1.2); 1.0-5.0	3.0 (1.3); 1.0-5.0	0.462

First, regarding finding paid employment, significantly more participants in the experimental group found paid employment after six months (T2) than participants in the control group (50.7% versus 26.1%, p=0.003). Similarly, after twelve months (T3), significantly more participants in the experimental group found paid employment (53.8% versus 34.4%, p=0.026). Logistic regression analyses were conducted for each follow-up measurement as described above. After three months (T1), more often finding paid employment was associated with being single, <12 months unemployed and having searched or applied for a job at baseline at baseline (regression analysis not shown in table). After six months (T2), more often finding work was associated with participating in the intervention and having searched or applied for a job at baseline. After twelve months (T3), more often finding aid employment was associated with ever having had a psychiatric diagnosis, higher positive wellbeing and having searched or applied for a job at baseline (see Table 3).

Second, concerning retaining paid employment, significantly more participants of the experimental group retained paid employment after twelve months (T3) than participants of the control group (49.2% versus 23.4%, p=0.002; see Table 2.). Logistic regression analyses were conducted for each follow-up measurement. After three months (T1), no significant differences were found on retaining paid employment. After six months (T2), more often retaining paid employment was associated with having a non-Dutch nationality, <12 months unemployed and having searched or applied for a job at baseline. After twelve months (T3), more often retaining paid employment was associated with participating in the intervention and having searched or applied for a job at baseline (see Table 3).

At all measurements, no significant differences were found between control and experimental group on decisional conflict, including stage of decision making regarding disclosure (see Table 2). Subsequently, two linear multilevel analyses were conducted to examine which factors were associated with 1) decisional conflict and 2) stage of decision making. An unstructured covariance structure was used for decisional conflict percentage and an AR(1) covariance structure was used for stage of decision making because they showed the lowest BIC/AIC. For decisional conflict, participants of the experimental group had significantly higher decisional conflict at baseline than participants of the control group. Furthermore, lower decisional conflict was associated with better positive wellbeing, and having a preference to disclose mental illness during the job application process or to not disclose mental illness at work (compared to not knowing if and when to disclose) at baseline (see Table 4). Later stage of decision making regarding disclosure (i.e. more certainty towards the disclosure decision) was associated with having a non-Dutch nationality, ≥12 months unemployed, having searched or applied for a job and having fewer self-reported mental health diagnoses, having a preference to disclose (or not) at work (compared to not knowing if and when to disclose), and both never experienced discrimination as well as ever experienced discrimination at baseline during finding or having work (compared to never had or searched for work) at baseline (see Table 4).

Table 3. Logistic regression analysis for T2 (6 months) and T3 (12 months) for (1) finding work and (2) retaining work. All independent variables were measured at baseline level.

	Finding work						Retaining work					
	T2			T3			T2			T3		
	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p
Constant	0.005		**0.048**	0.000		**0.001**	0.007		0.088	0.000		**0.005**
Intervention	3.312	1,263, 8.682	**0.015**	2.446	0.922, 6.486	0.072	1.470	0.490, 4.413	0.492	3.704	1.300, 10.553	**0.014**
Age	1.009	0.968, 1.052	0.673	1.004	0.377, 2.179	0.837	1.035	0.987, 1.087	0.158	1.014	0.971, 1.059	0.527
Gender (0=Male)	0.955	0.403, 2.265	0.917	0.906	0.377, 2.179	0.825	0.765	0.275, 2.130	0.608	1.281	0.519, 3.157	0.591
Nationality (0=Dutch)	3.877	0.504, 29.842	0.193	1.065	0.148, 7.646	0.950	16.547	1.680, 163.006	**0.016**	0.621	0.074, 5.227	0.661
Marital status (0=No relationship)	0.787	0.212, 2.925	0.721	1.551	0.386, 6.229	0.536	0.441	0.107, 1.815	0.257	1.580	0.351, 7.115	0.551
Education			0.848			0.244			0.705			0.763
Low	Reference			Reference			Reference			Reference		
Medium	0.933	0.340, 2.560	0.893	0.435	0.161, 1.176	0.101	1.502	0.463, 4.874	0.498	0.745	0.275, 2.021	0.563
High	1.344	0.397, 4.554	0.635	0.538	0.149, 1.943	0.344	0.831	0.183, 3.764	0.810	0.652	0.172, 2.474	0.530
Ever had been diagnosed for mental illness	2.792	0.744, 10.472	0.128	6.051	1.617, 22.652	**0.008**	2.532	0.534, 12.006	0.242	3.285	0.848, 12.727	0.085
Ever had a chronic disease	0.561	0.215, 1.464	0.237	0.559	0.207, 1.507	0.250	0.405	0.132, 1.244	0.114	0.410	0.148, 1.132	0.085
≥ 12 months unemployed	0.390	0.144, 1.053	0.063	0.752	0.269, 2.096	0.585	0.154	0.045, 0.527	**0.003**	0.877	0.312, 2.468	0.804
Ever admitted to a psychiatric hospital	1.217	0.347, 4.266	0.759	0.468	0.134, 1.634	0.234	1.865	0.413, 8.419	0.418	0.705	0.196, 2.537	0.593
Indications of PHQ diagnosis	1.314	0.749, 2.306	0.342	1.268	0.741, 2.171	0.387	1.073	0.555, 2.075	0.835	1.079	0.608, 1.913	0.796
Positive wellbeing	1.045	0.984, 1.110	0.151	1.085	1.017, 1.158	**0.013**	1.023	0.958, 1.094	0.492	1.060	0.990, 1.134	0.092
Internalized stigma	1.189	0.374, 3.783	0.770	3.060	0.927, 10.096	0.066	1.668	0.441, 6.312	0.451	1.706	0.527, 5.521	0.373
Experienced discrimination finding and/or keeping work			0.376			0.533			0.839			0.208
Not applicable (did not searched for work and did not had a job yet)	Reference			Reference			Reference			Reference		
Did not experience discrimination	0.847	0.235, 3.055	0.800	1.403	0.392, 5.020	0.602	1.404	0.311, 6.338	0.659	2.666	0.699, 10.159	0.151
Did experience discrimination	1.756	0.601, 5.128	0.303	1.838	0.633, 5.339	0.263	0.956	0.262, 3.492	0.946	2.536	0.831, 7.734	0.102
Timing of disclosure			0.203			0.263			0.243			0.613
Do not know if and when to disclose	Reference			Reference			Reference			Reference		
Preference to disclose during job application process	1.637	0.411, 6.523	0.485	2.417	0.553, 10.567	0.241	2.043	0.391, 10.668	0.397	2.175	0.491, 9.636	0.306
Preference to disclose at work	1.931	0.651, 5.730	0.236	1.026	0.345, 3.049	0.964	1.756	0.512, 6.020	0.371	1.600	0.515, 4.972	0.417
Preference not to disclose at work	0.490	0.139, 1.726	0.267	0.426	0.117, 1.549	0.195	0.404	0.088, 1.849	0.243	0.884	0.242, 3.229	0.852
Searched or applied for a job	3.948	1.546, 10.081	**0.004**	4.023	1.576, 10.274	**0.004**	3.356	1088, 10.354	**0.035**	4.119	1.570, 10.810	**0.004**

Table 4. Linear multilevel regression analysis for (1) decisional conflict and (2) stage of decision making. All independent variables (except time) were measured at baseline level.

	Decisional conflict			Stage of decision making		
	Estimate	**95% CI**	**p**	**Estimate**	**95% CI**	**p**
Intercept	44.096	16.414, 71.778	**0.002**	3.432	1.266, 5.597	**0.002**
Time	-0.647	-2.036, 0.742	0.359	0.000	-0.192, 0.192	0.999
Intervention	7.069	1.719, 12.419	**0.010**	-0.021	-0.470, 0.428	0.926
Time*Intervention	-1.534	-3.503, 0.435	0.126	0.081	-0.192, 0.353	0.559
Age	0.202	-0.013, 0.418	0.066	0.002	-0.015, 0.018	0.852
Gender (0=Male)	-0.158	-4.888, 4.572	0.948	-0.144	-0.515, 0.227	0.444
Nationality (0=Dutch)	6.752	-3.933, 17.438	0.213	-1.061	-1.901, -0.222	**0.013**
Marital status (0=No relationship)	-5.776	-12.623, 1.070	0.097	0.441	-0.096, 0.978	0.107
Education			**0.016**			1.000
Low	Reference			Reference		
Medium	-0.605	-5.949, 4.739	0.823	0.019	-0.399, 0.437	0.930
High	-2.184	-8.686, 4.318	0.508	0.296	-0.217, 0.809	0.256
Ever had been diagnosed for mental illness	1.266	-5.087, 7.619	0.694	0.332	-0.167, 0.832	0.191
Ever had a chronic disease	-4.165	-9.247, 0.917	0.107	0.189	-0.210, 0.589	0.351
≥ 12 months unemployed	-4.187	-9.507, 1.133	0.122	0.533	0.115, 0.951	**0.013**
Ever admitted to a psychiatric hospital	5.182	-1.407, 11.770	0.122	-0.115	-0.633, 0.403	0.662
Indications of PHQ diagnosis	1.435	-1.535, 4.404	0.341	-0.273	-0.505, -0.040	**0.022**
Positive wellbeing	-0.445	-0.773, -0.116	**0.008**	-0.008	-0.034, 0.018	0.533
Internalized stigma	5.526	-0.946, 11.999	0.094	-0.481	-0.985, 0.024	0.062
Experienced discrimination finding and/or keeping work			**0.014**			**0.022**
Not applicable (did not searched for work and did not had a job yet)	Reference			Reference		
Did not experience discrimination	-1.708	-7.343, 3.926	0.550	0.609	0.169, 1.049	**0.007**
Did experience discrimination	0.842	-5.551, 7.235	0.795	0.668	0.164, 1.049	**0.010**
Timing of disclosure			**<0.001**			**<0.001**
Do not know if and when to disclose	Reference			Reference		
Preference to disclose during job application process	-7.678	-14.159, -1.197	**0.021**	1.498	0.992, 2.004	**<0.001**
Preference to disclose at work	-3.685	-12.346, 4.976	0.401	0.976	0.299, 1.653	**0.005**
Preference not to disclose at work	-6.885	-13.529, -0.240	**0.042**	1.375	0.855, 1.895	**<0.001**
Searched or applied for a job	-1.443	-6.362, 3.476	0.563	0.422	0.037, 0.808	**0.032**

For the second aim of this study, the effects of the intervention on secondary outcomes were studied. No significant differences were found between control and experimental group on secondary outcomes in follow up measurements, except for the quality of support at T2 (6 months). Participants of the experimental group were significantly more positive about the support, professionalism and overall support of their employment specialists at T2 than participants of the control group (see Table 2).

DISCUSSION

The findings of the current study show that the stigma awareness intervention was highly effective in improving work participation outcomes; six months after baseline, significantly more participants of the experimental group had *found* paid employment compared to the control group (50.7% versus 26.1%). Moreover, twelve months after baseline, significantly more participants of the experimental group had *retained* paid employment compared to the control group (49.2% versus 23.4%). The intervention had no effect on decisional conflict and stage of decision making. Interestingly, six months after baseline, in the experimental group participants were significantly more positive about the support received from their employment specialists.

This study adds to the growing evidence that stigma and discrimination also contributed to lower employment rates of people with mental illness, and cannot solely be attributed to the mental illness. Our trial showed that *communication about mental illness*, rather than the actual illness itself, largely determined if people found and retained paid work. The disclosure process therefore is of key importance for reemployment success. This was also concluded by others (8, 13-15), e.g. Rusch and colleagues who found that greater reluctance to disclose mental health problems among the unemployed, predicted finding employment 6 months later (13). An important new insight from the present study, is that this disclosure process could successfully be influenced by the intervention, resulting in higher and more sustainable employment rates of our study population. As the percentage of people who found and retained paid work almost doubled, this suggests that on a societal level, a vast number of unemployed people could be reemployed with a relatively simple intervention, potentially leading to increased health and recovery, and major savings on social benefits.

In contrast to earlier studies (14, 17), no effects on decisional conflict and stage of decision making were found. This might be explained by the differences in selection criteria. The current study did not use cut off scores for selecting people having at least moderate decisional stress, like the earlier study by Henderson and colleagues (14). Or this could be explained by cultural and legal differences. Most Dutch people

with mental illness have preferences to disclose their mental illness to their employer (28). Possibly, this is related to the highly protective Dutch legislation for employees, including legislation to protect sick listed employees, financial subsidies for employees with disabilities and financial obligations for employers when an employee becomes sick (29). This may stimulate people with mental illness to disclose, whilst simultaneously leads to a higher reluctance for employers to hire an employee with mental illness.

The successful employment rates but lack of effect on decisional conflict and stage of decision making, suggests that the stigma awareness training for employment specialists may be a key element of the intervention. Employment specialists are important stakeholders for the employment opportunities of unemployed people with mental illness. However, because of their mediating role between unemployed people and employers, employment specialists might prefer disclosure of mental illness to not harm the professional relationships with employers (15). Increasing awareness amongst employment specialists about stigma and discrimination in the work environment, e.g. employers are reluctant to hire employees who have (had) mental illness (11, 15), and giving insight into the effects of one's personal attitudes, prejudices and actions may have improved the quality of the vocational rehabilitation services. Moreover, participants in the experimental group reported a higher quality of support by their employment specialist. Although these seem plausible explanations for the reported effect of the intervention, more insight is needed into the working elements of the intervention and what works for whom.

A key strength of this study is the randomised controlled design with clusters at practice level, which prevents contamination between individual participants. Another strength is the use of several measurements over 12 months, during which large efforts were taken to prevent drop out of participants, resulting in lower dropout rates than expected. A key limitation of the study is that participants were recruited mostly via employment specialists. This may have caused selection bias from the individual employment specialist, e.g. because an employment specialist is not aware of the mental illness of some of his clients or because an employment specialist wants to protect the person with (severe) mental illness from participating in the study. Other limitations of the study is the lack of involvement of employers in this intervention, as they are important stakeholders (10), and the use of only self-report data.

Future research should focus on the effects of the intervention implemented in existing evidence-based practices to improve employment outcomes. For example, Individual Placement and Support (IPS), the evidence-based supported employment model for people with severe mental illness helping them in achieving paid employment, found comparable employment rates as the current intervention (30). Discussing the disclosure dilemma is nowadays an element of IPS practices in The Netherlands, however it is unknown whether this is systematically implemented. Although both IPS and current intervention have successful employment rates, yet a large group of people with (severe) mental illness do not find work despite participating in one of these interventions. It would be of relevance in future studies to focus in more detail on their characteristics and subsequently to study which specific populations have benefits by using current intervention, IPS or a combination of both.

In conclusion, this RCT showed that the participants in the experimental group had considerably better employment outcomes than participants in the control group. If replicated by other studies, this stigma awareness intervention may contribute substantially to improved sustainable employment rates of unemployed people with mental illness, potentially leading to improved quality of life and substantial reductions in costs for society.

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APPENDIX 1: CORAL.NL DECISION AID

Can be found on page 178.

CHAPTER 5

Economic evaluation of a
stigma awareness intervention
on reemployment of people with mental illness:
results from a cluster randomized controlled trial

Will be submitted as
Janssens KM, Geraerds AJLM, Polinder, S, van Weeghel J, , Henderson C, Joosen MC, Brouwers EP. Economic evaluation of a stigma awareness intervention on reemployment of people with mental illness: results from a cluster randomized controlled trial.

ABSTRACT

Background

People with mental illness are more often unemployed, which may party be explained by the stigma attached to mental illness. Both unemployment and mental ill-health is associated with high economic and societal costs. In this study the costs and benefits of implementing a stigma awareness intervention into vocational rehabilitation is investigated.

Methods

In a cluster randomized controlled trial, 119 unemployed people with mental illness were allocated into two groups: (a) vocational rehabilitation as usual and (b) vocational rehabilitation combined with a stigma awareness intervention. Primary outcomes were finding and retaining employment and becoming independent of social benefits. These data were extracted from nationwide registers over 12 months. Using self-report healthcare costs and quality-adjusted life years were assessed at baseline, 3, 6 and 12 months.

Results

Participants of the intervention group had better work participation outcomes and better outcomes concerning becoming independent of social benefits than participants of the control group. For participants of the control group, mean total costs for social benefits and healthcare costs together were €11,228 (SD=€6,451, IQR=€6,367-€14,324). For the intervention group, mean total costs for social benefits, healthcare costs and intervention costs were €9,893 (SD=€5,181, IQR=€5,187-€13,745; p=0.411, d=0.080). However, the differences in these costs and use did not reach statistical significance.

Conclusions

Although the intervention is not cost-effective, implementing a stigma awareness intervention may be beneficial for unemployed people with mental illness, as it is not more expensive than vocational rehabilitation as usual.

INTRODUCTION

People with mental illness are three to seven times more often unemployed than people without mental illness (1, 2). This is disadvantageous, because being unemployed has negative effects on individual aspects such as (mental) health (3-5), financial strain (5) and increases the risk of suicide (6), whilst employment has positive effects on (mental) health (1). Subsequently, from a wider perspective, both unemployment (7) and mental ill-health (8, 9) involve high economic and societal costs.

In the Netherlands, people who are unemployed and do not have sufficient income or financial capital are entitled to unemployment insurances. This means that local governments ensure an income (i.e. social benefits) and vocational rehabilitation for people who are able to work but unable to directly find sustainable work (10). Of the people receiving social benefits, 31% receives mental health care (11). However, considering the treatment gap (i.e. the proportion of people with mental illness who actually receive treatment for the illness) (12), this is likely to be an underestimation of the actual amount of people with mental illness who receive social benefits. People with mental illness who are receiving social benefits reintegrate 45% less often to paid work than people receiving social benefits without mental illness, involving higher costs for governments and society (13).

There is growing evidence showing that one of the factors of influence on unemployment among people with mental illness is stigma (14-18). This manifests itself in discrimination, i.e. people with mental illness not being invited for job interviews or offered a job (19-22), and also in anticipated discrimination, i.e. refraining from applying to work, education or training out of fear of rejection (23, 24). Therefore, the decision whether to disclose or not is often perceived as a stressful process (25, 26), as both disclosure and non-disclosure can have advantages and disadvantages (27). For example, non-disclosure can have positive outcomes (i.e. avoiding stigma) but also negative consequences (e.g. not getting the support or work adjustments needed). In addition, disclosure of mental illness could lead to improved wellbeing as a result of being able to be authentic and to receive emotional support from the work environment, but could also lead to stigma and discrimination (27).

Decision aids for making informed decisions about disclosing mental illness seem promising in increasing employment opportunities (28-32), and are relatively easy to implement. Recently, the effectiveness of the COnceal or ReveAL (CORAL) decision aid, i.e. a decision aid for people with mental illness about disclosure of mental illness in the work context (28), in combination with a stigma awareness training for employment specialists was tested in the Dutch municipal practice (33). In this study, twice as many participants of the intervention group had found paid employment compared to the

control group (51% vs. 26%). Moreover, after twelve months, 49% of the intervention group had *retained* paid employment, compared to 23% of the control group (33).

The aim of the current study was to investigate what the costs and benefits are when implementing the current stigma awareness intervention into vocational rehabilitation, compared to vocational rehabilitation as usual, studied from a societal perspective. It was hypothesized that implementing the stigma awareness intervention would be cost-effective compared to vocational rehabilitation as usual due to the low intervention costs and because it was found to be effective in more often finding and retaining paid employment (33).

METHOD

Study design

Data were collected alongside a cluster randomized controlled trial (RCT) evaluating a stigma awareness intervention. More details of the study have been reported elsewhere (34). The Ethics Review Board of Tilburg University evaluated and approved the study design and materials (EC-2018.06t). The study was registered at the Dutch Trial Register under trial registration number NL7798. In this economic evaluation, the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) were followed (35).

Setting

In the Netherlands, people are entitled to social benefits when they have insufficient income or capital and have no rights on other provisions or benefits (such as unemployment benefits). Social benefits are paid out by municipalities. In order to receive social benefits, several obligations must be met, such as cooperate in vocational rehabilitation given by employment specialists and putting in enough effort to try to enter the job market. Municipalities organise their own vocational rehabilitation services which consist of various facilities, such as one-by-one support from employment specialists, education facilities and group training (e.g. job application training). In case income is received, e.g. by finding paid employment, this will be deducted from the social benefits.

Participants

Participants were recruited by employment specialists on eight locations in the southern part of The Netherlands, i.e. municipalities and organisations commissioned by municipalities during personal contacts with clients between April 2018-July 2019. In addition, they were recruited via newsletters and personal letters from the locations to potential participants. Locations were cluster randomized into two arms: (a) four

locations into vocational rehabilitation as usual (control group) and (b) four locations into vocational rehabilitation as usual combined with the intervention (intervention group). Participants were assessed with a 12 months follow-up period and were eligible to participate if they (a) were unemployed, i.e. received social benefits because of an income below minimum income (b) sought treatment for mental illness or addiction problems (with or without official diagnosis), currently or in the past, from a health professional, (c) speak Dutch, as the intervention and questionnaires were in Dutch; and (d) gave additional permission to collect anonymised data from Statistics Netherlands.

Intervention

In addition to vocational rehabilitation as usual, participants in the intervention group received a stigma awareness intervention, consisting of: (a) a printed version of the CORAL.NL decision aid for participants; and (b) a 3x2 hours workplace stigma awareness training for employment specialists who guided participants of current study.

The CORAL.NL decision aid is based on the English COnceal or ReveAL (CORAL) decision aid (28). Translation and development into a version for Dutch practice was done by conducting a focus group study in the Netherlands (27). The decision aid consists of a 14-pages booklet. In this booklet, choices about disclosure are discussed, including pros and cons of disclosure, and personal disclosure needs and values. In addition, attention is paid to the personal situation, and it deals with questions about to whom and when to disclose. The tool summarizes with a plan about whether to disclose or not, and if so, to whom and when and what to disclose. As people with concentration and literacy problems participated in the study, two one-page infographics were developed, summarizing pros, cons and tips regarding disclosure during the job application process and during employment. Participants of the intervention group received the CORAL.NL tool after filling out the baseline questionnaire (T0) (see appendix 1).

The stigma awareness training for employment specialists was developed for the purpose of this study, using literature about implementing stigma awareness interventions (36-39). In most training sessions a mental health advocate was present, because social contact with people with mental illness is an important element to increase stigma awareness (39). In addition, a film was developed with personal experiences of workplace stigma and discrimination of people with lived experiences. The aims of the training sessions were: (a) creating awareness of workplace stigma and discrimination, (b) creating awareness of the effects of employment specialists' own attitudes, prejudices and actions, (c) increasing understanding of how people with mental illness can experience the disclosure dilemma and how it affects them, and (d) learning to work with the CORAL.NL tool, including how they can be implemented in daily practice. More information of the intervention can be found in the study protocol (34).

Measures

Effectiveness

In the current study, effectiveness in terms of finding employment and becoming independent of social benefits was measured using microdata from Statistics Netherlands. Statistics Netherlands is a governmental organization which collects data from Dutch citizens, companies and institutions (40). Identified data were removed and replaced by a pseudo key before they became available as microdata to conduct statistical research. For this study, data on employment history (i.e. having paid employment (=minimum of 1 hour a month), retaining paid employment (=minimum of 12 hours a week for 3 months), income, working hours per week and days from baseline until start employment) and social benefits (i.e. receiving social benefits, days from baseline until end social benefits and amount of social benefits) during the total study period (i.e. 12 months) were used.

Effectiveness in terms of utility was assessed at baseline, 3, 6 and 12 months using the Euroqol-5D-5L (EQ-5D-5L) (41), i.e. a self-administered health-related quality of life instrument consisting of five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Participants self-rate their level of problems for each dimension using a five level scale from 'having no problems' to 'being unable to do/having extreme problems'. The EQ-5D demonstrates good psychometric properties comparable to other generic measures, as expressed in the validity and reliability of the instrument, and is one of the most common used measures in health-utility evaluations (42). A domain-related scoring algorithm based on a Dutch general population value set was used to determine utilities. With these utilities, QALYs (Quality of Life adjusted Years) were calculated. One QALY equates to one year in perfect health.

Costs

Healthcare costs were assessed according to the Dutch guidelines for economic evaluations (43). Healthcare use was measured using the Treatment Inventory of Costs in Patients with psychiatric disorders (TiC-P) (44). The TiC-P is a reliable self-report instrument with satisfactory validation (45) and was assessed at baseline for healthcare use in the three months prior to the study, and after 3, 6 and 12 months for healthcare use during the study period. Unit prices were taken from the cost manual (43) and indexed to 2019 using the national consumer price index (46). Full details on unit prices per type of care can be found in appendix 2. Healthcare use was assessed as costs for number of visits to a general practitioner, social worker, physio-, cesar- or manual therapist and/or mental health care professional, an outpatient clinic, and number of days of hospital day care or hospital admission and/or the emergency care. In addition, it was assessed as frequencies of medication use, divided in medication for physical or mental health problems and medication with a low or high cost price (see Appendix 2).

Intervention costs were based on (a) the development of the training, (b) organizing the three training sessions at four different locations, (c) costs per hour for employment specialists to participate in the training sessions and (d) the printing costs of the CORAL. NL decision aid. A list of costs can be found in Appendix 3.

Statistical analysis

Baseline demographics and health characteristics of participants in the control and intervention group were compared with a chi-square test or Mann-Whitney U-test. An intention-to-treat analysis was performed. For primary outcomes, frequencies and descriptives were determined. Participants of the control and intervention group were compared using chi-square tests or Mann-Whitney U tests. Mean costs were reported in euro (€) with the interquartile range (IQR). Differences in costs between the intervention and control group were compared using Mann–Whitney U test, since costs were not normally distributed. P-values <0.05 were considered to indicate statistical significance. All analyses were carried out with the statistical package SPSS 25.0.

RESULTS

Fifty-nine participants were in the intervention group and sixty in the control group. Mean age for the intervention group was 37.4 years (SD=12.2) and for the control group 40.9 years (SD=12.4; p=0.375), and respectively 41% (N=24) and 45% (N=27) was male (p=0.634). Most participants had received a diagnosis for their mental illness (intervention group: N=47, 80%; control group: N=51, 85%), one fifth did not have an official diagnosis for their mental illness (intervention group: N=12, 20%; control group: N=9, 15%; p=0.445). Participants' demographics and health characteristics did not differ significantly between the groups. Table 1 provides an overview of all demographics and health characteristics.

Primary outcomes

Within the study period, respectively 59% (N=35) and 47% (N=28) of the participants of the intervention and control group found paid work (X^2=1.912, p=0.167). Regarding retaining work, 39% (N=23) of the intervention group and 28% (N=17) of the control group had retained paid work (X^2=1.512; p=0.219). Mean number of days until the start of the employment was 230 days (SD=135; IQR25-75%=91-365) for participants of the intervention group, and 246 days (SD=145, IQR25-75%=68-365) for participants of the control group (Mann Whitney U: p=0.549). On average, participants of the intervention group worked 56 hours a month (SD=56, IQR25-75%=0-98), participants of the control group worked 35 hours a month (SD=50, IQR25-75%=0-65; p=0.051). Mean salary per month was €740 for the intervention group (SD=€865, IQR25-75%=€0-€1,191), and €452 for the control group (SD=€710, IQR25-75%=€0-€679; p=0.053). The total

amount of salary during the study period was on average €5,040 for participants of the intervention group (SD=€6,303, IQR25-75%=€0-€9,522) and €3,257 for the control group (SD=€5,538, IQR25-75%=€0-€5126; p=0.082)

Table 1. Characteristics of the sample (N (%) / M (SD); IQR25%-75%)

	Intervention group (N=59)	Control group (N=60)	Mann-Whitney U	X^2 test
Demographics				
Age	37.4 (12.2); 26.0-49.1	40.9 (12.4); 30.7-51.9	p=0.115, d=0.144	
Gender: male	24 (41%)	27 (45%)		X^2=0.227, p=0.634, d=0.044
Marital status: single	53 (80%)	52 (87%)		X^2=0.287, p=0.592, d=0.049
Education				X^2=3.075, p=0.215, d=0.161
Low educated	31 (53%)	22 (37%)		
Medium educated	17 (29%)	24 (40%)		
High educated	11 (19%)	24 (23%)		
Health characteristics				
Ever had been diagnosed for mental illness	47 (80%)	51 (85%)		X^2=0.583, p=0.445, d=0.070
Ever admitted to a psychiatric hospital	10 (17%)	12 (20%)		X^2=0.184, p=0.668, d=0.039
Ever had chronic health issues	28 (48%)	30 (50%)		X^2=0.077, p=0.781, d=0.025
Ever been ill for more than 4 weeks	35 (59%)	44 (73%)		X^2=2.617, p=0.106, d=0.148

No significant differences were found between the two groups regarding the proportion of participants receiving social benefits (X^2 = 0.738, p = 0.390) and the amount of social benefits received by participants (p=0.454). Forty-one percent (N=24) of the intervention group and 32% (N=19) of the control group had left social benefits during the study period (X^2=1.047, p=0.306; see Table 2.).

Intervention costs

Intervention costs comprised €1,665 for the development of the stigma awareness intervention (€867, fixed costs), including developing a film about personal experiences of people with mental illness on stigma and discrimination in the work context (€798, fixed costs), €3,832 for organizing the stigma awareness intervention of 3 x 2 hours at the four locations of the intervention group (variable costs), €3,162 for costs for employment specialists to participate in the training sessions (variable costs) and €295 printing costs for the CORAL.NL tool (variable costs). Therefore, intervention cost in total were €8,955. Costs per participant were €8,955/59 = €152.

Healthcare costs and use

Health care costs of participants of the intervention group were on average €2,409

(SD=€2,152; IQR25-75%=€484-€3,846). Participants of the control group spent on average €2,989 (SD=€4,547; IQR25-75%=€324-€2,595) on healthcare costs (p=0.445). At baseline, participants of the control group had lower costs for visiting a physio-, cesar or manual therapist (M=€22, SD=€69; IQR25-75%=€0-€0) than participants of the intervention group (M=€77, SD=€168; IQR25-75%=€0-€72; p=0.030). No differences were found between the two groups on other health care costs and frequencies of medication use, both prior to the study as well as during the study period (see Table 3 and Appendix 3). Finally, participants of the intervention group had on average 0.73 QALYs (SD=0.20, IQR25-75%=0.65-0.89) and participants of the control group had on average 0.75 QALYs (SD=0.18, IQR25-75%=0.68-0.89; p=0.608, d=0.045).

Table 2. Primary outcomes (N (%)/ M (SD); IQR25-75%)

	Intervention group (N=59)	Control group (N=60)	Mann-Whitney U	X^2 test
Paid work				
Paid work (>1h)	35 (59%)	28 (47%)		X^2=1.912, p=0.167, d=0.127
Retained work (>12h a week, >3 m)	23 (39%)	17 (28%)		X^2=1.512, p=0.219, d=0.113
Days from baseline until start employment (>1h)	230 (135); 91-365	246 (145); 68-365	p=0.549, d=0.05	
Days from baseline until start sustainable employment (>12h a week, > 3m)	304 (90); 243-365	314 (96); 335-365	p=0.350, d=0.09	
Months of paid employment (>1h)	4 (4); 0-9	3 (4); 0-7	p=0.240, d=0.108	
€ total salary	5040 (6303); 0-9522	3257 (5538); 0-5126	p=0.082, d=0.159	
€ salary per month	740 (866); 0-1191	452 (710); 0-679	p=0.053, d=0.177	
Hours a month	56 (56); 0-98	35 (50); 0-65	p=0.051, d=0.179	
Social benefits				
Has left social benefits	24 (41%)	19 (32%)		X^2=1.047, p=0.306, d=0.094
Days from baseline until becoming independent of social benefits	293 (101); 183-365	317 (92); 312-365	p=0.165, d=0.127	
Months receiving social benefits	9 (4); 5-12	10 (3); 8-12	p=0.111, d=0.146	
€ total social benefits	7428 (4523); 3726-11531	7844 (4070); 4301-11670	p=0.454, d=0.069	
€ social benefits per month	763 (334); 579-973	750 (294); 572-977	p=0.890, d=0.013	
Additional self-report information				
Other forms of employment				
Voluntary work	30 (51%)	26 (43%)		X^2=0.674, p=0.412, d=0.075
Internship	15 (25%)	15 (25%)		X^2=0.003, p=0.958, d=0.005
Other	17 (29%)	15 (25%)		X^2=0.220, p=0.639, d=0.043

Table 3. Healthcare costs

	Intervention group* Costs € M (SD); IQR25-75%	Control group** Costs € M (SD); IQR25-75%	Mann Whitney U
Costs visiting a			
General practitioner			
3 m prior to study	52 (71); 0-70	72 (112); 0-70	p=0.441, d=0.062
During study (12 m)	160 (169); 35-211	167 (133); 35-282	p=0.885, d=0.012
Mental health care professional			
3 m prior to study	590 (1385); 0-514	364 (820); 0-385	p=0.335, d=0.078
During study (12 m)	1101 (1772); 0-1706	1358 (2346); 0-1499	p=0.358, d=0.074
Social worker			
3 m prior to study	162 (345); 0-139	102 (318); 0-52	p=0.581, d=0.045
During study (12 m)	428 (960); 0-694	611 (1331); 0-486	p=0.944, d=0.006
Physio-, cesar- or manual therapist			
3 m prior to study	77 (168); 0-72	21 (69); 0-0	p=**0.030**, d=0.176
During study (12 m)	163 (332); 0-215	128 (255); 0-143	p=0.626, d=0.039
Outpatient visit			
3 m prior to study	34 (92); 0-0	54 (117); 0-88	p=0.235, d=0.096
During study (12 m)	131 (199); 0-263	138 (268); 0-175	p=0.706, d=0.030
Hospital day care or hospital admission			
3 m prior to study	39 (164); 0-0	31 (147); 0-0	p=0.996, d=0.000
During study (12 m)	342 (974); 0-295	522 (2763); 0-0	p=0.450, d=0.061
Emergency care			
3 m prior to study	23 (78); 0-0	14 (61); 0-0	p=0.983, d=0.002
During study (12 m)	85 (225); 0-0	65 (165); 0-0	p=0.733, d=0.028
Total healthcare costs			
During study (12 m)	2409 (2152); 484-3845	2989 (4547); 323-2595	p=0.411, d=0.070

** Intervention group: 3 months prior to study N=59 participants, during study (12 months) N = 55 participants;*
*** Control group: 3 months prior to study N=60, during study (12 months) N = 47 participants.*

Total costs

To conclude, total costs in this study are mean total costs of one-year vocational rehabilitation (i.e. social benefits costs), mean total healthcare costs for one-year and for the intervention group, intervention costs per participant. For participants of the control group, mean total costs were €11,228 (SD=€6,451, IQR=€6,367-€14,324). For the intervention group, mean total costs were €9,893 (SD=€5,181, IQR=€5,187-€13,745; p=0.411, d=0.080).

DISCUSSION

To the best of our knowledge, this study is the first study examining the costs and benefits of a stigma awareness intervention in the work context from a societal perspective. The current study shows that participants of the intervention group had better work participation outcomes and better outcomes concerning becoming independent of

social benefits than participants of the control group. However, the differences between groups on employment outcomes, social benefits and healthcare costs and use did not reach statistical significance.

Regarding the costs of the intervention, participants of the intervention group had on average lower total costs (i.e. intervention costs, healthcare costs and social benefits) than participants of the control group (i.e. healthcare costs and social benefits), although this also did not reach significance. This indicates that although the intervention is not cost-effective, implementing a stigma awareness intervention may be beneficial for unemployed people with mental illness, as it is not more expensive than vocational rehabilitation as usual.

Concerning the effects of the intervention, more participants of the intervention group had found (59%) and retained (39%) paid employment compared to the control group (47% and 28% respectively). In addition, participants of the intervention group had found paid employment on average two weeks earlier than the control group, and retained paid employment on average 10 days earlier. Participants of the intervention group gained more salary (both over twelve months, as well as average salary per months) and had worked more hours a month, compared to the control group. Regarding social benefits, 41% of the intervention group had left social benefits during the study period, compared to 32% of the control group. Participants of the intervention group had left social benefits on average three weeks earlier the control group. Although the trend on both employment and social benefits outcomes showed that the intervention group scored better on all outcomes, differences between the intervention and control group on all outcome measures did not reach statistical significance.

Prior to the current study, an effectiveness study was conducted, using self-report data of employment, health, wellbeing, stigma and discrimination (33). This RCT consisted of participants of the current study together with participants who did not gave consent to collect data from Statistics Netherlands. Remarkably, in the RCT with self-report data, significantly more participants of the intervention group had found and retained paid employment than participants of the control group after six and twelve months. Also, they were more positive about the support of their employment specialist after six months compared to the control group (33). These results suggest that implementing the stigma awareness intervention is considered as beneficial by the participants.

The differences between the current study and the effectiveness study may be explained by several factors. First, the current study has a lower sample size and therefore lower power to detect significant differences. However, participants with and without data from Statistics Netherlands did not differ from each other on baseline demographics

and health characteristics (data not shown). Second, data from Statistics Netherlands only includes regular employment, i.e. declared employment that is known to the tax authorities. In the self-report study, participants could also indicate that they had paid employment when doing undeclared employment. In addition, doing undeclared employment could have been a reason for participants to not give consent to retrieve their income and social benefits information from Statistics Netherlands, for which reason they could not be included in the current study.

As the current study is the first to investigate the costs and benefits of the stigma awareness intervention into vocational rehabilitation services, it is difficult to compare the results to existing studies. However, there are indications that intensified vocational rehabilitation support for people with mental illness is successful in finding (and retaining) paid employment (47, 48). Earlier studies on the cost-effectiveness of supported employment programs found also promising results. For example, studies examining the cost-effectiveness of the supported employment program Individual Placement and Support (IPS) compared to vocational rehabilitation as usual, found that implementing IPS was effective and cost-effective in finding paid employment (49, 50).

Strengths and limitations

A strength of the current study is the use of data from Statistics Netherlands (40). Using this source ensures that data is available of all participants for the total study period. In addition, data from Statistics Netherlands is more accurate (i.e. it entails the exact income and starting dates) and less burdensome for clients. The second strength of this study is the societal perspective in this economic evaluation. By including healthcare costs, it gives insight into both direct as well as indirect effects of the intervention. A limitation of the study is the follow-up period of twelve months. Because finding employment is a time intensive process, the full potential of the intervention may not be measured within twelve months. The Dutch National Health Care Institute even recommends a life-long time horizon for economic healthcare evaluations (51). Therefore, future studies with a longer follow-up period are recommended. Another limitation of the study is that not all data could be reported. Statistics Netherlands has guidelines regarding reporting results of participants to ensure data cannot be traced back to individual participants. Therefore, self-report loss of production of participants could not be reported.

Conclusions

Implementing a stigma awareness intervention into vocational rehabilitation services could become cost-effective in the future. Although differences did not reach significance, participants of the intervention group found employment earlier and had lower costs compared to the control group. In addition, in practice, intervention costs per client will be lower, because development costs are no longer incurred and costs for organizing

and costs for employment specialists to follow the intervention can be divided by a larger caseload of clients. However, future studies with a larger scale and longer follow-up period are recommended to make deliberate decisions on further implementation of the stigma awareness intervention.

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APPENDIX 1: CORAL.NL DECISION AID

Can be found on page 178.

APPENDIX 2: MEDICATION USE

	Intervention group* number of medications M (SD); IQR25-75%	Control group** number of medications M (SD); IQR25-75%	Mann Whitney U
Did use medication			
3 m prior to study	1.3 (1.3); 0.0-2.0	1.7 (1.5); 0.3-2.0	p=0.206, d=0.102
During study (12 m)	2.5 (1.9); 1.0-4.0	2.8 (2.1); 1.0-4.0	p=0.581, d=0.044
Medication for mental health problems			
3 m prior to study	0.6 (0.9); 0.0-1.0	0.6 (0.8); 0.0-1.0	p=0.943, d=0.006
During study (12 m)	0.7 (0.9); 0.0-1.0	0.6 (0.9); 0.0-1.0	p=0.396, d=0.069
Medication for physical health problems			
3 m prior to study	0.7 (1.0); 0.0-1.0	1.1 (1.4); 0.0-1.8	p=0.121, d=0.125
During study (12 m)	1.8 (1.9); 0.0-3.0	2.2 (2.0); 1.0-3.0	p=0.265, d=0.090
Medication with a low cost price			
3 m prior to study	1.3 (1.3); 0.0-2.0	1.6 (1.5); 0.3-2.0	p=0.172, d=0.110
During study (12 m)	2.4 (1.9); 1.0-3.0	2.7 (2.1); 1.0-4.0	p=0.626, d=0.039
Medication with a high cost price			
3 m prior to study	0.1 (0.2); 0.0-0.0	0.1 (0.2); 0.0-0.0	p=0.687, d=0.032
During study (12 m)	0.1 (0.3); 0.0-0.0	0.1 (0.4); 0.0-0.0	p=0.774, d=0.023

** Intervention group: 3 months prior to study N=59 participants, during study (12 months) N = 55 participants;*
*** Control group: 3 months prior to study N=60, during study (12 months) N = 47 participants.*

APPENDIX 3. UNIT PRICES PER TYPE OF COSTS IN EUROS

Cost category	Indexed unit price (2019)
Healthcare costs	
General practitioner	€35 per consult
Social worker	€69 per consult
Mental health care professional	
Mental health institution	€112 per consult
Psychologist, psychotherapist or psychiatrist with own practice	€100 per consult
Psychologist, psychotherapist or psychiatrist in the hospital	€569 per consult
Addiction care institution	€112 per consult
Self help group	€69 per consult
Physio-, cesar or manual therapist	€36 per consult
Outpatient visit	€88 per consult
Hospital day care or hospital admission	
Hospital day care	€295 per day
Hospital admission	€473 per night
Emergency care	€277 per consult
Intervention costs	
Trainer costs	
Senior researcher	€92 per hour
PhD student	€61 per hour
Coachee costs	
Employment specialist	€21 per hour

CHAPTER 6

Improving work participation outcomes among unemployed people with mental illness: Feasibility of a stigma awareness intervention

Will be submitted as
Janssens KM, Joosen MC, Henderson C, van Weeghel J, Brouwers EP. Improving Work Participation Outcomes among Unemployed People with Mental Illness: Feasibility of a Stigma Awareness Intervention.

ABSTRACT

Purpose

As stigma is a barrier to work participation of unemployed people with mental illness, a stigma awareness intervention can be helpful to make informed decisions about disclosing mental illness in the work context. The aim of this process evaluation was to investigate the feasibility of a stigma awareness intervention, to explore experiences of clients and their employment specialists; and to give recommendations for further implementation.

Methods

The intervention consisted of stigma awareness training for employment specialists and a decision aid tool for their unemployed clients with (a history of) mental illness. Six process components were examined: recruitment, reach, dose delivered, dose received, fidelity and context. Quantitative and qualitative data were collected and analyzed, using administrative data, questionnaires and interviews.

Results

The intervention was largely implemented as planned. Participants were mainly positive about the intervention. Of the clients, 94% found the tool useful and 87% would recommend it to others. In addition, more than half (54%) indicated the tool had been helpful in their disclosure decision. Nevertheless, only a minority of clients and employment specialists had actually discussed the tool together. According to both, the intervention had increased their awareness of workplace stigma and the disclosure dilemma.

Conclusion

The implementation of a stigma awareness intervention was feasible and did increase stigma awareness in both clients and employment specialists. Experiences with the intervention were mainly positive. When implementing the tool, it is recommended to embed it in the vocational rehabilitation system, so that discussing the disclosure dilemma becomes a routine.

INTRODUCTION

Background

People with mental illness are 3 to 7 times more often unemployed than people without mental illness (1, 2). This is problematic, because being unemployed is associated with poorer (mental) health and financial strains (3, 4) and under favourable conditions, employment contributes to health, wellbeing and recovery (1, 5). There is growing evidence showing that stigma and discrimination are important barriers for the employment opportunities of people with mental illness (6-9). Stigma is the process of (negatively) labelling and excluding groups of people from society, which subsequently could lead to discriminatory behavior (10). Negative attitudes and discrimination on the part of employers, as well as internalized stigma among people with mental illness, could hamper finding and retaining paid employment (6, 11-14).

Decisions about disclosure of a mental illness to employers are complex and several studies have shown that deliberate decisions are very important for the (re-)employment success of people with mental illness (6, 15-17), but are also complicated and personal (18). Disclosure of mental illness can lead to positive outcomes such as support or adjustments in the work environment (15), but could also have negative consequences such as stigma and discrimination (e.g. not getting hired) (15, 16). A recent study found that the great majority of employees in the Netherlands had a strong preference to disclose mental illness, as around 75% of Dutch employees indicated they had disclosed, or would want to disclose, their mental illness to their manager (19, 20). However, 64% of Dutch managers were found to be reluctant to hire job applicants with mental illness (12).

Rationale

Decision aids for making informed decisions about disclosing mental illness in the work context seem promising (17, 21, 22). For example, the COnceal or ReveAL (CORAL) decision aid has shown to be effective in reducing decision-making stress, and in improving work participation of unemployed people with mental illness in the UK (17). Recently, the effectiveness of CORAL in combination with a stigma awareness training for employment specialists was tested in a randomized controlled trial (RCT) in Dutch municipal practice (23). The intervention was found to be effective for unemployed people with mental illness in finding and retaining paid employment. However, in addition to investigating the effectiveness of an intervention, it is also relevant to evaluate what elements contributed to the effectiveness, and to evaluate how the intervention was implemented in practice. Therefore, in this study, a process evaluation was conducted, in order to have a better understanding of the results of the RCT and the implementation of this intervention in the future (24).

Aim

The aim of this process evaluation was to 1) investigate the feasibility of the stigma awareness intervention, 2) explore experiences of participants (i.e. clients and their employment specialists); and 3) give recommendations for further implementation of the stigma awareness intervention.

METHOD

In this mixed methods study, data for the process evaluation was gathered alongside a cluster RCT (23, 25), conducted between March 2018 and July 2020. For the process evaluation, six process components of the framework of Linnan and Steckler (24) were used: i.e. recruitment, reach, dose delivered, dose received, fidelity and context. Quantitative and qualitative methods were used to collect data on the process components among participants of the intervention group: questionnaires for clients and employment specialists, administrative data and telephone interviews with clients and employment specialists.

Study context

In the Netherlands, people who are above 18 years and have insufficient income or capital and who do not make use of other provisions or benefits (such as disability benefits), are entitled to social benefits. Of the people receiving social benefits, 31% receive mental health care (26). Taken into account the treatment gap among people with mental illness (27), this is likely to be an underestimation of the actual percentage of people with mental illness who receive social benefits. Receiving social benefits involves specific rights and obligations through the *Work and Social Assistance Act* (2004). One of these obligations is cooperating in the support municipalities offer, aimed at entering the job market or returning to existing employment. Municipalities are authorized to organize this support by themselves. Mostly, this is provided by employment specialists during one-on-one appointments or via job application training sessions.

Study population

The intervention focused on two groups of participants: 1) unemployed people with mental illness receiving social benefits, hereafter *clients* and 2) employment specialists working at the local municipalities who provided clients with guidance to find paid employment, hereafter *employment specialists*.

Clients

N=76 clients participated in the intervention group of the study. Inclusion criteria were 1) being unemployed, i.e. an income below minimum income and receiving social benefits; 2) having sought any treatment (currently or in the past) for mental illness, including addiction, by a health professional (e.g. general practitioner, psychologist); and 3) adequate command of the Dutch language, as the intervention and questionnaires were in Dutch.

After completing the intervention study, 32 clients of the intervention group were invited by the researchers for a telephone interview. The invited clients were a representation of the total sample in age, gender, educational level and did/did not found paid employment during the study period. In total, 16 clients were willing to participate in the telephone interview and signed an informed consent. N=7 clients were not reached. Other reasons for not participating in the interviews were: not interested (N=4), too busy (N=3), personal reasons (N=1), and did not remember participating in the intervention study (N=1).

Employment specialists

Participating employment specialists were working at one of the four organizations, i.e. municipalities and organizations who work on behalf of municipalities. The employment specialists provided vocational rehabilitation to the clients who participated in this process evaluation and received the stigma awareness training for employment specialists, which was part of the intervention. In total, self-report data from N=35 employment specialists was used.

In addition, after completing the intervention study, employment specialists who were still working at their organization (N=13) were invited by the researchers for a telephone interview. Of them, N=12 responded positively and signed an informed consent to participate in the interview. One employment specialist was not willing to participate in the interview.

Intervention

The stigma awareness intervention had two elements: 1) a printed booklet of the decision aid CORAL.NL for people with mental illness and two infographics, i.e. simplified versions of the decision aid for those with literacy or concentration problems and 2) a 3x2 hours training targeted at employment specialists to increase their awareness about workplace stigma. In the RCT, the control group received vocational rehabilitation without the stigma awareness intervention, i.e. practice as usual.

CORAL.NL tool

The CORAL.NL entails a printed booklet consisting of four parts with several paragraphs: 1) choices about disclosure, including pros and cons of (non-)disclosure and personal needs and values; 2) identifying the personal situation, including preferences about

when and to whom to disclose; 3) tips; and 4) a recap of previous sections to make a plan about whether and what to disclose or not, and if so, to whom and when. When pilot tested by employment specialists who worked with people with mental illness, the CORAL.NL (a 14-pages booklet) was seen as too elaborate for people with lower concentration or reading skills. Therefore, two one-page infographics summarizing the most important information were developed and added to the CORAL.NL booklet in the current study: one version about disclosure during the job application process and the other about disclosure during employment (see Appendix 1).

Stigma awareness training for employment specialists

Employment specialists participated in a stigma-awareness training about disclosure of mental illness in the work context, specifically designed for the purpose of this study. While developing the training, input from a focus group study was used (15) combined with recent literature about working elements in destigmatizing interventions (28-30). Important working elements are education about (people with) mental illness and social contact between people with and without mental illness in a context of equality (28). Therefore, these elements were included in all training sessions, for example through live interviews with mental health advocates with lived experience and interactive discussion sessions. Aims of the training were enhancing awareness for 1) mental health workplace stigma and discrimination; 2) the disclosure dilemma; and 3) practice use of CORAL.NL and enhance skills for implementation. An overview of the learning goals and format of the training sessions is shown in Appendix 2.

The training consisted of three meetings of two hours, guided by 2-3 researchers (KJ and EB and/or MJ) and were provided in groups of 4-12 employment specialists at their own organizations. During the first meeting, employment specialists were trained to start to work with CORAL.NL in practice. In the training sessions, employment specialists were stimulated and reminded to use the CORAL.NL tool in practice, after clients had completed the baseline questionnaire.

Data collection

Feasibility of the intervention

To examine the feasibility of the intervention, the framework of process components by Linnan and Steckler (24) was used. The process components were described on the level of (a) clients and (b) employment specialists.

- *Recruitment*: the procedures used to approach participants for the intervention. The recruitment of both clients and employment specialists was described.
- *Reach*: the proportion of the intended target group that participated in the intervention. For clients, reach was defined as the proportion of those who actually participated in the study divided by the number of clients that were reached by the various recruitment strategies. For employment specialists, reach was the proportion that participated in the intervention group divided by the number of employment specialists that were invited to participate.
- *Dose delivered*: the number of intended interventions that is actually delivered. In the present study dose delivered was defined for clients as the number who received the CORAL.NL tool (i.e. the booklet and infographics) by the intervention providers. For employment specialists, dose delivered is the proportion that attended the training meetings according to the protocol.
- *Dose received*: the extent to which participants engaged in the intervention. For clients, dose received was defined as the proportion that 1) has read the intervention, and 2) has discussed the content of the CORAL.NL tool with their employment specialist. For employment specialists, dose received is the proportion that participated in the training meetings, and the proportion that actively worked with the CORAL.NL tool which was introduced in the training (i.e. who had introduced the booklet and/or the infographic to one or more clients with mental illness).
- *Fidelity*: the extent to which the intervention was implemented and delivered as planned. For clients, fidelity was defined as the extent to which the CORAL.NL tool was implemented as planned, i.e. as a tool for clients and employment specialists to think more deliberate about disclosing mental illness and/or have a conversation about the disclosure dilemma. For employment specialists, fidelity is the extent to which the training meetings were delivered as planned, and the extent to which the CORAL.NL was implemented in their support to clients. This was evaluated by self-report data from clients about their disclosure decisions and attitudes towards the CORAL.NL tool. Attitudes towards the CORAL.NL tool were measured using eight statements (e.g. 'I believe the CORAL.NL infographics were useful') with four answer categories: totally disagree, disagree, agree, totally agree. In this study, totally disagree and disagree were merged into 'disagree', totally agree and agree were merged into 'agree'. In addition, data from telephone interviews with both clients and employment specialists were used.
- *Context:* aspects of the environment that may have influenced the implementation of the intervention. Both the context for clients and employment specialists will be described. The process component context was assessed by telephone interviews.

Telephone interviews with clients and their employment specialists

Telephone interviews were held with clients and employment specialists to collect qualitative data for the process components *fidelity* and *context*. Prior to the interviews, two topic lists (one for clients and one for employment specialists) were developed that consisted of questions about experiences regarding feasibility, working elements and effects of the intervention on finding and retaining paid employment, and on what experienced barriers and facilitators were for a successful implementation. Telephone

interviews lasted for about 15-30 minutes. Clients received a financial remuneration of 10 euros.

Data analysis

Data of the questionnaires were analyzed using descriptive statistics. These statistical analyses were performed using SPSS version 25.0 for Windows. Interviews with participants were digitally recorded and transcribed verbatim. Transcripts were anonymized before analyses were performed. Interviews were coded and categorized through thematic coding by researcher KJ, using the qualitative data analysis software program Atlas.ti, version 9. Researchers EB, MJ and JW each checked the coding of two interviews (one of clients and one of employment specialists). Code agreements and disagreements were discussed within the team.

RESULTS

Mean age of clients was 37.4 years, and 58% was female. Most frequent self-reported psychiatric diagnoses were depression (26%), autism spectrum disorder (18%) and burnout (16%). For employment specialists, the mean age was 42.7 years and 84% was female. The mean years of work experience was 17.2 years, and the mean years of experience working with clients with mental illness was 7.7 years (see Table 1).

Recruitment

Clients were recruited through the four participating organizations. Employment specialists personally asked eligible clients if they were willing to receive more information about the study by telephone by the researchers. However, this recruitment strategy did not ensure enough eligible clients. Therefore, eligible clients were also recruited via personal invitation letters and leaflets from the organizations where the participating employment specialists were employed. Table 2 gives an overview of the number of clients recruited via the various recruitment strategies.

Employment specialists were recruited within the four organizations. Two small organizations invited all their employment specialists to participate in the study. In one large organization, team managers invited a selection of employment specialists who were not involved in other projects or studies. In the other large organization, team managers selected the employment specialists of their team, as there were also other professionals (i.e social workers) involved in their teams.

Table 1. Characteristics of the research sample

	M (SD)/N (%)
Clients (N=76)	
Age	37.4 (11.9)
Gender: male	32 (42%)
Marital status: no relationship	62 (82%)
Education level	
Lower educated or no education	39 (51%)
Medium educated	24 (32%)
High educated	13 (17%)
Self-report diagnosis*	
Anxiety	6 (8%)
Attention deficit (hyperactivity) disorder	11 (15%)
Autism spectrum disorder (including asperger and PDD-NOS)	14 (18%)
Bipolar disorder	2 (3%)
Burnout, stress, overload	12 (16%)
Depression	20 (26%)
Personality disorder	11 (15%)
Psychotic disorder	3 (4%)
Posttraumatic stress disorder	12 (16%)
Other diagnosis	7 (9%)
Don't know	7 (9%)
No official diagnosis	11 (15%)
Have had employment before baseline: yes	72 (95%)
Employment specialists (N=35)	
Age	42.7 (8.1)
Gender: male	8 (16%)
Years of work experience	17.2 (7.9)
Years of experience working with people with mental illness	7.7 (5.7)

** Percentage is above 100% because of comorbidity.*

Table 2. Recruitment strategies and number of clients that were reached for participating in the RCT (intervention group).

Recruitment strategies	Recruited*	Willing to have an introduction by telephone**	Reached***	
	(N)	(N)	(N)	(%)
Recruited by employment specialists				
In one-by-one contact	88	77	59	59/88=67%
During job application training sessions	20	7	5	5/20=25%
Personal letter or email from the municipality/ organization	320	21	12	12/320=4%
Leaflets in waiting rooms of municipality/ organization	Unknown	0	0	0%
Total	**Minimum of 428**	**105**	**76**	**76/428=18%**

**Recruited=eligible clients that were recruited to participate in the RCT;*
***Willing to have an introduction by telephone=eligible clients who gave consent to be contacted by researchers for more information about participating in the RCT;*
****Reached=intended target group that actually participated in the intervention.*

Reach

After being recruited by employment specialists, *clients* were contacted by telephone by the researchers to give information, check the inclusion criteria and to invite to participate. With some recruitment strategies (e.g. personal letters), clients who did not meet the inclusion criteria (e.g. not having (had) mental illness) were also recruited, but they were excluded from participating in the study. Furthermore, clients may have been recruited in two or more ways (e.g. via the employment specialist and via a personal letter). The reach percentages for the recruitment strategies were: 59/88=67% for personal invitations by employment specialists, 5/20=25% for recruitment during job application training sessions, 12/320=4% for invitations via personal letter or email from the organizations, and 0/0=0% for leaflets in waiting rooms of the organizations. The reach percentage for all recruitment strategies together was 76/428=18% (see Table 2).

For *employment specialists*, the reach percentage was 100% for two small organizations (N=17). For one large organization, ten employment specialists were invited by their team manager to visit an information session about the research. After the sessions, eight employment specialists were willing to participate, therefore the reach percentage was 8/10=80%. Within the other large organization, eight employment specialists were reached by their team managers and willing to participate (8/8=100%). The total reach percentage was 33/35=94%.

Dose delivered

All *clients* received the CORAL.NL booklet and infographics from the researcher after filling out the baseline questionnaire. This resulted in a dose delivered of 100%.

For *employment specialists*, all of them (N=35, 100%) participated in the first training session. N=7 employment specialists dropped out after the first training session because of several reasons: not willing to participate in the study anymore (N=3), not working in the organization anymore (N=3) and maternity leave (N=1). After the second training session, N=8 employment specialists dropped out (not working in the organization anymore: N=7, not willing to participate in the study anymore: N=1). In total, N=20 employment specialists (57%) completed the full training.

Dose received

After filling out the baseline questionnaire, clients received the CORAL.NL tool by the researchers. Although employment specialists were instructed not to hand out the tool to clients before their participation at baseline, N=3 clients (4%) had received the tool from their employment specialist prior to baseline (data not shown in table). Three months after baseline, 59% of the *clients* remembered the tool. Respectively, after six and 12 months, 61% and 69% of the clients remembered the tool. The CORAL.NL infographics had been read by 71% of the clients, and the booklet by 65% of the clients after 12 months. Around 16-18% of the clients discussed the tool with their employment specialist during the study period (see Table 3).

Table 3. Clients' use and experiences with the CORAL.NL tool (N (%)). Statements: N (%) who agreed with the statement.*

	T1	T2	T3
	3 months	6 months	12 months
Remembered the CORAL.NL tool	41 (59%)	41 (61%)	45 (69%)
Has read the CORAL.NL infographics	37 (54%)	37 (55%)	46 (71%)
Has read the CORAL.NL booklet	35 (51%)	39 (58%)	42 (65%)
Has discussed the CORAL.NL tool with their employment specialist	13 (19%)	11 (16%)	11 (17%)
Statements about the CORAL.NL tool			
I believe the CORAL.NL infographic is useful	34 (83%)	39 (91%)	45 (94%)
I believe the CORAL.NL booklet is useful	34 (83%)	39 (93%)	43 (92%)
I have benefited a lot from the CORAL.NL tool	20 (54%)	22 (51%)	21 (45%)
The CORAL.NL tool has played an important role during the application process	9 (24%)	10 (23%)	10 (22%)
The CORAL.NL tool has played an important role in finding paid employment	6 (16%)	10 (24%)	10 (21%)
The CORAL.NL tool has helped me in deciding whether or not disclosing my mental illness to an employer	23 (59%)	23 (55%)	26 (54%)
The CORAL.NL tool has changed my mind about disclosure of mental illness	26 (53%)	17 (41%)	21 (45%)
I would recommend the CORAL.NL tool to others	35 (85%)	36 (86%)	41 (87%)

**Clients received the CORAL.NL tool* after *filling out the baseline questionnaire.*

After completing the stigma awareness training, 68% of *employment specialists* indicated they had used the CORAL.NL infographics and 26% had used the CORAL.NL booklet in their contact with clients with mental illness. Employment specialists who indicated they used the tool did not use these during every client contact. Of the employment specialists who used the tool (N=13), six indicated to use them 'because of the importance of the topic', three 'because clients asked questions about disclosure' and three for other reasons. One year after the training, 41% reported still using the infographics and 26% the booklet. Of the employment specialists who reported using the tool, only one specialist used the tool during every client contact. Of the employment specialists who still used the tool (N=11), one reported using them 'because of the importance of the topic', three 'because clients asked questions about disclosure' and three for other reasons (see Table 5).

Table 4. Percentage of employment specialists that actively engaged with the intervention (N (%)).

	After completing stigma awareness training	One year after completing stigma awareness training
Did you use the CORAL.NL infographics in supporting clients with mental illness	13 (68%)	11 (41%)
Did you use the CORAL.NL booklet in supporting clients with mental illness	5 (26%)	7 (26%)
Why did you use the CORAL.NL tool?		
Because of the importance of the topic	6 (46%)	1 (9%)
Because clients asked questions about disclosure	3 (23%)	3 (27%)
Other	3 (23%)	3 (27%)
Unknown (did not answer)	1 (8%)	5 (46%)
Do you still use the CORAL.NL tool in supporting clients with mental illness?		
Yes, always	0 (0%)	1 (4%)
Yes, sometimes	10 (53%)	6 (22%)
No	9 (47%)	20 (74%)

Fidelity

Clients received the CORAL.NL tool, i.e. a decision aid to make more deliberate disclosure decisions in the work context, after filling out the baseline questionnaire. In case clients lost the tool or did not remember it anymore at follow-up questionnaires, the tool was provided again. After 12 months, 94% of the clients indicated that they believe the CORAL.NL infographic was useful, and 92% of the clients believed the CORAL.NL booklet had been useful. The CORAL.NL tool was recommended to others by 87% of the clients. For 54% of the clients the tool was helpful in deciding whether or not disclosing their mental illness to an employer, and 45% indicated that the tool had changed their mind about disclosure of mental illness. About one in five (22%) of the clients indicated that the tool had played an important role during their job application process and 21% indicated that the tool had been important during finding paid employment (see Table 3). In the interviews, most clients mentioned they believed that discussing the tool and the disclosure decision with their employment specialist would have been useful, although they had not discussed it.

Employment specialists' training sessions were provided at their organizations. If an employment specialist could not be present at a training session, a separate training session (alone or together with other employment specialists who could not be present) was organized. In the interviews, employment specialists mentioned that through the training sessions, the topic of disclosure had become more part of the conversation with clients with mental illness. Employment specialists experienced more awareness about the disclosure dilemma and the everyday presence of stigmas because of the training sessions. Employment specialists mentioned to use the tool especially with

clients who were actively searching for work and not to use it with clients who would deny their mental illness, had concentration or literacy problems or were not ready to search for work yet. One of the most appreciated aspects by employment specialists was the presence of a mental health advocate with lived experience during the training sessions, which had impressed them. Furthermore, employment specialists mentioned that they had appreciated the presentations on scientific research of workplace stigma and the disclosure dilemma and the interactive debates about topic related statements, and had found these to be informative.

Context

Clients did not always have frequent meetings with their employment specialist, e.g. because employment specialists could postpone appointments in case they estimated the mental illness at that moment as too severe, which hindered discussing the CORAL.NL tool with their employment specialists. In the interviews clients were asked about their opinion of the feasibility of the CORAL.NL tool. Clients found the CORAL.NL tool clear and well structured, with good explanations. Some clients mentioned that they were not yet actively seeking for a job and therefore did not see the importance of thinking whether to disclose or not. Other clients were afraid to discuss the disclosure dilemma with their employment specialist because they had the feeling that their employment specialist was not really there for clients and wanted to guide them to work as soon as possible. Facilitators mentioned for the use of the CORAL.NL tool was having a good relationship with their employment specialist and having an employment specialist who was interested in the disclosure dilemma.

In the interviews, the majority of the *employment specialists* mentioned that working with the tool had not become a routine and that using the tool was not necessary to discuss the disclosure dilemma with clients. They indicated that it would have helped if they would have been reminded more often to use the tool by the researchers. In addition, employment specialists indicated that more frequent contact with the researchers and/or more training sessions could have been a facilitator to maintain focus on the disclosure topic. Employment specialists reported in the interviews that the content of the training quickly became of minor importance in their guidance of clients because of other tasks and work activities.

Previous disclosure experiences and experiences regarding participating in the intervention

At baseline, of the *clients* who had applied for work, 12% of the clients had disclosed their mental illness in some job application letters, and 23% of the clients had disclosed their mental illness sometimes or always during a first job application interview. After 12 months, none of the clients had disclosed their mental illness in a job application

letter and 19% of the clients had disclosed their mental illness in a first job interview (see Table 5).

Table 5. Frequencies of clients' disclosure decisions in the work context (N (%))

	T0 baseline	T1 3 months	T2 6 months	T3 12 months
In the past four weeks, did you disclose your mental illness in the following activities?				
Job application letter				
Never	29 (88%)	30 (91%)	33 (94%)	28 (100%)
Sometimes	4 (12%)	2 (6%)	1 (3%)	0 (0%)
Always	0 (0%)	1 (3%)	1 (3%)	0 (0%)
First job application interview				
Never	25 (76%)	27 (77%)	28 (82%)	22 (82%)
Sometimes	7 (21%)	5 (14%)	3 (9%)	5 (19%)
Always	1 (2%)	3 (9%)	3 (9%)	0 (0%)
Follow up job application interview				
Never	19 (76%)	24 (77%)	25 (81%)	21 (81%)
Sometimes	6 (24%)	6 (19%)	4 (13%)	4 (15%)
Always	0 (0%)	1 (3%)	2 (7%)	1 (4%)
After being hired				
Never	15 (60%)	21 (63%)	21 (63%)	21 (64%)
Sometimes	9 (36%)	11 (33%)	7 (21%)	6 (19%)
Always	1 (4%)	1 (3%)	4 (12%)	0 (0%)

In the interviews, *clients* experienced that increasing awareness of the disclosure dilemma was an important effect of the CORAL.NL tool. Clients said that as a result of the CORAL.NL tool they had become more aware of the pros and cons of both disclosure and non-disclosure. In some cases, clients retained their original disclosure decision, however this decision was now more deliberate rather than intuitive only. Other clients reported that they had changed their mind after using the tool, especially from disclosure to non-disclosure but also from non-disclosure towards disclosure.

Most employment specialists were motivated to participate in the training sessions and reported that they had become more aware about stigma of mental illness and the disclosure dilemma. Some of the interviewed *employment specialists* mentioned that they had hoped to learn more about how to deal with and support clients with mental illness in their vocational rehabilitation and were somewhat disappointed that the stigma awareness intervention had not addressed this.

DISCUSSION

The aim of this process evaluation was to investigate the feasibility of a stigma awareness intervention, to report experiences of clients and their employment specialist, and to give recommendations for further implementation in practice. The stigma awareness intervention consisted of the Dutch CORAL.NL decision aid and a newly developed stigma awareness training for employment specialists. The overall results show that the intervention was feasible to implement and that the intervention proved to be successful in increasing stigma awareness and awareness about the disclosure dilemma in both clients and their employment specialists.

The results of the study showed that the majority of the clients were positive about the content of the CORAL.NL tool. Clients had become more aware about the importance of deliberate disclosure decisions and most of the clients would recommend the tool to others. In addition, the tool was reported to be helpful for the majority of the clients in making a decision about whether to disclose mental illness or not, and 40-53% of the clients had changed their mind about disclosure of mental illness due to the tool. About one in five clients indicated that the tool had helpful in applying and/or finding work. This suggests that the timing of presenting the tool to clients may be important, where it is more helpful for those people who are actively searching and/or applying for work (17). Another explanation may be that the tool makes people feel more empowered, which may reduce self-stigma and increase someone's self-esteem (31, 32). Subsequently, this could lead to more positive work participation outcomes.

Results of a separately conducted RCT examining the effects of current stigma awareness intervention have shown that participants of the intervention group had found (51%) and retained (49%) paid employment twice as often compared to the control group (respectively 26% and 23%) (23). Although the CORAL.NL tool was not often used by employment specialists during client contact, both groups indicated in the interviews that they had become (more) aware about the disclosure dilemma. Around 30% of the clients indicated that the CORAL.NL tool was useful for their job application process and/or finding work. The majority of the clients (87%) would recommend the decision aid to others. This suggest that the CORAL.NL tool is especially helpful when people are actively searching and/or applying for work, which was also suggested by Henderson and colleagues (17).

Concerning the stigma awareness training, most employment specialists adhered to completing all training sessions. Employment specialists' opinions about the training sessions were divided. Most (teams of) employment specialists were very enthusiastic and motivated to participate in the training sessions, whilst others did not see added

value. Employment specialists mainly dropped out the training sessions because of job changes. However, four employment specialists dropped out because they lost interest to participate in the study. Perhaps, this may be the result of some employment specialists' disappointment about the content not being more broadly about how to help people with mental illness. Effective elements in stigma awareness interventions are face-to-face contact with someone with lived experience and the educative components (28, 33-35), and these were also present in the current stigma awareness intervention and much appreciated by the employment specialists. However, in further implementation, more facilitators with an employment specialist background in the training sessions might increase participation of employment specialists.

In this process evaluation, six process components of Linnan and Steckler's framework (24) were explored. Of all strategies, recruitment via personal invitations from employment specialists had the highest reach percentage. Other strategies (such as invitations via personal letters or email) had a lower reach percentage but were less time intensive and included in total more eligible clients. Recruitment of clients via employment specialists can cause difficulties because of keeping them involved and motivated to recruit (36). For this reason, in this study other recruitment strategies were needed. In addition, recruitment via employment specialists could create selection bias (37), e.g. employment specialists who prevent their clients from participating or because they were unaware of the clients' mental illness because the client did not disclose.

This process evaluation has shown that the intervention was largely implemented and conducted as planned. However, the adherence to the intervention by clients and employment specialists could have been better. Around two third of the clients had read the CORAL.NL tool and one fifth of the clients had discussed the CORAL.NL tool with their employment specialists. For employment specialists, after completing the training sessions, half of them used the tool during some of their client contact. After one year, a quarter of the employment specialists still used it (sometimes). Improving the adherence of the intervention by clients and employment specialists in future implementation may even improve the effectiveness of the intervention on employment outcomes. Therefore, it might be helpful to systematically embed the CORAL.NL into vocational rehabilitation services. This may ensure that the tool is accessible to everyone who wants to, as the tool was not always at the forefront of employment specialists' minds. Currently, in the Netherlands, practitioners of the supported employment method Individual Placement and Support (38) have already incorporated the tool into their guidance.

Strengths and limitations

A strength of this process evaluation is the use of the theoretical framework of Linnan & Steckler (24). Using a theoretical framework ensures several relevant process components are assessed thoroughly. Second, a strength of the current study is the use of both quantitative and qualitative data, as well as the combination of data from clients together with data from their employment specialists. A limitation of this study is the lack of a fidelity instrument to measure the feasibility of the stigma awareness intervention in a structured fashion. Another limitation was the lack of information available from eligible clients who decided not to participate in the study. Therefore, it was not possible to conduct a non-response analysis.

Implications for research and practice

As the previously published RCT showed that the stigma awareness intervention was highly effective in finding and retaining paid employment after six and 12 months respectively (23). This indicates that more attention towards mental illness stigma awareness and the disclosure dilemma contributes to improved (and sustainable) labor participation. These findings have major implications for practice, as this suggests that implementing this feasible and relatively simple stigma awareness intervention in municipal practice, could possibly double the employment rates of unemployed people with mental illness. Improving the employment outcomes of people with mental illness, will both have personal positive effects, e.g. better health and wellbeing (1, 5), as well as societal benefits, such as lower societal costs.

Conclusion

This process evaluation showed that the implementation of a stigma awareness intervention was feasible and did increase stigma awareness in both clients and employment specialists. Experiences with the intervention were mainly positive, as 87% of the clients would recommend the CORAL.NL tool to others. When implementing the tool, it is recommended to embed the tool in the vocational rehabilitation system, so that it is accessible for everyone.

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APPENDIX 1: CORAL.NL DECISION AID

Can be found on page 178.

APPENDIX 2: LEARNING GOALS AND COMPONENTS OF THE TRAINING

	Training components	Learning goals of training
Training session I	• Informative presentation 'What is stigma and why it is a problem for labor participation?' • Discussion about statements on the attitudes of managers. • Interview with a mental health advocate with lived experience. • Discussion about own attitudes and acting. • Explaining how to use the CORAL.NL tool. • Formulating personal learning goals.	• Create/increase awareness of stigma and discrimination in the work environment: 1) What stigma is and how does it work, what are the effects? 2) Increase awareness into stigma and discrimination by employers/managers; 3) Increase awareness into the effects of own attitudes, personal prejudices and actions; 4) Increase awareness into negative effects of disclosure during job applications. • Learn to use the CORAL.NL tool in conversations with clients, without influencing too much. • Motivate and enthuse for this theme and new working method.
Training session II	• Evaluating the progress of recruiting participants • Displaying film with stories of workers with lived experience, created for the purpose of this training. • Improving conversation skills and using the CORAL.NL tool. • Role play to practice the conversation between employment specialist and client about disclosure of mental illness. • Discussion about statements on the effectiveness of a disclosure decision aid. • Formulating personal learning goals.	• Improve skills for working with CORAL.NL: 1) What is going well? 2) What is going not so well? What are barriers? 3) For whom does it work or not? 4) When does it work or not? 5) What are reactions to CORAL.NL and/or the conversation about disclosure? • Provide extra information for the successful use of the CORAL.NL tool and on how to enter into a conversation about disclosure. • Increase awareness of stigma and discrimination in the work environment: 1) Increase awareness into stigma and discrimination by employers/managers. 2) Increase awareness into how stigma can be experienced/what it does to people.
Training session III	• Informative presentation about the attitudes of different stakeholder groups towards disclosure of mental illness. • Improving conversation skills and using CORAL.NL. • Role play with a mental health advocate with lived experience to practice the conversation about the disclosure-dilemma.	• Discussion of the content of CORAL.NL and how to work with the CORAL.NL tool: 1) Topics covered in CORAL.NL. 2) Learn to work with CORAL.NL. • Increase awareness into stigma and discrimination by employers/managers. • Increase awareness into how the disclosure dilemma can be experienced/what it does to people.

CHAPTER 7

General discussion

DISCUSSION

In this thesis, the two aims were 1) to gain more insight into the attitudes and hiring intentions of Dutch managers towards people who have or have had mental illness, and 2) to evaluate the effectiveness of a stigma awareness intervention for unemployed people with mental illness and their employment specialists, compared to usual vocational rehabilitation. The main findings of the thesis will be presented in this chapter. In addition, explanations for the findings will be discussed, together with strengths and limitations of the study, implications for practice and recommendations for future research. The chapter will end with a conclusion.

THE MAIN FINDINGS OF THE THESIS

Concerning the first aim of this thesis, in a cross-sectional study, line managers' knowledge and attitudes concerning job applicants with current or past mental illness were studied. In addition, the factors associated with the intention (not) to hire an applicant with mental illness were assessed. The results showed that the majority of managers (64%) were reluctant to hire someone with current mental illness. Moreover, about one-third of the managers (30%) was reluctant to hire an applicant with past mental illness. This reluctance was remarkable, considering the finding that only 7% of the managers indicated to have actual negative personal experiences with employees with mental illness, whereas the 52% even had positive personal experiences. The factors that were associated with a higher reluctance to hire a job applicant with mental illness were managers' concerns about a) long-term sickness absence, b) the employee not being able to handle the work, and c) not being able to count on the employee. Moreover, a higher managers' education level was associated with higher reluctance to hire an applicant with mental illness. In contrast, we found that managers' being in favor of diversity and/or inclusive enterprise out of principle was associated with positive hiring intentions.

For the second aim of the thesis, a cluster randomized controlled trial (RCT) was conducted to study the effectiveness of a stigma awareness intervention among unemployed people with current or past mental illness in Dutch municipal practice. The design of the study was described in a study protocol, following the Consolidated Standards of Reporting Trials (CONSORT) 2010 statement and the Standard Protocol Items: Recommendation for Interventional Trials (SPIRIT) 2013 statement (1, 2). Subsequently, the following studies were conducted: 1) an effectiveness study to investigate the effects of the intervention on employment outcomes and decisional conflict, 2) an economic evaluation to investigate the costs and benefits from a societal perspective, and 3) a process evaluation in which the feasibility, experiences and recommendations for successful implementation of

the intervention were studied. Participants were assessed with a follow-up period of twelve months. Participants in the control group received vocational rehabilitation as usual. Participants of the intervention group received vocational rehabilitation as usual combined with a stigma awareness intervention, which consisted of a) the CORAL.NL tool (i.e. a decision aid booklet and two infographics) on disclosure of mental illness in the work context for (unemployed) people with mental illness, and b) a stigma awareness training for employment specialists, especially designed for the purpose of this study. An explanation of the conditions can be found in Box 1 below.

Box 1. Explanation of the conditions (a) vocational rehabilitation as usual and (b) vocational rehabilitation as usual combined with a stigma awareness intervention.

Control group

Vocational rehabilitation as usual
Various facilities organized by the local municipality: i.e. guidance from employment specialists, education and training (e.g. job application training).

Intervention group

Vocational rehabilitation as usual

In combination with a s**tigma awareness intervention,** consisting of two elements:

A. CORAL.NL tool for unemployed people with mental illness
The CORAL.NL tool is a decision aid based on the Conceal Or ReveAL (CORAL) decision aid (3), which was translated and developed further into the CORAL.NL for the Dutch practice (4). The tool consists of a 14-pages booklet containing four parts:
- *Part 1* deals with choices about disclosure, the pros and cons of disclosure, and personal disclosure needs and values.
- *Part 2* is about one's personal situation and deals with questions about to whom and when to disclose.
- *Parts 3* and *part 4* summarize previous sections to make a plan about whether to disclose or not, and if so, to whom and when and what to disclose.

In addition, for people with concentration and literacy problems, two very brief infographics were developed, summarizing pros, cons and tips regarding disclosure during the job application process and during employment, respectively.

B. Stigma awareness training for employment specialists
This training was developed for the purpose of this study, using literature on effective elements of stigma interventions (5-8) and input from a focus group study (4). The full training consisted of three meetings within 6 months. Each meeting has a duration of 2 hours and was provided in groups of 4–12 employment specialists under guidance of 2–3 trainers.

Aims of the training were:
- Creating awareness of stigma and discrimination in the work environment and creating insight into the effects of employment specialists' own attitudes, personal prejudices and actions;
- Increasing understanding of how the disclosure dilemma can be experienced by people with mental illness and how it affects them,
- Learning to work with the CORAL.NL tool and infographics, including how they can be implemented in daily practice.

The findings of the effectiveness study showed that the stigma awareness intervention was highly effective in improving work participation outcomes. Six months after baseline, the percentage of people who *found* employment was significantly higher in the intervention group compared to the control group (51% versus 26%). Moreover, after 12 months, significantly more participants of the intervention group had *retained* paid employment compared to the control group (49% versus 23%). In addition, compared to the control group, participants of the intervention group were on average significantly more positive about the support received from their employment specialists six months after baseline. The intervention had no effect on decisional stress, i.e. decisional conflict and stage of decision making. Furthermore, no significant differences were found between the control and intervention group on secondary outcomes (such as mental health and self-stigma) in follow up measurements. However, participants of the intervention group were significantly more positive about the quality of guidance by their employment specialists compared to the control group after six months.

In an economic evaluation, the costs and benefits of the stigma awareness intervention were examined from a societal perspective. Although differences did not reach statistical significance, we found that participants of the intervention group had lower costs on healthcare and social benefits, compared to participants of the control group. Similarly, participants of the intervention group had better work participation outcomes (e.g. on finding employment, days until start employment and working hours a month), and better outcomes concerning becoming independent of social benefits (e.g. on days until becoming independent of social benefits) than participants of the control group. However, again, differences between groups on all outcome measures did not reach statistical significance.

Finally, a process evaluation was conducted to investigate the feasibility of a stigma awareness intervention, to report experiences of participants (i. e. unemployed people with mental illness and their employment specialist), and to give recommendations for further implementation in practice. The overall results showed that the intervention was feasible to implement. In general, the stigma awareness intervention had increased awareness of workplace stigma and disclosure decisions in both unemployed people and their employment specialists. Experiences with the intervention among unemployed people were mainly positive, as 87% would recommend the CORAL.NL tool to others. When implementing the tool in municipal practice, it is recommended to embed the tool more systematically into the vocational rehabilitation services, as employment specialists not always had the tool and/or disclosure topic on top of their minds.

THEORETICAL EXPLANATION OF THE INFLUENCE OF DISCLOSURE DECISIONS ON EMPLOYMENT OUTCOMES

The study adds to the growing evidence that employment rates of people with mental illness are not only determined by the illness but to a large extent also by psychosocial factors such as stigma and discrimination. Similar to the findings of earlier studies (3, 4, 9, 10), our study underlines the importance of deliberate disclosure decisions for successfully finding and retaining paid employment.

This research suggests that people with mental illness do not automatically make deliberate decisions about what they want or do not want to disclose about their mental illness in a job application or during work. It is promising that a relatively simple and affordable intervention had influence on the employment opportunities of unemployed people with mental illness. As this is the first study investigating the role of stigma and workplace disclosure on employment outcomes of the unemployed people in the Netherlands, more studies are urgently needed to investigate this further. If future studies can confirm our findings, this would mean that twice as many unemployed people with mental illness can find and retain paid employment using the intervention. This would greatly benefit themselves e.g. health and wellbeing benefits (11), and the society at large (in terms of costs) (12).

In the past, theoretical frameworks have been developed about e.g. conceptualizing stigma (13) and disclosure decision making (14). Recently, Hastuti and Timming (15) conducted an interdisciplinary review on workplace mental illness disclosure and designed a comprehensive framework for mental illness disclosure decisions in the workplace (see Figure 1). In this framework, it is shown that internal and external (organizational and non-organizational) factors are of influence on disclosure decisions for employees and job applicants with mental illness. Organizational factors can both have a direct and indirect influence on someone's disclosure decision. For example, a supportive organizational climate may stimulate someone to disclose their mental illness and can lead to positive reactions on an employee disclosing their mental illness. On the other side, managers' negative attitudes towards employees or applicants with mental illness can lead to negative disclosure outcomes. The CORAL.NL tool may have had influence on internal factors such as attitudes towards disclosure and disclosure motives. In addition, the CORAL.NL tool and the stigma awareness training for employment specialists were designed to improve employment specialists' knowledge and skills in how to support people with mental illness in their personal disclosure decision (i.e. non-organizational factors). Subsequently, this support in making a deliberate decision in whether to disclose a mental illness or not, and to whom and when, may have had a positive influence on their disclosure outcome (see Figure 1).

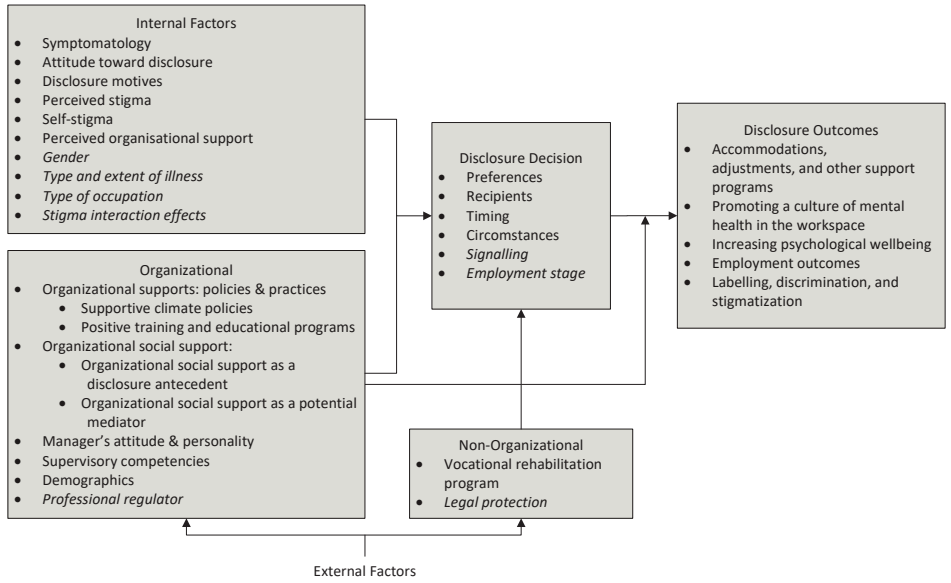

*Figure 1. Mental illness disclosure model from Hastuti and Timming (15). (note: words in **italic** are directions for future research.)*

Results from earlier studies on disclosure decision aids

Our stigma awareness intervention was innovative for the Dutch context. Previous studies have also shown that planning disclosure decisions strategically is important in decreasing the harmful effects of stigma (16, 17). In addition, studies on the effects of the English CORAL and other disclosure decision aids also found an improvement in work participation outcomes among participants who had used those interventions (3, 17, 18). However, these RCT studies had smaller sample sizes and a shorter follow-up period (3, 17). Our study is the first to examine this with a longer follow-up period and using a larger sample size. Also, innovative in our study is the stigma awareness training for employment specialists, specially designed for the purpose of this study. Altogether, these studies show that using a decision aid for making mental illness disclosure decisions seems promising for helping people with mental illness in communicating about their mental illness and subsequently for improving their employment opportunities.

In contrast to the effects on decisional stress of the CORAL (3) and the online decision aid READY (18), in this study we did not find any effect on decisional stress. In general, from baseline, participants in our study had a below average decisional conflict score. In addition, participants also had a low internalized stigma score at baseline. Recent Dutch studies showed that the majority of employees disclosed or would like to disclose their mental illness to their employer (19, 20) and most Dutch employees have predominantly

positive expectations about disclosing mental illness in the workplace (21). Rüsch and colleagues (10) have shown that greater reluctance to disclose mental illness is associated with better work participation outcomes after six months. In our study, the higher work participation outcomes in the intervention group suggest that the default position of all participants may also have been disclosure. Subsequently, the decision aid may have had an impact in changing the default position into non-disclosure for the intervention group and therefore has had its influence on the work participation outcomes. Another possible explanation of the different effects found on decisional stress may be due to differences in the selection criteria while recruiting participants. The CORAL RCT by Henderson and colleagues (3) used cut off scores for selecting people having at least moderate decisional conflict. In our study, we decided not to apply such inclusion criteria and to test the effectiveness of the tool in all unemployed people with mental illness receiving social benefits.

In addition, our RCT differed from other studies on disclosure decision aids for unemployed people (3, 17) regarding the inclusion criteria of mental illness. Henderson and colleagues (3) and McGahey and colleagues (17) included participants with especially severe mental illnesses. In our study, anyone with self-identified mental illness could participate in the study, which represented all types of mental illness, from mild to severe. Because of the wide diversity of self-identified mental illnesses, we could not do additional analyses on the type of mental illness, However, perhaps people with severe mental illness experience more often higher decisional stress, e.g. because of more severe symptoms or complaints. Future research is needed to study if the CORAL(.NL) decision aid is even more effective when it is more tailormade, e.g. for the type of job and/or the situation someone is in.

Explanations for the increased employment outcomes

Each year, of those who receive social benefits in the Netherlands, 15% stops receiving social benefits, i.e. becomes independent of social benefits (22). Most of them become independent because of finding (sustainable) paid employment, however, some do so because of other reasons, such as starting a relationship with someone who has sufficient income and/or capital. For people with mental illness, it is more difficult to become independent of social benefits compared to people without mental illness (22). It is remarkable that over time, in our study not only the employment rates of the intervention group improved, but also those of the control group were higher than the average outflow of social benefits. There may be two possible explanations for this.

First, participants of both the intervention and control group received questions and statements about disclosure of mental illness and the disclosure dilemma at each measurement. This may have raised more awareness about the importance of the

disclosure dilemma and indirectly may have influenced employment outcomes in both groups. In the face-to-face appointments between researchers and participants to complete the questionnaires, participants sometimes mentioned that they had never thought about disclosure or the disclosure dilemma before. However, because of the questions posed in the questionnaire they now suddenly realized that this was an interesting topic for them. If this indeed explains the increased work participation outcomes in the control group, this greatly underlines the importance of increasing awareness to workplace stigma and the disclosure decision and suggests that increasing awareness is a very powerful yet simple way to increase work participation of unemployed people with mental illness.

Second, although the exact intervention was not known by the control group, employment specialists of both conditions were aware that they were participating in a study on improving work participation outcomes of people with mental illness. Being aware of participating in a study could have impact on the behavior of participants in both groups, i.e. employment specialists of both groups could have become more motivated to support people with mental illness, this is also known as the *Hawthorne Effect* (23). This effect was also seen in the *Dutch Local Trust Experiments (24)*, in which the effects of different forms of vocational rehabilitation (*Trust Experiments,* e.g. earnings release or tailer-made supervision) were studied on the number of unemployed people becoming independent of social benefits. In this study, no differences were found between the intervention and control groups, but the researchers did find a positive effect when comparing the intervention and control group with a reference group of non-participants (24). Because we did not have a reference group in our study, it is not possible to make a similar comparison.

Using self-report data versus microdata

In the effectiveness study and economic evaluation of our RCT, we have used different data sources. In the effectiveness study, self-report data of all participants on employment and secondary outcomes such as current mental health, wellbeing, stigma and discrimination was used. In the economic evaluation, microdata from Statistics Netherlands (25) on employment and social benefits of participants who gave consent to collect their data from Statistics Netherlands was used, combined with self-report data of healthcare use. These different data sources in the studies were used as not all participants of the RCT had given consent to use their data from Statistics Netherlands, but self-report data on employment outcomes was gathered of all participants. As we did not want to exclude participants who had not given (additional) consent for the use of data from Statistics Netherlands, we used the self-report data of participants in the effectiveness study.

In our effectiveness study we found that significantly more participants of the intervention group had found – and retained – paid employment than participants of the control group. In the economic evaluation, using another data source (i.e. microdata from Statistics Netherlands), employment rates of the intervention group were also higher than those of the control group. However, in this study the differences did not reach statistical significance. The differences between those studies are puzzling, although there are several possible explanations for this. First, an explanation may be the smaller sample size in the economic evaluation, resulting in a lower power to detect significant differences. Because the trend on both employment and social benefits outcomes is promising, it is recommended to use a larger sample size in future research.

Participants were asked separately for their consent to retrieve data on income and social benefits from Statistics Netherlands. Some participants deliberately chose not to give permission for this, possibly because they were reluctant to share their data. For example, in the appointments with participants, it was sometimes mentioned that the participant had undeclared employment, e.g. for a friend or family member's business. Having undeclared employment, i.e. employment that is not known to the tax authorities, is not allowed and therefore it might have been that participants choose to not share their income data from the authorities.

Furthermore, concerning the outcome measures of both studies, it needs to be stressed that finding and retaining paid employment was defined as a dichotomous variable, i.e. found paid employment: yes/no, retained paid employment: yes/no. In the effectiveness study, this was measured at four separate measurements within twelve months (i.e. baseline, 3, 6 and 12 months). However, in the economic evaluation this was measured as having found, or retained, paid employment (at least once) in 12 months. Therefore, both variables contain slightly different information, which may partly explain the different results found in the two studies.

Finally, an advantage of using data from Statistics Netherlands is that it entails exact data on income and social benefits, including start and end dates, amount of income and hours of work, of all participants (who gave consent) during the whole study period. Statistics Netherlands obtains information on wages from the Dutch tax authorities and information on social benefits from the administrations of Dutch municipalities. However, while obtaining and processing this information, it is inevitable that registration mistakes can be made sometimes. In addition, also self-report data can have flaws. Self-report data was collected at four moments with several months of time within, participants could have made mistakes in e.g. start or end dates or the amount of income. Therefore, both data sources may be subjected to flaws and should not be seen as completely reliable.

Feasibility of the intervention

A process evaluation was conducted to examine the feasibility of the stigma awareness intervention, and to report experiences and recommendations for future implementation. The main finding of this study was that the intervention proved to be successful in increasing stigma awareness in both unemployed people with mental illness and their employment specialists. Most clients had positive attitudes towards the CORAL.NL tool and would recommend the tool to others. In addition, clients reported that the tool was useful in making deliberate decisions about whether to disclose mental illness or not. Employment specialists mentioned the timing of introducing the tool and/or having a conversation about disclosure as important. They reported that the tool was especially helpful when people were actively searching and/or applying for employment, which was also suggested by Henderson and colleagues (3).

Concerning the employment specialists, most of the specialists completed all training sessions of the stigma awareness training. However, the adherence of employment specialists using the CORAL.NL tool could have been better, as the tool was not often used by employment specialists. Employment specialists might have felt confident enough to have a conversation with clients about the disclosure dilemma without the tool. However, employment specialists also noticed that the tool was not always on top of their minds. In the interviews, employment specialists suggested that more training sessions or more reminders in between could have been helpful in not forgetting to use the tool. Therefore, for implementation in practice it is important to embed the CORAL.NL tool in the regular operating procedures of the vocational rehabilitation practice.

Importantly, analyses on secondary outcomes of the effectiveness study showed that participants of the intervention group were significantly more positive about the quality of guidance by their employment specialist compared to the control group. The data does not certify what causes the higher rated quality of guidance. However, an explanation might be that, due to the stigma awareness training, employment specialists gained understanding and improved their skills in having conversations about the impact of mental illness and its consequences about whether to disclose this or not. Subsequently they could have delivered better vocational guidance to people with mental illness.

The stigma awareness training was developed using scientific literature of effective interventions to reduce mental illness related stigma and/or discrimination (5-8, 26). Important effective elements are educative material and personal contact with someone with lived experience in various forms (e.g. a presentation of or interview with someone with lived experience) (5). Employment specialists varied in their personal opinions about the stigma awareness training. At some locations, the entire team of employment specialists was enthusiastic and motivated to participate in the training sessions, whilst in other teams the motivation of participants was strongly divided. These elements were included in this stigma awareness training and very much appreciated by the employment specialists. However, training sessions were given by the researchers, who were experts in the field of stigma and mental health at the workplace but had no experience in vocational rehabilitation services and were not officially educated as trainers. Many employment specialists were educated trainers themselves, with experiences in e.g. giving job application training sessions. Some employment specialists expressed resistance to the content and design of the training, such as not wanting to engage in role play exercises on how to discuss the CORAL.NL tool, possibly because the trainers were not part of their *ingroup*. Those employment specialists who showed most resistance to the training indicated they had hoped to learn more know-how and skills (e.g. about how to support people with mental illness in general) during the training.

Managers' reluctance to hire applicants with mental illness

In our cross-sectional study, we found evidence that stigma and discrimination are important barriers to the employment opportunities of people with mental illness, as two third of the managers was reluctant to hire an applicant with mental illness, and one third was reluctant to hire someone who had had mental illness in the past. This illustrates the importance for people with mental illness to make deliberate decisions about disclosure of mental illness in the work context.

The three most frequently reported concerns by managers in this study were concerns about long-term sickness absence (43%), concerns that the employee would not be able to handle the work (55%), and concerns about not being able to count on the employee (41%). In addition, managers felt insecure about how to help an employee with mental illness (39%) and how to deal with an employee with mental illness (19%). Managers having concerns about employees with mental illness has also been found in other studies (27, 28). These concerns and negative attitudes may be a result of insufficient knowledge of (people with) mental illness (29). Limited or biased knowledge of mental illness may be a result of typical negative stereotypes, often emphasizing unreliability and dangerousness. Media, such as entertainment and news channels are sources that endorse these negative stereotypes (30, 31), e.g. in news items and films and series. Accommodating correct information and a representative presentation of people with mental illness, for example through personal contact with people with mental illness, can have destigmatizing effects (5).

Previous research has found that mostly lower educated people are more stigmatizing towards people with mental illness (32, 33). In contrast, the current study shows that managers with higher educational attainment were more reluctant to hire someone with current mental illness. It is possible that the managers with a higher education level

in our study are responsible for higher educated employees, with more complex tasks and higher responsibilities. However, as we do not have a compelling explanation for this finding, this should be further investigated in future studies.

METHODOLOGICAL CONSIDERATIONS

Methodological strengths and limitations have already been addressed for each of the studies in the previous chapters. Therefore, in this section, strengths and limitations related to the design of the main study and the research process will be described.

Minimal loss of follow up

A strength of our RCT, is that loss to follow up of participants was relatively low. People who are less socially integrated, e.g. being unemployed or receiving social benefits, are less likely to participate in clinical trials (34, 35). In addition, they are more likely to drop out in longitudinal studies (36, 37). Participants could experience barriers to participate in a study, such as transport or time difficulties (34). Therefore, in this study, a client panel from one of the municipalities was asked for advice about how to reach the potential participants best. Several actions were successfully taken to avoid barriers and to prevent drop out in the study. First, there was frequent personal contact with participants. This contact took place in the way participants preferred and was mostly by telephone and via text messages (Whatsapp) or via email. Furthermore, questionnaires were filled out in face-to-face appointments with the researcher, at one of the participating organizations. These organizations were located in the municipality the participants were living in, making it easy for them to visit the location. And finally, even if a participant had forgotten or canceled the appointment several times, they were still asked again if they wanted to participate at another moment.

External data from Statistics Netherlands

The economic evaluation of the RCT was done using data from Statistics Netherlands (25). A strength of using this data ensures that data of all participants is available for the complete study period. However, a limitation is that reporting data from Statistics Netherlands is bound by strict rules to avoid data being traceable to individuals. Because of these *output* rules, not all data could be reported or data had to be adjusted (e.g. merging subgroups) to be able to report.

Sample size

A limitation of our RCT is the relatively small sample size of participants. Although the assumption of the power calculation was achieved, i.e. 75 participants per group, a higher sample size might have resulted in a higher power to detect significant differences. Teare et al. (38) recommends a sample size of 70 participants for each group for continuous outcomes and 60-100 participants for an event rate to have a sufficient power. Because of drop out and the fact that not all participants gave consent to collect data from Statistics Netherlands, we did not achieve these sample sizes in both our effectiveness study and economic evaluation.

Follow-up period

A strength of our RCT is a longer follow-up period than other studies investigating the effects of a decision aid in the work context (3, 17). The follow-up period is comparable to other studies investigating the effects of IPS (39, 40) with similar outcome measures, i.e. finding paid employment. However, concerning measuring costs and benefits, a longer follow up period is preferred. The Dutch National Health Care Institute recommends a life-long time horizon for economic healthcare evaluations (41).

(Non-)participants bias

Participants of the RCT were recruited by employment specialists working at the eight organizations who participated in the study. The recruitment via employment specialists had several challenges. First, it is a limitation that employment specialists could only recruit those clients of whom they knew (or suspected) to have (had) mental illness. In addition, employment specialists could deliberately decide not to invite certain clients, because they did not want to burden them with participating in a study, e.g. because of the severity of the mental illness (42). This may have led to selection bias, keeping participants with more severe mental illnesses away from participating in the study.

Cluster randomization of eight organizations

In the RCT, eight organizations (i.e. municipalities and organizations who worked on behalf of these municipalities) were cluster randomized into a control and intervention group. A strength of this is that it prevented contamination between the conditions as employment specialists within organizations work together on a daily basis. However, in our study we noticed that some organizations were more motivated to participate and recruit participants for our study than other organizations. This resulted in some municipalities recruiting many participants, and one municipality delivering a small amount of participants. The intervention and control groups were evenly divided among the municipalities. However, as municipalities organize their own facilities and vocational rehabilitation services for people receiving social benefits and we did not control for the municipality a participant was living in, there may be an unobserved bias of the municipality on the employment outcomes.

Representativeness of the cross-sectional data

A strength of our cross-sectional study about the attitudes and hiring intentions of Dutch managers was that data from the representative Longitudinal Internet Studies for the Social Sciences (LISS-)panel was used (43). This panel is a true probability sample of at that time 5000 Dutch households, i.e. 8280 panel members, who participate in monthly internet surveys. For our study, an online survey was sent to all LISS-panel members who held a position of manager in February 2018, therefore the study provided a good insight into the attitudes of Dutch managers.

IMPLICATIONS FOR PRACTICE

Because the stigma awareness intervention was found to be effective in improving the employment opportunities of unemployed people with mental illness, it is recommended to take further actions to implement the intervention. For example, this could be done via organizations committed to increasing mental health stigma awareness. The CORAL.NL tool already is freely accessible on the internet, and the stigma awareness training could also be implemented in practice. However, in our process evaluation we found opportunities for improvement for more adherence of employment specialists in the stigma awareness training. Most importantly, the training might be better received when it is delivered by peers, i.e. employment specialists who have experience with using the tool in their vocational rehabilitation practices. As a recent study found further evidence of the importance of social contact with people with mental illness in anti-stigma interventions (44), this is an important element of the training sessions that must be remained. In addition, we recommend that the tool is embedded in the working procedures of vocational rehabilitation services, as employment specialists do not always have the tool and/or disclosure topic on top of their minds. In the past few years, the disclosure topic and the CORAL.NL tool have already been successfully embedded in the educational program for employment specialists in the supported employment program Individual Placement and Support (IPS) (45) in the Netherlands.

As we found that almost one-third of Dutch managers was reluctant to hire job applicants with mental illness, and almost two-third of the managers were reluctant to hire job applicants with current mental illness, this has major implications for the social inclusion of people with mental illness. These findings suggest that it is important for people with mental illness to make deliberate decisions about whether to disclose or not, but also to prepare this well to increase the chances for a positive outcome (4). Simultaneously, it is important to reduce stigmatizing attitudes in managers. For example, studies have found that social support in the work context and managers' attitudes and behaviors can facilitate return to work in people with (mental) illness (46-49). Therefore, destigmatizing interventions that improves managers' knowledge, attitudes, skills and behavior are important (6), as this could increase the (sustainable) employment opportunities for people with mental illness (50).

A significant amount of people will have a mental illness at some point in their (working) lives (51, 52). In addition, a negative work environment is associated with poorer mental health (53, 54). Initiatives such as the MENTUPP study (55) examines the effects of education both employers and employees about mental health and wellbeing and work. It facilitates implementing tools for employers to promote this and to reduce risk factors in the psychosocial work context, as well as personal tools for coping with stressful events and supporting each other. Insights from these studies could also contribute to decreasing stigma and increasing mental wellbeing and sustainable employment.

RECOMMENDATIONS FOR FUTURE RESEARCH

As this is the first study examining the stigma awareness intervention in its current form, more research into the effectiveness and the working elements is needed. Therefore, it is important to develop a fidelity instrument, i.e. a measurement that investigates to what degree an intervention is delivered in accordance to model standards. Having a fidelity measure is important for successfully implementing an intervention into practice (56). Developing a fidelity measurement should be done by using input from national as well as international experts on the field of workplace stigma and disclosure decisions. In addition, also people with other health problems, such as physical disabilities or illnesses, face stigma (57). It is likely that those people will encounter similar challenges while entering or retaining the labor market. Therefore, the intervention adapted to other health problems may be of use for people with physical disabilities or chronic illnesses. More research on this area is needed to investigate this further.

Using a realist evaluation approach (58) may be of added value in future research on this stigma awareness intervention. Realist evaluation is a technique used to study 'what works, for whom, under what circumstances, and how' in complex interventions. Realist studies are theory-driven and focus on the complexity of causal relations in social interactions (58). As the current intervention is a very complex intervention, i.e. working on both the level of unemployed people with mental illness and employment specialists, in a field with even more stakeholders (e.g. employers, HR professionals but also other job applicants) it is important to gain more insight into the context, working elements and outcomes of the intervention.

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Finally, as our study of the attitudes and hiring intentions of Dutch managers' found that a significant amount of managers is reluctant to hire a job applicant with mental illness, whilst other studies found that Dutch employees prefer to disclose their mental illness in the work context (19, 20), it is important to conduct more research into the disclosure decisions of people with mental illness. This is also emphasized by Rüsch and colleagues (10), who found that non-disclosure is associated with more often finding paid employment. More insight is needed into reasons why people prefer to disclose and what their reasons are for non-disclosure. In addition, our current RCT did not study the association between disclosure decision and the actual consequence in employment terms, however it would be relevant to study this in the future, preferably in a longitudinal design.

CONCLUSIONS

To conclude, stigma of mental illness is present and is a major barrier to sustainable employment rates of unemployed people with mental illness. This is problematic, as the majority of Dutch employees would disclose their mental illness in the work context (19, 20). This cluster RCT showed that implementing a stigma awareness intervention was highly effective in improving employment outcomes for unemployed people with mental illness. Participants of the intervention group found and retained paid employment almost twice as often, compared to a control group. If replicated, this may substantially contribute to increased employment opportunities of people with mental illness. Subsequently, this could have great financial implications on a societal level and on a personal level, as it can greatly improve quality of life and wellbeing.

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CHAPTER 8

English summary

INTRODUCTION (Chapter 1)

Employment – under favorable conditions – is beneficial for people with mental illness and contributes to social participation and inclusion. Furthermore, employment is associated with better health, recovery, self-esteem, mastery and happiness. In contrast, unemployment is associated with factors such as stress, shame and poverty. People with mental illness are three to seven times more often unemployed than people without mental illness. As globally around one in three people will develop a mental illness at least once in their life, this poses a public health inequality problem.

An underestimated yet important factor of influence on the work participation of people with (mental) illness is workplace stigma and discrimination. The word stigma has its origin in the old Greek language and means burn. It refers to specific people being burned to show others that this person was of lower status, for example a slave or criminal. Stigma occurs when the people who stigmatize have social, cultural, economic and/or political power, and therefore have the power to separate groups from each other. In addition, it is argued that stigma refers to problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behavior (discrimination).

Mental illness stigma and discrimination occur in different life domains, such as in personal relationships and in education. In addition, several studies have found that the work context is one of the areas in which discrimination occurs most frequently. This is problematic in several ways. First, employers have negative attitudes towards people with mental illness. Second, both disclosure and non-disclosure of mental illness can have positive outcomes, but also negative consequences. Third, anticipated discrimination, self-stigma and the so-called 'why try'-effect may withdraw people with mental illness from actively finding paid employment. The 'why try'-effect arises when people with mental illness stop trying to, for example, apply for work. Lastly, stigma and discrimination is associated with mental health treatment avoidance.

The various domains in which stigma may occur illustrate that in order to reduce stigma, multiple areas need attention. First, more research is needed on how to destigmatize mental illness in the work environment. For instance, research on stigmatizing attitudes and discrimination behavior among managers, but also in other stakeholders such as HR professionals and employment specialists, is scarce. Therefore, it is important to gain more insight into the attitudes of managers towards persons who have or have had mental illness. Second, it is important to investigate how people with mental illness can protect themselves against stigma, and how they can learn to deal with its consequences. For instance, research on how people with mental illness can make more deliberate disclosure decisions in the workplace can provide insights into its importance on employment outcomes.

As a result of stigma, whether or not to disclose mental illness in the workplace is a major dilemma for many people with mental illness. The decision whether or not to disclose is often perceived as a stressful process, because both disclosure and non-disclosure can have advantages and disadvantages. Therefore, decisional stress can be experienced, which refers to uncertainty and dissatisfaction when trying to make a decision.

In 2010, the Conceal or reveal (CORAL) decision aid was developed, a tool to support people in their decision about whether to disclose mental illness in the work context or not. The decision aid is based on the principle that people know their own situation best. Therefore, they can make the best choices themselves, but can still benefit from help with making a choice. Several studies investigated the effect of the decision aid on finding paid employment, as well as experiencing decisional conflict about whether to disclose mental illness or not. These studies found that CORAL was highly effective in employment outcomes, i.e. significantly more people who used CORAL were working full time compared to people who did not used the CORAL after three months. Using CORAL also resulted in less decision-making stress.

AIM OF THE THESIS

As workplace stigma is increasingly being acknowledged as a major barrier to sustainable work participation of people with mental illness, this thesis aimed to get more insight in managers' views and concerns regarding hiring a job applicant with mental illness. Therefore, a cross-sectional study was conducted, investigating managers' attitudes and hiring intentions towards hiring people with mental illness, and their concerns and reasons (not) to hire a job applicant with past or current mental illness. Secondly, the aim of this thesis was to study the effects of a stigma awareness intervention, which may protect people against the harmful effects of stigma. Therefore, we conducted a cluster randomized controlled trial (RCT) to study the effects of the Dutch version of the CORAL decision aid tool (i.e. CORAL.NL), combined with a stigma awareness training for employment specialists are examined on finding and retaining paid employment, and on decisional conflict.

The group studied in this thesis concerns unemployed people who have, or have had, mental illness and who receive social benefits. In the Netherlands, people who are (long-term) unemployed, have insufficient income or capital and are unable to make use of other provisions or benefits (such as disability benefits), are entitled to social benefits. Mental illness could be formally diagnosed as a (common or severe) mental disorder, but can also concern self-reported (undiagnosed) mental health issues.

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RESULTS (CHAPTER 2-6)

In **Chapter 2** we examined managers' knowledge, concerns and positive reasons to hire a job applicant with past or current mental illness. In addition, factors associated with the intention (not) to hire a job applicant with past or current mental illness were studied. The results show that whereas only 7 percent of managers had negative personal experiences with employees with mental illness, the majority of managers were reluctant to hire someone with current mental illness or alcohol addiction problems (respectively 64% and 82%). Moreover, about one third of managers were reluctant to hire someone with past mental illness or alcohol addiction problems (respectively 30% and 32%). The great majority (91%) of managers had one or more concerns regarding hiring employees with mental illness. Strongest predictors for being reluctant to hire an applicant with current mental illness were concerns about long-term sickness absence, concerns that the employee would not be able to handle the work, the concern of not being able to count on the employee, and higher manager education level. In contrast, significant predictor for positive hiring intentions was managers' being in favor of social inclusion out of principle.

Subsequently, we conducted a cluster RCT to investigate the effects of a stigma awareness intervention for unemployed people with mental illness and their employment specialists on finding and retaining paid employment. In **Chapter 3** the design of the study was described in a study protocol. In this cluster RCT a stigma awareness intervention is examined, which existed of a disclosure decision aid tool (CORAL.NL) for unemployed people with mental illness and a workplace stigma awareness training especially designed for employment specialists in the municipal practice. The intervention is focused on how to support unemployed people in their mental illness disclosure decisions. Cluster randomization took place on organization level, i.e. municipalities and organizations who work on behalf of municipalities. Participants, i.e. unemployed people with mental illness, in the intervention group received support from their trained employment specialists and receive the CORAL.NL decision aid after baseline. Participants in the control group received support as usual from their employment specialists. Primary outcomes were (1) finding paid employment, (2) retaining paid employment and (3) decisional conflict about disclosing mental illness. Secondary outcomes were mental health and wellbeing, stigma and discrimination and work related factors. Data was collected by questionnaires at baseline, and at 3, 6 and 12 months and by administrative data via Statistics Netherlands for those participants who gave separate informed consent for this.

In **Chapter 4**, findings of the cluster RCT showed that the stigma awareness intervention was highly effective in improving work participation outcomes for unemployed people with mental illness. N=153 participants were recruited (experimental group: N=76, control group: N=77). Six months after baseline, significantly more participants of the experimental group had found paid employment compared to the control group (50.7% versus 26.1%). Moreover, twelve months after baseline, significantly more participants of the experimental group had retained paid employment compared to the control group (49.2% versus 23.4%). The intervention had no effect on decisional conflict. Interestingly, six months after baseline, in the experimental group participants were significantly more positive about the support received from their employment specialists.

Subsequently, in **Chapter 5** an economic evaluation was conducted, examining the costs and benefits of a stigma awareness intervention in the work context from a societal perspective. The study showed that participants of the intervention group had better work participation outcomes and better outcomes concerning becoming independent of social benefits than participants of the control group. Regarding the costs of the intervention, participants of the intervention group had on average lower total costs (i.e. intervention costs, healthcare costs and social benefits) than participants of the control group (i.e. healthcare costs and social benefits). However, the differences between groups on employment outcomes, social benefits and healthcare costs and use did not reach statistical significance.

Finally, in **Chapter 6**, the results of a process evaluation are described. The aim of this study was to investigate the feasibility of the stigma awareness intervention, to report experiences of participants and their employment specialist, and to give recommendations for further implementation in practice. The overall results showed that the intervention was feasible to implement and that the intervention proved to be successful in increasing stigma awareness and awareness about the disclosure dilemma in both participants and their employment specialists. Furthermore, the majority of the participants were positive about the content of the CORAL.NL tool. Participants had become more aware about the importance of deliberate disclosure decisions and most of the participants would recommend the tool to others. In addition, the tool was reported to be helpful for the majority of the participants in making a decision about whether to disclose mental illness or not, and 40-53% of the participants had changed their mind about disclosure of mental illness due to the tool. About one in five participants indicated that the tool had helpful in applying and/or finding work.

DISCUSSION (Chapter 7)

In this thesis, the two aims were 1) to gain more insight into the attitudes and hiring intentions of Dutch managers towards people who have or have had mental illness, and 2) to evaluate the effectiveness of a stigma awareness intervention for unemployed

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people with mental illness and their employment specialists, compared to usual vocational rehabilitation. The thesis adds to the growing evidence that employment rates of people with mental illness are not only determined by the illness but to a large extent also by psychosocial factors such as stigma and discrimination.

The results of the cross-sectional study among Dutch managers showed that the majority of managers (64%) were reluctant to hire someone with current mental illness. Moreover, about one-third of the managers (30%) was reluctant to hire an applicant with past mental illness. The findings of the effectiveness study showed that the stigma awareness intervention was highly effective in improving work participation outcomes. Six months after baseline, the percentage of people who found employment was significantly higher in the intervention group compared to the control group (51% versus 26%). Moreover, after 12 months, significantly more participants of the intervention group had retained paid employment compared to the control group (49% versus 23%).

It is promising that a relatively simple and affordable intervention had influence on the employment opportunities of unemployed people with mental illness. As this is the first study investigating the role of stigma and workplace disclosure on employment outcomes of the unemployed people in the Netherlands, more studies are urgently needed to investigate this further. If future studies can confirm our findings, this would mean that twice as many unemployed people with mental illness can find and retain paid employment using the intervention. This would greatly benefit individuals e.g. health and wellbeing benefits, and the society at large (in terms of costs).

Remarkably, over time, in our study not only the employment rates of the intervention group improved, but also those of the control group were higher than the average outflow of social benefits. There may be two possible explanations for this. First, participants of both the intervention and control group were asked questions and statements about disclosure of mental illness and the disclosure dilemma at each measurement. This may have raised more awareness about the importance of the disclosure dilemma and indirectly may have influenced employment outcomes in both groups. If this indeed explains the increased work participation outcomes in the control group, this suggests that increasing awareness to workplace stigma and the disclosure decision is a very powerful yet simple way to increase work participation of unemployed people with mental illness. Second, although the exact intervention was not known by the control group, employment specialists of both conditions were aware that they were participating in a study on improving work participation outcomes of people with mental illness. Being aware of participating in a study could have impact on the behavior of participants in both groups, i.e. employment specialists of both groups could have become more motivated to support people with mental illness, which is also known as the Hawthorne Effect.

In our effectiveness study we found that significantly more participants of the intervention group had found – and retained – paid employment than participants of the control group. In the economic evaluation, using another data source (i.e. microdata from Statistics Netherlands), employment rates of the intervention group were also higher than those of the control group. However, in this study the differences did not reach statistical significance. There are several possible explanations for this. First, an explanation may be the smaller sample size in the economic evaluation, resulting in a lower power to detect significant differences. Because the trend on both employment and social benefits outcomes is promising, it is recommended to use a larger sample size in future research. Second, participants were asked separately for their consent to retrieve data on income and social benefits from Statistics Netherlands. Some participants deliberately chose not to give permission for this, possibly because they were reluctant to share their data, e.g. because of having undeclared employment. Furthermore, concerning the outcome measures of both studies, it needs to be stressed that finding and retaining paid employment was defined as a dichotomous variable, i.e. found paid employment: yes/no, retained paid employment: yes/no. In the effectiveness study, this was measured at four separate measurements within twelve months (i.e. baseline, 3, 6 and 12 months). However, in the economic evaluation this was measured as having found, or retained, paid employment (at least once) in 12 months. Finally, both data (i.e. self-report data and microdata from Statistics Netherlands) sources may be subjected to flaws and should not be seen as completely reliable.

In contrast to the effects of earlier disclosure decision aids, in this study we did not find any effect on decisional stress. There may be different explanations for this. First, participants in our study had a below average decisional conflict score at baseline compared to earlier studies on disclosure decision aids. In addition, participants also had a low internalized stigma score at baseline. Recent Dutch studies showed that most of Dutch employees have predominantly positive expectations about disclosing mental illness in the workplace. The majority of Dutch employees disclosed or would like to disclose their mental illness to their employer. In addition, our RCT differed from other studies on disclosure decision aids for unemployed people regarding the inclusion criteria of mental illness. These studies included participants with especially severe mental illnesses. In our study, anyone with self-identified mental illness could participate in the study, which represented all types of mental illness, from mild to severe. It could be possible that people with severe mental illness experience more often higher decisional stress, e.g. because of more severe symptoms or complaints. However, more research is on this needed.

A process evaluation was conducted to examine the feasibility of the stigma awareness intervention, and to report experiences and recommendations for future implementation.

The main finding of this study was that the intervention proved to be successful in increasing stigma awareness in both unemployed people with mental illness and their employment specialists. Most participants had positive attitudes towards the CORAL.NL tool and would recommend the tool to others. In addition, participants reported that the tool was useful in making deliberate decisions about whether to disclose mental illness or not. Employment specialists mentioned the timing of introducing the tool and/or having a conversation about disclosure as important. They reported that the tool was especially helpful when people were actively searching and/or applying for employment. The adherence of employment specialists using the CORAL.NL tool could have been better, as the tool was not often used by employment specialists. In the interviews, employment specialists suggested that more training sessions or more reminders in between could have been helpful in not forgetting to use the tool. Therefore, for implementation in practice it is important to embed the CORAL.NL tool in the regular operating procedures of the vocational rehabilitation practice.

In our cross-sectional study, we found evidence that stigma and discrimination are important barriers to the employment opportunities of people with mental illness, as two third of the managers was reluctant to hire an applicant with mental illness, and one third was reluctant to hire someone who had had mental illness in the past. This illustrates the importance for people with mental illness to make deliberate decisions about disclosure of mental illness in the work context. It calls for the development of destigmatizing interventions and manager training, but research on workplace stigma and especially on destigmatizing interventions is still in its infancy. Work related anti-stigma interventions could improve managers' knowledge, skills and supportive behavior which can be important positive facilitators for sustainable return to work for people with mental illness. Also, studies have shown that the work context itself plays a critical role in (sustainable) employment of people with mental illness.

METHODOLOGICAL CONSIDERATIONS

In this section, strengths and limitations related to the design of the main study and the research process will be described.

Minimal loss at follow up - A strength of our RCT, is that loss to follow up of participants was low. Several actions were successfully taken to avoid barriers and to prevent drop out in the study. First, there was frequent personal contact with participants. Furthermore, questionnaires were filled out in face-to-face appointments with the researcher, at one of the participating organizations. And finally, even if a participant had forgotten or canceled the appointment several times, they were still asked again if they wanted to participate at another moment.

External data from Statistics Netherlands - The economic evaluation of the RCT was done using data from Statistics Netherlands. A strength of using this data ensures that data of all participants is available for the complete study period. However, a limitation is that reporting data from Statistics Netherlands is bound by strict rules to avoid data being traceable to individuals. Because of these output rules, not all data could be reported or data had to be adjusted (e.g. merging subgroups) to be able to report.

Sample size - A limitation of our RCT is the relatively small sample size of participants. Although the assumption of the power calculation was achieved, i.e. 75 participants per group, a higher sample size might have resulted in a higher power to detect significant differences.

Follow-up period - A strength of our RCT is a longer follow-up period than other studies investigating the effects of a decision aid in the work context. However, concerning measuring costs and benefits, a longer follow up period is preferred.

(Non-)participants bias - Participants of the RCT were recruited by employment specialists working at the eight organizations who participated in the study. The recruitment via employment specialists had several challenges. First, it is a limitation that employment specialists could only recruit those clients of whom they knew (or suspected) to have (had) mental illness. In addition, employment specialists could deliberately decide not to invite certain clients, because they did not want to burden them with participating in a study, e.g. because of the severity of the mental illness. This may have led to selection bias, keeping participants with more severe mental illnesses away from participating in the study.

Cluster randomization of eight organizations - In the RCT, eight organizations (i.e. municipalities and organizations who worked on behalf of these municipalities) were cluster randomized into a control and intervention group. A strength of this is that it prevented contamination between the conditions as employment specialists within organizations work together on a daily basis. The intervention and control groups were evenly divided among the municipalities. However, as municipalities organize their own facilities and vocational rehabilitation services for people receiving social benefits and we did not control for the municipality a participant was living in, there may be an unobserved bias of the municipality on the employment outcomes.

Representativeness of the cross-sectional data - A strength of our cross-sectional study about the attitudes and hiring intentions of Dutch managers was that data from the representative Longitudinal Internet Studies for the Social Sciences (LISS-)panel was used.

IMPLICATIONS FOR PRACTICE

Because the stigma awareness intervention was found to be effective in improving the employment opportunities of unemployed people with mental illness, it is recommended to take further actions to implement the intervention. For example, this could be done via organizations committed to increasing mental health stigma awareness.

Concerning the CORAL.NL intervention, the CORAL.NL tool already is freely accessible on the internet, and the stigma awareness training could also be implemented in practice. However, in our process evaluation we found opportunities for improvement of more adherence of employment specialists in the stigma awareness training. Most importantly, the training might be better received when it is delivered by peers, i.e. employment specialists who have experience with using the tool in their vocational rehabilitation practices. In addition, we recommend that the tool is embedded in the working procedures of vocational rehabilitation services, as employment specialists do not always have the tool and/or disclosure topic on top of their minds. In the past few years, the disclosure topic and the CORAL.NL tool have already been successfully embedded in the training of employment specialists in the supported employment program Individual Placement and Support (IPS) in the Netherlands.

As we found that almost one-third of Dutch managers was reluctant to hire job applicants with mental illness, and almost two-third of the managers were reluctant to hire job applicants with current mental illness, this has major implications for the social inclusion of people with mental illness. These findings suggest that it is important for people with mental illness to make deliberate decisions about whether to disclose or not to increase the chances for a positive outcome. Simultaneously, it is important to reduce stigmatizing attitudes in managers. For example, studies have found that social support in the work context and managers' attitudes and behaviors can facilitate return to work in people with (mental) illness. Therefore, destigmatizing interventions that improve managers' knowledge, attitudes, skills and behavior are important, as this could increase the (sustainable) employment opportunities for people with mental illness.

Initiatives such as the MENTUPP study examine the effects of education both employers and employees about mental health and wellbeing and work. It facilitates implementing tools for employers to promote this and to reduce risk factors in the psychosocial work context, as well as personal tools for coping with stressful events and supporting each other. Insights from these studies could also contribute to decreasing stigma and increasing mental wellbeing and sustainable employment.

RECOMMENDATIONS FOR FUTURE RESEARCH

As this is the first study examining the stigma awareness intervention in its current form, more research into the effectiveness and the working elements is needed. Therefore, it is important to develop a fidelity instrument, i.e. a measurement that investigates to what degree an intervention is delivered in accordance to model standards. Using a realist evaluation approach may be of added value in future research on this stigma awareness intervention. Realist evaluation is a technique used to study 'what works, for whom, under what circumstances, and how' in complex interventions. As the current intervention is working on both the level of unemployed people with mental illness and employment specialists, in a field with even more stakeholders (e.g. employers, HR professionals but also other job applicants) it is important to gain more insight into the context, working elements and outcomes of the intervention.

Furthermore, as our study of the attitudes and hiring intentions of Dutch managers' found that a significant amount of managers is reluctant to hire a job applicant with mental illness, whilst other studies found that Dutch employees prefer to disclose their mental illness in the work context, it is important to conduct more research into the disclosure decisions of people with mental illness. More insight is needed into reasons why people prefer to disclose and what their reasons are for non-disclosure. In addition, our current RCT did not study the association between disclosure decision and the actual consequence in employment terms, however it would be relevant to study this in the future, preferably in a longitudinal design.

CONCLUSIONS

Stigma of mental illness is present and is a major barrier to sustainable employment rates of unemployed people with mental illness. This is problematic, as the majority of Dutch employees would disclose their mental illness in the work context. This cluster RCT showed that implementing a stigma awareness intervention was highly effective in improving employment outcomes for unemployed people with mental illness. Participants of the intervention group found and retained paid employment almost twice as often, compared to a control group. If replicated, this may substantially contribute to increased employment opportunities of people with mental illness. Subsequently, this could have great implications on a societal level and on a personal level, as it can considerably improve quality of life and wellbeing of people with mental illness.

CHAPTER 9

Nederlandse samenvatting

INTRODUCTIE (Hoofdstuk 1)

Werk is belangrijk voor mensen met psychische problemen, en draagt – onder goede voorwaarden – bij aan maatschappelijke participatie en inclusie. Het hebben van werk is geassocieerd met een betere gezondheid, beter herstel, meer zelfrespect en meer geluk. Werkloosheid wordt daarentegen in verband gebracht met factoren als stress, schaamte en armoede. Mensen met psychische problemen zijn drie tot zeven keer vaker werkloos dan mensen zonder psychische problemen. Aangezien wereldwijd ongeveer één op de drie mensen minstens één keer in hun leven psychische problemen zal krijgen, vormt deze ongelijkheid een serieus aandachtspunt op het gebied van de volksgezondheid en is het een publiek gezondheidsprobleem.

Een onderschatte, maar belangrijke factor van invloed op de arbeidsparticipatie van mensen met een (psychische) aandoening is stigmatisering en discriminatie op de arbeidsmarkt. Het woord *stigma* vindt zijn oorsprong in de oude Griekse taal en betekent 'brandmerk'. Het verwijst naar specifieke mensen die worden gebrandmerkt om anderen te laten zien dat deze persoon een lagere status had, zoals een slaaf of crimineel. Stigma treedt op wanneer de mensen die stigmatiseren sociale, culturele, economische en/of politieke macht hebben, en dus de macht hebben om groepen van elkaar te scheiden. Daarnaast wordt betoogd dat stigma verwijst naar problemen op het gebied van kennis (onwetendheid), attitude (vooroordelen) en gedrag (discriminatie).

Stigmatisering en discriminatie vanwege psychische problemen komt voor in verschillende levensdomeinen, zoals in persoonlijke relaties en in de maatschappij. Daarnaast is uit meerdere studies gebleken dat de werkcontext één van de gebieden is waar discriminatie het vaakst voorkomt. Dit is op verschillende manieren problematisch. Ten eerste hebben werkgevers een negatieve attitude ten aanzien van mensen met psychische problemen. Daarnaast kan zowel het open als het niet open zijn over psychische problemen positieve, maar ook negatieve gevolgen hebben. Ten derde kunnen geanticipeerde discriminatie (de verwachting om gediscrimineerd te worden), zelfstigma (vooroordelen over iemands eigen psychische problemen hebben) en het zogenaamde 'why try'-effect mensen met psychische problemen ervan weerhouden om actief betaald werk te vinden. Het 'why try'-effect ontstaat wanneer mensen met psychische problemen zichzelf ervan weerhouden om bijvoorbeeld te solliciteren, omdat ze erin geloven dat ze toch niet zullen worden aangenomen. Ten slotte kan stigma en discriminatie ervoor zorgen dat mensen met psychische problemen hulp vermijden die ze nodig hebben.

De verschillende domeinen waarin stigma kan voorkomen, illustreert dat om stigma te verminderen, meerdere gebieden aandacht behoeven. Meer onderzoek is

nodig naar het destigmatiseren van psychische problemen in de werkomgeving. Tot op heden is er weinig onderzoek gedaan naar stigmatiserende attitudes en discriminatiegedrag bij managers of bij andere stakeholders zoals HR-professionals en re-integratieprofessionals. Daarom is het belangrijk om meer inzicht te krijgen in de houding van managers ten opzichte van personen die psychische problemen hebben (gehad). Daarnaast is het belangrijk om te onderzoeken hoe mensen met psychische problemen zichzelf kunnen beschermen tegen stigmatisering en hoe ze kunnen leren omgaan met de gevolgen ervan. Onderzoek naar hoe mensen met psychische problemen een meer weloverwogen beslissing kunnen nemen op het gebied van wel of niet open zijn over psychische problemen, kan inzicht geven in het belang ervan voor de kansen op het vinden en behouden van betaald werk.

Als gevolg van stigma is het al dan niet open zijn over psychische problemen in de werkomgeving een groot dilemma voor veel mensen met psychische problemen. De keuze om wel of niet open te zijn wordt vaak als een stressvol proces ervaren, omdat het zowel voordelen als nadelen kan hebben. Zogenaamde *keuzestress* kan worden ervaren, wat verwijst naar onzekerheid en ontevredenheid bij het nemen van een beslissing.

In 2010 is in Engeland de beslishulp Conceal or reveal (CORAL) ontwikkeld, een beslishulp om mensen te ondersteunen bij hun keuze om in de werkomgeving al dan niet open te zijn over psychische problemen. De beslishulp is gebaseerd op het principe dat mensen hun eigen situatie het beste kennen. Daardoor kunnen zij zelf de beste keuze maken, maar wel baat hebben bij begeleiding bij het maken van een keuze. Verschillende studies onderzochten het effect van de beslishulp CORAL op het vinden van betaald werk, evenals het ervaren van keuzestress over het wel of niet open zijn over psychische problemen. Uit deze studies bleek dat CORAL zeer effectief was op het gebied van het vinden van werk. Na drie maanden werkten meer mensen die CORAL gebruikten fulltime dan mensen die CORAL niet gebruikten. Het gebruik van CORAL zorgde ook voor minder stress bij het nemen van beslissingen.

DOEL VAN DE STUDIE

Stigma in de werkcontext wordt steeds meer erkend als een belangrijke belemmering voor duurzame arbeidsparticipatie van mensen met psychische problemen. Het eerste doel van dit proefschrift was om meer inzicht te krijgen in de opvattingen en zorgen van managers met betrekking tot het aannemen van een sollicitant met psychische problemen. Hiervoor werd een cross-sectioneel onderzoek uitgevoerd, waarin de attitudes en bereidheid van managers om mensen met psychische problemen aan te nemen werd onderzocht. Daarnaast werden redenen onderzocht om wel of niet

een sollicitant met een eerdere of huidige psychische problemen aan te nemen. Ten tweede was het doel van dit proefschrift om de effecten te bestuderen van een stigma bewustwordingsinterventie, die mensen kan behoeden voor de negatieve effecten van stigmatisering. Deze interventie bestond uit de Nederlandse versie van de CORAL beslishulp (CORAL.NL) in combinatie met een stigma bewustwordingstraining voor re-integratieprofessionals. In een cluster *randomized controlled trial* (RCT) hebben we de effecten hiervan onderzocht op het vinden van betaald werk, het behouden van betaald werk en op keuzestress.

Dit proefschrift richt zich op werkzoekenden die psychische problemen hebben, of hebben gehad, en een bijstandsuitkering ontvangen. Het betreft hierbij psychische problemen die zijn gediagnosticeerd, bijvoorbeeld een veelvoorkomende of ernstige psychische stoornis, maar het kan ook gaan om zelf gerapporteerde (niet-gediagnosticeerde) psychische problemen. In Nederland hebben mensen recht op een bijstandsuitkering als ze (langdurig) werkzoekend zijn, onvoldoende inkomen of vermogen hebben en geen gebruik kunnen maken van andere voorzieningen of uitkeringen (zoals arbeidsongeschiktheidsuitkeringen).

RESULTATEN (Hoofdstuk 2-6)

In **hoofdstuk 2** onderzochten we de kennis, zorgen en redenen van managers om een sollicitant met eerdere of huidige psychische problemen aan te nemen. Daarnaast zijn factoren onderzocht die samenhangen met het (wel of niet) voornemens zijn om een sollicitant met eerdere of huidige psychische problemen in dienst te nemen. De resultaten laten zien dat de meerderheid van de managers terughoudend was om iemand in dienst te nemen met huidige psychische problemen of alcoholverslaving (respectievelijk 64% en 82%), terwijl slechts 7 procent van de managers negatieve persoonlijke ervaringen had met werknemers met psychische problemen. Bovendien was ongeveer een derde van de managers terughoudend om iemand in dienst te nemen die psychische problemen of een alcoholverslaving in het verleden heeft gehad (respectievelijk 30% en 32%). De overgrote meerderheid (91%) van de managers had één of meer zorgen over het aannemen van werknemers met psychische problemen. De sterkste voorspellers voor terughoudendheid bij het aannemen van een sollicitant met huidige psychische problemen waren zorgen over langdurig ziekteverzuim, zorgen dat de werknemer het werk niet aan zou kunnen, de zorg niet op de werknemer te kunnen rekenen, en hoger opleidingsniveau van de manager. Daarentegen waren managers die uit principe voorstander waren van sociale inclusie eerder bereid om iemand met psychische problemen aan te nemen.

Met behulp van een cluster RCT hebben we vervolgens onderzocht wat de effecten van een stigma bewustwordingsinterventie zijn op het vinden en behouden van betaald werk voor werkzoekenden met psychische problemen. De stigma bewustwordingsinterventie bestaat uit een beslishulp (CORAL.NL) voor werkzoekenden met psychische problemen, en een stigma bewustwordingstraining voor re-integratieprofessionals in de gemeentelijke re-integratiepraktijk. De interventie is gericht op het ondersteunen van werkzoekenden bij het nemen van beslissingen over het wel of niet open zijn over psychische problemen op het werk. In **hoofdstuk 3** is de opzet van het onderzoek beschreven in een *study protocol*. Clusterrandomisatie vond plaats op organisatieniveau (gemeenten en organisaties die in opdracht van gemeenten werken). Deelnemers aan het onderzoek waren werkzoekenden die een bijstandsuitkering ontvingen en psychische problemen hebben, of hebben gehad. Deelnemers van de interventiegroep kregen ondersteuning van hun getrainde re-integratieprofessional en ontvingen na de eerste vragenlijst (baseline) de beslishulp CORAL.NL. Deelnemers van de controlegroep kregen zoals gebruikelijk ondersteuning van hun re-integratieprofessional. Primaire uitkomsten waren (1) het vinden van betaald werk, (2) het behouden van betaald werk en (3) keuzestress over het wel of niet open zijn over psychische problemen. Secundaire uitkomsten waren mentale gezondheid en welzijn, stigmatisering, discriminatie en werk gerelateerde factoren. Gegevens zijn verzameld door middel van vragenlijsten bij baseline en na 3, 6 en 12 maanden, en door administratieve gegevens geworven via het CBS van deelnemers die hiervoor afzonderlijk geïnformeerde toestemming hebben gegeven.

In **hoofdstuk 4** laten de bevindingen van de cluster RCT zien dat de stigma bewustwordingsinterventie zeer effectief was in het verbeteren van de arbeidsparticipatie van werkzoekenden met psychische problemen. In totaal werden N=153 deelnemers geworven (interventiegroep: N=76, controlegroep: N=77). Zes maanden na baseline hadden in de interventiegroep significant meer deelnemers betaald werk gevonden dan in de controlegroep (50,7% versus 26,1%). Bovendien hadden twaalf maanden na baseline significant meer deelnemers van de interventiegroep betaald werk behouden in vergelijking met de controlegroep (49,2% versus 23,4%). De interventie had geen effect op keuzestress. Interessant is dat zes maanden na baseline de deelnemers van de interventiegroep positiever waren over de ondersteuning die ze kregen van hun re-integratieprofessional dan de controlegroep.

Vervolgens is in **hoofdstuk 5** een economische evaluatie uitgevoerd, waarbij de kosten en baten van een stigma bewustwordingsinterventie in de werkcontext vanuit een maatschappelijk perspectief zijn onderzocht. De studie toonde aan dat deelnemers van de interventiegroep betere resultaten hadden op het gebied van arbeidsparticipatie en betere resultaten met betrekking tot het onafhankelijk worden van een bijstandsuitkering dan deelnemers van de controlegroep. Wat de kosten van de interventie betreft, hadden

deelnemers van de interventiegroep gemiddeld lagere totale kosten (bestaande uit interventiekosten, zorgkosten en uitkeringen) dan deelnemers van de controlegroep (bestaande uit zorgkosten en uitkeringen). De verschillen tussen groepen op het gebied van arbeidsparticipatie, bijstandsuitkering en zorgkosten en -gebruik bereikten echter geen statistische significantie.

Tot slot worden in **hoofdstuk 6** de resultaten van een procesevaluatie beschreven. Het doel van dit onderzoek was om de haalbaarheid van de stigma bewustwordingsinterventie te onderzoeken, en daarbij ervaringen van deelnemers en hun re-integratieprofessionals te rapporteren en aanbevelingen te doen voor verdere implementatie in de praktijk. Het onderzoek toonde aan dat de interventie haalbaar was om te implementeren in de praktijk en dat de interventie succesvol bleek te zijn in creëren van meer bewustwording over en het openheidsdilemma bij zowel deelnemers als hun re-integratieprofessionals. Verder was de meerderheid van de deelnemers positief over de inhoud van de beslishulp CORAL.NL. Deelnemers zijn zich meer bewust geworden van het belang van bewuste keuzes rondom wel of niet open zijn en de meeste deelnemers zouden de tool aan anderen aanbevelen. Bovendien werd gemeld dat de tool voor de meerderheid van de deelnemers nuttig was bij het nemen van een beslissing over het al dan niet open zijn over psychische problemen, en 40-53% van de deelnemers was van gedachten veranderd over open zijn over psychische problemen als gevolg van de tool. Ongeveer één op de vijf deelnemers gaf aan dat de tool behulpzaam was bij het solliciteren en/of vinden van werk.

DISCUSSIE (Hoofdstuk 7)

De twee doelen van dit proefschrift waren 1) meer inzicht verkrijgen in de attitudes van Nederlandse managers ten aanzien van mensen die psychische problemen hebben (gehad) en hun bereidheid om deze mensen aan te nemen, en 2) het evalueren van de effectiviteit van een stigma bewustwordingsinterventie voor werkzoekenden met psychische problemen en hun re-integratieprofessionals, vergeleken met de gebruikelijke re-integratiebegeleiding. Dit proefschrift draagt bij aan de evidentie dat de arbeidsparticipatie van mensen met psychische problemen niet alleen wordt bepaald door de ziekte, maar voor een groot deel ook komt door psychosociale factoren zoals stigma en discriminatie.

Uit de resultaten van het cross-sectionele onderzoek onder Nederlandse managers bleek dat de meerderheid van de managers terughoudend was om iemand met huidige psychische problemen in dienst te nemen. Bovendien was ongeveer een derde van de managers terughoudend om een sollicitant met psychische problemen in het verleden

aan te nemen. De bevindingen van de effectiviteitsstudie lieten zien dat de stigma bewustwordingsinterventie zeer effectief was in het verbeteren van de arbeidsparticipatie van mensen met psychische problemen. Zes maanden na baseline was het percentage deelnemers dat werk vond in de interventiegroep significant hoger dan in de controlegroep. Bovendien hadden na 12 maanden significant meer deelnemers van de interventiegroep betaald werk behouden in vergelijking met de controlegroep.

Het is veelbelovend dat een relatief eenvoudige en betaalbare interventie invloed heeft gehad op de arbeidskansen van werkzoekenden met psychische problemen. Dit is de eerste studie die de rol van stigmatisering en het openheidsdilemma in de werkcontext op de arbeidsparticipatie van werkzoekenden in Nederland onderzoekt. Als toekomstige studies onze bevindingen kunnen bevestigen, zou dit betekenen dat twee keer zoveel werkzoekenden met psychische problemen betaald werk kunnen vinden en behouden met behulp van de stigma bewustwordingsinterventie. Dit zou mensen in kwetsbare posities enorm ten goede komen, o.a. op het gebied van gezondheid en welzijn, maar ook de samenleving als geheel.

Opvallend is dat in ons onderzoek in de loop van de tijd niet alleen de arbeidsparticipatie van de interventiegroep verbeterde, maar ook die van de controlegroep. Hiervoor kunnen twee mogelijke verklaringen zijn. Ten eerste werden deelnemers van zowel de interventie- als de controlegroep bij elke meting vragen gesteld over het wel of niet open zijn over psychische problemen en het openheidsdilemma. Dit kan hebben geleid tot meer bewustwording over het belang van het openheidsdilemma en kan indirect van invloed zijn geweest op de arbeidsparticipatie in beide groepen. Als dit inderdaad de toegenomen arbeidsparticipatie in de controlegroep verklaart, suggereert het dat meer bewustwording van stigmatisering in de werkcontext en het overwegen om wel of niet open te zijn een zeer krachtige maar eenvoudige manier is om de arbeidsparticipatie van werkzoekenden met psychische problemen te vergroten. Ten tweede, hoewel de exacte interventie niet bekend was bij de controlegroep, waren re-integratieprofessionals van beide groepen zich ervan bewust dat ze deelnamen aan een onderzoek naar het verbeteren van de arbeidsparticipatie van mensen met psychische problemen. Bewust zijn van deelname aan een onderzoek kan van invloed zijn op het begeleiden van deelnemers in beide groepen. Re-integratieprofessionals van beide groepen zouden meer gemotiveerd kunnen zijn om mensen met psychische problemen te ondersteunen, ook wel bekend als het Hawthorne-effect.

In ons effectiviteitsonderzoek vonden we dat significant meer deelnemers van de interventiegroep betaald werk hadden gevonden en behouden dan deelnemers van de controlegroep. In de economische evaluatie werd gebruik gemaakt van een andere databron (namelijk CBS microdata). In deze studie was de arbeidsparticipatie van de

interventiegroep ook hoger dan die van de controlegroep, maar bereikten de verschillen geen statistische significantie. Hiervoor zijn meerdere verklaringen mogelijk. Ten eerste kan de kleinere steekproefomvang in de economische evaluatie een verklaring zijn, wat resulteert in een lagere power om significante verschillen te detecteren. Omdat de trend op het gebied van zowel werkgelegenheid als bijstandsuitkeringen veelbelovend is, wordt aanbevolen om in toekomstig onderzoek een grotere steekproef te gebruiken. Ten tweede is aan deelnemers apart toestemming gevraagd voor het opvragen van gegevens over inkomen en uitkeringen bij het CBS. Sommige deelnemers hebben er bewust voor gekozen hier geen toestemming voor te geven, mogelijk omdat ze terughoudend waren met het delen van hun gegevens om diverse mogelijke redenen, zoals het hebben van zwart werk. Verder moet met betrekking tot de uitkomstmaten van beide onderzoeken worden benadrukt dat het vinden en behouden van betaald werk werd gedefinieerd als een dichotome variabele, namelijk betaald werk gevonden: ja/nee, behoud betaald werk: ja/nee. In het effectiviteitsonderzoek werd dit gemeten bij vier afzonderlijke metingen binnen twaalf maanden (baseline, 3, 6 en 12 maanden). In de economische evaluatie werd dit echter gemeten als het vinden of behouden van betaald werk (minstens één keer) in 12 maanden. Ten slotte kunnen beide databronnen (zelfrapportagegegevens en CBS microdata) fouten bevatten.

In tegenstelling tot de effecten op keuzestress van eerdere beslishulpen rondom de keuze om wel of niet open te zijn over psychische problemen, hebben we in dit onderzoek geen effect op keuzestress gevonden. Hier kunnen verschillende verklaringen voor zijn. Ten eerste hadden de deelnemers aan onze studie een minder dan gemiddelde score voor keuzestress bij aanvang van de studie in vergelijking met eerdere studies over beslishulpen. Bovendien hadden de deelnemers bij aanvang ook een lage geïnternaliseerde stigmascore. Uit recent Nederlands onderzoek blijkt dat de meeste Nederlandse werknemers overwegend positieve verwachtingen hebben over open zijn over psychische problemen op de werkvloer. De meerderheid van de Nederlandse werknemers hebben hun psychische problemen aan hun werkgever verteld of zouden dit willen vertellen. Bovendien verschilde onze RCT van andere onderzoeken naar beslishulpen met betrekking tot de inclusiecriteria van psychische problemen. Deze studies omvatten deelnemers met bijzonder ernstige psychische problemen. In onze studie kon iedereen met een zelf-geïdentificeerde psychische problemen deelnemen aan de studie, die daarom alle soorten psychische problemen vertegenwoordigde, van mild tot ernstig. Het is mogelijk dat mensen met ernstige psychische problemen vaker hogere keuzestress ervaren, bijvoorbeeld vanwege ernstigere symptomen of klachten. Hier is echter meer onderzoek naar nodig.

Een procesevaluatie is uitgevoerd om de haalbaarheid van de stigma bewustwordings-interventie te onderzoeken en om ervaringen en aanbevelingen voor toekomstige

implementatie te rapporteren. De belangrijkste bevinding van dit onderzoek was dat de interventie succesvol bleek te zijn in het vergroten van stigma bewustwording bij zowel werkzoekenden met psychische problemen als bij hun re-integratieprofessionals. De meeste deelnemers stonden positief tegenover CORAL.NL en zouden de tool aan anderen aanbevelen. Bovendien meldden de deelnemers dat de tool nuttig was bij het nemen van weloverwogen keuzes over het al dan niet open zijn over psychische problemen. Re-integratieprofessionals noemden de timing van de introductie van de tool en/of het voeren van een gesprek over het openheidsdilemma belangrijk. Ze meldden dat de tool vooral nuttig was wanneer mensen actief op zoek waren naar en/of solliciteerden naar werk. Re-integratieprofessionals hadden de CORAL.NL vaker in de praktijk kunnen gebruiken. In de interviews suggereerden re-integratieprofessionals dat meer trainingssessies of meer herinneringen tussendoor nuttig hadden kunnen zijn om de tool niet te vergeten. Voor implementatie in de praktijk is het daarom belangrijk om de CORAL.NL tool in te bedden in de reguliere werkwijzen van de gemeentelijke re-integratiepraktijk.

In onze cross-sectionele studie vonden we dat stigma en discriminatie belangrijke belemmeringen zijn voor de arbeidskansen van mensen met psychische problemen, aangezien twee derde van de managers terughoudend was om een sollicitant met psychische problemen aan te nemen en één derde deel terughoudend was om iemand aan te nemen die in het verleden psychische problemen heeft gehad. Dit illustreert het belang voor mensen met psychische problemen om weloverwogen beslissingen te nemen over het wel of niet open zijn over psychische problemen in de werkcontext. Het pleit voor de ontwikkeling van destigmatiserende interventies en training van managers. Onderzoek naar stigmatisering in de werkcontext en vooral naar destigmatiserende interventies staat echter nog in de kinderschoenen. Werkgerelateerde anti stigma-interventies kunnen de kennis, vaardigheden en ondersteunend gedrag van managers verbeteren, wat belangrijke positieve factoren kunnen zijn voor duurzame terugkeer naar het werk voor mensen met psychische problemen.

METHODOLOGISCHE OVERWEGINGEN

Hieronder worden de sterke punten en limitaties met betrekking tot de opzet van het hoofdonderzoek en het onderzoeksproces beschreven.

Minimaal verlies van follow-up - Een sterk punt van onze RCT is dat de uitval van deelnemers gedurende de studieperiode laag was. Er zijn met succes verschillende acties ondernomen om barrières om deel te nemen te vermijden en uitval in het onderzoek te voorkomen. Ten eerste was er veelvuldig persoonlijk contact met deelnemers. Verder zijn vragenlijsten ingevuld tijdens één-op-één afspraken met de onderzoeker, bij één

van de deelnemende organisaties. En tot slot, zelfs als een deelnemer de afspraak meerdere keren was vergeten of afgezegd, werd hem toch nog een keer gevraagd of hij op een ander moment wilde deelnemen.

Externe CBS microdata - De economische evaluatie van de RCT is uitgevoerd met behulp van gegevens van het CBS (CBS microdata). Een sterk punt van het gebruik van deze gegevens is dat de gegevens van alle deelnemers beschikbaar zijn voor de volledige onderzoeksperiode. Een beperking is echter dat rapportagegegevens van het CBS aan strikte regels gebonden zijn om te voorkomen dat gegevens tot personen herleidbaar zijn. Door deze outputregels konden niet alle gegevens worden gerapporteerd of moesten gegevens worden aangepast (bijvoorbeeld het samenvoegen van subgroepen) om te kunnen rapporteren.

Steekproefomvang - Een beperking van de RCT is de relatief kleine steekproefomvang van deelnemers. Hoewel de aanname van de powerberekening werd bereikt, namelijk 75 deelnemers per groep, zou een grotere steekproefomvang kunnen hebben geleid tot een grotere power om significante verschillen te detecteren.

Follow-up periode - Een sterk punt van de RCT is een langere follow-up periode dan andere onderzoeken naar de effecten van een beslishulp in de werkcontext. Wat betreft het meten van kosten en baten heeft echter een nog langere follow-up periode de voorkeur.

(Niet-)deelnemersbias - Deelnemers van de RCT zijn geworven door re-integratie-professionals die werkzaam zijn bij de acht organisaties die deelnamen aan het onderzoek. De werving via re-integratieprofessionals kende een aantal uitdagingen. Ten eerste is het een beperking dat re-integratieprofessionals alleen die cliënten konden werven van wie zij wisten (of vermoedden) dat zij psychische problemen hebben (gehad). Daarnaast konden re-integratieprofessionals er bewust voor kiezen om bepaalde cliënten niet uit te nodigen, omdat ze hen niet willen belasten met deelname aan een onderzoek, bijvoorbeeld vanwege de ernst van de psychische problemen. Dit kan hebben geleid tot selectiebias, waardoor deelnemers met ernstigere psychische problemen niet aan het onderzoek konden deelnemen.

Clusterrandomisatie van acht organisaties - In de RCT zijn acht organisaties (gemeenten en organisaties die in opdracht van deze gemeenten werkten) gerandomiseerd volgens clusterrandomisatie in een controle- en interventiegroep. Een sterk punt hiervan is dat re-integratieprofessionals die wel en niet getraind zijn niet met elkaar in contact kwamen. De interventie- en controlegroepen waren gelijk verdeeld over de gemeenten. Aangezien gemeenten hun eigen voorzieningen en diensten voor arbeidsre-integratie

organiseren voor mensen die een bijstandsuitkering ontvangen en we in de analyses niet hebben gecontroleerd voor de gemeente waarin een deelnemer woonde, kan er een *bias* van organisatieniveau zijn over op de arbeidsparticipatieresultaten.

Representativiteit van de cross-sectionele data - Een sterk punt van ons cross-sectionele onderzoek naar de attitudes en wervingsintenties van Nederlandse managers was dat er gebruik werd gemaakt van data van het representatieve Longitudinal Internet Studies for the Social Sciences (LISS-) panel.

IMPLICATIES VOOR DE PRAKTIJK

Omdat de stigma bewustwordingsinterventie effectief bleek te zijn in het verbeteren van de kansen op werk van werkzoekenden met psychische problemen, wordt aanbevolen om verdere acties te ondernemen om de interventie uit te voeren. Dit kan bijvoorbeeld worden gedaan via organisaties die zich inzetten voor het tegengaan van het stigma op het gebied van mentale gezondheid.

Wat betreft de CORAL.NL tool is de tool al vrij toegankelijk op internet en zou de stigma bewustwordingstraining in de praktijk toegepast kunnen worden. In onze procesevaluatie vonden we echter verbetermogelijkheden voor meer therapietrouw van re-integratieprofessionals in de stigma bewustwordingstraining. Het belangrijkste daarbij is dat de training mogelijk beter wordt ontvangen wanneer deze wordt gegeven door collega-re-integratieprofessionals die ervaring hebben met het gebruik van de tool in hun werk. Daarnaast raden we aan dat de tool wordt ingebed in de werkprocedures van de gemeentelijke re-integratiepraktijk, aangezien re-integratieprofessionals de tool en/of het openheidsdilemma niet altijd in hun hoofd hebben. De afgelopen jaren zijn het openheidsdilemma en de CORAL.NL tool al succesvol ingebed in het opleidingsprogramma voor Individuele Plaatsing en Ondersteuning (IPS) trajectbegeleiders in Nederland.

Aangezien we ontdekten dat bijna één derde deel van de Nederlandse managers terughoudend was met het aannemen van sollicitanten met psychische problemen, en bijna twee derde van de managers terughoudend was met het aannemen van sollicitanten met huidige psychische problemen, heeft dit grote gevolgen voor de sociale inclusie van mensen met psychische problemen. Deze bevindingen suggereren dat het belangrijk is voor mensen met psychische problemen om weloverwogen beslissingen te nemen om de kans op een positieve uitkomst te vergroten. Tegelijkertijd is het belangrijk om stigmatiserende attitudes bij managers te verminderen. Studies hebben bijvoorbeeld aangetoond dat sociale steun in de werkcontext en de houding en het gedrag van managers de terugkeer naar het werk kunnen vergemakkelijken bij mensen

met een (psychische) aandoeningen. Destigmatiserende interventies die de kennis, attitudes, vaardigheden en gedrag van managers verbeteren zijn belangrijk, omdat dit de (duurzame) arbeidsparticipatie voor mensen met psychische problemen zou kunnen vergroten.

Initiatieven zoals de MENTUPP-studie bestuderen de effecten van voorlichting van zowel werkgevers als werknemers op de mentale gezondheid, welzijn en werk. Het faciliteert de implementatie van tools voor werkgevers om dit te bevorderen en om risicofactoren in de psychosociale werkcontext te verminderen, evenals persoonlijke tools om met stressvolle gebeurtenissen om te gaan en elkaar te ondersteunen. Inzichten uit deze onderzoeken kunnen ook bijdragen aan het verminderen van stigma en het vergroten van het mentale welzijn en duurzame arbeidsparticipatie.

AANBEVELINGEN VOOR TOEKOMSTIG ONDERZOEK

Aangezien dit de eerste studie is naar de stigma-bewustwordingsinterventie in zijn huidige vorm, is meer onderzoek nodig naar de effectiviteit en de werkzame elementen. Het is belangrijk om een *fidelity* instrument te ontwikkelen, een meetinstrument waarmee wordt vastgesteld in hoeverre een interventie volgens modelstandaarden wordt geleverd. Het gebruik van een *realist evaluation* benadering kan van toegevoegde waarde zijn in toekomstig onderzoek naar deze stigma bewustwordingsinterventie. *Realist evaluation* is een techniek die wordt gebruikt om te bestuderen 'wat werkt, voor wie, onder welke omstandigheden en hoe' in complexe interventies. Omdat de huidige interventie werkt op zowel het niveau van werkzoekenden met psychische problemen als arbeidsspecialisten, in een vakgebied met nog meer stakeholders (bijvoorbeeld werkgevers, HR-professionals maar ook andere sollicitanten) is het belangrijk om meer inzicht te krijgen in de context, werkelementen en resultaten van de interventie.

Bovendien bleek uit ons onderzoek naar de attitudes en wervingsintenties van Nederlandse managers dat een aanzienlijk aantal managers terughoudend is om een sollicitant met psychische problemen aan te nemen, terwijl uit andere onderzoeken bleek dat Nederlandse werknemers de voorkeur geven om hun psychische problemen te vertellen in de werkcontext. Het is daarom belangrijk om meer onderzoek te doen naar het openheidsdilemma mensen met psychische problemen. Er is meer inzicht nodig in de redenen waarom mensen de voorkeur geven aan open zijn en wat hun redenen zijn om niet open te zijn. Daarnaast is in onze huidige RCT niet gekeken naar het verband tussen openheid en de daadwerkelijke gevolgen in arbeidsvoorwaarden, maar het zou relevant zijn om dit in de toekomst te onderzoeken, bij voorkeur in een longitudinaal design.

CONCLUSIE

Het stigma op psychische problemen is aanwezig en vormt een belangrijke belemmering voor duurzame arbeidsparticipatie van werkzoekenden met psychische problemen. Dit is problematisch, aangezien de meerderheid van de Nederlandse werknemers hun psychische problemen in de werkcontext bekend zou maken. Deze cluster RCT toonde aan dat het implementeren van een stigma bewustwordingsinterventie zeer effectief was in het verbeteren van de werkgelegenheidsresultaten voor werkzoekenden met psychische problemen. Deelnemers van de interventiegroep vonden en behielden bijna twee keer zo vaak betaald werk in vergelijking met een controlegroep. Wanneer in toekomstig onderzoek soortgelijke resultaten worden gevonden, kan dit aanzienlijk bijdragen aan meer arbeidsparticipatie van mensen met psychische problemen. Dit kan vervolgens grote financiële gevolgen hebben op maatschappelijk en persoonlijk niveau, omdat het de kwaliteit van leven en het welzijn van mensen met psychische problemen aanzienlijk kan verbeteren.

APPENDIX

APPENDIX 1.
CORAL.NL DECISION AID

CORAL.NL
Afwegingen rond openheid over psychische gezondheidsproblemen op het werk:
Een keuzehulp

Colofon

Titel: CORAL.NL. Afwegingen rond openheid over psychische gezondheidsproblemen op het werk: Een keuzehulp.
Oorspronkelijke titel: CORAL: Conceal or Reveal
Auteur: Dr. Claire Henderson, King's College London

Deze keuzehulp is een aangepaste versie van de Nederlandse vertaling 'Verzwijgen of Vertellen'.
Deze versie is een uitgave van Samen Sterk Zonder Stigma en is tot stand gekomen in samenwerking tussen Kenniscentrum Phrenos, Tranzo/Tilburg University en Samen Sterk Zonder Stigma.

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CORAL.NL
Afwegingen rond openheid over psychische gezondheidsproblemen op het werk: Een keuzehulp

Wat is het doel van deze keuzehulp?
Kun je wel of niet open zijn over psychische gezondheidsproblemen[1] op je werk, of als je gaat solliciteren? Wat is de meest verstandige keuze? Daarover twijfelen veel mensen. Deze vragen kunnen vaker terugkomen en het kan per situatie verschillen wat verstandig is. Het doel van deze keuzehulp[2] is om mensen die hierover nadenken te ondersteunen. De keuze ligt altijd bij de persoon zelf. Door het lezen van de overwegingen in deze keuzehulp kunnen mensen op nieuwe ideeën komen die helpen bij het maken van eigen keuzes. Ook biedt het handvatten bij het ondersteunen van anderen die voor deze keuzes staan.

Voor wie is deze keuzehulp?
Deze keuzehulp is voor iedereen die psychische gezondheidsproblemen heeft of heeft gehad en nadenkt over wat hij/zij hierover wel en niet aan een huidige of toekomstige werkgever of anderen in de werkomgeving wil vertellen. Daarnaast kunnen professionals, op het gebied van bijvoorbeeld arbeidsre-integratie, en werkgevers deze keuzehulp inzetten. Ook naasten van iemand die vragen heeft over het bespreekbaar maken van psychische gezondheidsproblemen, kunnen baat hebben bij deze keuzehulp.

Inhoud
In het eerste deel van deze keuzehulp komen argumenten aan bod die een rol kunnen spelen bij open of niet open zijn in de werkomgeving (Deel 1: Keuzes rond openheid). Hier gaat het erom inzicht te krijgen in wat je nodig hebt en belangrijk vindt. In deel 2 word je uitgenodigd na te denken over of je wel of niet open wilt zijn. En zo ja, wanneer en met wie je in gesprek zou willen gaan. (Deel 2: Mijn eigen situatie). Deel 3 geeft nog een aantal tips, die je verder kunnen helpen bij je keuzes. Op basis van je persoonlijke afwegingen kun je in deel 4 aangeven wat op dit moment je keuzes (zouden) zijn rond het bespreekbaar maken van psychische gezondheidsproblemen in de werkomgeving (Deel 4: Een keuze maken).

1 Waar we het hebben over psychische gezondheidsproblemen kan ook gedacht worden aan psychische aandoeningen/stoornissen/kwetsbaarheid/gevoeligheid. Je kunt afwegen welke term je wilt gebruiken wanneer je het hebt over je psychische gezondheid.
2 Deze keuzehulp is onderdeel van een module die tevens een programma voor een startbijeenkomst en intervisiebijeenkomsten voor professionals, en een handleiding voor professionals bevat.

DEEL 1: Keuzes rond openheid

1.1 Argumenten
Er zijn verschillende argumenten te bedenken om wel of niet open te zijn over psychische gezondheidsproblemen in de werkomgeving of bij een sollicitatie. Hieronder vind je eerst een aantal argumenten voor openheid en daarna een aantal argumenten tegen. Je kunt aanvinken welke hiervan voor jou gelden en het meest belangrijk of relevant voor je zijn.

Argumenten om open te zijn over psychische gezondheidsproblemen in de werkomgeving
- ❑ Als je niets hoeft te verzwijgen, is dat goed voor je zelfvertrouwen.
- ❑ Je kunt begrip en steun krijgen van je leidinggevende of collega's.
- ❑ Het kan voor jou als (toekomstige) werknemer en voor je werkgever fijn zijn om je psychische gezondheid te bespreken, vooral als er aanpassingen op je werk nodig zijn. Er kan rekening mee gehouden worden.
- ❑ Het kan voor problemen zorgen als anderen er later achter komen.
- ❑ Het kan moeilijk en stressvol zijn om met een 'geheim' rond te lopen.
- ❑ Het kan zijn dat men al wist of vermoedde dat er iets aan de hand was.
- ❑ Door eerlijk te zijn tegen anderen op je werk laat je zien dat je hen vertrouwt. Contacten kunnen verbeteren en je weet wat je aan elkaar hebt.
- ❑ Als je het niet vertelt, en mensen merken iets aan je, dan zouden ze dat op een bepaalde manier kunnen gaan invullen, waardoor het misschien erger wordt ingeschat dan wanneer je open bent.
- ❑ Je kunt het onderwerp psychische gezondheid meer bespreekbaar maken en het makkelijker maken voor anderen om over hun psychische gezondheid te praten.
- ❑ Als je werkgever ziet dat jij je werk kan doen, is de kans groter dat hij/zij nog iemand aanneemt met psychische gezondheidsproblemen.
- ❑ Het kan zijn dat je een gat in je CV hebt als gevolg van gezondheidsproblemen en dit wilt kunnen toelichten.
- ❑ Het kan zijn dat je een baan hebt of wilt, waarbij het in je voordeel zou kunnen werken dat je zelf psychische gezondheidsproblemen hebt (gehad).
- ❑ Door open te zijn kun je ook meer van je (andere) positieve eigenschappen laten zien.
- ❑ Een extra argument voor openheid is volgens mij:

_____

_____

Argumenten om niet open over psychische gezondheidsproblemen te zijn in de werkomgeving

- ❑ Het is niet van invloed op hoe je je werk doet.
- ❑ Je wilt geen onnodig risico lopen op negatieve reacties.
- ❑ Je wordt misschien niet aangenomen als je vertelt over je psychische gezondheidsproblemen in een sollicitatie- of arbeidsvoorwaardengesprek.
- ❑ Je (toekomstige) werkgever kan bang zijn dat je gaat uitvallen en te veel kijken naar waar het misgaat.
- ❑ Je kunt het gevoel krijgen dat je op je tenen moet gaan lopen als je erover zou vertellen.
- ❑ Je kunt je onprettig voelen als bepaalde informatie bij je werkgever bekend is.
- ❑ Erover vertellen kan de kans op promotie of een verlenging van je contract verminderen.
- ❑ Je werkgever zal je bepaalde verantwoordelijkheden misschien niet toevertrouwen.
- ❑ Je leidinggevende of collega's zouden kunnen denken dat je vanwege je gezondheidsproblemen niet in staat bent je werk (goed) te doen.
- ❑ Als je niet lekker in je vel zit of als je een slechte dag hebt, zouden ze kunnen denken dat dit te ermee te maken heeft en de conclusie trekken dat je niet geschikt bent voor dit soort werk (zelfs als het alledaagse problemen zijn die ieders werk zouden beïnvloeden).
- ❑ Als je collega's het weten, zouden ze je anders kunnen behandelen.
- ❑ Je collega's zouden zich in jouw aanwezigheid ongemakkelijk of opgelaten kunnen voelen, achter je rug vervelende dingen over je kunnen zeggen, je buiten kunnen sluiten, of je niet vertrouwen.
- ❑ Misschien heb je behoefte aan privacy. Volgens de Autoriteit Persoonsgegevens mag een werkgever niet informeren naar de aard en oorzaak van de ziekte van een werknemer.
- ❑ Een extra argument tegen openheid is volgens mij:

_____

_____

De belangrijkste argumenten om open te zijn op het werk zijn voor mij:

_____

_____

_____

De belangrijkste argumenten om niet open te zijn op het werk zijn voor mij:

_____

_____

_____

TIP:
Meer informatie over privacy en wet- en regelgeving vind je hier:
- https://www.samensterkzonderstigma.nl/stigma-en-werk/artikelen/bespreekbaarheid-privacy/
- https://www.psynip.nl/actueel/themas/thema/toolbox-werk-en-psychische-klachten/wet-en-regelgeving/wetgeving-toolbox-werk-en-psychische-klachten/

1.2 Wat heb ik nodig?

Nadenken over wat je nodig hebt op het werk of op je werkplek kan een nuttige manier zijn om erachter te komen of je wel of niet wilt vertellen over je psychische gezondheid. Hieronder vind je een lijst met verschillende behoeften die een rol kunnen spelen bij het maken van je keuzes. In de onderstaande lijst kun je de stellingen aanvinken waarmee je het eens bent.

- ❑ Ik heb behoefte aan werkaanpassingen (bijvoorbeeld aangepaste werktijden, andere werktaken, een rustige omgeving).
- ❑ Ik heb ruimte nodig om onder werktijd naar afspraken met mijn arts of behandelaar te gaan.
- ❑ Ik moet verlof op kunnen nemen vanwege mijn psychische gezondheidsproblemen.
- ❑ Ik heb er baat bij als ik (alleen of samen met iemand anders) voor mijn werkgever een plan opstel, waarin staat wat er moet gebeuren als ik ziek word, als ik last krijg van symptomen op mijn werk of als ik verlof moet opnemen.
- ❑ Ik zou graag willen weten tegen wie in mijn werkomgeving ik het beste open kan zijn als ik het wil vertellen.
- ❑ Ik zou meer willen weten over hoe ik erover kan praten; over wat ik wel en beter niet kan zeggen.
- ❑ Ik wil me graag ontwikkelen.
- ❑ Openheid kan helpen bij mijn behoefte om:

_____

_____

Ik functioneer het beste op mijn werk of werkplek als:

_____

_____

_____

Ik heb hiervoor het volgende nodig:

_____

_____

_____

1.3 Wat vind ik belangrijk?

Hieronder vind je een lijst met dingen die je belangrijk kunt vinden bij je keuze om wel of niet open te zijn over je psychische gezondheid. Hier kun je de stellingen aanvinken waarmee je het eens bent.

- ❑ Ik vind dat mijn psychische gezondheid een deel van mijn privéleven is. Ik wil dat niet met anderen delen.
- ❑ Ik wil op de werkvloer net als ieder ander behandeld worden.
- ❑ Ik wil mezelf kunnen zijn op m'n werk, zelfs als dit betekent dat mensen me afkeuren of me anders behandelen.
- ❑ Ik vind het belangrijk dat ik op de werkvloer gesteund word.
- ❑ Ik zou graag een voorbeeld willen zijn voor andere mensen met gezondheidsproblemen, zodat zij ook open durven te zijn.
- ❑ Ik vind het belangrijk om door openheid vooroordelen tegen te gaan.
- ❑ Ik zou mijn werkgever en collega's graag willen informeren over wat het betekent om psychische gezondheidsproblemen te hebben.
- ❑ Ik vind het belangrijk om te voorkomen dat mensen medelijden met me krijgen, me betuttelen, me afwijzen of over me roddelen.
- ❑ Ik vind de werkrelatie met mijn werkgever belangrijk.
- ❑ Ik vind het belangrijk om:

_____

_____

- ❑ Voor mij is het in de werkomgeving belangrijk, dat:

_____

_____

_____

TIP:
Eigen keuzes en het keuzeproces

- Realiseer je dat werkgevers en anderen in de werkomgeving niet alles hoeven te weten. Je weegt zelf af of je je psychische gezondheidsproblemen bespreekbaar wilt maken, en als je dit wilt, wat je tegen wie wilt vertellen.
- Probeer niet in te vullen voor de ander. Je kunt negatieve verwachtingen hebben, terwijl de realiteit meevalt.
- Vaak zijn keuzes over openheid deel van een (herstel)proces. Het zijn meestal geen keuzes die je één keer maakt. Je keuzes kunnen per situatie, persoon en moment verschillen. Het kan helpen om later nog eens terug te kijken naar (delen van) deze keuzehulp.

DEEL 2: Mijn eigen situatie

2.1. Wanneer wel of niet vertellen?

In dit keuzeproces is het nuttig om ook na te denken over het moment waarop je open zou willen zijn over je psychische gezondheid of de gevolgen die deze voor je werk of werkomgeving kan hebben.

Het beste moment om het te vertellen is voor mij (vink jouw keuze aan):

- ❑ Tijdens of rond de sollicitatie.
- ❑ Als ik begonnen ben aan een nieuwe baan.
- ❑ Als ik klachten krijg/heb die van invloed zijn op hoe ik mijn werk doe.
- ❑ Als ik een contract voor onbepaalde tijd heb/in vaste dienst ben.
- ❑ Op een (later) moment, wanneer het relevant is voor de uitvoering van mijn werkzaamheden/functie.
- ❑ Niet.

TIP: Als je ergens langer werkt, heb je al kunnen laten zien wat je kunt. Veel mensen vinden dat dat een beter moment voor openheid is dan tijdens een sollicitatiegesprek.

2.2 Aan wie wel of niet vertellen?

Sommige mensen vertellen aan niemand over hun psychische gezondheidsproblemen, terwijl anderen bewust uitkiezen aan wie ze het wel of niet vertellen. Weer anderen zijn heel open over hun psychische gezondheid en vinden dat iedereen het mag weten.

Wat op dit moment het beste voor mij zou werken is (vink één strategie aan):

- ❑ **Het geheim houden**: *je vertelt niemand op je werk erover.*
- ❑ **Selectief open zijn**: *je vertelt het een aantal mensen, van wie jij denkt dat ze je zullen steunen of dat ze ervan moeten weten.*
- ❑ **Open zijn zonder onderscheid te maken**: *je maakt je niet druk over wie ervan weet. Je vertelt het aan iedereen die je ontmoet.*
- ❑ **Doelbewust bekend maken:** *je brengt je ervaringen met psychische gezondheidsproblemen over aan een grote groep.*

TIP: Als je al ergens werkt, kun je misschien inschatten hoe je werkgever of leidinggevende omgaat met psychische gezondheidsproblemen. Hoe open is de cultuur? Is er ruimte om erover te praten? Wat heb je nodig om open te kunnen zijn? Verwacht je dat je werkgever zich flexibel opstelt? Dit kun je meewegen in je afwegingen.

DEEL 3: Tips

In dit deel wordt nog een aantal tips gegeven die je mee kunt wegen in je keuzeproces.

Wat doe, wil en kun je zelf?

- Denk na over wat je er zelf aan kunt doen en al aan hebt gedaan om je werk goed te kunnen uitoefenen.
- Laat zien waar je motivatie ligt om het betreffende werk uit te voeren.
- Geef aan welke werkzaamheden/taken je goed kunt en graag doet en waar je ingezet kunt worden. Een focus op wat je talenten en kwaliteiten zijn en op wat je nodig hebt om die in te kunnen zetten, kan helpen bij het uitvoeren van je werk.
- Vertel wat je nodig hebt om je werk goed te kunnen uitoefenen.

Oefenen

- Als je open wilt zijn, kun je ook eerst oefenen met wat je wilt zeggen, alleen of met iemand die je vertrouwt. Let op de manier waarop je je presenteert (verbaal en non-verbaal gedrag, welke woorden kies je?).
- Door te oefenen met wat je wel en niet vertelt, merk je wat goed werkt voor jou.

Als je het wel vertelt

- Als je het vertelt kan goede voorlichting belangrijk zijn. Je hoeft niet te zeggen wat je 'hebt', maar kunt wel uitleg geven over de eventuele gevolgen op de werkvloer.
- Geef anderen de mogelijkheid te reageren op je verhaal/mededeling

Ondersteuning van anderen

- Bespreek je situatie met vrienden/familie die je in deze volledig vertrouwt.
- Als je niet vertelt over je psychische gezondheidsproblemen, kun je nog wel ondersteuning krijgen van bijvoorbeeld een job coach.
- Probeer jezelf, of wanneer je iemand begeleidt, de ander, niet onder druk te zetten bij het maken van keuzes rond openheid.
- Deze keuzehulp kan de basis zijn voor een goed gesprek over openheid, waarin of waarna je tot je keuzes rond wel of niet vertellen kunt komen.

DEEL 4: Een keuze maken

Je hebt nu de hele keuzehulp doorgenomen en over de volgende dingen nagedacht:

- Wat zijn argumenten (1.1), ondersteuning of behoeften (1.2) en waarden (1.3) die je belangrijk vindt bij keuzes rond bespreekbaarheid in de werkomgeving?
- Je eigen situatie: op welk(e) moment(en) (2.1) en tegen wie (2.2) zou je (eventueel) open willen zijn?
- Tips die je mee kunt nemen bij je keuzes (3).

Bekijk de antwoorden die je aan het eind van deel 1 en 2 hebt gegeven. Deze kun je eventueel bespreken met vrienden, familie, een coach of een behandelaar. Je kunt nadenken over wat je zou willen op de korte en op de langere termijn.

1.a Ik kies ervoor om het niet te vertellen, omdat:

1.b Ik kies ervoor om het wel te vertellen, omdat:

2. Ik kies ervoor om het te vertellen op het moment dat:

3. Ik kies ervoor om het te vertellen aan:

4. Dit is wat ik ga zeggen:

5. Ik wil mijn besluit eerst nog voorleggen aan:

_____

_____

Tot slot

Waar komt de informatie in deze keuzehulp vandaan?
De informatie in de oorspronkelijke Engelstalige versie en de Nederlandse vertaling daarvan - Verzwijgen of Vertellen - is gebaseerd op een uitgebreide literatuurstudie en interviews met mensen die psychische gezondheidsproblemen hebben.

Vervolgens is deze keuzehulp in het project 'Doorontwikkeling CORAL', waarin samengewerkt is door Samen Sterk Zonder Stigma (initiatiefnemer), Kenniscentrum Phrenos en Tranzo, Tilburg University, vernieuwd.

Deze herschreven versie is tot stand gekomen met medewerking van ervaringsdeskundigen/cliënten, professionals op het gebied van Human Resources en arbeidsre-integratie, en werkgevers.

Met wie kan ik contact opnemen over deze keuzehulp?
Als je meer informatie wilt over deze beslishulp kun je contact opnemen met onderzoeker Kim Janssens: k.m.e.janssens@tilburguniversity.edu.

Psychische gezondheidsproblemen

Veel mensen die psychische problemen hebben (gehad), vragen zich af of het verstandig is om dit te vertellen tijdens een sollicitatie.

Hebt u hier al over nagedacht?

BELANGRIJKE REDENEN OM NIET OVER UW PSYCHISCHE PROBLEMEN TE VERTELLEN TIJDENS EEN SOLLICITATIE:

Er zijn veel vooroordelen, waardoor u mogelijk

- Niet aangenomen wordt.
- Een korter contract, lager salaris of geen vast contract krijgt.
- Anders (negatiever) behandeld wordt.

BELANGRIJKE REDENEN OM WEL OVER UW PSYCHISCHE PROBLEMEN TE VERTELLEN TIJDENS EEN SOLLICITATIE:

- Uw werkgever kan beter rekening houden met wat u nodig heeft.
- U kunt beter toelichten waarom u bijvoorbeeld periodes niet heeft gewerkt (gaten in uw CV) of langer heeft gestudeerd.
- Als u zich hier veel prettiger bij voelt of als u zo meer uzelf kan zijn.

TIPS

- De sollicitatieperiode is vaak minder geschikt om open te zijn over psychische gezondheidsproblemen, omdat mensen u dan nog niet goed kennen. Het is vaak beter om eerst te laten zien wie u bent en wat u kunt.
- Voor uw werkgever is het belangrijk om te weten wat u nodig hebt om uw werk goed te doen.
- Uw werkgever hoeft niet alles van u te weten, het is normaal dat sommige dingen privé zijn.

Tilburg University
School of Social and Behavioral Sciences

Meer weten?
Lees dan de brochure
'CORAL.NL'.

Tranzo
Wetenschappelijk centrum voor zorg en welzijn

Psychische gezondheidsproblemen

Veel mensen die psychische problemen hebben (gehad), vragen zich af of het verstandig is om dit te vertellen op het werk.

Hebt u hier al over nagedacht?

BELANGRIJKE REDENEN OM NIET OVER UW PSYCHISCHE PROBLEMEN TE VERTELLEN OP HET WERK:

Er zijn veel vooroordelen, waardoor u mogelijk:

- Geen contractverlenging krijgt.
- Geen promotie maakt omdat u lager wordt ingeschat.
- Anders (negatiever) behandeld wordt.

BELANGRIJKE REDENEN OM WEL OVER UW PSYCHISCHE PROBLEMEN TE VERTELLEN OP HET WERK:

- Uw werkgever kan beter rekening houden met wat u nodig heeft.
- Openheid kan leiden tot meer begrip voor u en uw situatie.
- U kunt mogelijk meer uzelf zijn.
- Als u open bent zullen anderen zich ook sneller openstellen en persoonlijke dingen durven te vertellen.

TIPS

- Als uw psychische problemen niet van invloed zijn op het werk is het belangrijk goed na te denken of u het wel wilt vertellen.
- Als u open wilt zijn, vertelt u dan vooral wat u nodig heeft om uw werk goed te doen en leg minder de nadruk op privézaken of medische dingen.

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ABOUT THE AUTHOR

Kim Janssens was born on May 28th, 1993 in Breda, the Netherlands. She graduated from pre-university education at the Onze Lieve Vrouwe lyceum in Breda in 2011. Subsequently she studied Psychology at Tilburg University from 2011 until 2015 and graduated with distinction. She conducted a masterthesis about crying at the workplace among physicians, medical interns and nurses. Afterwards she wrote multiple Dutch and English publications about her thesis. In 2016, Kim started as junior researcher at the Police Academy and INTERVICT, which was part of the Tilburg Law School of Tilburg University. Here, she studied the concept of resilience in the police context. In 2017, Kim started working on a PhD-project about disclosure of mental illness at the workplace at the Academic Collaborative Center Work and Health of Tranzo, Tilburg University. Her supervisors were prof. dr. Evelien Brouwers, prof. dr. Jaap van Weeghel and dr. Margot Joosen. Kim is currently working at the same academic collaborative center of Tranzo as a postdoctoral researcher. Here, she focuses on the return to work of patients with traumatic injuries and on the value of work for healthcare professionals. Both research projects are in collaboration with the Elisabeth-Twee Steden Hospital (ETZ). In addition, she coordinates the Tranzo mastertrack Health, Wellbeing and Society and is one of the teachers of the course Health and Policy.

Over de auteur

Kim Janssens is op 28 mei 1993 geboren in Breda. Zij heeft in 2011 haar VWO-diploma behaald aan het Onze Lieve Vrouwe lyceum te Breda.Daarna studeerde zij van 2011 tot 2015 Psychologie aan Tilburg University waar zij cum laude is afgestudeerd. Haar masterscriptie schreef ze over huilen op de werkvloer door artsen, coassistenten en verpleegkundigen. Hier schreef zij meerdere Nederlandstalige en Engelstalige publicaties over. In 2016 startte Kim als junior onderzoeker bij de Politieacademie en INTERVICT, onderdeel van de Tilburg Law School van Tilburg University. Hier deed zij onderzoek naar weerbaarheid bij politieagenten. Vervolgens startte zij in 2017 met haar PhD-project naar openheid over psychische problemen op de werkvloer bij de Academische Werkplaats Arbeid en Gezondheid van Tranzo, Tilburg University. Ze werd begeleid door prof. dr. Evelien Brouwers, prof. dr. Jaap van Weeghel en dr. Margot Joosen. Kim is momenteel bij dezelfde academische werkplaats van Tranzo werkzaam als postdoctoraal onderzoeker. Hier richt ze zich op terugkeer naar werk van patiënten met traumatisch letsel en de werkwaardes van zorgprofessionals. Deze projecten zijn in samenwerking met het Elisabeth-Twee Steden Ziekenhuis (ETZ). Daarnaast is ze betrokken bij de Tranzo mastertrack Health, Wellbeing and Society en is ze daarbij een van de docenten van het vak Health and Policy.

LIST OF PUBLICATIONS

International publications

Janssens, K. M. E., van Weeghel, J., Henderson, C., Joosen, M. C. W., & Brouwers, E. P. M. (2020). Evaluation of an intervention to support decisions on disclosure in the employment setting (DECIDES): study protocol of a longitudinal cluster-randomized controlled trial. Trials, 21, 1-10.

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Janssens, K. M., Sweerts, C., & Vingerhoets, A. J. (2019). The physician's tears: Experiences and attitudes of crying among physicians and medical interns. Journal of clinical psychology in medical settings, 26(4), 411-420.

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Janssens, K. M. E., Sweerts, C., & Vingerhoets, A. J. J. M. (2015). Schaamte over tranen. Medisch Contact, 50, 2442-2444.

Janssens, K. M. E., Sweerts, C., & Vingerhoets, A. J. J. M. (2017). Tranen bij verpleegkundigen: Geaccepteerd of een taboe?. Verpleegkunde, 2017(3), 4-6.

Janssens, K. M. E., & Vingerhoets, A. J. J. M. (2017). De tranen van de behandelaar. In Zelfonthulling: Openheid van professionals in de GGZ (pp. 87-98). Boom.

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