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The Mental Health of Mental Healthcare Professionals (MHCPs): A Shared Responsibility

—A Concurrent Exploratory Mixed-Methods Study Exploring Experiences, Needs & Barriers

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Abstract

Mental healthcare professionals (MHCPs) are vulnerable to mental health problems, including stress and emotional exhaustion. This study explored determinants of mental health among MHCPs in the southern Netherlands using a concurrent mixed methods design. Thirty-three participants completed demographic and mental health questionnaires (MHI-5), and five focus groups provided qualitative insights. Quantitative results showed that nearly half scored below the MHI-5 threshold, indicating reduced well-being. Thematic analysis revealed challenges in maintaining work-life balance and identified social support and job autonomy as protective factors. Organizational issues such as workload, stigma, and limited autonomy contributed to psychological strain. Findings highlight the need for integrated workplace strategies, including proactive policies, structural support, and involvement of MHCPs in intervention design. Tailoring approaches to career stage may promote sustainable employability and mental health in the sector.

Keywords

Mental Health, Mental Healthcare Professionals, Sustainable Employability

1. Introduction

We are currently living in a time where the pressure on mental health services is unprecedented. According to recent data from 2024, a significant proportion of mental healthcare professionals (MHCPs) are experiencing psychological difficulties, including stress, emotional exhaustion, and burnout (RIVM Monitor; RIVM,

2023; COVID-19 Mental Disorders Collaborators, 2021; van den Broek et al., 2022). This pressure is driven by a rapidly changing society and an evolving vision of healthcare. MHCPs are confronted daily with high workloads, complex cases, and ongoing organizational changes (WHO, 2020). Contributing factors include an ageing population, staff shortages, and increased incidents of aggressive behavior (Carrieri et al., 2018; Van Dam et al., 2022). While workload was already a major concern prior to the emergence of COVID-19, the pandemic has exacerbated the issue, further intensified demands and posing a threat to both job satisfaction and the quality of care provided (Maghsoud et al., 2022; Pérez-Francisco et al., 2020; van den Broek et al., 2023).

Internationally, there is growing recognition of the mental health challenges faced by MHCPs, as well as the complaints they report (World Health Organization, 2020). Since the emergence of the COVID-19 pandemic in 2020, research into this professional group has gained significant momentum. The "Don't-Forget-Yourself" (DFY) study, which focuses on the mental wellbeing of (M)HCPs, published findings from its first survey in January 2022 and a second in May 2023. In the initial online survey (N = 1372), 50% of respondents reported stress-related complaints, while 30% experienced symptoms of depression because of the pandemic. Despite these challenges, MHCPs continued their work with perseverance throughout the pandemic, although maintaining a healthy work-life balance proved to be extremely difficult (van den Broek et al., 2022).

Despite growing awareness and various governmental initiatives aimed at strengthening workforce wellbeing, limited knowledge exists regarding the contributing factors and protective mechanisms involved. A study by Brugman et al. (2022) found that 25% of MHCPs in the southern region of the Netherlands reported high levels of emotional exhaustion. This study also identified a mediating effect of social support on psychological outcomes. Previous research has highlighted intrinsic factors related to mental health, such as social support (Kleinjan et al., 2020) and resilience (Ungar et al., 2017). Moreover, these psychological protective factors—particularly social support and resilience—have been shown to be translatable into effective preventive strategies and sustainable employability frameworks.

The workload placed on MHCPs not only affects individual professionals, but also has broader implications for team functioning and the overall stability of mental health systems. Considering the increasing pressure on these systems, sustainable employability has become a key priority for healthcare institutions (van den Broek et al., 2022). Stress-related sick leave imposes a significant burden on employers and, by extension, on society (Wolvetang et al., 2023; Korošec et al., 2023). Sick leave rates among mental health professionals have risen from 4.7% in 2014 to 7.3% in 2024 (Ministry of Health, Welfare and Sport, 2024). In the first quarter of 2025, the average sick leave rate among regular employees was 5.8%. Within the healthcare and welfare sector, this figure increased to 8.1%, and in mental health care specifically, it reached 8.3%. These figures indicate that absenteeism has risen most sharply within the mental health sector in the Netherlands (CBS, 2025).

In addition, there is a persistent structural shortage of personnel: currently, nearly 62,500 vacancies remain unfilled in the healthcare sector, and many professionals are considering leaving the field. This increases the burden on those who stay, perpetuating a vicious cycle (CBS, 2025). Another striking issue is that mental health complaints among MHCPs are often neither recognized nor acknowledged. A degree of stigma around seeking help still exists—particularly within mental health care itself. Resilience is valuable, yet it is not an inexhaustible resource (Shaul et al., 2024). Professionals often feel responsible for their clients and tend to postpone attending to their own wellbeing. This is not merely an individual concern, but a systemic issue. It affects the quality of care, the continuity of treatment, and the long-term sustainability of the sector.

Previous research has predominantly focused on quantitative studies, examining issues such as stress, burnout, and premature job exit (O'Connor et al., 2018; Zerban et al., 2023). In contrast, qualitative research exploring MHCPs' subjective experiences has received comparatively less attention. An integrated approach—one that considers both the extent and the perception of experiences, needs, and barriers—is therefore essential. The aim of this study is to explore the lived experiences, needs, and barriers related to mental health among MHCPs in the southern region of the Netherlands. By combining different research methods, this study provides in-depth insights and practical recommendations for supporting MHCPs' mental wellbeing. To achieve this, a concurrent exploratory mixed methods design is employed, in which quantitative and qualitative data are collected and analyzed simultaneously (Creswell & Plano Clark, 2017).

The following research questions were included in the present study:

1a) How do MHCPs in the southern region of the Netherlands experience their mental health?

1b) What kind of mental health complaints are present amongst MHCPs in the southern region of the Netherlands?

2) Which factors are related to mental health according to MHCPs in the southern region of the Netherlands?

3a) What are the needs and barriers of MHCPs in the southern region of the Netherlands concerning their mental health?

3b) What recommendations do MHCPs in the southern region of the Netherlands have for their employers regarding preventing sick leave and establishing sustainable employment?

2. Methods

Design

A concurrent exploratory mixed methods design was used for this study. Where quantitative findings indicate trends and potential gaps in understanding, the qualitative data help clarify what is missing in the numerical patterns. In doing so, the interviews provide explanatory depth that strengthens the interpretation of the quantitative results. Quantitative and qualitative data were collected simultaneously, aimed at deepening the quantitative findings through qualitative insights.

Participants, all MHCPs employed in one of the four participating institutions in the southern region of the Netherlands, were included based on voluntary application, in order of registration. Participants were successively recruited, based on advertising on the intranet of the participating institutions. Also, recruitment calls were sent to internal departments to support snowball sampling. Participants were assigned to one of five focus groups that were categorized on the basis of employer. In addition to the focus groups, participants were asked to complete two quantitative questionnaires. Although the quantitative sample size is modest (N = 33), the quantitative component was not intended to support inferential statistics but to provide descriptive patterns that inform and enrich the qualitative inquiry. In exploratory mixed methods research, small N quantitative data are commonly used to identify trends, guide interpretation, and contextualize qualitative findings rather than to draw generalizable conclusions. The qualitative focus groups aimed for data saturation; after data saturation was obtained in the fifth focus group, recruitment on the present study was closed.

Sample/Participants

Thirty-six MHCPs, all employed in one of the four participating institutions in the southern region of the Netherlands, registered for the present study. Thirty-five of thirty-six registered MHCPs provided written informed consent; hence the total study sample included thirty-five participants. Finally, thirty-three MHCPs participated both in the quantitative and qualitative part of the study.

Inclusion and exclusion criteria

Inclusion criteria ensured employed MHCPs in one of the four participating institutions. We aimed to include a heterogeneity of MHCPs across age, gender, employer, job role, years of experience and contract scope to capture different perspectives and experiences. Consequently, (student) psychologists, nurses, doctors, and social workers of different ages participated in the present study. As the questionnaires and focus groups were taken in Dutch an exclusion criterion was not being able to speak Dutch fluently.

Power calculation

In this context, statistical power is not a central requirement, as the quantitative strand supports—not replaces—the in depth qualitative analysis. The quantitative data describe the prevalence and determinants of mental health complaints in the sample of this study. Qualitative data from focus groups provide insight into MHCPs experiences, needs, barriers, and recommendations for support in practice. Because this study is partly qualitative, power calculation for number of participants does not apply to the study. Braun and Clarke (2006) recommend a minimum of thirty participants for a large thematic analysis project. In total thirty-five MHCPs were included in the present study.

Ethical considerations

The study was approved by all Ethical Committees of the four participating mental healthcare institutions. Thirty-five of thirty-six participants provided written informed consent. Data were collected anonymously and handled confidentially. The transcribed data will be saved for ten years.

Talking about related themes can bring up stressful memories which can cause (strong) emotions. Aftercare of participants and contact details of a complaints officer were offered, but none of the participants claimed support, nor charges afterwards the study.

Procedure

In the preparation phase participants were recruited based on an online advertisement call on the intranet, successively in one of four participating institutions. After applying, participants received a phone call from a researcher (DB), in which extra information on the study was given upon request. In order of registration, a maximum of ten participants for a focus group were assigned, and over-recruitment was possible considering possible dropouts to reach a minimum of six participants in each group. A demographic questionnaire and an open-ended question list for the focus groups (**Appendix**) were formulated, recording facilities and locations for the focus groups. Based on the number of registrations, focus groups one and two took place at health care institution GGZ Breburg. Focus group three was held at GGZ Westelijk Noord-Brabant. Focus group four happened at GGZ Oost Brabant and focus group five took place at GGZ Eindhoven.

Each focus group was led by one of three professionals accompanied by a researcher (DB). The three involved professionals were randomly assigned to the focus groups (two Healthcare Psychologists and one Clinical Psychologist). In focus group four only a professional was present to lead the focus group, without the presence of a researcher, due to illness. For reporting the study accurately, the Coreq Checklist by Tong and colleagues (2007) was used. Participants joined one of five focus groups held on location. Due to logistic problems in group five, two participants joined online by a secure digital meeting link. At the start of each focus group meeting, the study and involved professionals were presented. Each focus group took sixty to seventy-five minutes and took place between January 2024 and June 2025. Belonging to the meeting, all participants were asked to complete an informed consent letter including voluntary participation, recording of the focus group interviews, the right to withdraw, confidentiality, non-disclosure, and risks of participating. Participants were also offered two quantitative questionnaires. The first questionnaire on demographic characteristics (gender, age, occupation, years of employment, and contract scope) was composed by the researchers of this study in which the number of open-ended items was six. The second questionnaire comprised the Mental Health Inventory-5 (MHI-5; Berwick et al., 1991).

Participant validation was achieved by summarizing findings at the end of each focus group discussion with participants, to verify that research findings corresponded with the lived experiences of the participants. Focus group discussions were digitally recorded, transcribed, and anonymized. A student assistant was asked to work out the voice records and perform the transcriptions, which were checked by a researcher (DB). In the phase of elaboration first impressions were written down after thoroughly reading the data. Then specific text segments were labeled with codes and clustered into broader themes, which structured the dataset. After thematically analyzing, the results were discussed and reported.

To ensure the reliability and validation of the data, the data were analyzed and interpreted inductively, firstly by a researcher (DB) and then secondly interpreted again by two researchers until an intercoder agreement between the three involved researchers arose. Additionally, an independent external expert was asked to interpret a randomly selected part of the data. The data analysis was supported by Atlas.ti (Atlas.ti Scientific Software Development GmbH, 2023), a computer software program for organizing and analyzing information and data in research. Relevant Dutch quotes have been translated to English for publication. The analyses on the quantitative questionnaire data were conducted using the Statistical Package for the Social Sciences (IBM SPSS Statistics; IBM Corp, 2019).

Data collection

Quantitative data were collected using two questionnaires, which included a first self-constructed questionnaire on demographic information (age, gender, employer, job role, years of experience and contract scope) and a second validated questionnaire (MHI-5):

The MHI-5 is a widely used, concise five-item questionnaire designed to assess mental health (Ware & Sherbourne, 1992). Respondents indicate how they have felt over the past four weeks, using six response categories: constantly, usually, often, sometimes, rarely, and never. For positively worded items (questions 3 and 5), scores range from 5 to 0; for negatively worded items (questions 1, 2, and 4), the scoring is reversed. Individual scores are summed up and multiplied by four, resulting in a total score ranging from 0 (very poor mental health) to 100 (excellent mental health). Based on new data from the NEMESIS-3 study (2019-2022), a revised cutoff score of 76 has been established. A score of 76 or below indicates a higher likelihood of experiencing anxiety or mood disorders in the past month, while a score above 76 suggests the absence of such symptoms. This adjustment improves both sensitivity and specificity, each reaching a value of 0.79. It is important to note that the MHI-5 is not a diagnostic tool, but rather a screening instrument reflecting emotional states over the previous four weeks. Scores are therefore interpreted as either "with feelings of anxiety or depression" or "without feelings of anxiety or depression" during that period. The MHI-5 is part of the Short Form 36 (SF-36), an internationally recognized standard for health assessment (Ware & Sherebourne, 1992).

Parallel on the quantitative data collection, qualitative research was conducted using five focus groups in which participants discussed experiences on mental health, mental health complaints, related factors, needs, barriers, and recommendations on preventing sick leave and sustainable employment. Focus groups are a widely used methodology in qualitative research (Braun & Clarke, 2006). They serve as a valuable approach for gaining in-depth insight into social issues and can offer supportive environments for participants. Rather than aiming for statistical representation, focus groups seek to gather data from a purposefully selected group of individuals. Their strength lies in the interactive nature of the discussion, which fosters rich, synergistic exchanges of both shared and divergent perspectives (Van Assema et al., 1992).

In the context of this study, focus group methodology is particularly appropriate for two key reasons: the heterogeneity of the research population, and the investigative character of research on MHCPs' mental health. Given the diversity within the participant group, focus group interaction facilitates the emergence of a wide range of perspectives and experiences (Morgan & Hoffman, 2018). The process of "sharing and comparing" allows for the exploration of both consensus and variation among participants (Morgan & Hoffman, 2018). Moreover, differing levels of awareness regarding mental health may influence the perceived needs and barriers, making it essential to include multiple viewpoints in this study.

Data analysis

Quantitative data were analyzed using descriptive statistics to summarize and present the characteristics of the data in an understandable way. Fundamental patterns, trends, and anomalies in the data were identified, which is essential for initial interpretation and to lay the foundation for further research.

Qualitative data were audio-recorded, transcribed verbatim, and thematically analyzed following the approach of Braun & Clarke (2006). The analysis focused on identifying recurring themes that could explain or deepen the quantitative findings. Thematic analysis is a method that can be distinguished in three main types: reflexive approach, coding reliability and codebook approaches. In this study, thematic analysis was performed inductively with open coding to identify and organize recurring patterns, ideas, and meanings (Clarke & Braun, 2018).

To develop a comprehensive understanding of quantitative and qualitative data, triangulation can be used as a research method. Triangulation refers to the use of multiple methods or data sources (Carter et al., 2014). In this study, the data were integrated during the interpretation phase, using the qualitative insights to explain and contextualize the quantitative outcomes.

Flow data

Figure 1 presents the flow chart of this study.

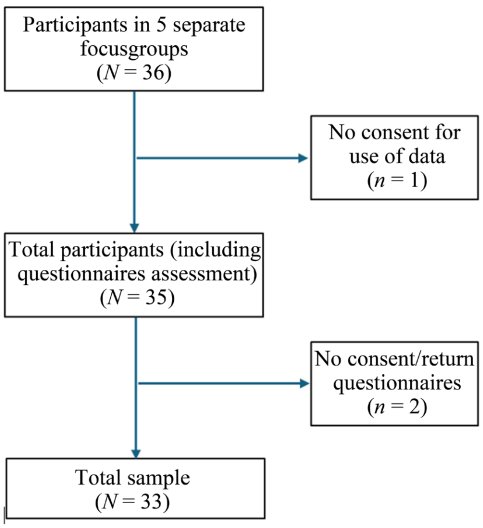

Figure 1. Flowchart of the participants in the current study.

3. Results

Quantitative Findings

Thirty-six MHCPs in the southern region of the Netherlands registered for the study. A total of thirty-five participants were included and thirty-three MHCPs completed all the forms needed. One participant did not complete the informed consent letter; therefore, this participant was not included. Two participants did not complete the two questionnaires.

The sample consisted of 35 MHCPs, including psychologists (n = 15), nurses (n = 10), doctors (n = 5), and social workers (n = 5). The average age of the 33 included participants was 44.03 years (SD = 14.37), with a range of 24 to 75 years. Most of the participants were women (n = 25; 75.80%).

The average score on the MHI-5 was 74.30 (SD = 12.08), with a minimum score of 28 and a maximum score of 92. Based on a commonly used cutoff score of <76 to indicate possible mental health problems, 16 of the 33 participants (48.48%) scored beneath this threshold. This indicates that almost half of the sample may be at increased risk for mental health problems such as depressive or anxiety symptoms. The remaining 17 participants (50%) scored above this threshold, thus demonstrating relatively better mental health. The score distribution was generally normal, although there was a slight skew toward lower scores (skewness = −0.41). No extreme outliers were observed.

Demographic information is presented in Table 1.

Table 1. Demographic information.

Variable	N	Minimum	Maximum	M	SD
Age	33	24	75	44.03	14.38
Gender	33	1	2	1.24	0.44
Employer	33	1	4	2.09	1.18
Profession	33	1	15	4.06	3.69
Years of experience	33	3	50	20.30	12.67
Contract hours	33	18.0	40.0	31.06	5.54

Note. N = number of participants; M = mean; SD = standard deviation.

Qualitative Findings

Thematic analysis of the qualitative data identified five overarching themes emerging from the focus groups: 1) Workload and Working Conditions, 2) The Role of Managers and Organizational Structures, 3) Team and Peer Support, 4) Self-Care and Boundary Setting, and 5) Moving Forward and Recommendations.

1) *Workload and Working Conditions*: Many professionals described difficulties in maintaining boundaries between work and private life, often leading to emotional exhaustion. High workload, understaffing, and complex client care have the most negative impact. These three factors lead to stress, burnout, and absenteeism, perpetuating the vicious cycle of overload in the work-private life

balance. Participants emphasize the burden of administrative tasks, the blurred lines between work and private life, and that the pressures on one side negatively impact mental health on the other. Participants emphasize the constant struggle to find "a healthy balance". —FG1

Within the context of preserving work-life balance, life stage was consistently highlighted as an influential factor. Multiple participants describe a shift in priorities:

"After turning 40, I notice quite a bit of change." —FG1

"Previously, the pressure was on work; now the focus is more on family." —FG1

Participants mention the abundance of administrative tasks and an overload of tasks ("to keep all the balls in the air") that lead to stress and a feeling of overload. Also, the role of the COVID-19 pandemic was mentioned repeatedly:

"There was a lot of absenteeism. A lot of pressure on full-timers, I really felt that." —FG1

"I really felt how the high workload during the Corona period led to less patience and more tension." —FG1

Some participants note that the client population has changed. There's an increase in "revolving door clients" and a lack of specialized care they were once accustomed to. This leads to a sense of futility and the questions:

"What am I still doing this for?" —FG3

Despite the high workload and challenges, respondents indicate that they enjoy their work. They mention the content of their work (psychotherapeutic work, the variety of tasks, and training others), client contact (the ability to directly apply acquired knowledge and the contact with the clients themselves) and learning opportunities (the chance to work with more experienced colleagues and the opportunity to take courses and training programs).

2) *Role of Managers and Organization*: Employees experience a lack of appreciation and visibility from management and directors. Team managers were seen as crucial; they should be more proactive, visible, and accessible in identifying stress and protecting their teams. Supportive leadership and open communication were seen as crucial for well-being. Organizational culture was frequently mentioned as either protective or risk factors.

Participants place responsibility for mental well-being on both employees and employers. "Employees must take the initiative and raise concerns, while employers must provide a culture and resources that facilitate this." —FG4

Participants believe that managers and management should play a more proactive role by making quicker adjustments and protecting employees from overload.

There is a strong desire for team leaders and managers to be visible. Walking around the department and making easy contact is considered very valuable, as this provides a more realistic picture of how people are doing than scheduled meetings. Experience shows that managers are often only visible "when things are going wrong." —FG2

Visible and supportive management that shows care for employees is perceived as highly valuable and contributes to a sense of appreciation. —FG3

Participants want not only a clear leader, but also one who takes them seriously and facilitates them. The team manager role is considered crucial because this person is "on-site", "keeps an eye" on the team, and can intervene more quickly to "put out fires". —FG1

Participants point out that the organization's treatment of professionals is at odds with its vision for client care. One participant remarks:

"Wouldn't it be wonderful if our organization treated us the same caring way as we do to our clients?" —FG1

Participants experience a tension between the desire for personal input and the reality of top-down decision-making, leading to frustration and a sense of unfairness. The lack of autonomy and top-down decision-making are more evident in these passages. A concrete example is the change in schedules:

"The team doesn't really know that." —FG1

This leads to a sense of injustice and "friction". A participant explains that the lack of feedback and clear reasoning for decisions increases the frustration. Although the decisions may be rationally explained, they feel imposed because the reasons are not shared. —FG1

Organizational changes, managerial turnover, and the lack of a clear vision are perceived as frustrating. In focus group five was told:

"Then another external company came along with a grand plan. And then it faded away again." —FG5

"When we come up with a lot of great ideas, but then there's no room to facilitate their implementation." —FG5

"There are so many changes. I've lost track of things a bit." —FG5

3) *Team and Peer Support*: Team dynamics and support from colleagues are considered as essential. Informal conversations, sharing caseloads, and listening to each other's feedback are seen as essential for well-being. However, shared responsibility within teams is under pressure due to production targets. Participants reported a range of coping mechanisms, including peer support, supervision, and mindfulness practices.

The importance of colleagues is repeatedly emphasized. Being able to let off steam, make jokes, or simply feel like you're not alone is considered crucial. A good team dynamic makes or breaks a work experience. Moments of relaxation, such as a cup of coffee or a chat about non-work-related matters, are considered important for job satisfaction and team connection. —FG3

Participants of focus group two mentioned team spirit as a positive factor; The positive team atmosphere and mutual support are considered as important factors in job satisfaction.

"Support at work is very important." —FG2

Team dynamics and the opportunity to brainstorm and vent with colleagues are seen as crucial social supporting factors contributing to well-being. Physical proximity and a consistent team facilitate this. The contrast is highlighted between clinic staff (with plenty of social contact) and outpatient staff (who feel more isolated). —FG4

"That you do it together. Not those private, team-like situations. That's so sickening." —FG1

"The opening up. And naming what it did to me. And once I did that, a shift occurred. And that didn't mean everything was resolved, not at all. But it's now open to discussion." —FG1

Showing vulnerability is perceived as a barrier, partly due to personal beliefs ("I must always be able to perform" —FG1) and partly due to the prevailing team culture.

The work atmosphere can be a determining factor: "That really affects me. I just sleep really badly." —FG1

Team dynamics, human connection and autonomy are crucial counterbalances. The ability to rely on colleagues, experience support from managers, and maintain one's own boundaries is seen as the foundation for persevering in this demanding work. Participants make a clear distinction between "the profession" (the substantive task they enjoy) and "the work" (the context and circumstances that are often frustrating). —FG4

A safe and supportive team culture is considered crucial. Participants who feel safe and seen in their team find it easier to share their vulnerabilities and set boundaries. Without this safety, for example, after reorganizations, the need to take care of one's own mental well-being becomes greater due to a lack of organizational support. —FG5

4) *Self-care and Boundaries*: Next to the organizational dynamics, the focus group discussions offered valuable insights into the influence of the commonalities and divergences in individual characteristics. Participants feel compelled to act themselves when experiencing stress, for example, by seeking support or maintaining personal boundaries. The term mentalization is presented as a direct participant quote. One participant explicitly used this clinical term to describe challenges in understanding clients' internal states, and the theme reflects this wording verbatim:

Signs that a colleague is not doing well include irritability, emotional reactions, fatigue and "less mentalization". —FG5

Participants discuss the choice to work fewer hours or struggle with the desire to "be there for everything" as part-timers. This illustrates the constant tension between professional ambition and the need for self-care. —FG1

Setting these boundaries is often seen as difficult, which can lead to tension. The participants with higher resilience described more proactive coping strategies:

Resilience is described as the ability to bounce back from a downturn. Participants emphasize that resilience also depends on team culture; "recognizing moments of calm and discussing less successful days are important." —FG4

Setting boundaries is an important skill that has had to be learned. One participant says she would "run and roll" "until I'd done everything", but that she is now better at setting her boundaries: "Now I think, no, these are my boundaries." —FG1

Participants recognize that mental health is influenced not only by work related and organizational factors, but also by life stage and personal responsibilities (family, children, sports, hobbies). "Finding the right balance between these factors is a constant challenge, especially with irregular shifts." —FG4

"It is noted that healthcare workers are naturally limitless and tend to do everything for others." —FG2

"I'm the type who likes to know the ins and outs. And I'm a control freak." —FG1

"And you push your boundaries. Then I'll just keep going back and forth." —FG1

Age and work experience play a significant role. Older, more experienced professionals have often learned the hard way to maintain their boundaries. Younger professionals struggle more with this, but are often more proactive in changing the organization. —FG5

5) *Moving forward and recommendations*: Participants perceived maintaining mental health as a significant challenge. They reported psychological symptoms including stress, emotional exhaustion, and a sense of being overwhelmed. Difficulties in achieving a sustainable work-life balance were frequently mentioned. Social support and autonomy in the workplace were identified as essential protective factors. Furthermore, the focus group discussions offered valuable insights into the influence of commonalities and divergences in individual characteristics.

Next to social support also autonomy is directly linked to "a healthy mental state". —FG1

There is a growing awareness that employees are people too, and more attention is being paid to their mental health. The desire for input and the opportunity to contribute to decision-making appears to be an important factor in the sense of appreciation and mental resilience. —FG1

Some teams use methods like the "traffic light method" in meetings or have personal conversations about job satisfaction. Special roles, such as a "job satisfaction manager", are even being adopted. —FG2

One participant introduces the concept of Self-Determination Theory (SDT). The factors discussed—autonomy (being able to determine your own work, such as in self-employment or in the treatment room), connectedness (team and management support), and competence (being able to do and develop new things)—are recognized as core needs essential for the motivation and well-being of professionals. —FG3

Participants demonstrate that appreciation and recognition are not luxuries, but fundamental requirements for managing work-related stress. The shared experiences emphasize that being seen and valued by the organization is crucial for the mental health of MHCPs. Recognition for employees' dedication and hard work is an essential buffer against the daily workload. Feeling valued for one's contributions, such as developing new projects, adds a sense of meaning.

Respondents believe that managers should play a more active role in limiting

workload, for example by intervening earlier or even announcing intake stops, which rarely happens in practice. —FG2

More transparency and insight into the reasons behind decisions would provide more peace of mind, "although it would not solve the workload itself." —FG2

Improvements should focus on proactive support, better communication, and increased appreciation from management. It's also important to reduce workload and strengthen team cohesion. This can be achieved, for example, by increasing the visibility and accessibility of team leaders and making it easier to discuss emotional burdens. —FG5

However, opinions are divided. Some expect little from management and focus on their own team and work to avoid frustration. Others, especially the younger generation, consider it important to be connected to the organization and expect management to create the conditions for a healthy work culture, such as facilitating team meetings and peer consultations.

4. Discussion

Main Findings

This study aimed to explore how MHCPs employed in the southern region of the Netherlands experience their own mental health, the types of complaints they report, and the factors they perceive as influencing their well-being. Additionally, the study investigated MHCPs' perceived needs, barriers, and recommendations for promoting sustainable employability and preventing sick leave.

The findings of this study highlight the multifaceted nature of challenges faced by MHCPs in the southern region of the Netherlands (Boumans et al., 2023). Participants reported a range of mental health complaints, including symptoms of stress, emotional exhaustion, and feelings of being overwhelmed. Quantitative descriptive data derived from the questionnaires in this study indicated a notable prevalence of mental health complaints among the participating mental health care professionals (MHCPs). Instead of in-depth clinical assessments, the study relied on brief self-report questionnaires, which may have captured only a limited range of symptoms. Specifically, 16 out of 33 respondents (48.48%)—nearly half of the sample—appeared to be at elevated risk for mental health issues, including symptoms of depression and anxiety.

Complementing these findings, qualitative insights obtained from the conducted focus groups enriched the understanding of underlying dynamics by highlighting key themes such as workload, social support, and autonomy. For example supportive leadership and open communication were frequently cited as protective factors, while high administrative burden and lack of recognition were perceived as detrimental. Participants frequently articulated a tension between their professional obligations and personal well-being, particularly in striving to maintain a sustainable work-life balance. Additionally, the focus group discussions yielded valuable insights into the role of organizational dynamics, as well as the shared and divergent personal characteristics among individuals.

Participants suggested a potential risk for burnout if adequate support is not provided, also they expressed a clear need for accessible mental health support, time for reflection, and structural changes within their organizations. Barriers to seeking help included stigma, fear of professional consequences, and a perceived lack of time. Interestingly, participants often prioritized the needs of their clients over their own, which may contribute to the underreporting or neglect of personal mental health issues.

In terms of recommendations, participants underscored the significance of proactive organizational policies, including regular supervision, structured peer support systems, and the cultivation of a workplace culture in which mental health is openly discussed and normalized. Additionally, they advocated for increased flexibility in work arrangements and a reduction in administrative burdens, thereby enabling greater emphasis on both client care and personal well-being.

Comparison with previous research

The prevalence rates of stress in this study are consistent with previous research among mental health professionals in Europe (e.g., Johnson et al., 2022; Trimbos-instituut, 2023). These results are consistent with previous research highlighting the psychological demands placed on professionals working in high-pressure care environments (e.g., Maslach & Leiter, 2016). These findings also align with earlier studies emphasizing the importance of organizational support in mitigating occupational stress (Schaufeli et al., 2009).

The qualitative data in this study further explains how these resources are experienced in daily practice, echoing findings from recent qualitative studies (Smith & Fieldsend, 2021). Sufficient time for non-patient-related activities and self-care are recurring themes in the research conducted by Beldman and Linssen (2025). The protective role of social support and autonomy aligns with the Job Demands-Resources (JD-R) model (Demerouti et al., 2001), which emphasizes the buffering effect of resources on work-related stress and burnout.

Strengths and limitations

A key strength of this study is the use of a concurrent exploratory mixed methods design, which enabled a comprehensive understanding of both the prevalence and experience of mental health challenges among professionals. The integration of quantitative and qualitative data provided nuanced insights that would not have been captured by a single-method approach. Another strength of this study was the acquisition of multiple perspectives through repeated focus group sessions, during which group dynamics emerged which enriched the depth of the data. Member checks were conducted by summarizing the collected data at the end of each focus group session, allowing participants to confirm or clarify the accuracy of the interpretations.

Despite the valuable insights gained, this study also has several limitations. First, the sample size was limited and may not fully represent the diversity of experiences within the broader MHCP population. There was an imbalance in the gender distribution of the sample, with a disproportionate number of female par-

ticipants compared to male participants. On the other hand, this may refer to a realistic distribution of women and men among MHCPs. Because of the relatively small sample and inherent low statistical power, quantitative analyses are not representative, cannot be generalized to the population and therefore cannot be performed. A possible reason for the small sample size in all institutions can be attributed to the high amount of workload. Not all interested individuals in the recruitment phase were able to join the meetings due to lack of time or difficulties with the travel distance of the location. However, the small sample size is acceptable for qualitative research because the goal is not to generalize, but to gain in-depth insights. Future research could similarly benefit from a mixed-methods approach, incorporating quantitative measures to validate and expand upon these results.

Second, self-report measures may be subject to social desirability bias, although the inclusion of qualitative focus groups helped to validate and contextualize the survey findings. This study acknowledges limitations associated with the use of focus groups. Group dynamics may have influenced individual responses, with dominant participants potentially shaping the discourse. The presence of others could have led to socially desirable answers, particularly on sensitive topics. Furthermore, the findings are based on a small, context-specific sample, which limits their generalizability. Another limitation concerns the absence of one researcher during focus group four, which may have introduced an uncontrollable source of bias. This potential bias should be considered when interpreting and generalizing the findings. Finally, it should be noted that illness prevented a researcher from attending one of the focus group sessions, which therefore proceeded with only the participating professional.

Implications

The findings of this study carry several important implications for mental health organizations, policymakers, and training institutions. First, the high prevalence of stress and emotional exhaustion among MHCPs underscores the need for proactive organizational policies that prioritize mental health. This entails not only reactive support for those experiencing difficulties, but also preventive measures such as regular supervision, peer support systems, and mental health education.

Second, the importance of workplace support was consistently emphasized. Structural interventions—such as reducing administrative burdens, promoting flexible work arrangements, and fostering a culture of openness—can significantly enhance resilience and job satisfaction. These measures should be embedded within the organizational framework rather than relying solely on individual coping strategies.

Third, the normalization of mental health discussions within professional settings is essential. Barriers such as stigma and time constraints must be addressed by cultivating psychologically safe environments where vulnerability is accepted and mental health is openly discussed without fear of professional repercussions.

Finally, involving professionals in the design and implementation of mental health initiatives is crucial. The recommendations provided by MHCPs offer a valuable, practice-informed foundation for policy development. By actively engaging staff in shaping interventions, organizations can ensure relevance, increase ownership, and improve the overall effectiveness of mental health strategies.

5. Conclusion

This study highlights the considerable psychological strain experienced by MHCPs in the southern region of the Netherlands, revealing a high prevalence of stress-related symptoms and emotional exhaustion. Through a concurrent exploratory mixed methods design, both systemic and interpersonal factors were identified as key contributors to mental health challenges, including workload, lack of support, stigma, and limited autonomy. Importantly, MHCPs expressed a clear need for more proactive organizational support, such as improved managerial communication, stronger team cohesion, and institutional recognition of self-care practices. Their recommendations—ranging from flexible work arrangements to mental health training for leadership—reflect a desire for a healthier and more sustainable work environment. These findings underscore the urgency of adopting a holistic approach that integrates individual, team, and organizational strategies to promote mental health, reduce burnout, and ensure the long-term viability of mental health services. Future research should focus on evaluating targeted interventions and exploring experience from MHCPs across diverse professional and regional contexts.

6. Recommendations

Our recommendations are firmly rooted in the qualitative themes, demonstrating a clear data-driven link between our findings and their practical implications. To support the mental health and sustainable employability of MHCPs, this study proposes a set of targeted recommendations. First, organizations should foster a culture of openness and psychological safety, where mental health is openly discussed, and help-seeking is encouraged without fear of stigma or professional consequences. Leadership plays a crucial role in modelling vulnerability and promoting dialogue.

Second, structural support systems such as regular supervision and peer support groups should be embedded into organizational routines. These platforms offer MHCPs opportunities for reflection, emotional support, and professional development. Reducing administrative burdens and streamlining non-clinical tasks can further alleviate stress and allow professionals to focus on client care and self-care.

Third, preventive interventions—including resilience training, mindfulness programs, and stress management workshops—should be made widely accessible. Tailored support for early-career professionals is also essential, as they may be particularly vulnerable to stress and self-doubt. Mentorship and targeted guidance

can help build confidence and professional identity.

Fourth, MHCPs should be actively involved in the development and implementation of mental health policies. Their insights ensure that interventions are relevant, feasible, and aligned with actual needs. Promoting autonomy, development, and time for coordination and reflection enhances engagement and ownership.

Finally, organizations must ensure clarity in communication, recognition of staff contributions, and responsiveness to employee needs. Listening to professionals and creating a sustainable, healthy work environment is not only vital for their well-being but also for the quality and continuity of mental health care services. MHCPs form the backbone of the sector; without adequate attention to their own well-being, the delivery of mental health care becomes increasingly complex.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Appendix: Question Route

☐ What is your experience with mental health?

☐ What mental health issues have you personally experienced or heard about from colleagues?

☐ Which factors do you think are related to mental health?

☐ What are the needs regarding mental health, and what advice would you give to the employer about opportunities and challenges in the work environment, particularly concerning absenteeism/turnover intentions?

☐ What contributes to work pressure?

☐ What contributes to job satisfaction?

☐ Do you feel sufficiently appreciated by your employer?

☐ Do you experience any obstacles from your employer regarding your mental health?

☐ What is your experience with these obstacles? Was anything missing? If so, what?

☐ What do you need to remain sustainably employable for your employer?

☐ Any other suggestions for support?

☐ Any other suggestions for the employer?

☐ Any other suggestions regarding mental health?