

Scientific report

on the pilot project implemented by the
Federal Agency for Occupational Risks

MARCH 31, 2023

Evaluation of a treatment programme for
workers experiencing early burn-out



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Abbreviations

BO: burnout
BAT: burnout assessment tool.
BOTP: burnout treatment programme.
CPAP: prevention advisor for psycho-social aspects
DASS: depression, anxiety and stress scale.
ENT: ear, nose and throat.
EM: employer.
Fedris: Federal Agency for Occupational Risks.
FinR: Final report.
FR: French speaking.
GP: General practitioner.
HR: Human Resources.
IBO: burnout treatment provider
ISI: individual sessions treatment provider.
M: mean
NL: Dutch-speaking.
OLBI: Oldenburg Burnout Inventory.
SD: standard deviation.
WO: worker.
WS: workstation.

1. Descriptive variables

We found that the description of the sample remained more or less the same, whether we considered participants who had at least taken part in the pre-test (N = 893), participants who had taken part in the pre-test and post-test 1 (N = 312) or participants who had taken part in the pre-test, post-test 1 and post-test 2 (N = 223). Detailed tables can be found in the annex (Annex 17.1).

Descriptive variables refer to the sample of workers (N = 223) who participated in the three measurement sessions (pre-test, post-test 1 and post-test 2). Women (80%) and Dutch speaking persons (69%) are the most represented (table 1.1). The majority of participants have a graduate degree (63%) and higher studies (21.5% bachelor's/master's). Age is primarily in the 35-45 and 46-55 categories, with a median age of 44. In terms of provinces, Walloon Brabant, Hainaut and Liège are the most represented (less than 5%) in the sample. There are no participants from the province of Luxembourg.

Table 1.1: Socio-demographic variables (N = 223)

	Number (N)	Percentage (%)
Gender		
- Men	44	19.7
- Women	179	80.3
Language		
- French	69	30.9
- Dutch	154	69.1
Level of education		
- Lower secondary education	3	1.3
- Higher secondary education (technical/vocational/artistic)	20	9.0
- General higher secondary education	7	3.1
- Graduate / bachelor	141	63.2
- Bachelor / Master degree	48	21.5
- PhD	4	1.8
Age		
- Under 35	48	21.5
- Between 35 and 45	69	30.9
- Between 46 and 55	74	33.2
- Over 55	32	14.3
	Median	Interquartile distance
Age (years)	44	16

Province		
- Antwerp	45	14.4
- Flemish Brabant	41	13.1
- Walloon Brabant	7	2.2
- Brussels-Capital	76	24.4
- East Flanders	30	9.6
- West Flanders	31	9.9
- Hainaut	7	2.2
- Liège	6	1.9
- Limburg	26	8.3
- Namur	43	13.8

As regards work-related characteristics (table 1.2), we find that workers in the hospital and healthcare sector make up the majority (78%), and that almost all have indefinite-term contracts (91%). A significant proportion works during the day (76%), while years of seniority and working hours are more variable.

Table 1.2: Work-related variables (N = 223)

	Number (N)	Percentage (%)
Sector		
- Healthcare sector	174	78.0
- Banking sector	49	22.0
Type of contract		
- Fixed-term contract	7	3.1
- Indefinite-term contract	203	91.0
- Statutory	13	5.8
Seniority		
- 0 - 1 year	15	6.7
- 1.5 - 5 years	58	26.0
- 6 - 10 years	40	17.9
- 11 - 20 years	62	27.8
- 21 - 30 years	29	13.0
- 31 - 40 years	19	8.5
Working hours		
- Fixed	108	48.4
- Variable	115	51.6

Day/night work		
- Daytime only	170	76.2
- Night-time only	4	1.8
- Day and night	48	21.5
- Unknown	1	0.4

As regards socio-demographic characteristics (table 1.3), there are significant differences by sector in terms of gender - more women are employed in healthcare ($p < .001$), in terms of province - workers in the banking sector work mainly in Brussels while workers in the healthcare sector work in various provinces ($p < .001$), but there are no differences in terms of language ($p = .769$) and level of education ($p = .122$) or age ($p = .540$).

Table 1.3: Socio-demographic variables by sector

	Banking sector		Healthcare sector	
	Number (N = 49)	Percentage (%)	Number (N = 174)	Percentage (%)
Gender				
- Men	21	42.9	23	13.2
- Women	28	57.1	151	86.8
Language				
- French	16	32.7	53	30.5
- Dutch	33	67.3	121	69.5
Level of education				
- Lower secondary education	1	2.0	2	1.1
- Higher secondary education (technical/vocational/artistic)	2	4.1	18	10.3
- General higher secondary education	1	2.0	6	3.5
- Graduate / bachelor	28	57.1	113	64.9
- Bachelor / Master degree	17	34.7	31	17.9
- PhD	0	0	4	2.3
Age				
- Under 35	4	8.2	44	25.3
- Between 35 and 45	14	28.6	55	31.6
- Between 46 and 55	24	49.0	50	28.7
- Over 55	7	14.3	25	14.4

Province				
- Antwerp	1	2.0	32	18.4
- Flemish Brabant	0	0	29	16.7
- Walloon Brabant	0	0	7	4.0
- Brussels-Capital	40	81.6	7	4.0
- East Flanders	1	2.0	21	12.1
- West Flanders	5	10.2	19	10.9
- Hainaut	0	0.0	6	3.4
- Liège	0	0.0	5	2.9
- Limburg	1	2.0	18	10.3
- Namur	1	2.0	30	17.2

There are significant differences (table 1.4) between the two sectors in terms of type of contract, i.e. all employees in the banking sector (100%) have an indefinite-term contract, compared with 88.5% in the healthcare sector ($p = .045$), in terms of working hours, i.e. the healthcare sector has more variable working hours ($p < .001$) and more day/night work ($p < .001$) than the banking sector, but there is no difference in terms of seniority ($p = .443$)

Table 1.4: Work-related variables by sector

	Banking sector		Healthcare sector	
	Number (N = 49)	Percentage (%)	Number (N = 174)	Percentage (%)
Type of contract				
- Fixed-term contract	0	0	0	4
- Indefinite-term contract	49	100	154	88.5
- Statutory	0	0	13	7.5
Seniority				
- 0 - 1 year	5	10.2	10	5.7
- 1.5 - 5 years	16	32.6	42	24.2
- 6 - 10 years	9	18.4	31	17.8
- 11 - 20 years	11	22.4	51	29.3
- 21 - 30 years	4	8.2	25	14.4
- 31 - 40 years	4	8.2	15	8.6
Working hours				
- Fixed	37	75.5	71	40.8
- Variable	12	24.5	103	59.2

Day/night work

- Daytime only	48	98.0	122	76.6
- Night-time only	0	0	4	1.8
- Day and night	1	2.0	47	21.6

2. Information provider and referrer

2.1 Information provider

The workers who took part in the pilot project were mostly informed about the project by their occupational physician (31.5%) (table 2.1). The prevention advisor for psycho-social aspects (CPAP) provided information on the pilot project to 13.1% of workers. The GP provided information to 5 persons (2.3%) and the psychologist to 18 persons (8.1%). The employer also informed workers about the pilot project in 11.7% of cases. Management and human resources (HR) provided information about the project to 15 and 9 employees respectively (6.8% and 4.1%, respectively). Furthermore, some employees also found out about the project themselves (6.9%). There is no significant difference between information providers by sector ($p = .244$), but there is by language ($p < .001$). The CPAP provided more information to French-speaking workers (FR), while the occupational physician mainly provided information to Dutch-speaking workers (NL).

Table 2.1: Providers of information about the pilot project to the worker (N = 222)

			Total N	%	Banking N	Healthcare N	FR N	NL N
Provider of information about the project	of	CPAP	29	13.1	8	21	19	10
		Occupational physician	70	31.5	13	57	9	61
		GP	5	2.3	2	3	3	2
		Psychologist	18	8.1	2	16	9	9
		Employer	26	11.7	5	21	4	22
		Management	15	6.8	1	14	2	13
		HR	9	4.1	4	5	3	6
		Person of trust	6	2.7	2	4	1	5
		Trade union	5	2.3	1	4	3	2
		Colleagues	13	5.9	1	12	6	7
		Family or friends	6	2.7	3	3	2	4
		Found out about the project themselves	13	6.9	5	8	5	8
		Other	7	3.2	2	5	3	4
		Total	222	100	49	173	69	153

2.2 Referrer

The occupational physician made the majority of referrals (47.5%). The GP made 30.5% of referrals to the project, and the CPAP 22% (table 2.2).

When the referral to the pilot project was made by the occupational physician, the latter was also the information provider in most cases. When the referral to the pilot project was made by the CPAP, the latter was also the information provider in most cases. In Flanders, it was mainly the occupational physician who provided information and referred, while in Wallonia, it was the CPAP who provided information and referred ($p < .001$).

When the information provider had another function (employer, GP, psychologist. etc.), the participants were mainly referred by the GP. According to the chi-square test, the proportion of information providers is significantly different depending on who the referrer was ($p < .001$).

Table 2.2: Referrer to the pilot project as shown on the request forms of the workers (N = 223)

	N	%
CPAP	49	22
Occupational physician	106	47.5
GP	68	30.5
Total	223	100

There was no significant difference between the information provider and the referrer according to sector ($p = .244$), gender ($p = .790$), education level ($p = .413$), age (< and > 45 years) ($p = .244$), job seniority / duration of employment ($p = .398$), working hours (fixed/variable) ($p = .288$), night / day ($p = .505$), burnout stage ($p = .111$), job status before the treatment ($p = .749$).

2.3 Socio-demographic and professional characteristics of participants by type of referrer

The majority (80.3%) of employees with a referral are women. **Gender** was not distributed differently according to referrer ($p = .119$).

86.5% of workers who were referred have a **higher diploma** (graduate/bachelor or higher). The CPAP and occupational physician refer slightly more Bachelor degree holders (65.3% and 65.1% respectively), while the GP refers more Master degree holders (29.4%). However, this difference was not significant ($p = .243$).

There is a significant difference between the workers referred by the different referrers, depending on the **sector** ($p < .001$). The majority of hospital workers are referred by the occupational physician (92 people - 86.6%) or the CPAP (40 people - 81.6%), while the GP is responsible for referring 42 people from the hospital sector (62.1%) and 26 workers from the banking sector (37.9%).

There is also a significant difference between the workers referred by different referrers, depending on the **language** ($p < .001$). The proportion of French-speaking workers referred by the CPAP is 61.2%, while workers from Flanders are mainly referred by the occupational physician (87.7%).

For **other person-related** factors (e.g. age ≤ 45 and > 45 , burnout stage, etc.) and **other work-related characteristics** (e.g. fixed/variable hours, day/night, job duration, etc.), there was no significant difference between the different referrers.

All tables relating to these analyses can be found in the annex (Annex 17.2).

3. Effectiveness of the mental health treatment programme

Table 3.1 shows the results of a 3-stage repeated-measures analysis of variance concerning changes in psychological indicators between the pre-test (at the diagnosis, before treatment), after treatment (post-test 1) and 3 to 6 months after the end of treatment (post-test 2), differentiating between the 2 sectors of activity. The same analysis was repeated, differentiating the results for age, language, gender, type of contract and burnout stage.

At the intra-individual level, we see that burnout (as measured by the OLBI and BAT) and depression, anxiety and stress scores (as measured by the DASS) were significantly reduced after treatment. It is also interesting to note that the reductions observed after the treatment are still observable 3 to 6 months after the end of the treatment.

According to the standards resumed in the annex (see Annex 17.4), for the OLBI, the subjects went from a high level of burnout to a medium level of burnout. For BAT, we also see a shift from a higher level of burnout risk to a lower one. More specifically, for the total sample of participants, we go from a red score of "High risk of burnout" to a green score of "In good health". This is also the case if we only consider the hospital and healthcare sector. For the banking sector, subjects went from a red score of "High risk of burnout" to an orange score of "Risk of burnout".

Still using the standards in the annex, for depression (DASS), subjects went from a "Moderate to High" level to a "Normal to Mild" level after treatment. In the case of anxiety (DASS), the level went from severe to mild after treatment. In the case of stress (DASS), the level went from severe to normal after treatment.

At the inter-individual level, there is only one significant difference, on the burnout score (BAT), according to sector of activity (Table 3.1). No matter what time the test was taken, there is a significant effect of sector of activity on burnout (BAT). Participants from the banking sector have a higher burnout score than those from the hospital and healthcare sector.

For the other socio-demographic variables (see Annex 17.3), there is no significant difference in scores according to age or type of contract. There are, however, several significant differences between language, gender and burnout stage.

For language, there was a significant difference in the depression (DASS) and stress (DASS) scores. Regardless of when the test was administered, there is a significant effect of the language variable on depression and stress. FR participants have higher depression and stress scores than NL participants.

For gender, there was a significant inter-subject difference in anxiety, with women showing a higher level of anxiety than men.

In terms of burnout stage, depression and anxiety levels are lower for participants diagnosed with stage 1 burnout.

Table 3.1: Changes in psychological indicators (pre-test, post-test 1 and post-test 2) by sector of

	Sector (PRE_T1_RE COD)	Mean (Standard deviation) Pre-test	Mean (Standard deviation) Post-test1	Mean (Standard deviation) Post-test2	Effects test	F(ddl)	P	Sign.
Burnout (OLBI)	Banking	62.40 (7.76)	53.85 (9.10)	54.58 (8.58)	Intra-subject	64.45 (1.80; 268.13)	$p < 0.001$	***
	Hospital	62.81 (6.17)	52.40 (9.82)	51.75 (9.60)	Inter-subject	0.71 (1; 149)	$p = 0.401$	/
	TOTAL	62.74 (6.44)	52.64 (9.69)	52.22 (9.47)				
Burnout (BAT)	Banking	3.46 (0.49)	2.89 (0.50)	2.99 (0.82)	Intra-subject	31.35 (1.78; 142.49)	$p < 0.001$	***
	Hospital	3.25 (0.56)	2.43 (0.66)	2.31 (0.73)	Inter-subject	6 (1; 80)	$p = 0.017$	*
	TOTAL	3.27 (0.55)	2.48 (0.66)	2.39 (0.77)				
Depression (DASS)	Banking	20.08 (9.95)	10.25 (9.53)	11.18 (11.79)	Intra-subject	93.46 (1.79; 401.85)	$p < 0.001$	***
	Hospital	20.35 (9.83)	9.69 (9.80)	9.43 (10.05)	Inter-subject	0.28 (1; 225)	$p = 0.598$	/
	TOTAL	20.29 (9.83)	9.81 (9.73)	9.80 (10.44)				
Anxiety (DASS)	Banking	16.58 (9.75)	8.62 (7.51)	9.29 (9.65)	Intra-subject	75.88 (1.78; 404.69)	$p < 0.001$	***
	Hospital	17.22 (10.27)	8.26 (8.43)	8.16 (8.47)	Inter-subject	0.06 (1; 227)	$p = 0.807$	/
	TOTAL	17.09 (10.14)	8.33 (8.23)	8.39 (8.72)				
Stress (DASS)	Banking	25.96 (8.42)	13.99 (8.63)	13.79 (10.66)	Intra-subject	124.88 (1.88; 423.67)	$p < 0.001$	***
	Hospital	26.81 (9.82)	14.08 (9.93)	13.75 (10.44)	Inter-subject	0.06 (1; 225)	$p = 0.804$	/
	TOTAL	26.63 (9.53)	14.06 (9.65)	13.76 (10.46)				

/ = NS; * = $< .05$; ** = $< .01$; *** = $< .001$

activity.

4. Self-reported physical and psychological health status

Table 4.1 shows the results of a 3-stage repeated measures analysis of variance for changes in self-reported physical and psychological health (on a score of 0 = very poor to 100 = very good) between pre-test (at the diagnosis, before treatment), post-treatment (post-test 1) and 3 to 6 months after the end of the treatment (post-test 2), distinguishing between the 2 sectors. The same analysis was repeated, with results differentiated by language and gender.

At the intra-individual level, we see that self-reported physical and psychological health improves significantly (scores increase) after the treatment. It is also interesting to note that the improvements observed in the score after the treatment were still observable 3-6 months after the end of the treatment. The difference is significant between pre-test and post-test 1, and between pre-test and post-test 2, but not between post-test 1 and post-test 2. Graphs are shown in annex (Annex 17.5).

The difference in the evolution of health status between workers in the banking and healthcare sectors is not significant. As regards the other socio-demographic variables, no significant differences were found between the evolution in physical condition and psychological state, with the exception of physical condition before the treatment, which was significantly worse for French-speaking workers than for Dutch-speaking workers (Annex 17.5).

Table 4.1: Evolution of physical condition and psychological state (mean and standard deviation) at pre-test, post-test 1 and post-test 2 by sector, language, gender (score 0 = very poor to 100 = very good)

		Mean (SD) Pre-test	Mean (SD) Post-test1	Mean (SD) Post-test2	Effects tests	F (ddl)	P	Sign.
Physical	Banking	44.09 (21.68)	70.00 (19.62)	69.32 (21.23)	Intra-subject	89.92 (1.83; 362.05)	$p < 0.001$	***
	Healthcare	49.68 (21.67)	66.48 (18.18)	66.68 (18.92)	Inter-subject	0.005 (1; 197)	$p = 0.943$	/
	TOTAL	48.44 (21.74)	67.26 (18.52)	67.26 (19.43)				
Psychological	Banking	35.57 (19.57)	67.05 (20.07)	68.64 (23.90)	Intra-subject	145.73 (1.75; 344.70)	$p < 0.001$	***
	Healthcare	38.74 (20.09)	67.29 (19.14)	67.35 (19.38)	Inter-subject	0.085 (1; 197)	$p = 0.770$	/
	TOTAL	38.04 (19.97)	67.24 (19.29)	67.64 (20.41)				
Physical	French	41.75 (20.64)	67.54 (18.47)	66.75 (19.22)	Intra-subject	107.28 (1.84; 363.53)	$p < 0.001$	***
	Dutch	51.54 (21.61)	67.13 (18.61)	67.50 (19.59)	Inter-subject	2.04 (1; 197)	$p = 0.155$	/
	TOTAL	48.44 (21.74)	67.26 (18.52)	67.26 (19.43)				
Psychological	French	33.50 (19.45)	64.92 (18.17)	65.50 (18.97)	Intra-subject	173.74 (1.75; 344.83)	$p < 0.001$	***
	Dutch	40.00 (19.95)	68.24 (19.74)	68.56 (21.00)	Inter-subject	3.87 (1; 197)	$p = 0.051$	/
	TOTAL	38.04 (19.97)	67.24 (19.30)	67.64 (20.41)				
Physical	Men	49.88 (22.48)	67.44 (19.37)	72.91 (17.23)	Intra-subject	73.34 (1.81; 356.91)	$p < 0.001$	***
	Women	48.04 (21.59)	67.21 (18.34)	65.71 (19.76)	Inter-subject	1.33 (1; 197)	$p = 0.251$	/
	TOTAL	48.44 (21.74)	67.26 (18.52)	67.26 (19.43)				
Psychological	Men	39.27 (18.89)	67.28 (19.68)	72.93 (18.16)	Intra-subject	134.74 (1.74; 342.33)	$p < 0.001$	***
	Women	37.72 (20.29)	67.07 (19.26)	66.27 (20.97)	Inter-subject	1.14 (1; 197)	$p = 0.286$	/
	TOTAL	38.04 (19.97)	67.24 (19.29)	67.64 (20.41)				

/ = NS; * = < .05; ** < .01; *** < .001

5. Consumption of medical care before, during and after the treatment programme

Participants were asked whether there had been any consultations with different healthcare providers, or not, and what their medical consumption was in the three months prior to the treatment (pre-test), during the treatment (post-test 1) and after the end of the treatment (post-test 2) (table 5.1).

Table 5.1: Medical consultations and consumption in the 3 months prior to the start of the treatment (N = 223), during the treatment (N = 223) and after the treatment (N = 222).

Consumption		Figures			
		N yes	% yes	N no	% no
Before the treatment	GP	186	83.4	37	16.6
	Occupational physician	116	52.3	106	47.7
	Specialist / other healthcare professional	128	57.4	95	42.6
	Medical examinations	80	35.9	143	64.1
	Medication	131	58.7	93	41.3
During the treatment	GP	158	70.9	65	29.1
	Occupational physician	105	47.1	118	52.9
	Specialist / other healthcare professional	97	43.5	125	56.3
	Medical examinations	81	36.3	142	63.7
	Medication	101	45.3	122	54.7
After the treatment	GP	77	34.5	146	65.5
	Occupational physician	47	21.2	175	78.8
	Specialist / other healthcare professional	58	26.2	163	73.8
	Medical examinations	40	18.1	181	81.9
	Medication	81	36.5	141	63.5

There was no significant difference in healthcare consumption by **sector** during the treatment programme, for GP, specialist, medical examinations, and medication consumption, but there was a significant difference as regards consultations with the occupational physician ($p = .032$): workers in the hospital and healthcare sector were more likely to seek a consultation than workers in the banking sector. There was no significant difference in healthcare consumption between the sectors immediately after the treatment and at post-test 2.

There was a significant difference in healthcare consumption according to **employment** during the treatment programme with a GP ($p < .001$) and a specialist/other healthcare professional ($p = .008$): people on sick leave were more likely to seek a consultation than people at work. Immediately after the treatment, there was a significant difference in the number of consultations with the GP ($p < .001$) and the occupational physician ($p < .001$): people on sick leave had an increasing number of consultations compared with people at work. At post-test 2, there were no longer any differences.

There was no significant difference in healthcare consumption according to **age** (< 45 and > 45) before the treatment. There was a significant difference in medication use just after the treatment ($p = .015$; > 45 years more use), at post-test 2 for consultations with a GP ($p = .037$; > 45 years more consultations).

There was a significant difference in healthcare consumption according to **language** during the treatment programme regarding consultations with the occupational physician ($p < .001$): Dutch speaking participants were more likely to seek a consultation than French speaking workers. Immediately after the treatment, there was a significant difference in consultations with specialists ($p = .022$), medical examinations ($p = .037$) and medication ($p = .002$): French-speaking participants consumed more than Dutch-speaking ones. Three to six months after the treatment, there was still a significant difference in medication use ($p = .061$): > NL.

There was no significant difference in healthcare consumption according to **burnout stage** before the treatment programme, just after the treatment and three to six months after the treatment.

Similarly, there was no significant difference in healthcare consumption according to **gender** before the treatment, just after the treatment and three to six months after the treatment.

To get an idea of the number of times participants consulted their **GP and occupational physician** before, during and after the treatment, the figures from the questionnaires were used.

Table 5.2: Frequency of contact with GP/occupational physician in the 3 months before, during and after the treatment

N Contacts with the GP		Figures	
		N	%
Before the treatment	1-4	163	87.6
	5-9	22	11.8
	10 and more	1	0.05
	Total	186	100
During the treatment	1-4	63	39.9
	5-9	67	42.4
	10 and more	28	17.7
	Total	158	100
After the treatment	1-4	62	80.5
	5-9	10	13.0
	10 and more	5	6.5
	Total	77	100

N Contacts with occupational physicians		Figures	
		N	%
Before the treatment	1-4	116	100
	5-9	0	0
	10 and more	0	0
	Total	116	100
During the treatment	1-4	90	86.5
	5-9	12	11.5
	10 and more	2	1.9
	Total	104	100
After the treatment	1-4	45	95.7
	5-9	2	4.3
	10 and more	0	0
	Total	47	100

To get an idea of the number of **specialists/other healthcare professionals** consulted by the participants before, during and after the treatment, the figures from the questionnaires were used; to ascertain the type of specialist/other healthcare, the free text was divided into a few common categories, and these were added up.

Table 5.3: Number and type of healthcare professionals consulted in the 3 months before, during and after the treatment.

Before the treatment	During the treatment	After the treatment
Number: N = 128	Number: N = 97	Number: N = 58
1 specialist: N = 75	1 specialist: N = 51	1 specialist: N = 23
2 specialists: N = 36	2 specialists: N = 28	2 specialists: N = 23
3 specialists: N = 14	3 specialists: N = 8	3 specialists: N = 7
≥ 4 specialists: N = 3	≥ 4 specialists: N = 10	≥ 4 specialists: N = 4
Type	Type	Type
Psychologists: 63	Psychologists: 29	Psychologists: 28
Physiotherapists: 18	Physiotherapists: 8	Physiotherapist: /
Coach: 10	Coach: 7	Coach: 2
Psychiatrist: 8	Psychiatrist: 13	Psychiatrist: 11
Cardiologist: 7	Cardiologist: 12	Cardiologist: 3
Gastroenterologist: 5	Gastroenterologist: 5	Gastroenterologist: 5
Neurologist: 4	Neurologist: 4	Neurologist: 2
Rheumatologist: 4	Rheumatologist: 1	Rheumatologist: 4
ENT: 3	ENT: 2	ENT: /
Ortho: 4	Ortho: 5	Ortho: 2

The Chi-square test showed no significant difference in the number of consultations according to sector, gender and burnout stage, but a significant difference for language Post-test 1: FR > NL ($p = .025$).

To get an idea of the number of **medical examinations** undergone by the participants before, during and after the treatment, the figures from the questionnaires were used; to ascertain the type of examination, the answers given in free text were divided into certain common categories, and then added up .

Table 5.4: Number and type of medical examinations performed in the last 3 months before, during and after the treatment.

Before the treatment	During the treatment	After the treatment
Number: N = 79	Number: N = 81	Number: N = 40
1 examination: N = 43	1 examination: N = 39	1 examination: N = 15
2 examinations: N = 23	2 examinations: N = 21	2 examinations: N = 15
3 examinations: N = 10	3 examinations: N = 11	3 examinations: N = 6
≥ 4 examinations: N = 3	≥ 4 examinations: N = 10	≥ 4 examinations: N = 4
Type of examination 1	Type of examination 1	Type of examination 1
Blood sampling: N = 60	Blood sampling: N = 44	Blood sampling: N = 19
Imaging: N = 12	Imaging: N = 5	Imaging: N = 7
Cardiology: N = 7	Cardiology: N = 16	Cardiology: N = 7
Gastroenterology: N = 1	Gastroenterology: N = 3	Gastroenterology: N = 1

Chi-square tests showed no significant difference in the number of medical examinations according to sector, gender and language, but did show a significant difference with regard to burnout stage: before the treatment (pre-test), workers in burnout stage 2 underwent more examinations than workers in stage 1 ($p = .036$).

To get an idea of the type of **medication** used by participants before, during and after the treatment, the figures from the questionnaires were used.

Table 5.5: Medication consumption in the last 3 months before (N = 221), during (N = 223) and after the treatment (N = 223)

	Before the treatment	During the treatment	After the treatment
Tranquilizers	35	25	14
Antidepressants	25	50	35
Painkillers	54	32	25
Sleeping pills	52	40	30
Gastro-intestinal	36	27	15
Cardiac	14	15	12

The analyses (Mc Nemar, repeated measures) showed for all types of medication (excluding antidepressants), significant differences in numbers in the pre-post 1 and pre-post 2 pair-wise comparisons: medication consumption fell during and after the treatment, compared with before the start of the treatment.

Before the treatment - Pre-test:

There was no difference in medication use between sector, gender or burnout stage.

There was a significant difference in the use of tranquilizers according to language: FR > NL ($p = .004$) and in the use of gastrointestinal medication: FR > NL ($p = .002$).

During the treatment - Post-test 1:

There was no difference in medication use between sector and burnout stage.

There was a significant difference in the use of tranquilizers according to language: FR > NL ($p = .004$); in the use of gastrointestinal medication with FR > NL ($p = .001$); in the use of sleeping pills with FR > NL ($p = .034$) and a difference in the use of cardiac medication according to gender: Men > Women ($p = .007$).

After the treatment - Post-test 2:

There was no difference in medication use depending on the burnout stage.

There was a significant difference in the use of antidepressants by sector: hospitals and healthcare > banking ($p = .018$); in the use of tranquilizers by language: FR > NL ($p = .028$) and a difference in the use of cardiac medication by gender: Men > Women ($p = .050$).

6. Effectiveness of the treatment programme in terms of perceived improvements

Table 6.1 shows the results of a 2-stage repeated measures analysis of variance concerning the perceived improvement on several indicators after the treatment (post-test 1) and 3 to 6 months after the end of the treatment (post-test 2), differentiating between the 2 sectors of activity. The same analysis was repeated, differentiating the results for age, language, gender, type of contract and burnout stage. The improvement was measured on a scale from 1 (strongly disagree) to 4 (strongly agree).

The results show that, on average, participants *Agree to Strongly agree* that there has been an improvement in their general well-being ($M = 3.22$), their quality of life ($M = 3.12$) and their work-life balance ($M = 3.12$). The participants tended to agree that their well-being at work ($M = 2.91$), sleep quality ($M = 3.00$) and ease of doing tasks ($M = 2.82$) had improved thanks to their treatment.

At the intra-individual level, there was no significant difference between post-test 1 and post-test 2, suggesting that the improvements remain unchanged over time.

There were no significant inter-subject differences by sector of activity (Table 6.1).

For the other socio-demographic variables (see Annex 17.6), there was no significant inter-subject difference when considering the scores according to language, gender and burnout stage. However, there are several significant differences by age and type of contract.

For age, there is a significant inter-subject difference for improvement in quality of life, for which more people over 55 states 'Agree' than those 35-55.

In terms of type of contract, we can see that people on fixed-term contracts perceive a greater improvement in their general well-being, their well-being at work, and the ease with which they carry out their tasks, than people on indefinite contracts or statutory contracts. These results should be interpreted with caution, as only 7 of the 223 participants are on fixed-term contracts. These 7 participants work in the healthcare sector, and 6 of them are under 35 (1 is in the 36-55 age group).

Table 6.1: Perceived improvement between post-test 1 and post-test 2 after the treatment, by sector of activity

	Sector (PRE_T1_REC OD)	Mean (SD) Post-test1	Mean (SD) Post-test 2	Effects test	F(ddl)	Probability	Sign.
Improvement in general well-being (J41)	Banking	3.17 (0.71)	3.09 (0.66)	Intra- subject	0.34 (1; 220)	$p = 0.561$	/
	Hospital	3.23 (0.71)	3.26 (0.66)	Inter- subject	1.33 (1; 220)	$p = 0.250$	/
	TOTAL	3.22 (0.71)	3.22 (0.66)				
Improvement in well-being at work (J412)	Banking	2.74 (0.83)	2.84 (0.82)	Intra- subject	0.93 (1; 195)	$p = 0.337$	/
	Hospital	2.96 (0.78)	2.99 (0.83)	Inter- subject	2.04 (1; 195)	$p = 0.155$	/
	TOTAL	2.91 (0.79)	2.96 (0.83)				
Easier to perform tasks (J42)	Banking	2.76 (0.72)	2.81 (0.81)	Intra- subject	1.37 (1; 193)	$p = 0.244$	/
	Hospital	2.84 (0.75)	2.96 (0.73)	Inter- subject	0.96 (1; 193)	$p = 0.328$	/
	TOTAL	2.82 (0.74)	2.93 (0.75)				
Improved sleep (J43)	Banking	3.00 (0.79)	2.91 (0.78)	Intra- subject	2.27 (1; 212)	$p = 0.133$	/
	Hospital	3.01 (0.79)	2.89 (0.81)	Inter- subject	0.003 (1; 212)	$p = 0.958$	/
	TOTAL	3.00 (0.78)	2.89 (0.80)				
Improvement in quality of life (J44)	Banking	3.02 (0.72)	3.02 (0.72)	Intra- subject	0.003 (1; 214)	$p = 0.959$	/
	Hospital	3.14 (0.75)	3.15 (0.71)	Inter- subject	1.26 (1; 214)	$p = 0.263$	/
	TOTAL	3.12 (0.74)	3.12 (0.71)				
Improved work/life balance (J45)	Banking	3.08 (0.59)	3.13 (0.62)	Intra- subject	0.03 (1; 193)	$p = 0.860$	/
	Hospital	3.13 (0.77)	3.06 (0.86)	Inter- subject	0.01 (1; 193)	$p = 0.938$	/
	TOTAL	3.12 (0.74)	3.07 (0.82)				

/ = NS; * = < .05; ** < .01; *** < .001

7. Employment status before, during and after the BOTP

Table 7.1 shows the employment status of the participants during the three time periods. Prior to the start of the treatment (pre-test) only 45.3% of participants were working, and just under half of these on a part-time basis. The level of employment increased to 81.9% just after the treatment (post-test 1), and even among these, just under half were still working part-time. Three to six months (post-test 2) after the treatment, there is no further rise in employment, nor is there a lot of progression from part-time to full-time employment. Overall, therefore, there is a positive trend in the employment of the participants, but the proportion of those employed part-time is higher after the treatment than before. It should also be borne in mind that 3.6% of the participants are jobseekers three to six months after their participation.

Table 7.1. Summary table of participants' employment during the 3 time periods

Employment status		Figures	
		N	%
Before the treatment	Full-time	53	23.8%
	Part-time	48	21.5%
	Career break	1	0.4%
	Sick leave	115	51.6%
	Other	6	2.7%
	Total	223	100%
Just after the treatment	Full-time	91	41.2%
	Part-time	90	40.7%
	Career break	1	0.5%
	Sick leave	28	12.7%
	Unemployed	2	0.9%
	Other	9	4.1%
	Total	221	100%
3-6 months after the treatment	Full-time	90	40.5%
	Part-time	87	39.2%
	Career break	3	1.4%
	Sick leave	27	12.2%
	Unemployed	8	3.6%
	Other	7	3.2%
	Total	222	100%

Employment status before the treatment (dichotomous yes/no) and just after the treatment were significantly different (McNemar $p < .001$): more people were in employment just after the treatment. Similarly, there were significantly more people employed 3 to 6 months after the treatment (dichotomous yes/no) than before the treatment (McNemar $p < .001$).

There was no significant difference in employment by **sector** before the treatment ($p = .646$), but there was a borderline significant difference just after the treatment ($p = 0.050$), and a significant difference three to six months after the treatment ($p = .035$). The number of workers returning to work in the healthcare sector is higher than in the banking sector (full-time and part-time combined: 81% vs. 73.4%).

There was no significant difference in employment by **age** before the treatment ($p = .448$), just after the treatment ($p = .216$) and three to six months after the treatment ($p = .825$).

There was no significant difference in employment by **gender** before the treatment ($p = .530$), but there was just after the treatment ($p = .013$), and three to six months after the treatment ($p = .006$). Women are more likely to work part-time just after the treatment and three to six months after the treatment.

There was no significant difference in employment by **language** before the treatment ($p = .214$), just after the treatment ($p = .215$) and three to six months after the treatment ($p = .762$).

There was no significant difference in employment according to **burnout stage** before the treatment ($p = .223$), just after the treatment ($p = .422$) and three to six months after the treatment ($p = .118$).

There was no significant difference in employment according to the **referrer** before the treatment ($p = .114$), just after the treatment ($p = .787$) and three to six months after the treatment ($p = .979$).

All tables relating to these analyses can be found in the annex (Annex 17.7).

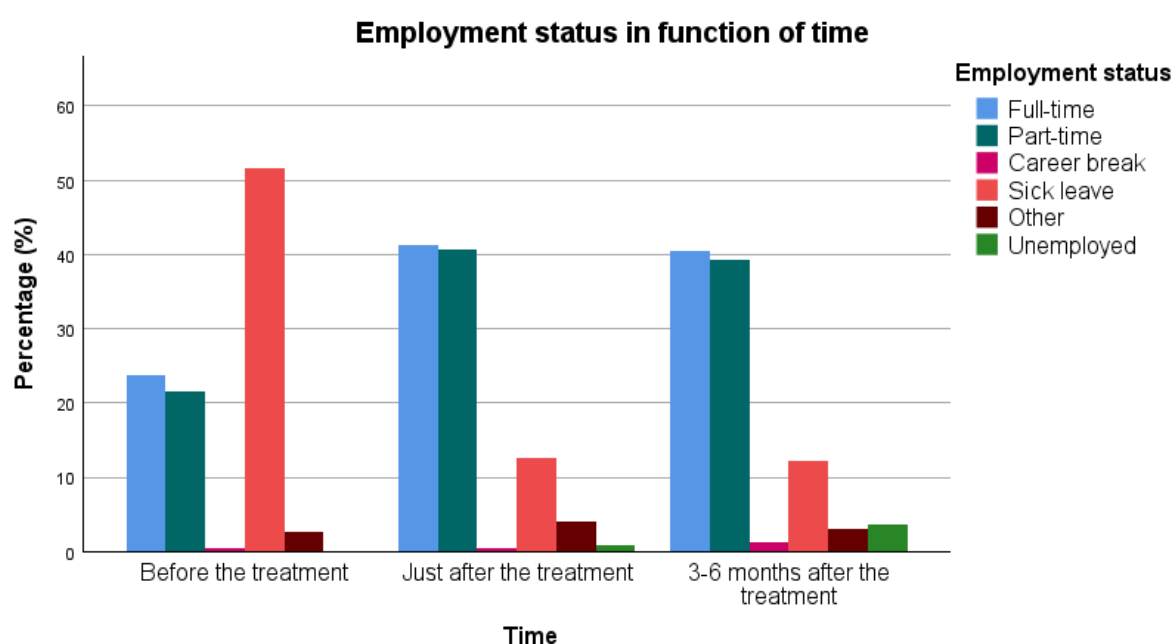


Figure 7.1: Employment status (%) of participants at three different points in time

8. Employment and occurrence or absence of burnout after the treatment

The data on employment status were taken from the questionnaires, and data from the final report informed us about the presence or absence of burnout (post-test 1) and the stage. Just after the treatment (post-test 1), 33 people at work were still in a state of burnout, compared with 139 with no burnout. 20 people in burnout were unemployed, and 10 people with no burnout were absent from work (table 8.1; $p < .001$).

Table 8.1: Employment (yes/no) just after the treatment (post-test 1) and occurrence of burnout (N = 210)

	occurrence of burnout		No more burnout		Total	
	N	%	N	%	N	%
At work	33	62.3	139	88.5	172	81.9
Not at work	20	37.7	18	11.5	38	18.1
Total	53	100.0	157	100.0	210	100.0

The same finding (no burnout, more participants at work) was made when the employment situation was presented in more detail (table 8.2; $p < .001$).

Table 8.2: Employment (all response options) just after the treatment (post-test 1) and occurrence of burnout (N = 210)

		Occurrence of burnout			
		Yes		No	
		N	%	N	%
Employment after the treatment	Full-time	13	24.5%	73	46.5%
	Part-time	20	37.7%	66	42.0%
	Career break	0	0.0%	1	0.6%
	Sick leave	16	30.2%	11	7.0%
	Unemployed	2	3.8%	0	0.0%
	Other	2	3.8%	6	3.8%
	Total	53	100%	157	100%

There was no difference between being at work and not being at work, depending on the stage of burnout (table 8.3; $p = .09$). This involves 51 people, 5 of whom are still in stage 3.

Table 8.3: Employment immediately after the treatment (post-test 1), according to burnout stage (N = 51)

		Burnout stage						Total	
		Stage 1		Stage 2		Stage 3			
		N	%	N	%	N	%	N	%
Employment after the treatment	Yes	23	69.7	7	53.8	1	20.0	31	60.8
	No	10	30.3	6	46.2	4	80.0	20	39.2
Total		33	100	13	100	5	100	51	100

9. Evaluation of the BO treatment programme (Post-test 1)

At the end of the treatment, the participants were invited to complete post-test 1. Various measures of satisfaction were assessed.

9.1 Satisfaction with the geographical distribution, distance from home or work to the place of treatment

Table 9.1.1 shows a very high percentage of satisfied and completely satisfied participants regarding the geographical distribution and the location of the treatment.

Table 9.1.1: Satisfaction with geographical distribution and location

Geographical distribution, distance from home or work to the place of treatment	Sector	N	Not at all satisfied	Dissatisfied	Satisfied	Completely satisfied
Proximity to place of treatment (POST1_D1)	Banking	67	1.50%	4.50%	26.90%	67.20%
	Hospital and healthcare	224	1.80%	6.30%	33.90%	58.00%
	TOTAL	291	1.70%	5.80%	32.30%	60.10%
Ease of access/accessibility of place of treatment (POST1_D2)	Banking	66	0%	1.50%	25.80%	72.70%
	Hospital and healthcare	220	0.50%	2.70%	32.30%	64.50%
	TOTAL	286	0.30%	2.40%	30.80%	66.40%
Adaptability of the location (POST1_D3)	Banking	65	0.00%	3.10%	26.20%	70.80%
	Hospital and healthcare	211	0.90%	2.40%	31.30%	65.40%
	TOTAL	276	0.70%	2.50%	30.10%	66.70%

The following data relate to participants' satisfaction with the logistics of the services of the BO treatment providers. Table 9.1.2 shows that most participants reported having been treated by the same BO treatment provider (58.9%) or 2 BO treatment providers (31.8%). Less than 10% of participants report having been treated by 3 or more BO treatment providers. We will therefore present the levels of satisfaction with the services provided by the BO treatment providers for BO treatment providers 1 and 2, thereby combining a high number of opinions.

Table 9.1.2: Number of BO treatment providers

Number of treatment providers	N	%
1 BO treatment	126	58.9
2 BO treatment providers	68	31.8
3 or more BO treatment providers	20	9.3
TOTAL	214	100

Table 9.1.3 shows that a very high percentage of participants are satisfied and very satisfied with the logistical aspects of their BO treatment provider 1, in terms of ease of making appointments, flexibility of time slots, punctuality and coordination of the BOTP. For the most part, the participants are satisfied or very satisfied with the sessions they had with BO treatment provider 1.

Table 9.1.3: Satisfaction with BO treatment provider 1 in terms of the logistics of their services

	Sector	N	Not at all satisfied	Dissatisfied	Satisfied	Completely satisfied
Easy to book appointments – Bo treatment provider 1 (POST1_E12)	Banking	74	0%	1.40%	20.30%	78.40%
	Hospital and healthcare	238	0.40%	0.40%	19.70%	79.40%
	TOTAL	312	0.30%	0.60%	19.90%	79.20%
Flexibility of time slots – BO treatment provider 1 (POST1_E13)	Banking	74	1.40%	0%	27.00%	71.60%
	Hospital and healthcare	237	0.40%	2.50%	19.80%	77.20%
	TOTAL	311	0.60%	1.90%	21.50%	75.90%
Punctuality of BO treatment provider 1 (POST1_E14)	Banking	73	0%	1.40%	20.50%	78.10%
	Hospital and healthcare	237	1.30%	0.40%	19.40%	78.90%
	TOTAL	310	1.00%	0.60%	19.70%	78.70%
Coordination of the BOTP – BO treatment provider 1 (POST1_E15)	Banking	67	0%	1.50%	28.40%	70.10%
	Hospital and healthcare	196	1.10%	3.10%	18.40%	77.60%
	TOTAL	263	0.80%	2.70%	20.90%	75.70%
Satisfaction with the sessions – BO treatment provider 1 (POST1_E16)	Banking	72	0%	2.80%	19.40%	77.80%
	Hospital and healthcare	236	0.40%	4.70%	21.20%	73.70%
	TOTAL	308	0.30%	4.20%	20.80%	74.70%

Table 9.1.4 shows that a very high percentage of participants are satisfied and very satisfied with the logistical aspects of their BO treatment provider 2, in terms of ease of making appointments, flexibility of time slots, their punctuality and coordination of the BOTP. For the most part, the participants are satisfied or very satisfied with the sessions they had with BO treatment provider 2.

Table 9.1.4: Satisfaction with BO treatment provider 2 in terms of the logistics of their services

	Sector	N	Not at all satisfied	Dissatisfied	Satisfied	Completely satisfied
Easy to book appointments – BO treatment provider 2 (POST1_E22)	Banking	32	3.10%	3.10%	37.50%	56.30%
	Hospital and healthcare	118	2.50%	2.50%	26.30%	68.60%
	TOTAL	150	2.70%	2.70%	28.70%	66.00%
Flexibility of time slots – BO treatment provider 2 (POST1_E23)	Banking	31	0%	6.50%	38.70%	54.80%
	Hospital and healthcare	117	3.40%	4.30%	25.60%	66.70%
	TOTAL	148	2.70%	4.70%	28.40%	64.20%
Punctuality of burnout treatment provider 2 (POST1_E24)	Banking	29	6.90%	3.40%	31.00%	58.60%
	Hospital and healthcare	118	2.50%	2.50%	19.50%	75.40%
	TOTAL	147	3.40%	2.70%	21.80%	72.10%
Coordination of the BOTP – BO treatment provider 2 (POST1_E25)	Banking	8	0%	0%	25.00%	75.00%
	Hospital and healthcare	26	7.70%	7.70%	15.40%	69.20%
	TOTAL	34	5.90%	5.90%	17.60%	70.60%
Satisfaction with the sessions – BO treatment provider 2 (POST1_E26)	Banking	30	10.00%	0%	33.30%	56.70%
	Hospital and healthcare	118	1.70%	7.60%	22.00%	68.60%
	TOTAL	148	3.40%	6.10%	24.30%	66.20%

9.2 Satisfaction with the content of the treatment programme.

First, Table 9.2.1 provides information on the type of professional preferred by the participant for their BO treatment. In 80% of cases, a psychologist was the only person involved in the participant's BO treatment. Their work was combined with that of a physiotherapist or physician in 16% and 2% of cases respectively. These results confirm that the psychologist plays a key role in the BO treatment: in terms of diagnosis, in the first BO treatment session and in coordinating the whole BO treatment programme. Physiotherapists may only be involved in individual sessions based on the psycho-physical approach. It should also be noted that the list of BO treatment providers did not include many physiotherapists.

Table 9.2.1: Type(s) of professional involved in the treatment programme.

	Type of professional for the treatment (FTF1CM)		
Sector	Banking	Hospital and healthcare	TOTAL
N	74	237	311
Psychologist	83.80%	78.50%	79.70%
Physiotherapist	0%	0%	0%
Psychologist + Physiotherapist	14.90%	17.30%	16.70%
Physician	0%	1.30%	1.00%
Psychologist + Physician	1.40%	2.50%	2.30%
Psychologist, Physician and Physiotherapist	0%	0.40%	0.30%

Overall, Table 9.2.2 provides information on participants' satisfaction with different dimensions of the BO treatment programme. Over 90% of participants were satisfied or very satisfied with the number and variety of sessions offered in the context of the BO treatment programme. Over 90% were satisfied or very satisfied with the modularity or level of personalisation of the BO treatment they were offered. Over 90% are satisfied or very satisfied with the duration of the BO treatment. More than 80% are satisfied or very satisfied with the possibility of being treated by several healthcare professionals. As regards the information given about the BO treatment programme, over 95% were satisfied or very satisfied with the information given by the BO treatment provider, compared with almost 90% by Fedris. Finally, with regard to the dynamics of the multidisciplinary meeting, overall, nearly 80% of participants were satisfied or very satisfied. This result is surprising given that there was only one request for a multidisciplinary meeting. Nevertheless, 191 of the 312 participants (61.21%) answered this question! It is therefore likely that the discussions on adapting or modifying the participant's working environment with prevention advisors or company representatives took place informally, without taking up Fedris' offer for a multidisciplinary meeting without anonymity.

Table 9.2.2: Satisfaction with the content of the BO treatment programme.

	Sector	N	Not at all satisfied	Dissatisfied	Satisfied	Completely satisfied
Number of sessions (POST1_G1)	Banking	71	1.40%	7.00%	35.20%	56.30%
	Hospital and healthcare	238	0.40%	7.60%	37.80%	54.20%
	TOTAL	309	0.60%	7.40%	37.20%	54.70%
Diversity of the proposed BO treatment programme (POST1_G2)	Banking	71	0%	7.00%	42.30%	50.70%
	Hospital and healthcare	235	0%	6.80%	42.60%	50.60%
	TOTAL	306	0%	6.90%	42.50%	50.70%
Modularity/degree of customisation of the proposed BO treatment programme (POST1_G3)	Banking	71	1.40%	4.20%	32.40%	62.00%
	Hospital and healthcare	236	0.40%	5.90%	30.50%	63.10%
	TOTAL	307	0.70%	5.50%	30.90%	62.90%
Duration of the BO treatment programme (POST1_G4)	Banking	72	1.40%	8.30%	44.40%	45.80%
	Hospital and healthcare	237	1.30%	9.30%	38.00%	51.50%
	TOTAL	309	1.30%	9.10%	39.50%	50.20%
Information of the BO treatment programme by the BO treatment provider (POST1_G5)	Banking	71	0%	2.80%	33.80%	63.40%
	Hospital and healthcare	234	0%	3.40%	28.20%	68.40%
	TOTAL	305	0%	3.30%	29.50%	67.20%
Information of the BO treatment programme by Fedris (POST1_G6)	Banking	68	0%	11.80%	57.40%	30.90%
	Hospital and healthcare	218	1.40%	8.30%	46.30%	44.00%
	TOTAL	286	1.00%	9.10%	49.00%	40.90%
BO treatment programme provided by various professionals (IB and ISI) (POST1_G7)	Banking	49	2.00%	20.40%	32.70%	44.90%
	Hospital and healthcare	142	2.80%	13.40%	30.30%	53.50%
	TOTAL	191	2.60%	15.20%	30.90%	51.30%
Dynamics of the multidisciplinary meeting (POST1_G8)	Banking	33	0%	15.20%	42.40%	42.40%
	Hospital and healthcare	81	8.60%	14.80%	30.90%	45.70%
	TOTAL	114	6.10%	14.90%	34.20%	44.70%

9.3 Overall evaluation of the BO treatment programme.

When participants were asked to rate the overall BO treatment programme on a scale of 1 to 10 (Table 9.3.1), we find that almost 75% of them give a score of over 8 out of 10 (this rises to almost 90% for scores of over 7 out of 10). The average overall rating was 8.01 out of 10 (with a standard deviation of 1.79).

Table 9.3.1: Overall evaluation of the BO treatment programme (on a scale of 1 to 10)

Overall evaluation of the BO treatment programme (on a scale of 1 to 10) (POST1_H1)			
Sector	Banking	Hospital and healthcare	TOTAL
N	67	227	294
1	0%	0.90%	0.70%
2	3.00%	1.30%	1.70%
3	0%	0.40%	0.30%
4	3.00%	1.30%	1.70%
5	3.00%	1.80%	2.00%
6	6.00%	5.30%	5.40%
7	17.90%	14.10%	14.30%
8	26.90%	29.10%	28.60%
9	26.90%	28.20%	27.90%
10	16.40%	17.60%	17.30%

There was no difference in the overall evaluation of the BO treatment programme according to the number of BO treatment providers involved ($F(2, 293) = 1.78, p = \text{NS}$) (Table 9.3.2).

Table 9.3.2: Overall evaluation of the BO treatment programme (on a scale of 1 to 10) according to the number of BO treatment providers who followed up the participant.

Overall evaluation - On a scale of 1 to 10	N	Mean	Standard deviation
1 BO treatment provider	147	7.97	1.72
2 BO treatment providers	117	8.09	1.72
3 or more BO treatment providers	30	8.60	1.16
Total	294	8.08	1.68

The following table (Table 9.3.3) suggests that almost 95% of participants would recommend this BOTP to others. Just over 75% of participants did not feel the need to continue the follow-up with their BO treatment provider, or individual session treatment provider.

Table 9.3.3: Overall evaluation of the BOTP - Recommendation and follow-up

Overall evaluation of the BOTP - Recommendation and follow-up				
Would you recommend the BOTP to others (POST1_H2)			Yes	No
	Banking	74	94.60%	5.40%
	Hospital and healthcare	238	95.00%	5.00%
	TOTAL	312	94.90%	5.10%
Continue the follow-up with the BO treatment provider (POST1_H3)			Yes	No
	Banking	74	21.60%	78.40%
	Hospital and healthcare	236	24.60%	75.40%
	TOTAL	310	23.90%	76.10%
Continue the follow-up with the individual treatment provider (POST1_H31)			Yes	No
	Banking	73	24.70%	75.30%
	Hospital and healthcare	232	31.90%	68.10%
	TOTAL	305	30.20%	69.80%

9.4 Perception of the current situation (post-test 1)

9.4.1 In terms of work organisation

The data presented in table 9.4.1 show the extent to which the participant perceives an improvement in his work organisation. There is more inter-individual variability in perceptions. Nearly 60% of participants felt that the company had not become aware of the problem at the collective level; nearly 80% felt that there had been no change in the approach of management; nearly 65% felt that there had been no further action to promote well-being; over 75% felt that there had been no further material support.

In terms of relations with management, opinions are divided. Between 45 and 50% of participants believe that there has been no improvement, while the remaining participants report an improvement. Opinions are more positive when it comes to relationships with colleagues, with almost 75% of participants perceiving an improvement in these relationships.

Table 9.4.1: Perception of the current situation at the level of the company

Perception of the current situation	Sector	N	Strongly disagree	Disagree	Agree	Strongly agree
Company is collectively aware of the problem (POST1_J11)	Banking	63	30.20%	27.00%	34.90%	7.90%
	Hospital and healthcare	210	28.10%	33.80%	30.50%	7.60%
	TOTAL	273	28.60%	32.20%	31.50%	7.70%
Change in the approach of management (POST1_J12)	Banking	64	31.30%	40.60%	21.90%	6.30%
	Hospital and healthcare	211	40.30%	39.80%	18.00%	1.90%
	TOTAL	275	38.20%	40.00%	18.90%	2.90%
More actions for well-being (POST1_J13)	Banking	65	27.70%	40.00%	24.60%	7.70%
	Hospital and healthcare	210	23.30%	40.00%	31.90%	4.80%
	TOTAL	275	24.40%	40.00%	30.20%	5.50%
Improved relations with management (POST1_J21)	Banking	55	20.00%	30.90%	38.20%	10.90%
	Hospital and healthcare	194	20.60%	23.20%	42.30%	13.90%
	TOTAL	249	20.50%	24.90%	41.40%	13.30%
Improved relations with colleagues (POST1_J22)	Banking	41	12.20%	22.00%	48.80%	17.10%
	Hospital and healthcare	182	9.30%	18.10%	55.50%	17.00%
	TOTAL	223	9.90%	18.80%	54.30%	17.00%
More material support (POST1_J23)	Banking	48	27.10%	47.90%	25.00%	0%
	Hospital and healthcare	163	38.70%	39.30%	19.60%	2.50%
	TOTAL	211	36.00%	41.20%	20.90%	1.90%

9.4.2 In terms of the individual's own relationship to work

Table 9.4.2 shows that over 65% of participants *Agree or Strongly agree* with the fact that they perceive more positive aspects in their work, almost 90% also agree with the fact that they have stepped back from work, and over 80% finally agree with the fact that they now have more realistic work expectations.

Table 9.4.2: Perception of relationship to work after the BOTP.

Relationship to work	Sector	N	Strongly disagree	Disagree	Agree	Strongly agree
Perception of positive aspects of work (POST1_J31)	Banking	63	7.90%	31.70%	47.60%	12.70%
	Hospital and healthcare	212	6.60%	24.10%	53.30%	16.00%
	TOTAL	275	6.90%	25.80%	52.00%	15.30%
Stepping back from work (POST1_J32)	Banking	65	1.50%	12.30%	43.10%	43.10%
	Hospital and healthcare	230	2.20%	7.00%	57.40%	33.50%
	TOTAL	295	2.00%	8.10%	54.20%	35.60%
More realistic expectations (POST1_J33)	Banking	64	4.70%	14.10%	68.80%	12.50%
	Hospital and healthcare	219	1.40%	12.80%	63.90%	21.90%
	TOTAL	283	2.10%	13.10%	65.00%	19.80%

10. Adjustments of the workstation

10.1 Same / different employer (EM) and/or workstation (WS)

According to the questionnaire data, just after the treatment (post-test 1) and 3 to 6 months after the treatment (post-test 2), around 88% of workers are still employed by the same employer, and almost 3 out of 4 still work at the same workstation. Around 11.5% have changed employer (tables 10.1.1 and 10.1.2).

Table 10.1.1: Same / different employer and/or workstation at post-test 1 (N = 216)

	Employment – post-test 1	
	N	%
Same EM, same WS	160	74.1
Same EM, different WS	31	14.4
Subtotal 1	191	88.5
Different EM, same WS	10	4.6
Different EM, different WS	15	6.9
Subtotal 2	25	11.5
Total	216	100

Table 10.1.2: Same / different employer and/or workstation at post-test 2 (N = 216)

	Employment – post-test 2	
	N	%
Same EM, same WS	153	72.2
Same EM, different WS	34	16.0
Subtotal 1	187	88.2
Different EM, same WS	12	5.7
Different EM, different WS	13	6.1
Subtotal 2	25	11.8
Total	212	100

183 final reports state that 54 people changed employer and/or workstation (29.5%), and 116 (63.4%) did not. 13 people also stated "other" (7.1%). 40 final reports did not mention anything.

163 final reports state that 4 people changed sector (2.5%) and 159 did not (97.5%). 60 final reports contain no relevant data.

With a sample of less than 5 participants (in some cells), it is not appropriate to carry out a statistical test on such a small sample.

There was no significant difference between post-test 1 ($p = 0.636$) and post-test 2 ($p = 0.396$) in terms of sector.

Table 10.1.3: Same / different employer and/or workstation at post-test 1 (N = 216)

	Employment – post-test1 - N	
	Banking	Hospital and healthcare
Same EM, same WS	34	126
Same EM, different WS	8	23
Subtotal 1	42	149
Different EM, same WS	1	9
Different EM, different WS	2	13
Subtotal 2	3	22
Total	45	171

Table 10.1.4: Same / different employer and/or workstation at post-test 2 by sector (N = 212)

	Employment – post-test 2 - N	
	Banking	Hospital and healthcare
Same EM, same WS	31	122
Same EM, different WS	10	24
Subtotal 1	41	146
Different EM, same WS	3	9
Different EM, different WS	1	12
Subtotal 2	4	21
Total	45	167

10.2 Adjustments of the workstation by the employer (EM) and/or the worker (WO)

Participants were asked about adjustments to their workstation immediately after the treatment (post-test 1) and three to six months after the end of the BOTP (post-test 2).

The employer adjusted the workstation for 30% of participants immediately after the BOTP, and for 28% of participants three to six months after the BOTP (table 10.2.1).

Workstation adjustments were made by the worker in 45.8% of cases after completion of the treatment, and in 41.4% of cases three to six months after completion of the treatment. There was a significant correlation between workstation adjustments by the employer and workstation adjustments by the worker, both after the end of the treatment ($p < .001$) and three to six months after the end of the treatment ($p < .001$). There is no significant difference between the sectors for adjustments made by either the employer or the worker, at any point in time.

In 183 final reports, 89 people stated that they had taken action at work (74.8%) and 30 people had not (25.4%).

Table 10.2.1: Frequency of adjustments of workstation by employer (EM) and worker (WO) post-test 1 and post-test 2

	Number/total	% Total	Banking	Hospital and healthcare
Adjustments of the workstation EM-post-test 1	65/217	30.0%	12/46	53/171
Adjustments of the workstation EM post-test 2	59/211	28.0%	12/45	47/166
Adjustments of the workstation WO post-test 1	99/216	45.8%	18/46	81/170
Adjustments of the workstation WO post-test 2	87/210	41.4%	13/45	74/165

Chi-square tests show no significant difference in post-test 1, but do show a significant difference in post-test 2:

Adjustments of the workstation EM post-test 2:

Age ($p = .031$): there are more adjustments among workers over 45.

Language ($p = .033$): there are more adjustments among NL workers.

Adjustments of the workstation WO post-test 2:

Referrer ($p = .039$): more adjustments after being referred by the occupational physician and CPAP.

10.3 Type of adjustments of the workstation by the employer (EM) and/or the worker (WO)

To get an idea of the type of workstation adjustments made, the workstation adjustments made by the worker and the employer that were noted in free text immediately after the treatment were encoded into different categories.

For workstation adjustments by the employer, we have 65 responses, some of which included several types of workstation adjustment. Table 10.3.1 shows the frequency by category. The most frequent workstation adjustments made by the employer are changes to the working schedule, reducing the number of working hours, changing departments for part or all the work, hiring additional colleagues and assigning other tasks. For each workstation adjustment, a sample answer was added below:

"No late hours on weekdays".

"Currently, part-time work and overtime only on certain days".

"For now, only maternity care and home care. ... No delivery room".

"The peer group has been extended".

"Other work for now, while I wait for another job within the company".

Table 10.3.1: Workstation adjustments by the employer immediately after the BOTP (post-test 1)

Adjustment of the workstation	Frequency
Changes to working schedule	14
Working fewer hours	12
Change of department for all or part of the job	9
Hiring additional colleagues	7
Another work	7
Adjust / limit / better distribute tasks	6
Take less overtime / recover overtime (more quickly)	4
Clarity of tasks / delimitation of tasks	4
Less workload	4
Communication with workers about the difficulties	3
Adjustments to desk / office space	3
Adaptation of leave arrangements	2
Support of colleagues / improved cooperation	2
More evaluations	2
Reduce the administrative burden	2
Customise the waiting system	2
Other	13

For workstation adjustments by the worker, we have 98 responses, some of which involved various kinds of workstation adjustment, but also changes in the personal coping style and work strategy. Table 10.3.2 shows the frequency by category. The workstation adjustments most frequently made by the worker are: reducing the number of hours worked, clarifying tasks / limiting tasks, adhering to working hours / finishing work on time / disconnecting after work, adhering to breaks / incorporating rest periods and adjusting the working schedule.

For each of the adjustments (workstation and personal coping), a sample answer has been added below:

"The workload is gradually increased every month, by mutual agreement and with me taking the lead".

"A return after sick leave is only possible if a clear framework has been laid down, including job descriptions and evaluation sessions at regular intervals".

"I don't take work home anymore".

"I forced myself to take a lunch break".

"No more shift work".

Table 10.3.2: Workstation adjustments by the worker immediately after the treatment (post-test 1)

Adjustment of the workstation	Frequency
Working fewer hours	16
Clarity of tasks / delimitation of tasks	14
Respect working hours / stop work on time / switch off after work	11
Respect breaks / incorporate extra breaks or rest periods	10
Changes to working hours	10
Communication in the workplace about the difficulties	8
Another work	8
Work less overtime / recover worked overtime (more quickly)	7
Set priorities / stop multitasking	7
Change of department for all or part of the job	5
Let go of work / step back more	5
Adaptation of the desk / office space	4
Adaptation of leave arrangements	3
Adjust / limit / better distribute tasks	3
Remote working envisaged	3
Dialogue with management	3
More structure	2
No longer performing a management function	2
Better communication within the team	2
Other	20

Among the adjustments to the employer's workstation that have led to a positive change in the job (i.e. coming back from sick leave/career break to part-time/full-time employment, and from part-time to full-time), the main ones are changes to working hours and transfers to another department within the company.

Among the adjustments to the worker's workstation that have led to a positive change in the job, the main ones are a reduction in working hours and a change of function. In addition, certain changes in the behaviour of workers are also important, such as prioritising work and setting limits, both in terms of the content of all tasks given and limiting working hours (not taking work home).

Further, we examined whether there was a significant difference between the occurrence of workstation adjustments and the change in employment status.

There was no significant difference in employment depending on whether or not the employer had made adjustments to the workstation after the end of the treatment ($p = .073$) and three to six months after the end of the treatment ($p = .508$). Nor was there any significant difference in terms of employment depending on whether or not the worker had made adjustments to the workstation after the end of the treatment ($p = .088$) and three to six months after the end of the treatment ($p = .370$).

When the participants were divided according to language, no significant differences in employment were found for French-speaking participants immediately after ($p = .279$) and three to six months after the treatment ($p = .571$), or for Dutch-speaking participants immediately after ($p = .202$) and three to six months after the treatment ($p = .727$), depending on the employer's adjustment of the workstation.

When the group of participants was broken down by sector, no significant differences in employment were found in the banking sector just after ($p = .718$) and three to six months after the treatment ($p = .440$), or in the healthcare sector just after ($p = .070$) and three to six months after the treatment ($p = .774$), depending on the employer's adjustment of the workstation.

Nor was there any significant difference in terms of employment depending on whether or not the worker had made adjustments to this workstation after the end of the treatment pathway ($p = .088$) and three to six months after the end of the treatment ($p = .370$).

When the participant group was broken down by language, no significant differences in terms of employment were found for French-speaking participants immediately after ($p = .279$) and three to six months after the treatment ($p = .419$), or for Dutch-speaking participants immediately after ($p = .202$) and three to six months after the treatment ($p = .910$), depending on the worker's adjustment of the workstation.

When the group of participants was broken down by sector, no significant differences in employment were found for the banking sector just after ($p = .408$) and three to six months after the treatment ($p = .292$), or for the healthcare sector just after ($p = .118$) and three to six months after the treatment ($p = .915$), depending on the worker's adjustment of the workstation.

Further tables are available in the annex (Annex 17.8).

11. Characteristics of the BOTP (based on data from the final report of the BO treatment provider)

On average, the total number of sessions was 12.41 (12.81 in the banking sector and 12.29 in the hospital and care sector). 161 participants (72.2%) took part in 10 or more sessions (142, or 63.7% in 12 or more sessions, and 119, or 53.4% in 14 or more sessions). Table 11.1 shows the frequency of participants according to the number of sessions they attended. You will also find this data by module in the tables in annex 17.9. These tables show that 86.8% of participants took part in 4 work clinic sessions, 74.4% in 3 Starter-kit sessions, 46.2% in 7 individual sessions (but also 22% who took part in 4 to 6 individual sessions), 80.2% in 1 or 2 follow-up sessions, and 27.8% in 1 or 2 reorientation sessions.

Table 11.1: Total number of sessions in which participants took part.

Total number of sessions	N	%	% valid	% cumulative
1 session	1	.4	.4	.4
2 sessions	2	.9	.9	1.3
3 sessions	3	1.3	1.3	2.7
4 sessions	3	1.3	1.3	4.0
5 sessions	4	1.8	1.8	5.8
6 sessions	7	3.1	3.1	9.0
7 sessions	8	3.6	3.6	12.6
8 sessions	16	7.2	7.2	19.7
9 sessions	18	8.1	8.1	27.8
10 sessions	9	4.0	4.0	31.8
11 sessions	10	4.5	4.5	36.3
12 sessions	10	4.5	4.5	40.8
13 sessions	13	5.8	5.8	46.6
14 sessions	16	7.2	7.2	53.8
15 sessions	17	7.6	7.6	61.4
16 sessions	44	19.7	19.7	81.2
17 sessions	12	5.4	5.4	86.5
18 sessions	22	9.9	9.9	96.4
19 sessions	6	2.7	2.7	99.1
21 sessions	2	.9	.9	100.0
Total	223	100.0	100.0	

Table 11.2 shows the average number of sessions per module of the BOTP. On average, we find 3.69 work clinic sessions; 2.45 psycho-education sessions (starter kit); 4.35 individual sessions; 1.32 follow-up sessions and 0.46 reorientation sessions. The BOTP therefore includes just over 6 sessions on average with the person's BO treatment provider and almost 4 sessions with their individual sessions treatment provider for a psycho-physical or cognitive-emotional approach. Between 2 and 3 psycho-education sessions are also requested. It should be noted that COVID modules were rarely used in the context of this treatment. The same goes for multidisciplinary meetings, a module of the BOTP that will not be analysed in this chapter. Finally, we see that very few sessions were cancelled.

Table 11.2: Characteristics of the BOTP

Characteristics of the BOTP	Sector	N	Yes	No	Number of sessions (Mean(SD))
Work clinic sessions (RF10Y - RF2CC)	Banking	74	97.30%	2.70%	3.70 (0.86)
	Hospital and healthcare	238	97.90%	2.10%	3.69 (0.83)
	TOTAL	312	97.80%	2.20%	3.69 (0.83)
Starter Kit sessions (RF30Y - RF4CC)	Banking	74	91.90%	8.10%	2.58 (0.94)
	Hospital and healthcare	238	89.10%	10.90%	2.41 (1.03)
	TOTAL	312	89.70%	10.30%	2.45 (1.01)
COVID Starter Kit sessions (RFCOV10Y - RFCOV2CC)	Banking	74	9.50%	90.50%	0.09 (0.30)
	Hospital and healthcare	238	4.60%	95.40%	0.05 (0.21)
	TOTAL	312	5.80%	94.20%	0.06 (0.23)
Individual sessions (RF50Y - RF6CC)	Banking	74	81.10%	18.90%	4.73 (2.78)
	Hospital and healthcare	238	71.80%	28.20%	4.23 (3.00)
	TOTAL	312	74.00%	26.00%	4.35 (2.95)
Follow-up sessions (RF70Y - RF8CC)	Banking	74	73.00%	27.00%	1.24 (0.86)
	Hospital and healthcare	238	77.30%	22.70%	1.34 (0.83)
	TOTAL	312	76.30%	23.70%	1.32 (0.83)
Reorientation sessions (RF90Y - RF10CC)	Banking	74	25.70%	74.30%	0.46 (0.81)
	Hospital and healthcare	238	26.50%	73.50%	0.47 (0.81)
	TOTAL	312	26.30%	73.70%	0.46 (0.81)
COVID module sessions (RFCOV30Y - RFCOV4CC)	Banking	74	0%	100%	0 (0.00)
	Hospital and healthcare	238	2.50%	97.50%	0.11 (0.70)
	TOTAL	312	1.90%	98.10%	0.08 (0.61)
Cancelled sessions (RF120Y - RF13CC)	Banking	72	11.10%	88.90%	0.14 (0.42)
	Hospital and healthcare	234	14.50%	85.50%	0.21 (0.59)
	TOTAL	306	13.70%	86.30%	0.20 (0.56)

It is also important to note that almost 74% of participants followed a complete BOTP, but 26% took a break from it (Table 11.3).

Table 11.3: Percentage of complete BOTP vs. interrupted BOTP

	Sector	N	Complete	Interrupted
Complete vs. interrupted BOTP (RF29CM)	Banking	74	77.00%	23.00%
	Hospital and healthcare	229	72.50%	27.50%
	TOTAL	303	73.60%	26.40%

With regard to the number of contracted BO treatment providers involved in the BOTP, the data in table 11.4 (reported by the BO treatment providers in their final report) show that almost 90% of participants benefited from the services of a maximum of 2 BO treatment providers.

Table 11.4: Number of contracted treatment providers involved in the BOTP (data from the BO treatment provider's final report)

Number of contracted BO treatment providers involved in the BOTP (RF14CC_REC0D)			
Sector	Banking	Hospital and healthcare	TOTAL
N	74	238	312
1	52.70%	50.80%	51.30%
2	35.10%	39.90%	38.80%
3 and more	12.20%	9.20%	9.90%

Table 11.5 shows the variety in terms of the sequence of the different types of sessions offered. Nevertheless, the first session is mainly a work clinic session (in over 80% of cases) or a psycho-education session. The final session is, logically, a follow-up session in nearly 60% of cases.

Table 11.5: Types of session for first and last consultation

Sector	Type of first BOTP session (RF23CM)			Type of last BOTP session (RF25CM)		
	Banking	Hospital and healthcare	TOTAL	Banking	Hospital and healthcare	TOTAL
N	74	236	312	74	238	312
Work clinic	81.10%	83.10%	82.60%	2.70%	6.30%	5.40%
Starter Kit	17.60%	13.60%	14.50%	12.20%	10.50%	10.90%
Individual	1.40%	2.10%	1.90%	21.60%	14.30%	16.00%
Follow-up	0%	0.40%	0.30%	54.10%	58.40%	57.40%
COVID module	0%	0.80%	0.30%	0%	0%	0%
Reorientation	0%	0%	0%	9.50%	10.50%	10.30%

Table 11.6 shows that most work clinic sessions and individual sessions are organised on a one-to-one basis, which is logical and is to be expected. As regards the psycho-education sessions (starter kit), 27% of cases in the banking sector, choose the group sessions compared with 12% of cases in the hospital and care sector. This seems justified insofar as the content of the psycho-education sessions is ideal for group sessions.

Table 11.6: Organisation of individual and group sessions

Organisation of individual or group sessions

	Sector	N	Individual	In a group	Both
Work clinic sessions (RF26CM)	Banking	69	98.60%	1.40%	0%
	Hospital and healthcare	213	100%	0%	0%
	TOTAL	282	99.60%	0.40%	0%
Starter Kit sessions (RF27CM)	Banking	67	73.10%	26.90%	0%
	Hospital and healthcare	195	86.70%	11.80%	1.50%
	TOTAL	262	83.20%	15.60%	1.10%
Individual sessions (RF28CM)	Banking	54	98.10%	1.90%	0%
	Hospital and healthcare	157	99.40%	0.60%	0%
	TOTAL	211	99.10%	0.90%	0%

12. Diagnosis aspects (based on data from the BO treatment provider's final report).

Table 12.1 looks at the aspects of diagnosis by the BO treatment providers based on their clinical judgment. In almost 90% of cases, the initial diagnosis of burnout is confirmed, and less than 3% of treatment providers consider it necessary to change the diagnosis to "non-burnout". Nearly 70% of cases are confirmed as stage 1 or 2 burnout, while less than 10% are confirmed as stage 3 burnout. In most cases, therefore, the subjects remain within the scope of secondary prevention. Lastly, we see that 70% of cases involve burnout which is primarily linked to work.

Table 12.1: Diagnosis based on clinical judgment after the BOTP.

Confirmation of diagnosis after BOTP (in final report)

	Sector	N	Yes	No
Confirmation of initial diagnosis (RF40OY)	Banking	29	93.10%	6.90%
	Hospital and healthcare	105	87.60%	12.40%
	TOTAL	134	88.80%	11.20%
	Sector	N	Burnout	No burnout
Change of the diagnosis (RF41CM)	Banking	63	98.40%	2%
	Hospital and healthcare	206	97.10%	2.90%
	TOTAL	269	97.40%	2.60%
	Sector	N	Not ticked	Ticked
BO Diagnosis - Early stage (1 or 2) (RF411PA)	Banking	74	33.80%	66.20%
	Hospital and healthcare	238	26.50%	73.50%
	TOTAL	312	28.20%	71.80%
BO Diagnosis - Advanced stage (3) (RF412PA)	Banking	74	89.20%	10.80%
	Hospital and healthcare	238	92.00%	8.00%
	TOTAL	312	91.30%	8.70%
BO Diagnosis - Primarily linked to work (RF413PA)	Banking	74	27.00%	73.00%
	Hospital and healthcare	238	30.70%	69.30%
	Total	312	29.80%	70.20%

In particular, Table 12.2 shows that, in the majority of cases (over 80%), burnout is indeed the main disorder causing the symptoms. In 5% of cases, after treatment, the treatment provider believes that the burnout is the cause of other psychological disorders, and in 12% of cases that the burnout is the consequence of previous difficulties or disorders.

Table 12.2: Revised initial diagnosis

Revised initial diagnosis (RF42CM)	Sector	N	BO main disorder causing the symptoms	BO stems from other psychological disorders	BO the consequence of previous difficulties or disorders
	Banking	51	86.30%	7.80%	5.90%
	Hospital and healthcare	165	81.80%	3.60%	14.50%
	TOTAL	216	82.90%	4.60%	12.50%

Table 12.3 provides information on the evolution of burnout symptoms after the treatment. In over 75% of cases, the diagnosis of burnout is no longer the case for the participant after the treatment. Of the 24% for whom BO is still present, more than 65% are in stage 1 of BO, 24% in stage 2 and less than 10% in stage 3. In almost 95% of cases, the symptoms improved; in almost 80% of cases, other psychological disorders did not appear. Finally, in 93% of cases, the BOTP was suitable for the worker.

Table 12.3: Evolution of the BO

	Sector	N	Yes	No	
BO still present (RF43OY)	Banking	70	32.90%	67.10%	
	Hospital and healthcare	226	20.80%	79.20%	
	TOTAL	296	23.60%	76.40%	
	Sector	N	Stage 1	Stage 2	Stage 3
BO still present - Stage (RF44CM)	Banking	23	65.20%	30.40%	4.30%
	Hospital and healthcare	43	67.40%	20.90%	11.60%
	TOTAL	66	66.70%	24.20%	9.10%
	Sector	N	Yes	No	
Improvement in BO symptoms (RF45OY)	Banking	58	87.90%	12.10%	
	Hospital and healthcare	171	96.50%	3.50%	
	TOTAL	229	94.30%	5.70%	
Emergence of other psychological disorders (RF46OY)	Banking	69	24.60%	75.40%	
	Hospital and healthcare	221	19.90%	80.10%	
	TOTAL	290	21.00%	79.00%	
BOTP suitable for the worker (RF47OY)	Banking	70	90.00%	10.00%	
	Hospital and healthcare	223	94.60%	5.40%	
	TOTAL	293	93.50%	6.50%	

12.1 Treatment continued with the BO treatment provider according to the evolution of the diagnosis and BO symptoms (in the final report (FinR))

Table 12.1.1 shows that 81% of participants who were no longer diagnosed with BO at the end of treatment did not continue treatment with their IBO. Among those who were still diagnosed with BO at the end of the treatment, 35% chose to continue their treatment with their IBO versus 65% who preferred to stop their treatment with their IBO ($\chi^2(1, 294) = 7.37, p = .007$).

Table 12.1.1: BO still present in final report x treatment continued by IBO.

			Treatment continued with IBO		Total
			Yes	No	
BO still present (FinR)	Yes	Effective	24	45	69
		% in BO still present (FinR)	34.8%	65.2%	100.0%
	No	Effective	43	182	225
		% in BO still present (FinR)	19.1%	80.9%	100.0%
Total		Effective	67	227	294
		% in BO still present (FinR)	22.8%	77.2%	100.0%

Table 12.1.2 shows that a higher percentage of participants (66.7%) who continue their treatment with the IBO are those who are still identified as being at stage 3 burnout in the final report after the BOTP. The statistical test is irrelevant, however, because the N of the cells is less than 5.

Table 12.1.2: Stage of BO specified in the final report x treatment continued by BO treatment provider.

			Treatment continued with BO treatment provider		Total
			Yes	No	
Stage of BO specified in FinR	Stage 1	Effective	14	29	43
		% in stage of BO in FinR	32.6%	67.4%	100.0%
	Stage 2	Effective	5	11	16
		% in stage of BO in FinR	31.3%	68.8%	100.0%
	Stage 3	Effective	4	2	6
		% in stage of BO in FinR	66.7%	33.3%	100.0%
Total		Effective	23	42	65
		% in stage of BO in FinR	35.4%	64.6%	100.0%

For the following table, the statistical test is also not significant ($\chi^2(1, 227) = .86, p = \text{NS}$).

For most participants, improvement in BO symptoms was observed, and there was no significant difference in treatment by the IBO depending on whether symptoms improved or not.

Table 12.1.3: Improvement of BO symptoms specified in the final report x treatment continued by BO treatment provider.

			Treatment continued with BO treatment provider		Total
			Yes	No	
Improvement of BO symptoms in FinR	Yes	Effective	57	157	214
		% in Improvement of BO symptoms in FinR	26.6%	73.4%	100.0%
	No	Effective	5	8	13
		% in Improvement of BO symptoms in FinR	38.5%	61.5%	100.0%
Total		Effective	62	165	227
		% in Improvement of BO symptoms in FinR	27.3%	72.7%	100.0%

Table 12.1.4 shows that 34.4% of participants with new psychological disorders continue the follow-up with their IBO, compared with 20% of those with no new psychological difficulties ($\chi^2(1, 288) = 4.65, p = .03$).

Table 12.1.4: Emergence of other difficulties specified in the final report x treatment continued by BO treatment provider.

			Treatment continued with BO treatment provider		Total
			Yes	No	
Emergence of other psychological disorders in the FinR	Yes	Effective	21	40	61
		% in Emergence of other psychological disorders in the FinR	34.4%	65.6%	100.0%
	No	Effective	48	179	227
		% in Emergence of other psychological disorders in the FinR	21.1%	78.9%	100.0%
Total		Effective	69	219	288
		% in Emergence of other psychological disorders in the FinR	24.0%	76.0%	100.0%

12.2 Treatment continued with the individual sessions treatment provider (ISI) according to the evolution of the diagnosis and BO symptoms.

Table 12.2.1 shows that 73% of participants who were no longer diagnosed with BO at the end of treatment did not continue treatment with their ISI. Among those who were still diagnosed with BO at the end of the treatment, 39% chose to continue their treatment with their ISI versus 61% who preferred to stop their treatment with their ISI ($\chi^2(1, 289) = 3.71, p = .05$).

Table 12.2.1: BO still present in final report x treatment continued by the ISI.

			Treatment continued with the ISI		Total
			Yes	No	
BO still present (FinR)	Yes	Effective	26	41	67
		% in BO still present (FinR)	38.8%	61.2%	100.0%
	No	Effective	59	163	222
		% in BO still present (FinR	26.6%	73.4%	100.0%
Total		Effective	67	85	204
		% in BO still present (FinR	22.8%	29.4%	70.6%

Table 12.2.2 shows that a higher percentage of participants (60%) who continue their treatment with the ISI are those who are still identified as stage 3 burnout in the final report after the BOTP. The statistical test is irrelevant because the N of the cells is less than 5.

Table 12.2.2: Stage of BO specified in the final report x treatment continued by the ISI.

			Treatment continued with the ISI		Total
			Yes	No	
Stage of BO specified in FinR	Stage 1	Effective	17	26	43
		% in stage of BO in FinR	39.5%	60.5%	100.0%
	Stage 2	Effective	5	10	15
		% in stage of BO in FinR	33.3%	66.7%	100.0%
	Stage 3	Effective	3	2	5
		% in stage of BO in FinR	60.0%	40.0%	100.0%
Total		Effective	25	38	63
		% in stage of BO in FinR	39.7%	60.3%	100.0%

For the following table, the statistical test is also not significant ($\chi^2(1, 223) = .09, p = \text{NS}$).

For most participants, improvement in BO symptoms was observed, and there was no significant difference in treatment by the ISI depending on whether symptoms improved or not.

Table 12.2.3: Improvement of BO symptoms specified in the final report x treatment continued by the ISI.

			Treatment continued with the ISI		Total
			Yes	No	
Improvement of BO symptoms in FinR	Yes	Effective	72	138	210
		% in Improvement of BO symptoms in FinR	34.3%	65.7%	100.0%
	No	Effective	5	8	13
		% in Improvement of BO symptoms in FinR	38.5%	61.5%	100.0%
Total		Effective	77	146	223
		% in Improvement of BO symptoms in FinR	34.5%	65.5%	100.0%

Table 12.2.4 shows that 48.3% of participants with new psychological difficulties continue the follow-up with their ISI treatment provider, compared with 24% of those with no new psychological difficulties ($\chi^2(1, 284) = 13.43, p < 0.001$).

Table 12.2.4: Emergence of other difficulties specified in the final report x treatment continued by the ISI.

			Treatment continued with the ISI		Total
			Yes	No	
Emergence of other psychological disorders in the FinR	Yes	Effective	29	31	60
		% in Emergence of other psychological disorders in the FinR	48.3%	51.7%	100.0%
	No	Effective	54	170	224
		% in Emergence of other psychological disorders in the FinR	24.1%	75.9%	100.0%
Total		Effective	83	201	284
		% in Emergence of other psychological disorders in the FinR	29.2%	70.8%	100.0%

13. Synthesis and discussion of results

ANNOUNCEMENT OF THE PROJECT, REFERRAL AND DESCRIPTION OF PARTICIPANTS

Most of the participants in the pilot project (85%) were informed by work-related sources (prevention advisors, employer, supervisor, etc.), while around 10-15% were contacted by non-work-related information sources (health care professional, psychologist, etc.). The referrer, as envisaged in the pilot project, was the occupational physician, the prevention advisor for psychosocial aspects (CPAP) or the general physician. The occupational physician was the main information provider and referrer, particularly for Dutch-speaking participants. French-speaking workers were mainly informed and also referred by the CPAP, while the GP referred workers who had been informed about the project by other information sources.

There is little comparative literature on the ideal channels to use to raise awareness of a pilot project on burnout and recruit participants. According to a 2017 review by Ahola et al., workers in five studies had participated in a survey and were offered the treatment because of their high burnout scores. In the three other studies, the participants had contacted an occupational health service, requested rehabilitation, or were admitted following a referral and through the media. Over the past few years, the Fedris pilot project has become known not only via its envisaged professional channels (prevention advisors, leaflets at the workplace, etc.) but also via 'mouth to mouth' (family, burnout healthcare providers). Orientation via three stakeholders/entry points is sufficient and accessible enough to ensure that any worker belonging to the target group can enter the programme.

Most participants in the pilot project were women, with a median age of 44 and a higher level of education. The hospital and healthcare sector is predominantly female, but these characteristics are very similar to those of participants in other burnout intervention studies. In their review of 16 studies Perski et al. (2017) state that the average age of participants ranged from 39.5 to 46, women were overrepresented, and they had a medium to high level of education. In 2018, Dreison et al., in their meta-analysis of 35 years of research on burnout among mental health professionals, display a similar picture. Most participants were female (70.6%), Caucasian (72.7%) and degree holders (59.7%). The most common job categories were nurses (44.1%) and therapists (34.7%). Similar observations can also be found in the 2021 study by De Simone et al. According to the “Vlaamse Werkbaarheidsmonitor”, there is no difference in burnout according to workers' level of education, but there is a difference regarding gender, age and profession: the proportion of workers with burnout symptoms is lower among men, in the under-30 age group, and higher in the education and healthcare sector (Sociaal-Economische Raad van Vlaanderen, 2022).

EFFECTIVENESS OF THE BOTP

The effectiveness of the BO treatment programme on mental health is demonstrated both in terms of burnout levels as in depression, anxiety and stress scores. For all these measures, there was a significant reduction after the treatment. It is also interesting to note that the reductions observed after the treatment remained unchanged 3 to 6 months after the end of the treatment.

Regardless of the moment of the test, the participants from the banking sector have a higher burnout score (BAT) than those from the hospital and healthcare sector. We also see that FR participants have higher depression and stress scores than NL participants. These results are in line with those of the Sciensano 2018 mental health survey (Gisle et al., 2020) according to which the inhabitants of Flanders are in a better mental state than the inhabitants of Brussels and Wallonia, whatever the disorders considered (depression, anxiety, eating disorders or suicidal thoughts). Women also show higher levels of anxiety than men. The same 2018 Sciensano survey (Gisle et al., 2020) also supports these findings, showing that there are gender inequalities in the distribution of mental health disorders examined in the population, with women more often affected than men. According to Mensah (2018), the difference is due to the segregation of men and women in society and different work sectors. Men and women are not exposed to the same levels of stress, because they do not perform the same jobs, they are not considered and treated in the same way in society, and they do not have access to the same working conditions. Finally, for the burnout stage, at the inter-subject level, the depression and anxiety level is lower for participants diagnosed with stage 1 burnout. The self-assessed physical and psychological level of health improves (increases) significantly after treatment. It is also interesting to note that the improvements observed after the treatment remained unchanged 3-6 months after the end of the treatment.

It is difficult to find points of comparison in the literature, given the differences in BO treatment methodologies from one study to another. Ahola et al. (2017) highlight a small number of studies on the effectiveness of the treatment, but above all underline the fact that the methodologies used are heterogeneous. Pijpker et al. (2019) point out that most of these studies only describe in very general terms the methodology of the treatments implemented, which makes comparisons difficult. Nevertheless, we can state that, overall, these positive results are consistent with the scientific literature. For example, Corbière and colleagues (2019) highlight the positive effects of therapy or medical follow-up in their scoping review on the reintegration of workers on sick leave, due to common mental disorders (including stress-related disorders in workers), back into work. The authors also agree that combined treatment (focusing on both the individual and the organisation) have a larger positive impact on burnout, with positive effects that remain unchanged over time. Westermann et al (2014) show that combined (and organisational) interventions have a long-term effect on burnout (of more than a year). Awa et al (2010) concur with this view, pointing out that combined interventions have positive effects on burnout, and that these effects remain unchanged over time. The Fedris programme was initially intended to be a combined programme, in which the participant requests a multidisciplinary meeting to adapt/improve their working conditions. This specific module was only requested by one participant. However, we see that over 60% of participants answered the question about how satisfied they were with the dynamics of the multidisciplinary meeting, suggesting that informal mechanisms have been put in place. It is

possible that the work clinic sessions, in which the BOTP helps the worker to think about solutions regarding his work and prepares the worker to discuss his working conditions with the relevant prevention or company actors, have stimulated active but informal steps by the participants in this direction.

We also assessed the effectiveness of the treatment in terms of improvements in general well-being, well-being at work, the ease of performing tasks, sleep, quality of life and work-life balance. On average, the participants agreed or strongly agreed that these aspects had improved following their BOTP. These positive results remained unchanged between post-test 1 and post-test 2, i.e. between 3 and 6 months after the end of the BOTP. Regardless of when the test took place, the participants over 55 stated that they 'Agree' that quality of life had improved more than the 35-55 group. These results are in line with the findings of the EUROFOUND 2015 survey (p.188), where we see that the older the respondent, the more negative they feel the impact of work on their health, except for workers over 55 who are still active. According to the authors, this can be explained by the 'healthy worker effect', the idea that older workers who are still active are the ones who benefit from positive working conditions and do not feel much of an impact of their working conditions on their health. Clearly, reflections on policies for age management need to continue within working environments. In addition, the 7 participants on fixed-term contracts (CDD), all from the healthcare sector, reported a bigger improvement in their general well-being, their well-being at work, and the ease with which they performed their tasks, compared to participants on indefinite or statutory contracts. This result could be explained by the fact that participants on fixed-term contracts and suffering from work-related complaints find it easier and less legally constrained than those on indefinite/statutory contracts to leave their working environment, rather than trying to negotiate an adaptation of their working conditions.

In conclusion, these results concur with Maslach and Leiter's (2016) finding that interventions to reduce the demands at work combined with improvements in recovery strategies (through better sleep, physical exercise, and healthy diet) have a direct effect on fatigue related to burnout. Combining a reflection on the realities of work (work clinic sessions) with psycho-education sessions could partly explain the results observed.

HEALTHCARE CONSUMPTION

The improvements reported by the participants after the treatment, both in terms of general well-being and sleep, quality of life and work-life balance (see above), are reflected in their healthcare consumption. The number of consultations with the various healthcare professionals during and after the treatment is lower than the number of contacts prior to the treatment. The same applies to the number of medical examinations and medication taken (except for antidepressants). Before the treatment, over 80% consulted their GP, and over 50% consulted their occupational physician and/or a specialist. After the treatment, this number falls considerably: 34.5% for the GP, 21.2% for the occupational physician and 26.2% for another healthcare professional. These data are not unexpected or exceptional, as the worker initially feels burnt out and presents various health problems for which they are looking for a cause and/or treatment. Medical examinations (primarily blood tests and imaging) are performed to establish a differential diagnosis. Participants who are unfit for work seek a consultation more than those who are still working: this first group may be affected by more and more serious complaints, but they also need a sick note (in the context of a legitimate absence) and have to visit a doctor in this regard. In addition to GPs, the most frequently consulted healthcare professionals are psychologists, physiotherapists, coaches and psychiatrists. During the BOTP, Fedris effectively works in collaboration with psychologists and physicians, as sources of support for victims of burnout, and with physiotherapists, as individual sources of support.

No differences in healthcare consumption were observed according to sector, gender or burnout stage.

There is, however, an important difference between French-speaking and Dutch-speaking participants: French-speakers use more health services and take more medication, especially tranquilizers. This difference is in line with the results of the Sciensano 2018 survey on mental health in the Flemish Region, Brussels, and the Walloon Region, discussed above (Gisle et al., 2020). Older workers (>45) also consult GPs more often and take more medication. Indeed, with age, there is more risk of chronic disease, and medication is often necessary.

In the epidemiological study of Swiss healthcare providers treating burnout patients (Plys et al., 2022), only 14.6% used biological analyses or measurements to refine their "diagnosis", such as salivary or blood cortisol (19.5%), inflammatory markers (43.7%) and heart rate variability (35.5%).

The main forms of therapy prescribed were sick leave (80.2%), medication (67.9%) and less work (49.8%). The most frequently prescribed medication were antidepressants, followed by tranquilizers and sleeping pills. However, in the discussion section, it was mentioned that instead of therapy with medication, it would be preferable to prescribe another type of therapy or a combined therapy (e.g. psychological therapy, psycho-education, relaxation, etc.), but that there are waiting times to see psychologists and that people on low incomes cannot afford these sessions, with the result that medication is an "easy" solution. On average, absenteeism, or cumulative absenteeism due to burnout was around 5 months.

The EBM Practice Net burnout guidelines (originally based on a Finnish Duodecim guideline and adapted to the Belgian healthcare context in 2017) and the Royal Dutch Medical Association (2018) recommend prescribing sick leave of 2 to 3 weeks in cases of severe fatigue. Since fatigue and exhaustion are at the heart of the problem, and functional ability is impaired, it is necessary to grant the worker rest time. During this period, the intention is for the worker to be able to rest, but not to be left alone. Activating and supportive treatment is then needed to structure the problems and seek solutions, in collaboration with the worker/patient and his environment. Resuming activities such as work makes sense if the worker/patient has specific solutions at his disposal. Normally, the worker/patient will be able to resume his function within 3 months. If the worker still feels unable to work after 4-6 weeks, further support is necessary, as well as referral to other specialists.

The use of medication by participants in the pilot project is inconsistent with the above-mentioned guidelines, in which medication for burnout is not recommended, as it has not been demonstrated that medication is effective in treating burnout. However, during the first period of absence from work due to psychological complaints, and in cases of severe sleep problems, benzodiazepines (sleeping pills) may be used briefly to treat sleep problems and restlessness, and symptomatic medication to treat functional physical complaints such as pain and gastrointestinal problems.

In contrast to the Netherlands and Belgium, the Swiss Expert Network on Burnout (SEB) recommends medication in its treatment guidelines (Hochstrassera et al., 2016). This is primarily antidepressants to treat comorbid depression, and sedatives to allow the patient to sleep again.

PARTICIPANTS' SATISFACTION WITH THE BOTP

As regards the logistical aspects of the BOTP, a very high percentage of participants are satisfied or very satisfied with the proximity, ease of access and adaptability of the location of the treatment. Given that almost 90% of participants were treated by one or two BO treatment providers, we can see that a very high percentage of participants are satisfied or very satisfied with the logistical aspects of the services provided by their treatment, in terms of ease of making appointments, flexibility of time slots, punctuality and coordination of the BOTP. For the most part, the participants are satisfied or very satisfied with the sessions they had with.

Regarding the content of the BOTP, over 90% of participants were satisfied or very satisfied with the number of sessions, the variety of the sessions on offer, the modularity or level of personalisation of the treatment on offer, and the duration of the treatment programme. As regards the information given about the BOTP, more than 95% were satisfied or very satisfied with the explanations given by the BO treatment provider, compared with almost 90% for those given by Fedris. Finally, with regard to the dynamics of the multidisciplinary meeting, overall, nearly 80% of participants were satisfied or very satisfied.

In 80% of cases, a psychologist was the only person involved in the participant's treatment. Their work was combined with that of a physiotherapist or physician in 16% and 2% of cases respectively. More than 80% of participants are satisfied or very satisfied with the possibility of being treated by several healthcare professionals.

Nearly 75% of participants gave their overall evaluation of the treatment programme a score of more than 8 out of 10 (this rises to nearly 90% for scores of over 7 out of 10). The average overall evaluation was 8.01 out of 10 (with a standard deviation of 1.79). There was no significant difference in the overall evaluation of the treatment according to the number of BO treatment providers involved in the BOTP. Almost 95% of participants would recommend this BOTP treatment to others. Just over 75% of participants did not feel the need to continue the follow-up with their BO treatment provider or individual session treatment provider.

PERCEPTION OF THE CURRENT SITUATION (POST-TEST 1)

Regarding the organisation of work, we see that nearly 60% of participants felt that the company had not become aware of the problem at the collective level; nearly 80% felt that there had been no change in the approach of management; nearly 65% felt that there had been no further action to promote well-being; over 75% felt that there had been no further material support. Our results are therefore more mixed when it comes to actions linked to work organisation. Nevertheless, the literature underlines the positive role of actions on the organisation in tackling burnout. Studies by Kärkkäinen et al (2017, 2018a, 2018b) show that adapting the workplace is beneficial. In the scoping review by Corbière et al. (2019) on reintegration into work after sick leave for stress-related disorders, most articles suggest that the necessary resources (material and human) need to be deployed. At Belgian level, advice no. 2330 of the “Conseil National du Travail (CNT)”

(<https://cnt-nar.be/fr/dossiers-thematiques/burnout>) concerning pilot projects for the primary prevention of burnout (initiated in the context of the implementation of the 2017-2018 inter-professional agreement and in close cooperation with the FPS Employment) stresses (freely translated) "how important it is, alongside treatments focusing on individual resources for coping with difficult work situations, to work on changing the organisational context and circumstances". The CNT confirms the following principles as good practice for the primary prevention of burnout: (1) a broad, multi-disciplinary approach, focused on both the individual and the organisation, (2) the need for a participative approach supported by both employer/management and workers, (3) an approach supported by consultative bodies in accordance with their respective competences, (4) an approach structurally integrated into the organisation's longer-term strategic policy. According to these principles, organisations need to be made more aware of and encouraged to think about primary prevention, and to question and improve the work organisation, content of the job, living conditions at work, working conditions, interpersonal relationships at work.

In addition, papers emphasise that the employer or HR must organise changes to the work, and make sure these are implemented. However, Bastien and Corbière (2019) explain that managers tend above all to focus on strictly work-related aspects (working hours and adapting tasks) rather than on actions aimed at reducing psychosocial risks (stress, conflicts, lack of social support, etc.). It would therefore be useful for the CPAP to provide follow-up after the treatment, by advising management on specific psychosocial risk treatments.

The "Multidisciplinary meeting" module of our BOTP was not requested by the participants, but almost 80% of participants were satisfied or very satisfied with the dynamics of this meeting. It is therefore likely that the discussions on adapting or modifying the participant's working environment with prevention advisors or company representatives took place informally, without taking up Fedris' offer for a multidisciplinary meeting without anonymity.

This is in line with the finding of Pijpker et al. (2019) whereby, in a systemic review of the literature on combined treatments to reduce burnout and promote work resumption, employee involvement in decision-making, improved job control and social support, and reduced stressors, explain the effectiveness of these interventions.

In terms of relations with management, opinions are divided. Between 45 and 50% of participants believe that there has been no improvement, while the remaining participants report an improvement. Opinions are more positive when it comes to relationships with colleagues, with almost 75% of participants perceiving an improvement in these relationships. According to Hämmig (2017), lack of support from the supervisor is a risk factor for well-being at work. Etuknwa (2019) and de Vries et al. (2017) stress the importance of support from colleagues and the supervisor when reintegrating back into work. A German study on reintegration back into work after a crisis (Schroder et al., 2022) conducted by BAuA, an institution like Fedris, goes even further. One of the conclusions is that (freely translated) "all the people surveyed most probably receive social support from colleagues, a little less from their supervisors and even less from the company", which is consistent with our results. The study goes further, highlighting that people with knowledge-based coping strategies benefit more from, and view positively, the social support

of colleagues and superiors than those who come back to work with other coping strategies. This highlights the importance and differentiated impact of individual coaching in maximising the contribution of organisational resources.

On the one hand, these results suggest that we need to think about how to raise awareness of these issues and provide more training for direct supervisors. In this regard, reference can be made to the competency framework on managerial skills relating to psychosocial risks by Yarker et al. (2008, see also FPS Employment, Labour and Social Dialogue 2017). On the other hand, it will be recommendable to offer follow-up by the CPAP during or after the end of the BOTP, to optimise the intervention for the psychosocial risks identified.

When it comes to their own relationship with work, over 65% of participants approve of the fact that they perceive more positive aspects in their work, almost 90% also approve of the fact that they have stepped back from work, and over 80% finally agree with the fact that they now have more realistic work expectations. These positive results are also supported by the literature. Several studies, including those by Karkkainen et al. (2017) and Gragnano et al. (2017), point to the fact that a positive relationship with work seems to be conducive to work resumption. In a meta-analysis, Etuknwa et al (2019) argue that a positive attitude towards work facilitates sustainable reintegration. Conversely, de Vries et al (2017) report that a poor relationship with work is detrimental.

Stegmann et al (2021), again in the study carried out by BAuA in Germany, go further by integrating personal resources as a lever to stimulate successful work resumption. In the view of these authors, overall, the return to work can be understood as a coherent, ongoing process. A successful and sustainable return to work can be described as a process based on resources. In this study, self-efficacy appears to be a central resource during the return to work. Workers make a successful return to work if they actively seek help and adopt an open-minded attitude towards cooperation, applying positive interaction (prosocial coping). The results of the study also show that people who focus their coping strategy on knowledge more often achieve a high level of work and performance after six months and have a better long-term outcome than other adaptation strategies.

EMPLOYMENT AND ADJUSTMENT OF WORKSTATIONS

Prior to the start of the BOTP, only 45% of participants were at work and just under half of them were working part-time. Employment increased after the BOTP to around 80%, but half of those concerned - particularly women - are still only working part-time. These positive results of increased being at work are in line with other studies (Pijpker et al., 2019; Perski et al., 2017; Ahola et al., 2017). However, not all studies report an increase in employment, and these results may be explained by differences in the duration and intensity of the interventions, the populations studied, the follow-up period, and so on.

Around 88% of participants remained employed by the same employer, and just over 70% stayed in the same job. The employer made adjustments in only 30% of cases, mainly for older workers (>45 years). Most of these were adjustments to the working hours and transfers of workers to other departments.

45% of workers also took action themselves, in particular after being referred by their occupational physician or CPAP. As was the case for the successful treatments described in the review by Perski et al. (2017), these participants received targeted advice through contact with the prevention advisor(s) and, by following a BO treatment programme, acquired the necessary skills to engage in dialogue on this topic with their employer/hierarchical superior or colleagues. A reduction in working hours and a different function were implemented in most situations. Changes were also made in their style of coping, resilience and behaviour, and these workers set boundaries, both in terms of the content of all their tasks, and their working hours.

Although the changes made by the employer on the one hand, and by the worker on the other, have a beneficial impact on employment and work resumption, they are not yet sufficient to have a widespread and lasting impact, according to the scientific literature. As described in the section above, a participative and preventive well-being policy needs to be pursued, focusing on individual and organisational interventions.

CHARACTERISTICS OF THE BOTP

On average, the total number of sessions was 12.41 (12.81 in the banking sector and 12.29 in the hospital and care sector), with an average of 3.69 work clinic sessions; 2.45 psycho-education sessions (starter kit); 4.35 individual sessions; 1.32 follow-up sessions and 0.46 reorientation sessions. The BOTP therefore includes just over 6 sessions on average with the BO treatment provider, and almost 4 sessions with their individual sessions treatment provider for a body-psychological or cognitive-emotional approach. Between 2 and 3 psycho-education sessions are also requested. Very few sessions were cancelled. Nearly 74% of participants followed a complete treatment programme, while only 26% interrupted.

It is interesting to note the variety in terms of the sequencing of the different types of sessions proposed. Nevertheless, the first session is mainly a work clinic session (in over 80% of cases) or a psycho-education session. The final session is, logically, a follow-up session in nearly 60% of cases.

Most work clinic sessions and individual sessions were organised on an individual basis, which is logical and was expected by the project team. As regards the psycho-education sessions (starter kit), the choice of group sessions was made in 27% of cases in the banking sector, compared with 12% of cases in the hospital and care sector. This seems justified insofar as the content of the psycho-education sessions is ideal for group sessions.

DIAGNOSTIC ASPECTS AND RELEVANCE OF THE TREATMENT PROGRAMME (based on data from the IBO's final report)

After the treatment, in almost 90% of cases, the initial diagnosis of burnout is confirmed, and less than 3% of BO treatment provider consider it necessary to update the diagnosis to "non-burnout". Nearly 70% of cases are confirmed as stage 1 or 2 burnout, while less than 10% are confirmed as stage 3 burnout. In most cases, therefore, the subjects remain within the scope of secondary prevention. Lastly, we see that 70% of cases involve burnout which is primarily linked to work.

In most cases (over 80%), burnout is indeed the main disorder causing the symptoms. In 5% of cases, after treatment, the BO treatment provider believes that the burnout is the cause of other psychological complaints, and in 12% of cases that the burnout is the consequence of previous difficulties or disorders.

As regards the evolution of the burnout symptoms after the treatment, in over 75% of cases, the diagnosis of burnout is no longer relevant for the participant. Of the 24% for whom BO is still present, more than 65% are in stage 1 of BO, 24% in stage 2 and less than 10% in stage 3. In almost 95% of cases, the symptoms improved; and, in almost 80% of cases, other psychological disorders did not appear. Finally, in 93% of cases, the BOTP was suitable for the worker.

The fact that workers suffering from burnout are at work is also found in other studies. According to Ahola et al (2017), burnout is not a stable phenomenon; it diminishes over time and most patients can carry on working. In the context of going back to work and reintegrating, it is not necessary for workers to be 100% fit to return to work. Various studies in the field of work psychology (Schaufeli & Bakker, 2013) have shown that employment contributes to health. Work acts as a 'medicine' and is even referred to as 'occupational therapy'. This can be linked to the fact that the individual plays an active role and makes a useful contribution to society, which has a positive impact on self-esteem.

Finally, our analysis of the results leads us to conclude that the effectiveness of the BOTP of this pilot project has been proven, with a focus on the need to address the aspects that make it possible to maximise the likelihood of an evolution/adaptation of working conditions. We can also conclude that all the modules within this treatment are beneficial. This is consistent with the findings of Maslach and Leiter (2016), in whose view the most widespread recommendations for the treatment and prevention of burnout include the following: (1) Change the work pattern (work less, take more breaks. etc.), (2) Develop coping strategies (conflict resolution, time management, etc.), (3) Get social support (from colleagues and family), (4) Use relaxation techniques, (5) Promote good health and (6) Develop better self-understanding (via therapy, self-analytical techniques, etc.). The pilot project as it was designed allows to encompass these various recommendations.

14. STRENGTHS AND WEAKNESSES

Most studies on the prevention and treatment of burnout are small-scale, with short follow-up periods. This longitudinal pilot project follows a large sample of 'hundreds' of workers over a long period. The results presented here involve 223 participants from whom data were collected at three points in time. i.e. before the start of the BOTP (pre-test), just after the BOTP (which lasts a maximum of 9 months, post-test 1) and three to six months after the BOTP (post-test 2). At these three measurement points, indicators of burnout, stress, depression and anxiety were studied using validated questionnaires (e.g. OLBI, DASS and BAT), as well as data on work capacity/incapacity, adaptations to work, and healthcare consumption. Immediately after the treatment, the participants and stakeholders (BO treatment providers, prevention advisors. etc.) were also questioned about their satisfaction with the proposed BOTP, in terms of content, number of sessions, practical organisation, etc. In addition to online data collection, clinical evaluations are carried out and reports drafted by IBO. These IBO must meet specific criteria, both in terms of training and experience with burnout patients.

The proposed BOTP is based on a review of the scientific literature and interviews with experts. The programme includes both targeted individual treatments and intervention focused on the organisation, to the extent that a combined approach produces the best results. One of the limitations of the pilot project is that the organisational intervention- the multidisciplinary meeting - almost did not take place. Nevertheless, from the data collected, it can be deduced that interventions focused on the organisation took place informally during the pilot project.

There may have been selection bias, given that Fedris put forward and funded the programme. Workers who do not want their employer, colleagues or prevention advisors to know about their state of health (burnout) do not take part in the project and/or meeting and look for support outside of work and the programme.

Other limitations include the fact that only workers from the banking and hospital/healthcare sectors were included in the pilot project. The question of whether the BOTP also has positive effects on burnout and employment in other sectors needs further study. The last data collection took place three to six months after the treatment, but to confirm any lasting effect, additional follow-up measures are needed, for example after one year, two years, etc.

The pilot project focused on the secondary prevention of burnout, i.e. workers in the early stages of burnout who are still at work, or who are only recently on sick leave (max. 2 months). The question of whether the BOTP is effective for people with more severe symptoms, or who are off sick for longer periods (tertiary prevention) needs to be studied separately. The natural evolution of burnout is not entirely understood, and the symptoms may spontaneously disappear. As there is no control group, we cannot make any assertions in this regard.

The project started in January 2019: the world and the workers were faced with the COVID-19 pandemic from March 2020. Many people developed physical and mental health problems. The BOTP was extended to include a COVID crisis module, but only 4 out of 223 people took part in these additional sessions. This number is too low to be able to make any relevant assertions.

15. RECOMMENDATIONS

- Due to the difference in information providers and referrers between the two national languages, it is crucial to continue informing workers and healthcare providers through other channels, in order to increase participation in the project. Men and women, in all three national languages, from all age groups and levels of education, should have the opportunity to participate in the BOTP. A continued appeal and awareness campaign is called for, as recently-graduated healthcare professionals and workers entering the job market are unlikely to be aware of the project, or not sufficiently aware.
- The present way of access to the BOTP should be continued, as the system in stages works effectively: first referral by the occupational physician, CPAP or GP, followed by a clinical diagnosis with the psychologist (via case history, questionnaires, and exclusion of other causes). The question is whether the third stage (verification of the diagnosis and stage of burnout by Fedris psychologists) should also be continued. This additional inspection/verification creates extra workload for the personnel at Fedris, but as it is currently difficult to establish clear objective criteria for diagnosing burnout, this third step remains necessary.

- The effectiveness of the BOTP was verified, with mixed confirmation of effects both in terms of self-reported levels of psychological and physical health or perceived improvements, and in terms of more objective variables such as healthcare and medication consumption, or changes in the participants' employment situation. We also see that the effects remain unchanged over time, and that participants are highly satisfied with the organisation and content of the treatment programme, the fact that they have changed their own relationship with work, and so on. These results suggest that the target population should be broadened, and a prevention programme should be implemented. A major challenge for Fedris will therefore be to define the methodology for recording occupational exposure, and to target the beneficiaries of such a programme.
- That being the case, we observe a less positive result in terms of the impact on the organisation of work. The opinions of participants are more mixed on this subject, or at least show significant inter-individual variability in levels of satisfaction. This observation highlights the importance of primary prevention, but also of raising awareness within organisations and among managers. What is really needed is an integrated approach: primary, secondary and tertiary prevention.
- As a reminder, the average total number of sessions is 12.41. More interestingly, 187 participants (83.9%) took part in between 8 to 18 sessions. In addition, the average number of sessions per module of the BOTP was 3.69 work clinic sessions (IBO); 2.45 psycho-education sessions (starter kit) (IBO or ISI); 4.35 individual sessions; 1.32 follow-up sessions (IBO) and 0.46 reorientation sessions (IBO). The average BOTP therefore includes just over 6 sessions with the IBO and almost 4 sessions with the ISI for a body-psychological or cognitive-emotional approach. Between 2 and 3 psycho-education sessions are also requested. These analyses lead to the following proposition. Bearing in mind that in psychotherapy, the patient tends to end the therapy when the gains reach a sufficient level (Stiles et al., 2015), we suggest a flexible approach according to the participant's needs for BOTP, based on a maximum of 18 sessions to be chosen from the range below:
 - Maximum 2 diagnosis sessions (+ if necessary, a debriefing or reorientation session in the event of refusal of the Fedris BOTP).
 - Maximum 4 work clinic sessions.
 - Maximum 3 Starter Kit sessions.
 - Maximum 7 individual sessions.
 - Maximum 2 reorientation sessions.
 - Maximum 2 follow-up sessions.

From the statistics for the pilot project (Annex 17.9), we see that the 2 reorientation sessions are only used by 21.1% of participants, with most not using them (72.2%). These sessions are nevertheless useful for some participants when alternatives to employment need to be considered. Most participants in the early stages of burnout are more interested in finding a solution to remain in their own jobs.

Furthermore, the statistics for the pilot project (Annex 17.9) show that the 2 follow-up sessions were only used by 58.7% of the participants (the others did not use them or only used one session). These follow-up sessions, and any consultation with the occupational physician, are important because after the treatment, 80% of participants are still at work, albeit mostly on a part-time basis, even after 3-6 months. These follow-up sessions could be useful in facilitating a return to full-time work. We also know that 23.6% of participants remain diagnosed with burnout after the BOTP (66.7% of them in stage 1 burnout). Overall, their burnout symptoms have diminished, but in some ways, they are still not 100% fit, and follow-up sessions could be useful in thinking about sustainable staying in work for the long term. To achieve this, the actions to be implemented are often devised in conjunction with the BO treatment provider, but also decided in consultation with the employee, the occupational physician and the various actors in the workplace.

- Our BOTP was designed for secondary prevention, i.e. for workers in the early stages of burnout, still at work or absent for less than 2 months. This raises the question of its relevance to tertiary prevention. For this type of prevention, the EBM recommends a slightly different time frame, with a rest phase at the start of the treatment programme, to allow the person to rest and recuperate. For tertiary prevention, it would also be necessary to focus more energy on preparing the individual for a return to work, reintegration and the quality of the return to work.
- The 'formal' multidisciplinary meeting was not requested by the participants. However, we see that over 60% of participants answered the question about how satisfied they were with the dynamics of the multidisciplinary meeting, suggesting that informal mechanisms have been put in place. The question is whether the fact there is no anonymity is the only reason for this reluctance. The formal nature of this approach, with the involvement of many prevention and company actors, is clearly also a factor. A less formal approach could be proposed, as this is considered less 'revealing': no 'official meeting' but rather a spontaneous conversation, a consultation with just 1 or 2 people chosen by the participant, and then a broadening if the participant so requests. The BOTP as envisaged was based on the importance of a mixed approach. Here, we can consider that the mixed approach has been put in place if we accept that the work clinic sessions question the work and prompt reflection on a possible adaptation or reorganisation of the working conditions. It is possible that the work clinic sessions, in which the burnout treatment provider helps the worker to think about solutions based on his work and prepares the worker to discuss his working conditions with the relevant prevention or company actors, have stimulated active but informal steps by the participants in this direction.

- It is also necessary to continue collecting data, and to conduct and publish statistical analyses of current (and future) data. We have a data file of over 1,000 variables that could be the subject of specific studies. For, example, we suggest studies on the symptoms of burnout, an in-depth study of the specific aspect of certain BOTP modules on our outcomes (mental and physical health, perceived improvements, consumption of medical care. etc.) or even the psycho-social aspects that have the most impact on these same outcomes. In addition to statistics, it would also be interesting to conduct qualitative research on the analysis of the practices of BO treatment providers and individual session treatment providers, in terms of both diagnosis and intervention techniques, through the diagnostic report and final report respectively requested from these health professionals.

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17. Annexes

17.1 Annex to point 1 "Descriptive variables".

Measurement times response at the	N	%
Pre-test	581	46.7
Pre-test + Post-test 1	89	7.2
Pre-test + Post-test 1 + Post-test 2	223	17.9
Other	350	28.2
TOTAL	1243	100

Sample 3 measurement times (N = 223)

Sector of activity	N	%
Banking sector	49	22
Hospital and healthcare sector	174	78
TOTAL	223	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Gender	Women	28	57.1	151	86.8	179	80.3
	Men	21	42.9	23	13.2	44	19.7
TOTAL		49	100	174	100	223	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Language	French	16	32.7	53	30.5	69	30.9
	Dutch	33	67.3	121	69.5	154	69.1
TOTAL		49	100	174	100	223	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
AGE	Under 35	4	8.2	44	25.3	48	21.5
	Between 35 and 45	14	28.6	55	31.6	69	30.9
	Between 46 and 55	24	49.0	50	28.7	74	33.2
	Over 55	7	14.3	25	14.4	32	14.3
TOTAL		49	100	174	100	223	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Province	Antwerp	1	2.0	32	18.4	33	14.8
	Flemish Brabant	0	0	29	16.7	29	13.0
	Walloon Brabant	0	0	7	4.0	7	3.1
	Brussels-Capital	40	81.6	7	4.0	47	21.1
	West Flanders	1	2.0	21	12.1	22	9.9
	East Flanders	5	10.2	19	10.9	24	10.8
	Hainaut	0	0.0	6	3.4	6	2.7
	Liège	0	0.0	5	2.9	5	2.2
	Limburg	1	2.0	18	10.3	19	8.5
	Namur	1	2.0	30	17.2	31	13.9
TOTAL		49	100	174	100	223	100

Sample who participated in pre-test and post-test 1 (N = 312)

Sector of activity	N	%
Banking sector	74	23.7
Hospital and healthcare sector	238	76.3
TOTAL	312	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Gender	Women	43	58.1	205	86.1	248	79.5
	Men	31	41.9	33	13.9	64	20.5
TOTAL		74	100	238	100	312	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Language	French	26	35.1	73	30.7	99	31.7
	Dutch	48	64.9	165	69.3	213	68.3
TOTAL		74	100	238	100	312	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
AGE	Under 35	8	10.8	60	25.2	68	21.8
	Between 35 and 45	19	25.7	73	30.7	92	29.5
	Between 46 and 55	36	48.6	70	29.4	106	34.0
	Over 55	11	14.9	35	14.7	46	14.7
TOTAL		74	100	238	100	312	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Province	Antwerp	3	4.1	42	17.6	45	14.4
	Flemish Brabant	0	0	41	17.2	41	13.1
	Walloon Brabant	0	0	7	2.9	7	2.2
	Brussels-Capital	63	85.1	13	5.5	76	24.4
	West Flanders	1	1.4	29	12.2	30	9.6
	East Flanders	5	6.8	26	10.9	31	9.9
	Hainaut	0	0	7	2.9	7	2.2
	Liège	0	0	6	2.5	6	1.9
	Limburg	1	1.4	25	10.5	26	8.3
	Namur	1	1.4	42	17.6	43	13.8
TOTAL		74	100	238	100	312	100

Sample who participated in at least the pre-test (N = 893)

Sector of activity	N	%
Banking sector	220	24.6
Hospital and healthcare sector	673	75.4
TOTAL	893	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Gender	Women	140	63.6	593	88.1	733	82.1
	Men	80	36.4	80	11.9	160	17.9
TOTAL		220	100	673	100	893	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Language	French	65	29.5	201	29.9	266	29.8
	Dutch	155	70.5	472	70.1	627	70.2
TOTAL		220	100	673	100	893	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
AGE	Under 35	20	9.1	169	25.1	189	21.2
	Between 35 and 45	64	29.1	232	34.5	296	33.1
	Between 46 and 55	98	44.5	190	28.2	288	32.3
	Over 55	38	17.3	82	12.2	120	13.4
TOTAL		220	100	673	100	893	100

		Sector				TOTAL	
		Banking sector		Hospital and healthcare sector			
		N	%	N	%	N	%
Province	Antwerp	7	3.2	93	13.8	100	11.2
	Flemish Brabant	6	2.7	122	18.1	128	14.3
	Walloon Brabant	0	0	17	2.5	17	1.9
	Brussels-Capital	180	81.8	35	5.2	215	24.1
	West Flanders	4	1.8	58	8.6	62	6.9
	East Flanders	20	9.1	98	14.6	118	13.2
	Hainaut	0	0	19	2.8	19	2.1
	Liège	0	0	22	3.3	22	2.5
	Limburg	2	0.9	91	13.5	93	10.4
	Luxembourg	0	0	1	0.1	1	0.1
	Namur	1	0.5	117	17.4	118	13.2
TOTAL		220	100	673	100	893	100

Working status according to diploma

			PRE – Working Status					Total
			Full-time	Part-time	Career break	Sick leave	Other	
PRE - Level of education	Higher secondary	N	2	3	0	16	2	23
	General higher secondary	N	2	2	0	2	1	7
	Graduate/Bachelor	N	30	33	1	74	3	141
	Bachelor's/Master's	N	17	9	0	22	0	48
	PhD	N	2	1	0	1	0	4
Total			53	48	1	115	6	223

17.2 Annex for point 2 "Information provider and referrer"

Socio-demographic and professional characteristics of participants by type of referrer (N = 223)

		Referrer							
		CPAP		Occupational physician		GP		Total	
		N	%	N	%	N	%	N	%
Gender (p = 0.119)	Men	11	22.4	15	14.2	18	26.5	44	19.7
	Women	38	77.6	91	85.8	50	73.5	179	80.3
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Education (p=0.845)	Lower secondary education	0	0	3	2.8	0	0	3	1.3
	Higher secondary TBK	6	12.2	9	8.5	5	7.4	20	9
	General higher secondary education	0	0	6	5.7	1	1.5	7	3.1
	Graduate/Bacalaureat	32	65.3	69	65.1	40	58.8	141	63.2
	Bachelor's / Master's degree	10	20.4	18	17.0	20	29.4	48	21.5
	PhD	1	2	1	0.9	2	2.9	4	1.8
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Sector (p<0.001)	Hospital sector	40	81.6	92	86.6	42	62.1	174	78.3
	Banking sector	9	18.4	14	13.2	26	37.9	49	21.7
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Language (p < .001)	French	30	61.2	13	12.3	26	38.2	69	30.9
	Dutch	19	38.8	93	87.7	42	61.8	154	69.1
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Age (p = .381)	≤ 45 years	30	61.2	53	50.0	34	50.0	117	52.5
	> 45 years	19	38.8	53	50.0	34	50.0	106	47.5
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Type of contract (p = .711)	Fixed-term	1	2	3	2.8	3	4.4	7	3.1
	Indefinite-term	45	91.8	95	89.6	63	92.6	203	91.0
	Statutory	3	6.1	8	7.5	2	2.9	12	5.8
	Total	49	100.0	106	100.0	68	100.0	223	100.0

Seniority ($p = .252$)	0 - 1 year	5		6		4		15	
	1.5 - 5 years	10		28		20		58	
	6 - 10 years	8		22		10		40	
	11 - 20 years	20		22		20		62	
	21 - 30 years	4		19		6		29	
	31 - 40 years	2		9		8		19	
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Working hours ($p = .438$)	Fixed	21	42.9	50	47.2	37	54.4	108	48.4
	Variable	28	57.1	56	52.8	31	45.6	115	51.6
	Total	49	100.0	106	100.0	68	100.0	223	100.0
Day / night ($p = .242$)	Day	36	73.5	79	75.2	55	80.9	170	76.6
	Night	2	4.1	0	0	2	2.9	4	1.8
	Day and night	11	22.4	26	24.8	11	16.2	48	21.6
	Total	49	100.0	105	100.0	68	100.0	223	100.0
Stage of burnout ($p = .899$)	1	13	27.1	21	21.4	14	22.2	48	23.0
	2	28	58.3	66	67.3	43	68.3	137	65.5
	3-4	7	14.6	11	11.2	6	9.5	24	11.5
	Total	48	100.0	98	100.0	24	100.0	209	100.0
Employment ($p = .140$)	Full-time	16	32.7	25	23.6	12	17.6	53	23.8
	Part-time	10	20.4	27	25.5	11	16.2	48	21.5
	Sickness	21	42.9	49	46.2	45	66.2	115	51.6
	Career break	0	0	1	0.9	0	0	1	0.4
	Other	2	4.1	4	3.8	0	0	6	2.7
	Total	49	100.0	106	100.0	68	100.0	223	100.0

17.3 Annex for point 3 "Efficiency of the mental health treatment programme"

Repeated measure analyses of variance (3 measurement times) differentiated by age, language, gender, type of contract and burnout stage.

Mental health X Age

	Age (years) (PRE_SD6 _RECOD)	Average Pre-test	Average Post-test1	Average Post-test2	Effects test	<i>F</i> (ddl)	P	Sign.
Burnout (OLBI)	under 35	63.37	51.50	51.70	Intra- subject	99.57 (1.81; 257.16)	<i>p</i> < .001	***
	35 – 45	61.96	52.39	50.87				
	46 – 55	63.35	52.98	53.16	Inter- subject	0.99 (3; 142)	<i>p</i> = .398	/
	over 55	63.03	55.99	55.74				
	TOTAL	62.86	52.84	52.42				
Burnout (BAT)	under 35	3.27	2.52	2.42	Intra- subject	83.80 (1.66; 121.26)	<i>p</i> < .001	***
	35 – 45	3.36	2.52	2.51				
	46 – 55	3.16	2.46	2.33	Inter- subject	0.690 (3; 73)	<i>p</i> = .561	/
	over 55	3.56	2.66	2.54				
	TOTAL	3.29	2.51	2.43				
Depression (DASS)	under 35	21.63	8.41	9.71	Intra- subject	134.12 (1.82; 393.69)	<i>p</i> < .001	***
	35 – 45	21.41	11.48	11.27				
	46 – 55	18.70	9.91	9.80	Inter- subject	0.867 (3 ; 216)	<i>p</i> = .459	/
	over 55	20.00	9.24	8.34				
	TOTAL	20.36	9.97	10.05				
Anxiety (DASS)	under 35	18.00	7.92	8.37	Intra- subject	110.21 (1.81 ; 393.87)	<i>p</i> < .001	***
	35 – 45	19.35	10.50	9.86				
	46 – 55	15.27	8.12	8.45	Inter- subject	2.450 (3 ; 218)	<i>p</i> = .065	/
	over 55	15.93	6.20	6.67				
	TOTAL	17.21	8.54	8.62				
Stress (DASS)	under 35	27.58	14.21	14.67	Intra- subject	159.48 (1.91 ; 412.69)	<i>p</i> < .001	***
	35 – 45	27.85	14.97	15.32				
	46 – 55	25.49	14.12	13.38	Inter- subject	0.988 (3 ; 216)	<i>p</i> = .399	/
	over 55	25.43	13.31	12.47				
	TOTAL	26.67	14.29	14.14				
/ = NS; * = < 0.05; ** < 0.01; *** < 0.001								

Mental health X Language

	Language (LANG)	Average Pre-test	Average Post-test1	Average Post-test2	Effects test	F(ddl)	P	Sign.
Burnout (OLBI)	French	63.11	53.92	52.58	Intra-subject	113.98 (1.80 ; 269.51)	$p < .001$	***
	Dutch	62.61	52.04	52.06	Inter-subject	0.60 (1 ; 150)	$p = .439$	/
	TOTAL	62.76	52.60	52.21				
Burnout (BAT)	French	3.21	2.60	2.54	Intra-subject	74.07 (1.78 ; 143.93)	$p < .001$	***
	Dutch	3.31	2.43	2.33	Inter-subject	0.44 (1 ; 81)	$p = .509$	/
	TOTAL	3.28	2.48	2.39				
Depression (DASS)	French	24.14	12.14	12.45	Intra-subject	142.10 (1.79 ; 409.17)	$p < .001$	***
	Dutch	18.66	8.65	8.59	Inter-subject	15.10 (1 ; 227)	$p < .001$	***
	TOTAL	20.36	9.73	9.79				
Anxiety (DASS)	French	18.39	9.21	8.85	Intra-subject	112.91 (1.79 ; 404.69)	$p < .001$	***
	Dutch	16.53	7.89	8.24	Inter-subject	1.53 (1 ; 229)	$p = .217$	/
	TOTAL	17.10	8.30	8.43				
Stress (DASS)	French	29.21	16.53	15.04	Intra-subject	173.95 (1.88 ; 426.37)	$p < .001$	***
	Dutch	25.65	12.82	13.28	Inter-subject	8.22 (1 ; 227)	$p = .005$	**
	TOTAL	26.76	13.97	13.83				
/ = NS; * = < .05; ** < .01; *** < .001								

Mental health X Gender

	Gender (PRE_SD7)	Average Pre-test	Average Post-test1	Average Post-test2	Effects test	F(ddl)	P	Sign.
Burnout (OLBI)	Men	62.17	52.11	50.87	Intra- subject	76.54 (1.80 ; 269.61)	$p < .001$	***
	Women	62.87	52.69	52.46	Inter- subject	0.38 (1 ; 150)	$p = .375$	/
	TOTAL	62.76	52.60	52.21				
Burnout (BAT)	Men	3.12	2.42	2.34	Intra- subject	43.74 (1.76 ; 142.24)	$p < .001$	***
	Women	3.30	2.49	2.39	Inter- subject	0.33 (1 ; 81)	$p = .569$	/
	TOTAL	3.28	2.48	2.39				
Depression (DASS)	Men	21.51	11.64	9.15	Intra- subject	102.93 (1.78 ; 403.36)	$p < .001$	***
	Women	20.08	9.26	9.95	Inter- subject	0.58 (1 ; 227)	$p = .447$	/
	TOTAL	20.36	9.73	9.79				
Anxiety (DASS)	Men	14.09	7.60	6.19	Intra- subject	70.16 (1.78 ; 408.49)	$p < .001$	***
	Women	17.83	8.47	8.97	Inter- subject	4.37 (1 ; 229)	$p = .038$	*
	TOTAL	17.10	8.30	8.43				
Stress (DASS)	Men	24.98	13.31	11.78	Intra- subject	122.11 (1.88 ; 426.86)	$p < .001$	***
	Women	27.19	14.13	14.33	Inter- subject	2.26 (1 ; 227)	$p = .134$	/
	TOTAL	26.76	13.97	13.83				
/ = NS; * = < .05; ** < .01; *** < .001								

Mental health X Type of contract

	Type of contract (PRE_T2)	Average Pre-test	Average Post-test1	Average Post-test2	Effects test	F(ddl)	P	Sign.
Burnout (OLBI)	Fixed-term contract	62.78	46.66	42.84	Intra-subject	41.88 (1.81 ; 269.04)	$p < .001$	***
	Indefinite-term contract							
	Statutory	62.87	52.72	52.59	Inter-subject	1.68 (2 ; 149)	$p = .190$	/
	TOTAL	61.20	54.49	52.73				
		62.76	52.60	52.21				
Burnout (BAT)	Fixed-term contract	2.54	2.10	1.76	Intra-subject	13.76 (1.75 ; 140.26)	$p < .001$	***
	Indefinite-term contract							
	Statutory	3.30	2.48	2.39	Inter-subject	1.13 (2 ; 80)	$p = .329$	/
	TOTAL	3.25	2.54	2.50				
		3.28	2.48	2.39				
Depression (DASS)	Fixed-term contract	22.86	7.43	6.57	Intra-subject	25.21 (1.80 ; 407.34)	$p < .001$	***
	Indefinite-term contract							
	Statutory	20.46	9.53	9.67	Inter-subject	0.35 (2 ; 226)	$p = .702$	/
	TOTAL	17.38	14.15	13.38				
		20.36	9.73	9.79				
Anxiety (DASS)	Fixed-term contract	15.14	6.86	7.43	Intra-subject	16.78 (1.79 ; 407.67)	$p < .001$	***
	Indefinite-term contract							
	Statutory	17.12	8.09	8.28	Inter-subject	1.05 (2 ; 228)	$p = .352$	/
	TOTAL	17.85	12.46	11.38				
		17.10	8.30	8.43				
Stress (DASS)	Fixed-term contract	28.86	13.14	15.43	Intra-subject	30.06 (1.89 ; 426.27)	$p < .001$	***
	Indefinite-term contract							
	Statutory	26.72	13.74	13.53	Inter-subject	0.84 (2 ; 226)	$p = .433$	/
	TOTAL	26.15	18.15	17.69				
		26.76	13.97	13.83				

/ = NS; * = < .05; ** < .01; *** < .001

Mental health X Burnout stage

	Burnout stage (STAF2CM)	Average Pre-test	Average Post-test1	Average Post-test2	Effects test	<i>F</i> (ddl)	P	Sign.
Burnout (OLBI)	Stage 1	61.49	52.88	52.22	Intra-subject	41.82 (1.91 ; 243.96)	<i>p</i> < .001	***
	Stage 2	63.67	53.65	53.18				
	Stage 3	61.89	51.73	50.20	Inter-subject	0.77 (2 ; 128)	<i>p</i> = .467	/
	TOTAL	62.94	53.32	52.74				
Burnout (BAT)	Stage 1	3.40	2.66	2.56	Intra-subject	29.06 (1.64 ; 104.61)	<i>p</i> < .001	***
	Stage 2	3.28	2.53	2.49				
	Stage 3	2.72	1.92	1.87	Inter-subject	2.48 (2 ; 64)	<i>p</i> = .092	/
	TOTAL	3.28	2.53	2.47				
Depression (DASS)	Stage 1 ^a	15.91	8.04	8.82	Intra-subject	68.78 (1.82 ; 353.02)	<i>p</i> < .001	***
	Stage 2 ^a	21.73	11.01	10.43				
	Stage 3	23.47	9.20	9.33	Inter-subject	3.55 (2 ; 194)	<i>p</i> = .031	*
	TOTAL	20.48	10.16	9.96				
Anxiety (DASS)	Stage 1 ^a	13.96	6.77	6.81	Intra-subject	50.26 (1.75 ; 343.06)	<i>p</i> < .001	***
	Stage 2 ^a	18.49	9.54	9.02				
	Stage 3	16.80	7.07	7.73	Inter-subject	3.84 (2 ; 196)	<i>p</i> = .023	*
	TOTAL	17.29	8.70	8.40				
Stress (DASS)	Stage 1	24.51	13.74	13.06	Intra-subject	79.19 (1.90 ; 369.04)	<i>p</i> < .001	***
	Stage 2	27.43	15.11	14.31				
	Stage 3	27.60	12.27	14.27	Inter-subject	1.10 (2 ; 194)	<i>p</i> = .335	/
	TOTAL	26.75	14.57	14.01				
/ = NS; * = < .05; ** < .01; *** < .001 - ^{ab} post-hoc differences								

17.4 Annex for point 3 "Efficiency of the mental health treatment programme": standards




OLBI STANDARDS (Standardised scores)

https://emploi.belgique.be/sites/default/files/content/documents/Bien-être%20au%20travail/Projets%20de%20recherche/burnout2019_annexes_rapport_recherche.pdf

	OLBI
Low	Less than 40
Moderate	Between 40 and 60
High	Over 60

BAT STANDARDS (*Manual BAT - Version 2.0, Table 66, p. 113*)

<https://burnoutassessmenttool.be/wp-content/uploads/2020/08/User-Manual-BAT-version-2.0.pdf>

		Scores				
		UIT	DIS	ECO	CCO	TOT
	Green score: "In good health"	1 – 3.05	1 – 2.49	1 – 2.09	1 – 2.69	1 – 2.58
	Orange score: "Risk of burnout"	3.06 – 3.3	2.5 – 3.29	2.1 – 2.89	2.7 – 3.09	2.59 – 3.01
	Red score: "High risk of burnout"	3.31 – 5	3.3 – 5	2.9 – 5	3.1 – 5	3.02 – 5

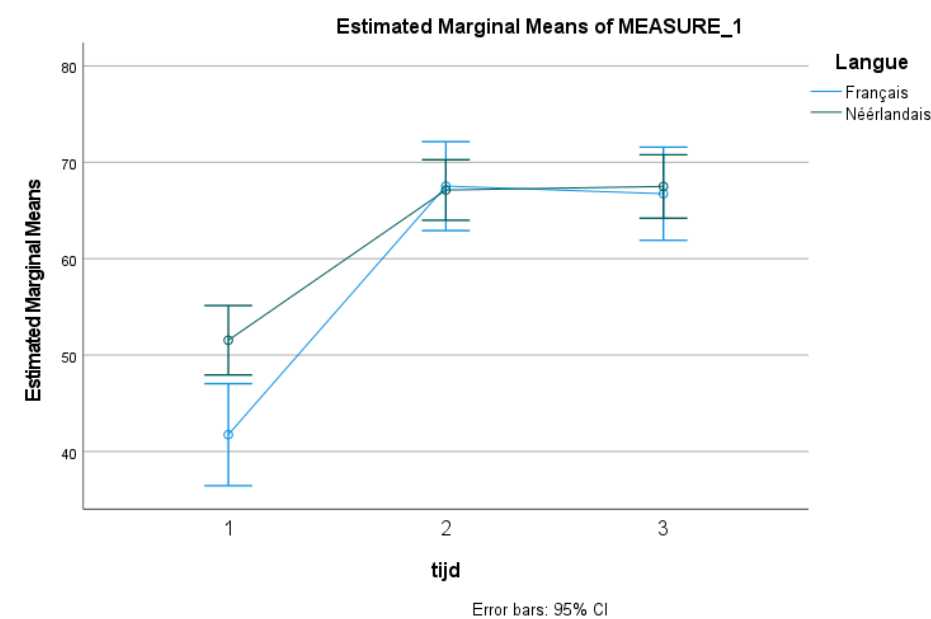
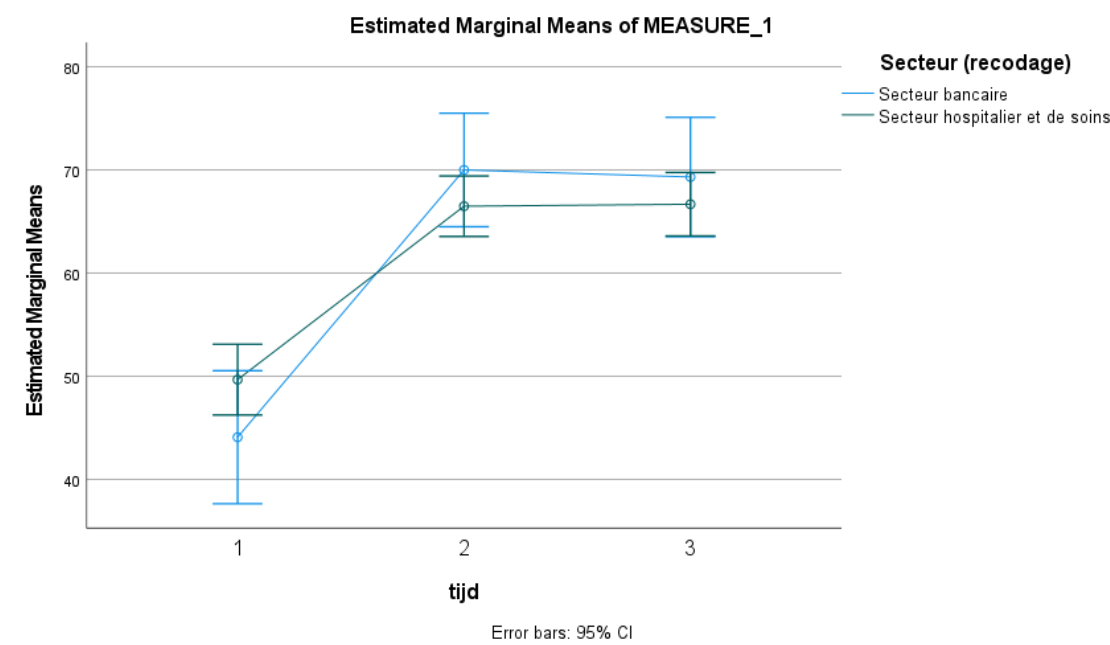
DASS STANDARDS

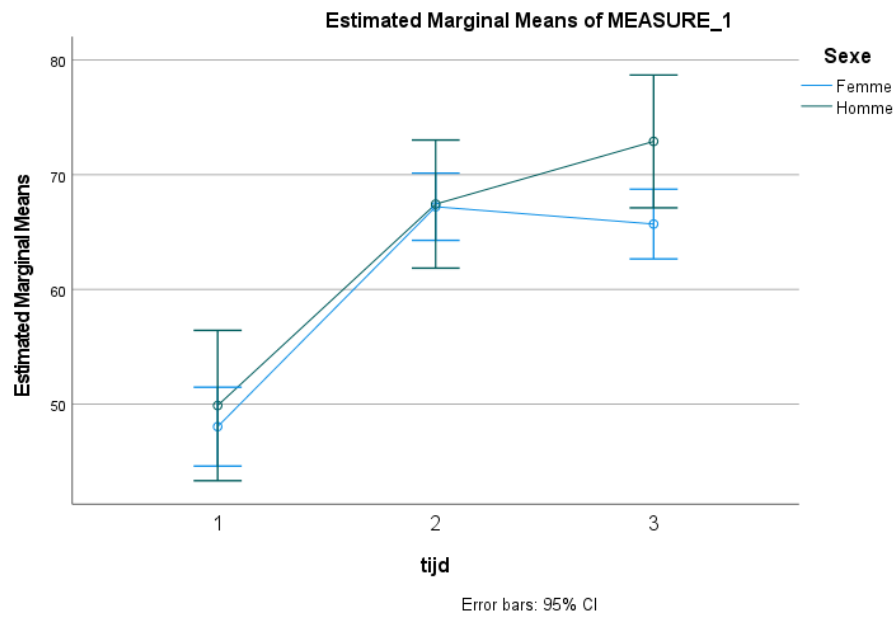
Lovibond. S.H. & Lovibond. P.F. (1995). Manual for the Depression Anxiety & Stress Scales. (2nd Ed.) Sydney: Psychology Foundation

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Light	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

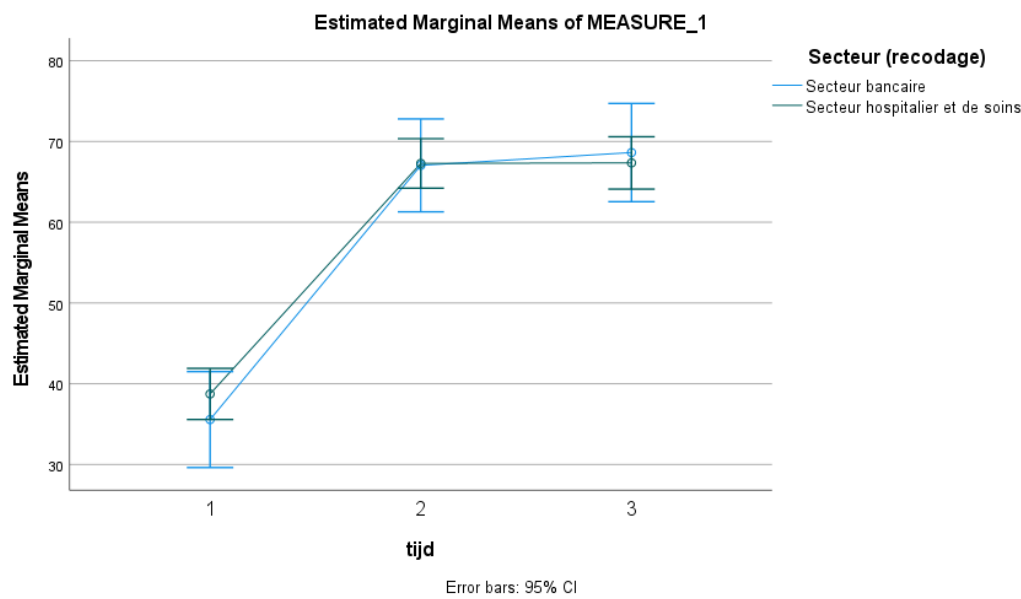
17.5 Annex to point 4 "Self-reported physical and psychological health status".

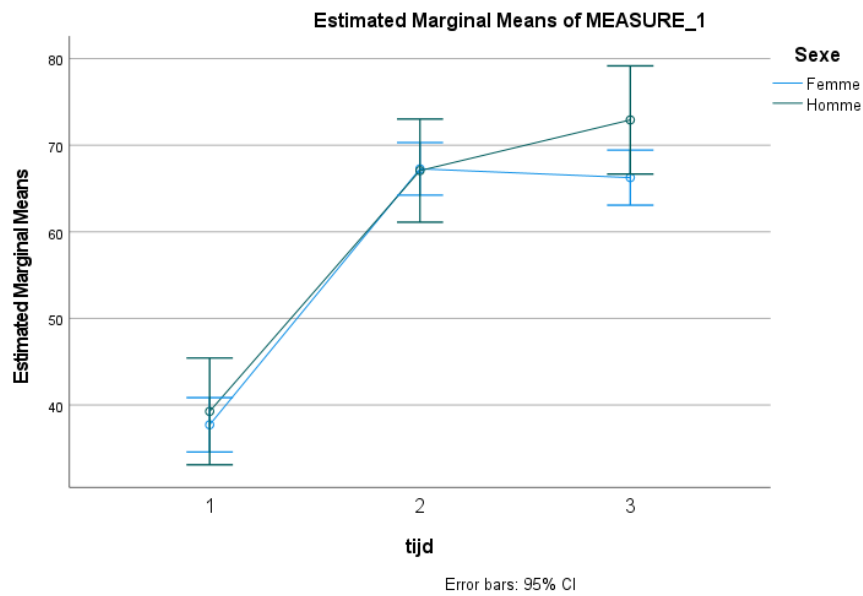
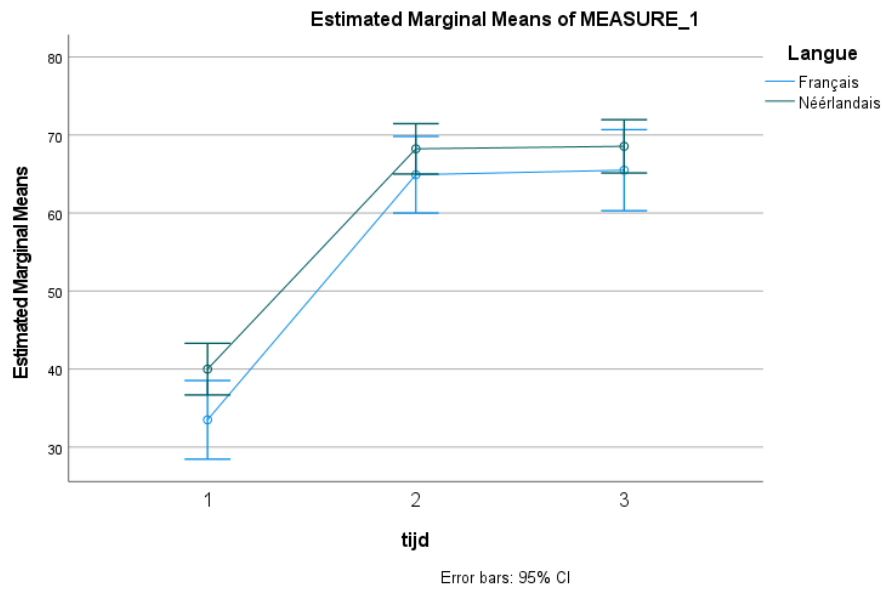
Evolution of physical condition over time by sector - language and gender





Evolution of psychological state over time by sector - language and gender





17.6 Annex to point 6 "Effectiveness of the treatment programme in terms of perceived improvements"

Repeated measure analyses of variance (3 measurement times) differentiated by age, language, gender, type of contract and burnout stage.

Perceived improvements X Age

	Age (years) (PRE_SD6 _REC0D)	Average Post-test1	Average Post-test 2	Effects test	F(ddl)	Probability	Sign.
Improvement in general well-being (J41)	under 35	3.30	3.30	Intra- subject	0.121 (1 ; 211)	$p = .728$	/
	35 – 45	3.20	3.18				
	46 – 55	3.09	3.11	Inter- subject	2.15 (3 ; 211)	$p = .095$	/
	over 55	3.36	3.43				
	TOTAL	3.20	3.21				
Improvement in well- being at work (J412)	under 35	2.95	3.12	Intra- subject	1.12 (1 ; 186)	$p = .235$	/
	35 – 45	3.02	3.00				
	46 – 55	2.77	2.83	Inter- subject	1.46 (3 ; 186)	$p = .227$	/
	over 55	2.79	2.88				
	TOTAL	2.89	2.95				
Easier to perform tasks (J42)	under 35	2.95	3.07	Intra- subject	2.91 (1 ; 184)	$p = .090$	/
	35 – 45	2.82	2.93				
	46 – 55	2.71	2.84	Inter- subject	1.23 (3 ; 184)	$p = .300$	/
	over 55	2.83	2.92				
	TOTAL	2.81	2.93				
Improved sleep (J43)	under 35	3.15	2.96	Intra- subject	3.97 (1 ; 204)	$p = .048$	*
	35 – 45	2.85	2.81				
	46 – 55	2.97	2.87	Inter- subject	1.84 (3 ; 204)	$p = .142$	/
	over 55	3.22	3.07				
	TOTAL	3.01	2.90				
Improvement in quality of life (J44)	under 35	3.15	3.13	Intra- subject	0.03 (1 ; 205)	$p = .870$	/
	35 – 45 ^a	2.95	3.03				
	46 – 55 ^b	3.13	3.03	Inter- subject	2.86 (3 ; 205)	$p = .038$	*
	over 55 ^{ab}	3.37	3.44				
	TOTAL	3.11	3.11				
Improved work/life balance (J45)	under 35	3.07	3.05	Intra- subject	1.79 (1 ; 184)	$p = .183$	/
	35 – 45	2.98	3.02				
	46 – 55	3.17	3.09	Inter- subject	0.69 (3 ; 184)	$p = .560$	/
	over 55	3.33	3.08				
	TOTAL	3.11	3.06				
/ = NS; * = < .05; ** < .01; *** < .001- ^{ab} post-hoc differences							

Perceived improvements X Language

	Language (LANG)	Average Post-test1	Average Post-test 2	Effects test	<i>F</i> (ddl)	Probability	Sign.
Improvement in general well-being (J41)	French	3.27	3.23	Intra- subject	0.03 (1 ; 232)	<i>p</i> = .869	/
	Dutch	3.21	3.23	Inter- subject	0.14 (1 ; 232)	<i>p</i> = .705	/
	TOTAL	3.23	3.23				
Improvement in well- being at work (J412)	French	2.92	3.05	Intra- subject	1.52 (1 ; 207)	<i>p</i> = .337	/
	Dutch	2.91	2.93	Inter- subject	0.31 (1 ; 207)	<i>p</i> = .581	/
	TOTAL	2.91	2.97				
Easier to perform tasks (J42)	French	2.79	3.00	Intra- subject	4.33 (1 ; 203)	<i>p</i> = .039	*
	Dutch	2.83	2.89	Inter- subject	0.10 (1 ; 203)	<i>p</i> = .755	/
	TOTAL	2.82	2.92				
Improved sleep (J43)	French	3.04	2.86	Intra- subject	5.20 (1 ; 224)	<i>p</i> = .024	*
	Dutch	2.99	2.92	Inter- subject	0.01 (1 ; 224)	<i>p</i> = .957	/
	TOTAL	3.01	2.90				
Improvement in quality of life (J44)	French	3.08	3.10	Intra- subject	0.04 (1 ; 224)	<i>p</i> = .833	/
	Dutch	3.14	3.14	Inter- subject	0.32 (1 ; 224)	<i>p</i> = .571	/
	TOTAL	3.12	3.13				
Improved work/life balance (J45)	French	3.07	3.07	Intra- subject	0.49 (1 ; 203)	<i>p</i> = .487	/
	Dutch	3.15	3.07	Inter- subject	0.13 (1 ; 203)	<i>p</i> = .720	/
	TOTAL	3.13	3.07				
/ = NS; * = < .05; ** < .01; *** < .001							

Perceived improvements X Gender

	Gender (PRE_SD7)	Average Post-test1	Average Post-test 2	Effects test	<i>F</i> (ddl)	Probability	Sign.
Improvement in general well-being (J41)	Men	3.09	3.16	Intra- subject	0.21 (1 ; 222)	<i>p</i> = .648	/
	Women	3.26	3.24	Inter- subject	1.50 (1 ; 222)	<i>p</i> = .222	/
	TOTAL	3.22	3.22				
Improvement in well- being at work (J412)	Men	2.77	3.03	Intra- subject	3.11 (1 ; 197)	<i>p</i> = .079	/
	Women	2.95	2.95	Inter- subject	0.15 (1 ; 197)	<i>p</i> = .698	/
	TOTAL	2.92	2.96				
Easier to perform tasks (J42)	Men	2.80	2.89	Intra- subject	1.52 (1 ; 195)	<i>p</i> = .219	/
	Women	2.83	2.94	Inter- subject	0.14 (1 ; 195)	<i>p</i> = .713	/
	TOTAL	2.83	2.93				
Improved sleep (J43)	Men	2.95	2.97	Intra- subject	0.78 (1 ; 214)	<i>p</i> = .379	/
	Women	3.03	2.88	Inter- subject	0.01 (1 ; 214)	<i>p</i> = .937	/
	TOTAL	3.01	2.89				
Improvement in quality of life (J44)	Men	3.02	3.07	Intra- subject	0.06 (1 ; 216)	<i>p</i> = .805	/
	Women	3.15	3.13	Inter- subject	0.77 (1 ; 216)	<i>p</i> = .380	/
	TOTAL	3.12	3.12				
Improved work/life balance (J45)	Men	3.08	3.14	Intra- subject	0.05 (1 ; 195)	<i>p</i> = .820	/
	Women	3.14	3.06	Inter- subject	0.01 (1 ; 195)	<i>p</i> = .926	/
	TOTAL	3.13	3.07				
/ = NS; * = < .05; ** < .01; *** < .001							

Perceived improvements X Type of contract

	Type of contract (PRE_T2)	Average Post-test1	Average Post-test 2	Effects test	<i>F</i> (ddl)	Probability	Sign.
Improvement in general well-being (J41)	Fixed-term contract ^{ab}	3.86	3.71	Intra-subject	0.06 (1 ; 221)	<i>p</i> = .806	/
	Indefinite-term contract ^a	3.22	3.21				
	Statutory ^b	2.92	3.15	Inter-subject	3.87 (2 ; 221)	<i>p</i> = .022	*
	TOTAL	3.22	3.22				
Improvement in well-being at work (J412)	Fixed-term contract ^{ab}	3.50	3.83	Intra-subject	3.96 (1 ; 196)	<i>p</i> = .048	*
	Indefinite-term contract ^a	2.93	2.95				
	Statutory ^b	2.36	2.82	Inter-subject	4.67 (2 ; 196)	<i>p</i> = .010	**
	TOTAL	2.92	2.96				
Easier to perform tasks (J42)	Fixed-term contract ^{ab}	3.83	3.33	Intra-subject	0.02 (1 ; 194)	<i>p</i> = .897	/
	Indefinite-term contract ^a	2.82	2.92				
	Statutory ^b	2.36	2.82	Inter-subject	5.24 (2 ; 194)	<i>p</i> = .006	**
	TOTAL	2.83	2.93				
Improved sleep (J43)	Fixed-term contract	3.29	3.14	Intra-subject	1.64 (1 ; 213)	<i>p</i> = .201	/
	Indefinite-term contract	3.01	2.90				
	Statutory	2.92	2.67	Inter-subject	0.86 (2 ; 213)	<i>p</i> = .426	/
	TOTAL	3.01	2.89				
Improvement in quality of life (J44)	Fixed-term contract	3.57	3.57	Intra-subject	0.25 (1 ; 215)	<i>p</i> = .620	/
	Indefinite-term contract	3.11	3.11				
	Statutory	3.17	3.00	Inter-subject	1.80 (2 ; 215)	<i>p</i> = .169	/
	TOTAL	3.12	3.12				
Improved work/life balance (J45)	Fixed-term contract	3.17	3.17	Intra-subject	0.38 (1 ; 194)	<i>p</i> = .538	/
	Indefinite-term contract	3.13	3.08				
	Statutory	3.09	2.91	Inter-subject	0.15 (2 ; 194)	<i>p</i> = .860	/
	TOTAL	3.13	3.07				
/ = NS; * = < .05; ** < .01; *** < .001- ^{ab} post-hoc differences							

Improvements felt X Burnout stage

	Burnout stage (STAF2CM)	Average Post-test1	Average Post-test 2	Effects test	<i>F</i> (ddl)	Probability	Sign.
Improvement in general well-being (J41)	Stage 1	3.17	3.28	Intra-subject	1.83 (1 ; 190)	$p = .178$	/
	Stage 2	3.20	3.17	Intra-subject			
	Stage 3	3.07	3.29	Inter-subject	0.90 (2 ; 190)	$p = .911$	/
	TOTAL	3.19	3.21	Inter-subject			
Improvement in well-being at work (J412)	Stage 1	2.95	2.98	Intra-subject	1.89 (1 ; 165)	$p = .171$	/
	Stage 2	2.89	2.89	Intra-subject			
	Stage 3	2.92	3.25	Inter-subject	0.51 (2 ; 165)	$p = .601$	/
	TOTAL	2.90	2.94	Inter-subject			
Easier to perform tasks (J42)	Stage 1	2.80	2.93	Intra-subject	3.65 (1 ; 163)	$p = .058$	/
	Stage 2	2.82	2.92	Intra-subject			
	Stage 3	2.75	3.08	Inter-subject	0.03 (2 ; 163)	$p = .967$	/
	TOTAL	2.81	2.93	Inter-subject			
Improved sleep (J43)	Stage 1	3.02	2.89	Intra-subject	0.03 (1 ; 184)	$p = .863$	/
	Stage 2	2.98	2.86	Intra-subject			
	Stage 3	2.79	3.00	Inter-subject	0.06 (2 ; 184)	$p = .940$	/
	TOTAL	2.98	2.88	Inter-subject			
Improvement in quality of life (J44)	Stage 1	3.15	3.11	Intra-subject	0.70 (1 ; 184)	$p = .404$	/
	Stage 2	3.09	3.09	Intra-subject			
	Stage 3	2.93	3.14	Inter-subject	1.14 (2 ; 184)	$p = .870$	/
	TOTAL	3.09	3.10	Inter-subject			
Improved work/life balance (J45)	Stage 1	3.15	3.15	Intra-subject	2.93 (1 ; 163)	$p = .089$	/
	Stage 2	3.04	3.04	Intra-subject			
	Stage 3	3.27	2.82	Inter-subject	0.35 (2 ; 163)	$p = .706$	/
	TOTAL	3.08	3.05	Inter-subject			

/ = NS; * = < .05; ** < .01; *** < .001

17.7 Annex to point 7 "Employment situation before, during and after the treatment"

Work incapacity by sector

There was no significant difference in employment by sector before the treatment ($p = .646$), but there was a borderline significant difference just after the treatment ($p = 0.050$), and a significant difference three to six months after the treatment ($p = .035$).

		Sector			
		Banking sector		Healthcare sector	
		N	%	N	%
Before the treatment	Full-time	10	20.4 %	43	24.7 %
	Part-time	10	20.4 %	38	21.8 %
	Career break	0	0.0 %	1	0.6 %
	Sick leave	29	59.2 %	86	49.4 %
	Other	0	0.0 %	6	3.4 %
	Total	49	100 %	174	100 %
After the treatment	Full-time	24	49.0 %	67	39.0 %
	Part-time	16	32.7 %	74	43.0 %
	Career break	0	0.0 %	1	0.6 %
	Sick leave	7	14.3 %	21	12.2 %
	Unemployed	2	4.1 %	0	0.0 %
	Other	0	0 %	9	5.2 %
	Total	49	100 %	172	100 %
4 months after the treatment	Full-time	25	51.0 %	65	37.6 %
	Part-time	11	22.4 %	76	43.9 %
	Career break	1	2.0 %	2	1.2 %
	Sick leave	7	14.3 %	20	11.6 %
	Unemployed	4	8.2 %	4	2.3 %
	Other	1	2.0 %	6	3.5 %
	Total	49	100 %	173	100 %

Work incapacity broken down by age

There was no significant difference in employment by age before the treatment ($p = .448$), just after the treatment ($p = .216$) and three to six months after the treatment ($p = .825$).

Job		Age			
		≤ 45 years		> 45 years	
		N	%	N	%
Before the treatment	Full-time	33	28.2 %	20	18.9 %
	Part-time	24	20.5 %	24	22.6 %
	Career break	0	0.0 %	1	0.9 %
	Sick leave	57	48.7 %	58	54.7 %
	Other	3	2.6 %	3	2.8 %
	Total	117	100 %	106	100 %
After the treatment	Full-time	53	45.7 %	38	36.2 %
	Part-time	42	36.2 %	48	45.7 %
	Career break	1	0.9 %	0	0.0 %
	Sick leave	12	10.3 %	16	15.2 %
	Unemployed	2	1.7 %	0	0 %
	Other	6	5.2 %	3	2.9 %
	Total	116	100 %	105	100 %
4 months after the treatment	Full-time	52	44.4 %	38	36.2 %
	Part-time	42	35.9 %	45	42.9 %
	Career break	1	0.9 %	2	1.9 %
	Sick leave	14	12.0 %	13	12.4 %
	Unemployed	4	3.4 %	4	3.8 %
	Other	4	3.4 %	3	2.9 %
	Total	117	100 %	105	100 %

Work incapacity broken down by referrer

There was no significant difference in employment according to the referrer before the treatment ($p = .114$), just after the treatment ($p = .787$) and three to six months after the treatment ($p = .979$).

Job		Referrer					
		Occupational physician		GP		Prevention advisor for psycho-social matters	
		N	%	N	%	N	%
Before the treatment	Full-time	25	24.0 %	12	17.9 %	16	32.7 %
	Part-time	27	26.0 %	11	16.4 %	10	20.4 %
	Career break	1	1.0 %	0	0.0 %	0	0.0 %
	Sick leave	48	46.2 %	44	65.7 %	21	42.9 %
	Other	3	2.9 %	0	0 %	2	4.1 %
	Total	104	100 %	67	100 %	49	100 %
After the treatment	Full-time	42	40.8 %	27	40.3 %	22	45.8 %
	Part-time	41	39.8 %	31	46.3 %	15	31.3 %
	Career break	1	1.0 %	0	0.0 %	0	0.0 %
	Sick leave	13	12.6 %	7	10.4 %	8	16.7 %
	Unemployed	1	1.0 %	1	1.5 %	0	0.0 %
	Other	5	4.9 %	1	1.5 %	3	6.3 %
	Total	103	100 %	67	100 %	48	100 %
4 months after the treatment	Full-time	43	41.7 %	26	38.8 %	21	42.9 %
	Part-time	40	38.8 %	27	40.3 %	17	34.7 %
	Career break	1	1.0 %	1	1.5 %	1	2.0 %
	Sick leave	13	12.6 %	8	11.9 %	6	12.2 %
	Unemployed	2	1.9 %	3	4.5 %	3	6.1 %
	Other	4	3.9 %	2	3.0 %	1	2.0 %
	Total	103	100 %	67	100 %	49	100 %

Work incapacity broken down by burnout stage

There was no significant difference in employment according to the stage of burnout, before the treatment ($p = 0.223$), just after the treatment ($p = 0.422$) and three to six months after the treatment ($p = 0.118$).

Job		Burnout stage					
		Stage 1		Stage 2		Stages 3 & 4	
		N	%	N	%	N	%
Before the treatment	Full-time	15	31.3 %	30	21.9 %	7	29.2 %
	Part-time	13	27.1 %	28	20.4 %	2	8.3 %
	Career break	0	0.0 %	0	0.0 %	0	0.0 %
	Sick leave	18	37.5 %	75	54.7 %	15	62.5 %
	Other	2	4.1 %	4	2.9 %	0	0.0 %
	Total	48	100 %	137	100 %	24	100 %
After the treatment	Full-time	14	29.8 %	59	43.4 %	12	50.0 %
	Part-time	25	53.2 %	53	39.0 %	6	25.0 %
	Career break	0	0.0 %	1	0.7 %	0	0.0 %
	Sick leave	6	12.8 %	17	12.4 %	4	16.0 %
	Unemployed	0	0.0 %	2	1.5 %	0	0.0 %
	Other	2	4.2 %	4	3.0 %	2	8.0 %
	Total	47	100 %	136	100 %	24	100 %
4 months after the treatment	Full-time	17	35.4 %	57	41.9 %	10	41.7 %
	Part-time	25	52.1 %	52	38.2 %	5	20.8 %
	Career break	0	0.0 %	2	1.5 %	0	0.0 %
	Sick leave	3	6.2 %	15	11.0 %	7	29.2 %
	Unemployed	2	4.2 %	6	4.4 %	0	0.0 %
	Other	1	2.1 %	4	3.0 %	2	8.3 %
	Total	48	100 %	136	100 %	24	100 %

Work incapacity broken down by gender

There was no significant difference in employment by gender before the treatment ($p = .530$), but there was just after the treatment ($p = .013$), and three to six months after the treatment ($p = .006$).

Job		Gender			
		Men		Women	
		N	%	N	%
Before the treatment	Full-time	14	31.8 %	39	21.8 %
	Part-time	8	18.2 %	40	22.3 %
	Career break	0	0.0 %	1	0.6 %
	Sick leave	22	50.0 %	93	52.0 %
	Other	0	0.0 %	6	3.3 %
	Total	44	100 %	179	%
After the treatment	Full-time	25	56.8 %	66	37.3 %
	Part-time	10	22.7 %	80	45.2 %
	Career break	0	0.0 %	1	0.6 %
	Sick leave	8	18.2 %	20	11.3 %
	Unemployed	1	2.3 %	1	0.6 %
	Other	0	0.0 %	9	5.1 %
	Total	44	100 %	177	100 %
4 months after the treatment	Full-time	27	61.4 %	63	35.4 %
	Part-time	8	18.2 %	79	44.4 %
	Career break	0	0.0 %	3	1.7 %
	Sick leave	7	15.9 %	20	11.2 %
	Unemployed	2	4.5 %	6	3.4 %
	Other	0	0.0 %	7	3.9 %
	Total	44	100 %	178	100 %

Work incapacity broken down by language

There was no significant difference in employment by language before the treatment ($p = .214$), just after the treatment ($p = .215$) and three to six months after the treatment ($p = .762$).

Job		Language			
		Dutch		French	
		N	%		%
Before the treatment	Full-time	38	24.7 %	15	21.7 %
	Part-time	38	24.7 %	10	14.5 %
	Career break	1	0.6 %	0	0.0 %
	Sick leave	72	46.8 %	43	62.3 %
	Other	5	3.2 %	1	1.5 %
	Total	154	100 %	69	100 %
After the treatment	Full-time	62	40.3 %	29	43.3 %
	Part-time	67	43.5 %	23	34.3 %
	Career break	1	0.7 %	0	0 %
	Sick leave	17	11.0 %	11	16.4 %
	Unemployed	0	0.0 %	2	3.0 %
	Other	7	4.5 %	2	3.0 %
	Total	154	100 %	67	%
4 months after the treatment	Full-time	61	39.9 %	29	42.0 %
	Part-time	62	40.5 %	25	36.2 %
	Career break	2	1.3 %	1	1.5 %
	Sick leave	18	11.8 %	9	13.0 %
	Unemployed	4	2.6 %	4	5.8 %
	Other	6	3.9 %	1	1.5 %
	Total	153	100 %	69	100 %

17.8 Annex to point 10 "Adjustments of the workstation"

17.8.1 ADJUSTMENTS TO THE WORKSTATION BY THE EMPLOYER AFTER THE TREATMENT

Adjustments to the workstation by the employer, after the treatment, according to age ($p = .523$)

Adjustments of the workstation		Age			
		≤ 45 years		> 45 years	
		N	%	N	%
	Yes	36	31.8 %	29	27.9 %
	No	77	68.2 %	75	72.1 %
	Total	113	100 %	104	100 %

Adjustments to the workstation by the employer, according to gender ($p = .149$)

Adjustments of the workstation		Gender			
		Men		Women	
		N	%	N	%
	Yes	9	20.9 %	56	32.2 %
	No	34	79.1 %	118	67.8 %
	Total	43	100 %	174	100 %

Adjustments to the workstation by the employer, after the treatment, according to referrer ($p = .784$)

Adjustments of the workstation		Referrer					
		Occupational physician		GP		Prevention advisor for psycho-social matters	
		N	%	N	%	N	%
	Yes	29	28.4 %	20	30.8 %	16	34.0 %
	No	73	71.6 %	45	69.2 %	31	66.0 %
	Total	102	100 %	65	100 %	47	100 %

Adjustments to the workstation, by the employer, after the treatment, according to burnout stage, before the start of the treatment ($p = .664$)

Adjustments of the workstation		Burnout stage					
		Stage 1		Stage 2		Stage 3	
		N	%	N	%	N	%
	Yes	13	27.1 %	40	30.5 %	9	37.5 %
	No	35	72.9 %	91	69.5 %	15	62.5 %
	Total	48	100 %	131	100 %	24	100 %

Adjustments to the workstation by the employer, after the treatment, according to language ($p = .175$)

Adjustments of the workstation		Language			
		Dutch		French	
		N	%	N	%
	Yes	50	32.7 %	15	23.4 %
	No	103	67.3 %	49	76.6 %
	Total	153	100 %	64	100 %

Adjustments to the workstation by the employer, after the treatment, by sector ($p = .519$)

Adjustments of the workstation		Sector			
		Bank		Healthcare	
		N	%	N	%
	Yes	12	26.0 %	53	31.0 %
	No	34	74.0 %	118	69.0 %
	Total	46	100 %	171	100 %

17.8.2 ADJUSTMENTS TO THE WORKSTATION BY THE WORKER AFTER THE TREATMENT

Adjustments to the workstation by the worker, after the treatment, according to age ($p = .546$)

Adjustments of the workstation		Age			
		≤ 45 years		> 45 years	
	Yes	54	47.8 %	45	43.7 %
	No	59	52.2 %	58	56.3 %
	Total	113	100 %	103	100 %

Adjustments to the workstation by the worker, after the treatment, according to gender ($p = .559$)

Adjustments of the workstation		Gender			
		Men		Women	
	Yes	18	41.9 %	81	46.8 %
	No	25	58.1 %	92	53.2 %
	Total	43	100 %	173	100 %

Adjustments to the workstation by the worker, after the treatment, according to referrer ($p = .344$)

Adjustments of the workstation		Referrer					
		Occupational physician		GP		Prevention advisor for psycho-social matters	
	Yes	51	50 %	25	38.5 %	21	45.7 %
	No	51	50 %	40	61.5 %	25	54.3 %
	Total	102	100 %	65	100 %	46	100 %

Adjustments to the workstation, by the worker, after the treatment, according to burnout stage, before the start of the treatment ($p = .430$)

Adjustments of the workstation		Burnout stage					
		Stage 1		Stage 2		Stage 3	
	Yes	18	37.5 %	62	47.7 %	12	50 %
	No	30	62.5 %	68	52.3 %	12	50 %
	Total	48	100 %	130	100 %	24	100 %

Adjustments to the workstation by the worker, after the treatment, according to language ($p = .485$)

Adjustments of the workstation		Language			
		Dutch		French	
	Yes	72	47.4 %	27	42.2 %
	No	80	52.6 %	37	57.8 %
	Total	152	100 %	64	100 %

Adjustments to the workstation by the worker, after the treatment, by sector ($p = .304$)

Adjustments of the workstation		Sector			
		Bank		Healthcare	
	Yes	18	39.1 %	81	47.6 %
	No	28	60.9 %	89	52.3 %
	Total	46	100 %	170	100 %

17.8.3 ADJUSTMENTS TO THE WORKSTATION BY THE EMPLOYER THREE TO SIX MONTHS AFTER THE TREATMENT

Adjustments to the workstation by the employer, 3-6 months after the treatment, according to age ($p = .031$)

Adjustments of the workstation		Age			
		≤ 45 years		> 45 years	
	Yes	24	21.6 %	35	35.0 %
	No	87	78.4 %	65	65.0 %
	Total	111	100 %	100	100 %

Adjustments to the workstation by the employer, 3-6 months after the treatment, according to gender ($p = .292$)

Adjustments of the workstation		Gender			
		Men		Women	
	Yes	9	21.4 %	50	29.6 %
	No	33	78.6 %	119	70.4 %
	Total	42	100 %	169	100 %

Adjustments to the workstation by the employer, 3-6 months after the treatment, according to referrer ($p = .800$)

Adjustments of the workstation		Referrer					
		Occupational physician		GP		Prevention advisor for psycho-social matters	
	Yes	27	27 %	19	30.2 %	11	24.4 %
	No	73	73 %	44	69.8 %	34	75.6 %
	Total	100	100 %	63	100 %	45	100 %

Adjustments to the workstation, by the employer, 3-6 months after the treatment, according to burnout stage, before the start of the treatment ($p = .375$)

Adjustments of the workstation		Burnout stage					
		Stage 1		Stage 2		Stage 3	
	Yes	15	33.3 %	31	24.0 %	8	33.3 %
	No	30	66.7 %	98	76.0 %	16	66.7 %
	Total	45	100 %	129	100 %	24	100 %

Adjustments to the workstation by the employer, 3-6 months after the treatment, according to language ($p = .033$)

Adjustments of the workstation		Language			
		Dutch		French	
	Yes	48	32.2 %	11	17.7 %
	No	101	67.8 %	51	82.3 %
	Total	149	100 %	62	100 %

Adjustments to the workstation by the employer, 4 months after the treatment, by sector ($p = .827$)

Adjustments of the workstation		Sector			
		Bank		Healthcare	
	Yes	12	26.7 %	47	28.3 %
	No	33	73.3 %	119	71.7 %
	Total	45	100 %	166	100 %

17.8.4 ADJUSTMENTS TO THE WORKSTATION BY THE WORKER THREE TO SIX MONTHS AFTER THE TREATMENT

Adjustments to the workstation by the worker, 3-6 months after the treatment, according to age ($p = .128$)

Adjustments of the workstation		Age			
		≤ 45 years		> 45 years	
	Yes	51	46.4 %	36	36.0 %
	No	59	53.6 %	64	64.0 %
	Total	110	100 %	100	100 %

Adjustments to the workstation by the worker, 3-6 months after the treatment, according to gender ($p = .624$)

Adjustments of the workstation		Gender			
		Men		Women	
	Yes	16	38.1 %	71	42.3 %
	No	26	61.9 %	97	57.7 %
	Total	42	100 %	168	100 %

Adjustments to the workstation by the worker, 3-6 months after the treatment, according to referrer ($p = .039$)

Adjustments of the workstation		Referrer					
		Occupational physician		GP		Prevention advisor for psycho-social matters	
	Yes	46	46.0 %	18	28.6 %	22	50 %
	No	54	54.0 %	45	71.4 %	22	50 %
	Total	100	100 %	63	100 %	44	100 %

Adjustments to the workstation, by the worker, 3-6 months after the treatment, according to burnout stage, before the start of the treatment ($p = .687$)

Adjustments of the workstation		Burnout stage					
		Stage 1		Stage 2		Stage 3	
	Yes	16		55		10	
	No	29		74		13	
	Total	45		129		23	

Adjustments to the workstation by the worker, 3-6 months after the treatment, according to language ($p = .833$)

Adjustments of the workstation		Language			
		Dutch		French	
	Yes	62	41.9 %	25	40.3 %
	No	86	58.1 %	37	59.7 %
	Total	148	100 %	62	100 %

Adjustments to the workstation by the worker, 3-6 months after the treatment, by sector ($p = .054$)

Adjustments of the workstation		Sector			
		Bank		Healthcare	
	Yes	13	28.9 %	74	44.8 %
	No	32	71.1 %	91	55.2 %
	Total	45	100 %	165	100 %

17.9 Annex to point 11 "Characteristics of the treatment programme (based on data from the final report of the BO treatment)"

17.9.1 Total number of work clinic sessions

Total number of work clinic sessions	N	%	% valid	% cumulative
0 session	1	.4	.4	.4
1 session	5	2.2	2.2	2.7
2 sessions	10	4.5	4.5	7.2
3 sessions	14	6.3	6.3	13.5
4 sessions	193	86.5	86.5	100.0
Total	223	100.0	100.0	

17.9.2 Total number of Starter-Kit sessions (Psycho-education)

Total number of starter-kit sessions	N	%	% valid	% cumulative
0 session	18	8.1	8.1	8.1
1 session	16	7.2	7.2	15.2
2 sessions	22	9.9	9.9	25.1
3 sessions	166	74.4	74.4	99.6
4 sessions	1	.4	.4	100.0
Total	223	100.0	100.0	

17.9.3 Total number of individual sessions

Total number of individual sessions	N	%	% valid	% cumulative
0 session	51	22.9	22.9	22.9
1 session	3	1.3	1.3	24.2
2 sessions	6	2.7	2.7	26.9
3 sessions	11	4.9	4.9	31.8
4 sessions	19	8.5	8.5	40.4
5 sessions	12	5.4	5.4	45.7
6 sessions	18	8.1	8.1	53.8
7 sessions	103	46.2	46.2	100.0
Total	223	100.0	100.0	

17.9.4 Total number of follow-up sessions

Total number of follow-up sessions	N	%	% valid	% cumulative
0 session	44	19.7	19.7	19.7
1 session	48	21.5	21.5	41.3
2 sessions	131	58.7	58.7	100.0
Total	223	100.0	100.0	

17.9.5 Total number of reorientation sessions

Total number of reorientation sessions	N	%	% valid	% cumulative
0 session	161	72.2	72.2	72.2
1 session	15	6.7	6.7	78.9
2 sessions	47	21.1	21.1	100.0
Total	223	100.0	100.0	