Report final evaluation 2023

Implementation of a pilot project for the secondary prevention of work-related psychosocial disorders



Copyright

Fedris

1 Avenue de l'Astronomie

B-1210 Brussels

All rights reserved. No part of this publication may be reproduced and/or published by print, photocopy, microfilm, electronic or any other means without the prior written consent of the publisher.

Please, cite this publication as follows: "Federal Agency for Occupational Risks. (2023). Implementation of a pilot project for the secondary prevention of work-related psychosocial disorders, final evaluation report. Brussels: Belgium. Legal deposit: D/2023/14.014/21

This publication is inseparable from the following publication:

Hansez, I. & Braeckman, L. (2023, 31 March). Evaluation of a treatment programme for workers experiencing early burn-out (secondary prevention). Scientific report on the pilot project implemented by the Federal Agency for Occupational Risks (Fedris). Brussels: Belgium. Legal deposit: D/2023/14.014/18

Any quotation must therefore reference both documents.

The full version of these two reports can be downloaded from: https://www.fedris.be/fr/professionnel/publications-scientifiques

For more information about this report, please contact: scientific.council@fedris.be

Acknowledgements

Fedris would like to thank Mrs. Sofie Balduyck, Dr. Kristien Bauwens, Mr. Koen Boonen, Mrs. Véronique Brouette, Mrs. Véronique Crutzen, Mrs. Tine Daeseleire, Mrs. Anne Dumbruch, Mrs. Myriam Pauwels, Dr. Olivier Poot, Mrs. Mélanie Straetmans and Mrs. Marthe Verjans for their participation in the working group that lead to the development of Fedris' pilot project on secondary prevention of burn-out.

About Fedris

Fedris, the Federal Agency for Occupational Risks, is the public social security institution for workers. Within the Belgian federal administration, Fedris is responsible for the occupational diseases and occupational accidents. Fedris is under the authority of the Minister of Social Affairs and Public Health.

The Agency was created on 1 January 2017 following the merger of the Fund for Occupational Accidents and the Fund for Occupational Diseases.

The institution is led by a **general management committee**, composed of an equal number of workers' and employers' representatives. Besides, there is also a specific management committee for occupational accidents and another one for occupational diseases. These management committees are assisted by **technical committees with advisory powers**. More specifically, for matters relating to occupational diseases, this involves:

- the Technical Committee for the Prevention of Occupational Diseases;
- the Scientific Council (which receives advice from eight medical commissions).

A general administrator is responsible for the day-to-day management of Fedris and for carrying out the decisions taken by the management committees. The general administrator is assisted in this mission by an assistant managing director administrator and the directors of the various departments.

The four main missions of Fedris are:

- monitoring insurance companies and employers in the context of occupational accidents;
- compensating certain categories of victims (and their dependants) of an occupationalaccident (not covered by insurance companies), and victims (and their dependants) of an occupational disease for all workers in the private sector or persons assimilated thereto. Fedris also intervenes in favour of public sector workers in provincial and local administrations;
- preventing occupational accidents and occupational diseases, in particular by implementing prevention projects and programmes;
- providing information (website, hotlines, brochures, etc.) to victims, employers, insurers, journalists, social partners, the Minister, etc., in particular by publishing brochures, running hotlines, maintaining its website, etc.

For further information: https://www.fedris.be/en/about-fund/who-we-are

TABLE OF CONTENTS

Tabl	e of cont	tents 5
List o	of abbre	viations 8
List o	of figure	s 9
List o	of Tables	s10
1.	INTRODU	ICTION
1.1 \$	Setting th	ne scene
1.2.	Prepar	ratory work
2. 1	DESCRIP	TION OF THE PILOT PROJECT
2.1.	Definitio	on of burn-out and conceptual framework14
2.2.	Project	scope15
2.3.	Impact	t of the health crisis caused by the Covid-19 epidemic15
2.4.	Prever	ntion actors
2.5.	Fedris	-approved support providers17
	2.5.1.	Burn-out support provider (BOSP)17
	2.5.2.	Individual sessions support provider(ISSP)
	2.5.3.	Covid-19 support provider (COSP)18
2.6.	Suppor	rt provider selection procedure18
2.7.	Suppor	rt provider training
	2.7.1.	Objectives
	2.7.2.	Tool available to providers19
2.8.	Descri	ption of the pathway20
	2.8.1.	Linking the different phases and levels of prevention
	2.8.2.	Phase 0: Screening
	2.8.3.	Phase 1: Diagnosis20
	2.8.4.	Phase 2: Support Pathway21
	2.8.5.	Phase 3: End of the support pathway22
3. I	PROJECT	EVALUATION METHODOLOGY
3.1.	Determi	ning an evaluation framework23
3.2.	Data col	lection, coding and analysis23
3.3.	Assessm	ent of the support pathway24
4. I	PROJECT	- EVALUATION

4.1. General quantitative data2	26
4.1.1. Sociodemographic data on all workers who submitted a screening form (PHASE	06
4.1.2 Descriptive data on detection and screening by provention actors (DUASE 0)	.0
4.1.2. Descriptive data on detection and screening by prevention actors (PHASE 0)2 4.1.3. Screening forms received and decisions made by Fedris (Phase 1)	17 31
4.1.4. Screening reports and decisions made by Fedris (Phase 2)	۲۲ 1
4.1.5 Support pathways in progress or completed (PHASE 3)	۲. 1
4.1.6. Processing times for pilot project requests	32
4 1 7 Impact of the Covid-19 crisis	<u>، -</u>
4.2. Scientific evaluation of the project	34
4.3 Evaluation by the network	25
4.4 Organisational efficiency and quality	36
4.4.1 Communication Information Training	2
4.4.1. Communication - Information - Training	90 97
4.4.2. Evaluation of diministrative aspects)/)0
4.4.5. Evaluation of the support pathway	ю 10
4.4.4. Evaluation of training activities	10 12
	+Z 1 /
5. DISCUSSION AND RECOMMENDATIONS	14
5.1. Identification	14
5.1. Identification 2 5.2. Diagnosis 2	14 15
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2	14 15 16
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2 5.4. Network 2	14 15 16 17
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4	14 15 16 17
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4	14 15 16 17 17
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4 5.5. Linking secondary prevention and primary prevention 4	14 15 16 17 17 18
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4 5.5. Linking secondary prevention and primary prevention 4 5.6. Adaptations of the project 5	14 15 16 17 17 18 19 50
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4 5.5. Linking secondary prevention and primary prevention 4 5.6.1. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5	14 15 16 17 17 18 19 50
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4 5.5. Linking secondary prevention and primary prevention 4 5.6.1. Adaptations of the project 5 5.6.2. Transition from pilot project to programme 5	14 15 16 17 17 18 19 50 50
5.1. Identification 4 5.2. Diagnosis 4 5.3. Pathway management and coordination 4 5.4. Network 4 5.4.1. Proximity 4 5.4.2. Attractiveness 4 5.5. Linking secondary prevention and primary prevention 4 5.6. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5 5.6.2. Transition from pilot project to programme 5 5.7. Information, training and development of expertise 5	14 15 16 17 17 18 19 50 50 51 53
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2 5.4. Network 2 5.4.1. Proximity 2 5.4.2. Attractiveness 2 5.5. Linking secondary prevention and primary prevention 2 5.6. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5 5.6.2. Transition from pilot project to programme 5 5.7. Information, training and development of expertise 5 5.8. Communication and information 5	14 15 16 17 17 18 19 50 50 51 53 54
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2 5.4. Network 2 5.4. Network 2 5.4.1. Proximity 2 5.4.2. Attractiveness 2 5.5. Linking secondary prevention and primary prevention 2 5.6. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5 5.6.2. Transition from pilot project to programme 5 5.7. Information, training and development of expertise 5 5.8. Communication and information 5	14 15 16 17 18 19 50 50 51 53 54 55
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2 5.4. Network 2 5.4. Network 2 5.4.1. Proximity 2 5.4.2. Attractiveness 2 5.5. Linking secondary prevention and primary prevention 2 5.6. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5 5.6.2. Transition from pilot project to programme 5 5.7. Information, training and development of expertise 5 5.8. Communication and information 5 6. LIMITATIONS 5 7. CONCLUSION 5	14 15 17 17 18 19 50 51 53 14 55 56
5.1. Identification 2 5.2. Diagnosis 2 5.3. Pathway management and coordination 2 5.4. Network 2 5.4.1. Proximity 2 5.4.2. Attractiveness 2 5.5. Linking secondary prevention and primary prevention 2 5.6. Adaptations of the project 5 5.6.1. Adaptations following the Covid-19 crisis 5 5.6.2. Transition from pilot project to programme 5 5.7. Information, training and development of expertise 5 5.8. Communication and information 5 7. CONCLUSION 5 8. REFERENCES 5	14 15 16 17 18 10 50 51 53 54 55 56 57

Appendix 1: Typical support provider profiles	. 59
Appendix 2: Support scheme	. 65
Appendix 3: List of experts involved	. 66

LIST OF ABBREVIATIONS

Burn-out support provider	BOSP				
Covid-19 support provider	COSP				
Curriculum vitae	CV				
Dutch-speaking	NL				
Federal Agency for Occupational Risks	Fedris				
French-speaking	FR				
General Data Protection Regulation	GDPR				
General practitioner	GP				
Human Resources	HR				
Individual sessions support provider	ISSP				
National Institute for Health and Disability Insurance	NIHDI				
Prevention Advisor for Psychosocial Aspects	ΡΑΡΑ				
Prevention Advisor - Occupational Physician	ΡΑΟΡ				
Progressive evaluation, level 2	EVAL2				
Progressive evaluation, level 3	EVAL3				
Standard deviation	Σ				

LIST OF FIGURES

Figure 1. Phases of the support pathway
Figure 2. Modular structure of the support pathway21
Figure 3. Timetable of the graduated evaluation approach presented in July 202225
Figure 4. Distribution of screening forms by sector
Figure 5. Distribution of screening forms by year
Figure 6. Distribution of screening forms by age27
Figure 7. Distribution of applications by gender27
Figure 8. Distribution of screening forms by type of signatory in accordance with language
used
Figure 9. Frequency of the risk factors mentioned in screening requests for all sectors28
Figure 10. Frequency of the risk factors mentioned in screening requests for the healthcare
sector
Figure 11. Frequency of the risk factors mentioned in screening requests for the banking
sector
Figure 12. Frequency of missing resources mentioned in screening requests
Figure 13. Frequency of missing resources mentioned in screening requests by the healthcare
sector
Figure 14. Frequency of missing resources mentioned in screening requests by the banking
sector
Figure 15. Distribution of screening reports according to Fedris' decision
Figure 16. Distribution of the number of files according to the Covid-19 impact mentioned
in the screening reports, by sector and language used
Figure 17. Proposed changes to the support pathway

LIST OF TABLES

Table 1. Average processing times for screening requests by quarter for 2022	32
Table 2. Average processing times for support requests by quarter for 2022	32

1. INTRODUCTION

1.1 Setting the scene

Work has changed radically since the 1970s. The standardisation of processes, the intensification of work and the demands of productivity and competitiveness have all increased, requiring workers to have more skills and versatility, greater flexibility and continuous training throughout their careers. These changes have accelerated in recent years, as the emergence and increasingly widespread use of new technologies and the gradual introduction of artificial intelligence are redefining most business activities and processes. Recently, the explosion in teleworking has redefined the boundary between the private and professional spheres and the interactions between these two facets of workers' lives.

All these changes are not without consequences, and in alongside changes in working conditions and organisation, we are seeing a significant increase in work incapacity linked to psychosocial disorders. These disorders are now a major public health issue.

In 2016, the National Institute for Health and Disability Insurance (NIHDI) estimated that 23,821 workers and jobseekers were on disability allowances due to burn-out. The estimated cost to the health and disability insurance system was 324,979,497.09 euros for this issue alone.

Faced with this observation and convinced that the Fund for Occupational Diseases (now the Federal Agency for Occupational Risks) could play an important role in the secondary prevention of work-related psychosocial issues, the Management Committee of the Occupational Diseases Fund decided, in 2016, to develop a prevention project. The aim of the project was to reach results that would lead to the recognition of burn-out and work-related psychosocial disorders as work-related diseases.

The concept of work-related disease is different from that of occupational disease. In 2006, it was incorporated into the legislation on occupational diseases, with the aim of reinforcing Fedris' preventive competence.

As a result, according to Article 62bis of the laws on the prevention of occupational diseases and compensation for any resulting damages, coordinated on 3 June 1970, work-related diseases are diseases which do not meet the conditions of occupational diseases but which, according to generally accepted medical knowledge, may be partially caused by exposure to a harmful influence, inherent in the occupational activity and greater than that incurred by the population in general, although this exposure, in groups of exposed persons, does not constitute the predominant cause of the disease.

In the case of an occupational disease, exposure to a harmful influence must be the predominant cause of the onset of the disease. However, in the case of work-related diseases, occupational exposure to a partial harmful influence is enough - it is one cause, but there may be others.

In both cases there must be an occupational exposure, i.e. exposure inherent to the exercise of the occupation which reaches a sufficient threshold in frequency, duration and intensity to cause the onset of the disease. However, in the case of an occupational disease, this exposure must be significantly greater than that experienced by the general population, whereas in the case of work-related diseases, higher exposure is sufficient. In the case of work-related diseases, eligible workers are offered secondary prevention measures to enable them to remain at work or return to work quickly after a short period of incapacity.

To verify the relevance and effectiveness of any new prevention measure concerning workrelated illnesses, the measure is tested first as part of a prevention pilot project that is limited in scope, duration and field of application; it is decided by the Management Committee on a proposal of the Scientific Council. The terms and conditions of the pilot project targeting the prevention of work-related burn-out were formalised in the Royal Decree of 7 February 2018 determining the conditions of a pilot project aimed at preventing work-related burn-out (*M.B* 07.05.2018).

If a pilot project is evaluated positively, on a proposal of the Management Committee for Occupational Diseases and after consulting the Scientific Council, it may be the subject of a more permanent prevention measure, as provided in Article 62bis of the 1970 coordinated laws.

The decision to investigate the possibility of recognising burn-out and work-related psychosocial disorders as work-related diseases rather than occupational diseases stems from the specific characteristics of these issues:

- the wide variety of symptoms that can constitute the burn-out syndrome, and therefore the difficulty of establishing an exhaustive definition;
- the specific nature of exposure to a harmful influence made up of different elements, not all of which constitute an occupational hazard;
- the absence of a validated method of quantitative analysis, according to current scientific knowledge, for characterising this occupational exposure;
- and the constant evolution of scientific knowledge on this subject, leading to frequent revisions of the elements that can contribute to exposure to a harmful influence that constitutes the burn-out syndrome, and hence its very definition.

1.2. Preparatory work

Following the Management Committee for Occupational Diseases' decision to launch a pilot project, Professors Lutgart Braeckman of Ghent University and Isabelle Hansez of University of Liège were commissioned to do a scientific literature review in order to:

- identify occupational activities and work environments with a high risk of burn-out, as well as the profiles most likely to develop symptoms of the syndrome, so as to determine one or more suitable target audiences for a national secondary prevention programme to be carried out by Fedris;
- formulate proposals for the implementation of a secondary prevention programme by Fedris;
- make a proposal for a name under which burn-out syndrome could be included in the list of work-related diseases.

On 25 May 2016, the Scientific Council validated this literature review and its conclusions, and on this basis issued a favourable opinion on implementing a pilot project for the secondary prevention of burn-out. On the basis of this opinion, on 14 September 2016, the Management Committee for Occupational Diseases decided to launch the

preliminary work required to develop a proposal for a pilot project on secondary prevention of psychosocial risks for the hospital and banking sectors.

Monitoring of the project was entrusted to the Technical Committee for the Prevention of Occupational Diseases. The project results were regularly presented to Fedris' Scientific Council and Management Committee for Occupational Diseases.

To develop its pilot project, Fedris set up a working group including the two scientific experts previously mentioned and a number of people working in this field (prevention advisors-occupational physicians (PAOP), a general practitioner (GP), prevention advisors for psychosocial aspects (PAPA), human resources managers (HR) and occupational psychologists) (see Appendix 3).

This working group met five times between January and March 2017 to:

- develop a support pathway for people at risk of burn-out or at an early stage of burnout;
- identify existing tools to allow early detection of burn-out;
- determine profiles and roles of the different support providers involved in the pathway;
- identify the interactions that need to be established between these protagonists, occupational health prevention services, GPs and medical advisors of health insurance funds, where applicable;
- develop the tools needed for the clinical and scientific management of the project.

This proposal was then presented to a wider panel of practitioners and to the social partners of the two selected sectors (hospital and banking) in a one-day workshop during which it could be confronted to reality and be improved on the basis of the advice and best practices received.

The Scientific Council validated the final proposal on 23 May 2017 and, on 7 October 2017, the Management Committee for Occupational Diseases approved the pilot project. They instructed the administration to finalise the work in order to launch it on 1 November 2018. The project was finally launched on 17 January 2019.

2. DESCRIPTION OF THE PILOT PROJECT

2.1. Definition of burn-out and conceptual framework

Fedris' burn-out pilot project aimed to:

- confirm the feasibility and validity of a support pathway for workers at risk of burn-out or at an early stage of burn-out;
- enable these workers to stay at work or return to work quickly.

It is part of secondary prevention, in conjunction with primary and tertiary prevention.

To carry out this project, Professors Hansez (ULiège) and Braeckman (Ghent University) used the definition of burn-out developed by Professors Schaufeli and De Witte from KU Leuven and accepted by the Superior Health Council (2017, p. 11):

"Due to work overload, often accompanied by personal vulnerability and/or difficulties in private life, the energy needed to regulate certain cognitive and emotional processes can no longer be mobilised. This loss of control in association with exhaustion lead to a self-protecting reaction in which mental distance is adopted from the source of exhaustion (in the case of burn-out: work). This is mainly a negative attitude, for example, in the form of cynicism. However, this attitude can also result in physical remoteness from work (e.g., avoiding contact with colleagues). A loss of control also leads to a depressive mood. This mood is the consequence of an emotional reaction and should not be equated with depression as an independent psychological disorder. Symptoms of nervous tension (stress) are considered secondary symptoms and can give a more complete picture of burn-out. They are often the first reason for which help is sought, and can be a warning sign of burn-out from overwork" (Desart et al., 2017).

The development of the support pathway was based on this definition, in particular for the choice of the recommended therapeutic approaches (namely the cognitive-emotional and mind-body approaches). Several studies have shown the benefits of cognitive-emotional interventions for healthcare workers faced with stress or burn-out on the management of emotions, attention and the ability to relax and care for themselves, with a consequent improvement in quality of life and professional and family relationships (Cohen-Katz et al., 2005; Moody et al., 2013; Huang et al., 2015; Eriksson et al., 2018).

Fedris has chosen to entrust health professionals with recognised training (mainly psychologists, but also doctors) with the task of confirming or invalidating the presence of early-stage burn-out and, if necessary, implementing a personalised therapeutic strategy. Given the number of psychological disorders that could be covered by the aforementioned symptomatology, it is essential that a differential diagnosis is carried out to avoid therapeutic wanderings and failures. However, the diagnosis of burn-out remains a diagnosis of exclusion which "is difficult to make externally by using evaluation scales or by observing people at work. It is by people observing their inner selves with the help of a professional that we can reach a diagnosis of burn-out" (Canouï, 2016, p. 31).

The particularity, the strength and probably the originality of this pilot project is that it lies at the crossroads of two worlds, namely work and health. At each stage (detection, screening and care), the methodology developed involves actors from different levels of prevention, with the aim of facilitating their coordination and promoting a linear, global

and multidisciplinary approach in providing support for burn-out care. Not only does it enable workers to receive an individual, personalised support pathway, it also allows prevention actors (PAOP, PAPA) to act at a more collective level on the organisational components that lead to burn-out.

2.2. Project scope

The project involved a minimum of 300 workers¹ in order to obtain the data required for the evaluation. To establish a financial framework for the project, a maximum of 1,000 workers was set at the outset. In 2021, the consequences for the mental health of workers impacted by the Covid-19 epidemic prompted the Management Committee for Occupational Diseases to increase this number to a maximum of 2,500 workers to better meet the needs in the field.

To be eligible to take part in the support pathway offered by Fedris' burn-out pilot project, workers had to meet two inclusion criteria:

1. Work in the hospital, healthcare or banking sector.

The choice of these sectors was guided, on one hand, by the literature review carried out in 2016 by Professors Hansez and Braeckman and, on the other, by the need for Fedris to be mandated to support workers in the sectors concerned.

Healthcare workers are particularly at risk of occupational burn-out due to their constant exposure to emotionally draining factors of stress in the complex treatment of patients (Woo et al., 2020).

Workers in the banking sector, on the other hand, have had to cope with numerous changes in organisation, structure and working methods over the last few years. Studies have shown that stress in the banking sector has reached a critical level that can have deleterious effects on the psychological and physical health of workers in this sector (Giorgi et al., 2017).

2. Present an early-stage occupational burn-out syndrome relevant to secondary prevention and so not have been off sick for more than two months at the time of their application to participate.

2.3. Impact of the health crisis caused by the Covid-19 epidemic

The Covid-19 epidemic had repercussions on the project and its target audiences, in particular the hospital sector, which was on the front line of the health crisis management. From the end of March 2020, as the first peak of contaminations approached, the Covid-19 context began to be mentioned in the files as an aggravating and/or triggering factor for burn-out. In line with the crisis management principle that "exceptional situations call for exceptional resources", the project team adopted a proactive approach and created an appropriate response, taking into account the scale of the crisis and feedback from the network of support providers. A review of international literature on previous (SARS, H1N1) and recent (Covid-19) epidemic experiences was carried out by Fedris in April 2020. This literature review highlighted a significant impact on mental health in the general

¹ The conditions of the pilot project were specified in the Royal Decree of 7 February 2018, amended by the Royal Decrees of 28 December 2020 and 10 January 2022, determining the conditions of a pilot project aimed at preventing work-related burn-out.

population, and in particular in frontline healthcare staff members exposed to specific professional and personal psychosocial risks (Kang et al., 2020).

From a clinical point of view, the sudden confrontation with coronavirus required the ability to adapt to changing information, acquire new knowledge and learn specific skills in crisis management, precaution, protection and care strategies. This scientific literature review also points to an increase in psychological distress, with the appearance or worsening of anxiety, depressive, addictive or post-traumatic stress disorders (Lai et al., 2020; Koh et al., 2005; Maunder, 2004), with the corollary risk of an increase in suicidal acts (Reger et al., 2020). These disorders can obviously have repercussions on work performance and lead to the development of burn-out or its aggravation. Past experience shows that complaints are expressed in the aftermath of a crisis, but also often at a later stage (up to two years; Maunder et al., 2006), when symptoms are no longer tolerable or when a significant dysfunction appears.

Given the major stakes in terms of protecting mental health in the workplace, Fedris felt that its pilot project on secondary prevention of burn-out, which was already in place and identified by prevention actors, could be one of the factors in this strategy.

Adaptations were made to enable workers who needed it to assess and manage the specific psychological consequences of the health crisis on their functioning, as a prerequisite for more comprehensive care of their burn-out. Taking the impact of Covid-19 into account, from the diagnosis phase and subsequently in the support pathway phase, ensures that the support pathway, as initially conceived, retains its full relevance and effectiveness. During the diagnostic phase, any disorders or difficulties linked to the health crisis and complicating the picture of early-stage burn-out were identified, so they could be assessed and, if necessary, treated. A secondary, but nonetheless essential, aim of these adaptations was to increase workers' resilience in the event of a future crisis. Objectifying the experience of working in a crisis situation and learning from it, both organisationally and personally, can be a protective factor against burn-out in the future.

In concrete terms, the adaptations involved:

- extending the pilot project to other healthcare sectors:
 - activities of general practitioners (Q86.210);
 - activities of specialist practitioners (Q86.220);
 - ambulance transport activities (Q86.903);
 - outpatient rehabilitation activities (Q86.905);
 - activities of nursing practitioners (Q86.906);
 - residential care activities for people with mental disabilities, psychiatric problems or drug addiction (Q87.2);
 - residential care activities for the elderly or those with a motor disability (Q87.3).
- extending the scope of the project from 1,000 to 2,500 workers eligible to benefit from the support pathway once the diagnosis was confirmed;
- taking into account the impact of the Covid-19 epidemic, from the diagnostic phase, and then in the support pathway phase with the addition of specific sessions.

These modifications were included in the Royal Decree of 28 December 2020 (published on 8 January 2021), modifying the Royal Decree of 7 February 2018 determining the conditions of a pilot project aimed at preventing work-related burn-out.

2.4. Prevention actors

The GPs, PAOP and PAPA are the gateways to the pilot project. They have the skills, knowledge, training and/or recognised qualifications to carry out an initial analysis and an assessment of the psychosocial risks faced by the worker as well as to rule out other disorders that could explain their health condition. The PAOP and PAPA also played a key role in linking the actions of the burn-out support provider (see point 2.5.1.) at the individual level with those of the employer at the collective and organisational levels. As part of the pilot project and with the worker's consent, they received a "transmission sheet" containing the relevant information that was useful for the worker's follow-up. They could also carry out an analysis to ensure the future of the worker concerned within the organisation and, on a more collective level, the well-being of all workers as part of the primary prevention of psychosocial risks within the organisation. Therefore they play a pivotal role between secondary and primary prevention, between the world of mental health and that of the workplace.

HR managers, local management, support staff and union representatives are all key players in identifying and referring cases to occupational medicine, implementing concrete actions to ensure that the worker concerned remains at and/or returns to work, and taking measures to prevent further cases in the future.

2.5. Fedris-approved support providers

In the preparatory phase of the project, after consultation with those working in the field and academics, Fedris chose clinical psychologists, doctors and physiotherapists to form its network of support providers, all professionals with recognised training in health or psychology. Moreover, as one of the objectives is to more precisely identify the phenomenon of burn-out in the workplace, it seemed important to combine the mental health expertise of psychologists and psychiatrists with that of prevention actors-occupational physicians and general practitioners.

To this end, three types of support providers (BOSP, ISSP, COSP), each with a different profile, were defined as part of the support pathway offered by Fedris (profiles detailed in Appendix 1). The selected professionals and centres annually signed a collaboration agreement with Fedris, according to the role(s) for which they were selected. These agreements were specific to each role and differentiate between centres and individual practitioners with self-employed status.

These agreements were improved as the project progressed, to make them as clear and precise as possible regarding the responsibilities and obligations of each role, as well as to emphasise the importance of coordination between these different roles.

2.5.1. Burn-out support provider (BOSP)

The burn-out support providers (BOSP) play a central role in the pilot project as reference operators. Initially, the BOSPs' task was to confirm or rule out the presence of an early stage of work-related burn-out, and the fact that the support pathway planned by Fedris suits the worker's situation. They then take on the role of coordinator. They support the worker, co-construct a pathway with the worker and coordinate it in liaison with the other support providers involved whose specific skills had been brought in. As part of their coordination role, it is up to them to prepare the multidisciplinary meeting with the worker and, if necessary, contact the prevention department to explain the context and the needs of the worker in their care. This provider is a contact person who can facilitate exchanges with prevention actors by preparing the worker and, if need be and with the worker's consent, passing on information deemed useful for the follow-up. Lastly, the burn-out support provider is also the one who drafts and forwards the screening and end-of-care reports to Fedris.

2.5.2. Individual sessions support provider (ISSP)

The Individual sessions support provider(ISSP) is responsible for carrying out cognitiveemotional and/or mind-body sessions with the worker. The cognitive-emotional approach refers to therapies that consider the cognitive, behavioural and emotional dimensions of the individual. This approach enables the person to become aware of his/her thoughts, emotions and behaviours and to learn how to manage them. The mind-body approach places the body and perceptions at the heart of the support provided. The body is seen as a gateway to both physical and psychological well-being. By acting on the body and its tensions, we also act on the psyche.

2.5.3. Covid-19 support provider (COSP)

In conjunction with the burn-out support provider, where necessary the Covid-19 support provider sets up a system for assessing and providing early treatment for the consequences of the health crisis on the personal and professional functioning of the worker included in the project. The issues addressed and lessons learned in the "COVID-19 Module" and/or "COVID-19 Starterkit" sessions feed into the support pathway and shed light on the occupational burn-out process in all its complexity.

2.6. Support provider selection procedure

All freelance providers interested in the pilot project had to send a curriculum vitae (CV), a cover letter, a copy of their diplomas and degree courses, and a copy of their registration with the Commission of Psychologists (for psychologists only) to Fedris.

Applications for the roles of BOSP, ISSP and COSP were analysed by Fedris' psychologists and physiotherapists on the basis of the criteria detailed in Appendix 1.

An additional interview was carried out by Fedris' psychologists for the role of burn-out support provider. This was an opportunity to test the candidates' experience in diagnostic assessment and providing support for burn-out, as well as their suitability as pathway coordinators. It also ensured that they understood the project and the framework within which the collaboration agreement had been signed. This validation was a prerequisite for adding the support provider to the network of Fedris-approved support providers set up as part of the burn-out pilot project. Once the application had been approved, the ad hoc agreement was sent for signature.

The selection procedure was identical for the inclusion of providers from centres. However, centres that wanted to participate in the project were also asked to designate a contact person for Fedris. This person was also interviewed by Fedris' psychologists. This interview gave a better understanding of how the centre operates, the profile of the people working there, and whether or not to approve the application. This approval was a prerequisite for adding a centre to the list of Fedris-approved support providers.

2.7. Support provider training

At the start of the project, Fedris set up a continuous information and training programme for its network of support providers and prevention actors. Each action was developed on the basis of questions asked by the network, as well as the team's own questions and reflections throughout the project. A systematic evaluation of these actions was carried out to guarantee the quality and constant improvement of this approach to information and ongoing training for the network of support providers.

2.7.1. Objectives

The information and training initiatives for the network of support providers and prevention actors had numerous objectives. The aim was both to enable them to understand and use the system set up by Fedris (e.g., conceptual framework, tools created, roles and missions) and to offer them space for sharing thoughts and clinical experience of the support pathway (good practices, transmission of knowledge and observations, etc.). It was also an opportunity to work towards consolidating a network of professionals active in burn-out prevention. Lastly, these meetings with professionals in the field also enabled Fedris to maintain an overview of the project, which was a prerequisite for adapting to the everchanging reality in the field.

2.7.2. Tool available to providers

Guidelines were created for support providers. They contained all the information they needed (the context of the pilot project, the definition of psychosocial risks, the support pathway methodology, a description of each stage of the support pathway, a description of the different roles, the coordination to be planned with other providers and actors in the field). Administrative procedures (invoicing, document dispatch, etc.) were also explained.

A *SharePoint* platform dedicated to support providers was also created. This platform contained all documents providers could or must use as part of the administrative procedures, the guidelines and the various tools for communicating or explaining the project to workers. This *SharePoint* was only accessible to Fedris-approved support providers. Support providers could receive this documentation in hard copy on request.

2.8. Description of the pathway

2.8.1. Linking the different phases and levels of prevention

The pathway comprised several phases (see Figures 1 and 2; Appendix 2), as detailed below.





2.8.2. Phase 0: Screening

Any prevention actor who identified a worker showing signs of burn-out could refer the worker to the pilot project. The screening request could also come from the worker directly. In both cases, a screening request had to be submitted to Fedris by the worker in consultation with their GP, PAOP and/or PAPA, who also signed the request.

When submitting the participation request, the worker was informed that a study was associated with the burn-out pilot project and that he/she could decide at any time to stop the pathway and/or the associated study. Based on this "screening" form, which included an initial assessment of the psychosocial risks faced by the worker, Fedris examined whether the worker met the above-mentioned inclusion criteria. Following this, and on the basis of an initial agreement, an administrative decision letter was sent to the worker, who then entered Phase 1.

2.8.3. Phase 1: Diagnosis

The worker selected and contacted a burn-out support provider from the list of Fedrisapproved support providers. The worker would meet with this "burn-out support provider" (psychologist or doctor), who assessed the situation during a maximum of two "diagnostic" sessions. Based on this in-depth assessment, the burn-out support provider, with the worker's agreement, sent a "screening report" to Fedris and, where appropriate, submitted a request for support. All the information in the file was then analysed and discussed by Fedris' psychologists during consultation meetings. The purpose of this analysis was to determine:

- the presence of an early stage of burn-out,
- the presence of a predominant link between burn-out and work,

- the relevance of early support,
- and the suitability of Fedris' support pathway for the worker's situation.

In the event of difficulties in reaching a decision on a case, Fedris' psychologists would liaise with the burn-out support provider for clinical consultation. This discussion time allowed for gathering additional information and comparing sometimes contradictory opinions. On a more methodological level, by constantly refining clinical thinking, it also contributed to the development of expertise in the field of mental suffering in the workplace.

If the presence of an early work-related burn-out syndrome was confirmed, Fedris agreed to cover the cost of the worker's support pathway. Phase 2 of the actual support pathway could then begin. If this was not the case, or if the proposed pathway was not suited to the worker's situation, Fedris would refuse the request. From 2021, the worker could benefit from an "orientation" session. This session enabled the worker to discuss the reasons for refusal with the burn-out support provider and to be redirected towards the help best suited to needs. Following the diagnostic sessions, a summary sheet drafted by the burn-out support provider and containing information relevant to follow-up was sent to the GP, PAOP and PAPA, with the worker's consent.

2.8.4. Phase 2: Support Pathway

On the basis of the assessment carried out during the diagnostic phase, the burn-out support provider coordinates and defines the support pathway with the worker, according to the needs and pace. The support pathway is made up of different modules that address both the organisational and individual dimensions that led to burn-out (see Figure 2 and Appendix 2).



Figure 2. Modular structure of the support pathway.

Each module has a specific function:

- "Work clinic": to enable the worker to talk about the reality of work, giving space to subjectivity and expression of suffering; to list the resources available (personal, collective or organisational resources, as well as medical and legal resources); to address certain legal aspects (labour law, welfare legislation); to review the situation at work, the causes of burnout and, finally, to consider organising a multidisciplinary meeting and prepare the worker for this meeting.

- "Starterkit: to provide basic knowledge on "wellness/health" topics such as stress management, healthy lifestyle, etc.
- "Individual session(s)": to offer support based on cognitive-emotional and/or mind-body approaches. Not all sessions were to be carried out using the same approach or with the same support provider.
- "Follow-up session(s): to review the situation with the worker. This was also an opportunity to adapt the support during or at the end of the pathway, to close and, if further action was required, to direct the worker towards the appropriate help.
- "*Reorientation session(s)*": in the event of difficulties to return to work, this gives the opportunity to discuss, with the worker, the possibility of a professional reorientation (e.g., change of job, employer, sector or trade).

The proposed support pathway was flexible, personalised and extended over a period of around nine months. Thanks to an ongoing assessment of the worker's needs, the burn-out support provider could use different types of modules, as well as different types of professionals, known as "individual session support providers" (see point 2.5.2.).

In addition, as previously mentioned, from the health crisis of 2020 (COVID-19), workers had the option of additional sessions in the event of specific psychological consequences of the health crisis on their functioning (see Figure 2).

- "COVID-19 Module": to encourage the expression and elaboration of experience and difficulties encountered during the health crisis. It was designed to help identify psychological disorders that have appeared since Covid-19, or the aggravation of pre-existing disorders caused by working in an exceptional health situation, and to facilitate support.
- "COVID-19 Starterkit": to provide basic knowledge of the psychological repercussions specific to a health crisis situation, while raising awareness of ways to prevent the onset or establishment of characteristic disorders, and identifying and/or developing effective coping strategies in the event of an exceptional health situation.

2.8.5. Phase 3: End of the support pathway

At the end of the support pathway, the burn-out support provider had to send a final report summarising the pathway taken, together with a summary sheet which, with the worker's agreement, was forwarded to the GP, PAOP and PAPA. The clinical analysis of these reports by Fedris' psychologists allowed an assessment of the impact the support pathway and its modules had had on the worker's psychological state.

3. PROJECT EVALUATION METHODOLOGY

3.1. Determining an evaluation framework

The evaluation framework was defined by the scientific experts and the administration, and validated by Fedris' Management Committee for Occupational Diseases in July 2018. It focused on two aspects:

- 1. The benefits of the support pathway for the worker (well-being, work situation) with three angles of analysis:
 - the worker's psychological and medical condition, at the start of the pathway, at the end of the pathway and three months after the pathway ("pre-test, post-test 1 and post-test 2" data);
 - the worker's employment situation at the start of the pathway, at the end of the pathway and three months after the pathway (factual data relating to the employment situation and changes in the employment situation);
 - the link between what was done during the pathway (data available in the reports) and its effectiveness on the worker's situation.
- 2. The efficiency and quality of the organisation of the pilot project as a whole:
 - the quality of services provided by BOSPs and ISSPs (evaluation of the BOSPs and ISSPs),
 - the quality of Fedris services (Fedris evaluation).

To this end, it was agreed that the support pathway should be evaluated both objectively and subjectively, in terms of both its benefits for the worker and its organisational effectiveness, in order to judge the effectiveness of a support pathway such as the one offered by Fedris and to draw up recommendations for its further development.

3.2. Data collection, coding and analysis

Data required for the burn-out pilot project initially came from two sources:

- Fedris' computer programme, developed to manage the files of workers who submitted a request;
- online questionnaires developed via the University of Liège to ask workers about their health condition (sent to workers by Fedris before the start of their support pathway, at the end of their support pathway and three to six months after the end of their support pathway), with self-reported scales on burn-out (Oldenburg Burnout Inventory (OLBI), Demerouti et al, 2003; Burnout Assessment Tool (BAT), Shaufeli & De Witte, 2019), the DASS (Depression Anxiety Stress Scales; Lovibond & Lovibond, 1995) another self-report scale, and questions on healthcare utilisation (see Scientific Report; Hansez & Braeckman, 2023).

In addition, to ensure the possibility of analysing the relevant data contained in the different reports received per file, it was decided in 2020 to code them. To this end, a request to amend the pilot project was submitted to and approved by the University of Liège's ethics committee. Data was fully coded and anonymised using a coding grid developed by Fedris' psychologists under the supervision of Professors Hansez and Braeckman. Data was processed in a cross-sectional file using computer software (SPSS for Windows, version 29).

3.3. Assessment of the support pathway

Scientific experts in charge of the project evaluation initially set the minimum sample size at 300 files, sufficient to run reliable statistical analyses of the pilot project data. In July 2021, a status report was presented to the Management Committee for Occupational Diseases, including a detailed inventory of the data available for assessment. It showed that the full evaluation of the project could not be carried out by the end of 2021, as initially agreed, as all necessary data would not yet have been collected (the 300 complete files had to include the different reports, as well as responses to the pre-test, post-test 1 and post-test 2).

In view of this finding, and on proposal of the administration, the Management Committee for Occupational Diseases decided to adapt the evaluation schedule and amend the Royal Decree to allow the inclusion of workers beyond 17 January 2022. A Royal Decree extending the project was published in the *Belgian Official Gazette* on 20 January 2022. The proposal was for a gradual, ongoing assessment throughout 2022, to strengthen the data validity over time (see Figure 3). This step-by-step evaluation made it possible to consider the evaluation in its entirety and highlight areas for improvement at each stage, in order to formulate recommendations for the continuation of the pilot project.

In 2022, considering the amount of data collected and coded, the scientific experts associated with the burn-out pilot project ran sensitivity tests (multiple linear regression and logistic regression, etc.). The result of this data analysis revealed medium to moderate effect sizes, with a minimum threshold of 100 files. This effect size was as expected in the field of this research. As this threshold was largely reached for EVAL3 (see Figure 3), on the advice of the experts, on 31 October 2022, it was decided to stop collecting data for the analyses done by the scientific experts 2022 (with a total of 223 complete files). A thorough anonymisation and verification of the encoded data was carried out and finalised at the end of November 2022 with the delivery of the consolidated data to the experts.

In addition, a qualitative assessment was carried out with external partners (Fedrisapproved support providers, prevention actors, HR, social partners). To this end, the project team sent out online questionnaires regarding the evaluation of the pilot project to its external partners. also set up interactive focus groups for gathering qualitative data (three focus groups with Dutch- and French-speaking network members and two with Dutch- and French-speaking prevention actors), as well as round-table discussions with social partners from the sectors concerned. Once all data from the evaluation had been collected, Fedris' team in charge of the project performed a qualitative and descriptive analysis.



Figure 3. Timetable of the graduated evaluation approach presented in July 2022.

4. PROJECT EVALUATION

4.1. General quantitative data

Data below represents all the files received by Fedris from the start of the project to 31 December 2022 (N = 1421). The files selected by Hansez and Braeckman (2023) for their study (N = 223) are included in this overall sample.

4.1.1. Sociodemographic data on all workers who submitted a screening form (PHASE 0)

Fedris received 1,421 screening forms during the project period. Of these, 1,054 forms (74.2%) came from the healthcare sector, 316 from the banking sector (22.2%) and 51 (3.6%) did not fall under a NACE code² covered by the project (see Figure 4). Of the 1,054 requests from the healthcare sector, 101 came from the new NACE codes introduced in January 2021.



Figure 4. Distribution of screening forms by sector.

Of these files, 1,013 (71.3%) were Dutch-speaking, 407 (28.6%) French-speaking and 1 (0.1%) German-speaking (see Figure 5). This proportion has not really changed since 2019, although there was an increase in French-speaking files during the course of the project.



Figure 5. Distribution of screening forms by year.

² Section K64 NACE 2008, Q86.1 NACE 2008, section, Q86.210 NACE 2008, section Q86.220 NACE 2008, section Q86.903 NACE 2008, section Q86.905 NACE 2008, section Q87.1 NACE 2008, section Q87.2 NACE 2008, section Q87.3 NACE 2008

As shown on Figure 6, 2.8% of screening forms came from workers under the age of 25, 22.5% from workers aged between 25 and 35, 29.1% from workers aged between 35 and 45, 31.7% from workers aged between 45 and 55, and 13.9% from workers aged between 55 and 65.



Figure 6. Distribution of screening forms by age.

Furthermore, as Figure 7 shows, the vast majority of applications were submitted by women (84% women and 16% men), with a higher proportion in the hospital and healthcare sector (88.6%) than in the banking sector (66.8%). It should be noted that this great disparity exists de facto in the hospital and healthcare sector, where the majority of staff are women.



Figure 7. Distribution of applications by gender.

4.1.2. Descriptive data on detection and screening by prevention actors (PHASE 0)

Results show that workers were mainly referred to the burn-out pilot project by prevention actors, in roughly similar proportions on the Dutch-speaking and French-speaking sides (65.6% NL; 64.8% FR).

There was, however, a difference between the Dutch-speaking and French-speaking sides of the country in terms of who signed the screening forms (see Figure 8). Dutch-speaking workers seem mainly to have been referred to the project by the PAOP, and French-speaking workers by the PAPA. In contrast, the PAOP signed the fewest screening forms on the French-speaking side. The GP came second, regardless of the language used (31.4% NL; 35.2% FR).



Figure 8. Distribution of screening forms by type of signatory in accordance with language used.

4.1.2.1. Risk factors mentioned in the screening requests

Of the 1,421 screening forms received, 1,413 mentioned psychosocial risk factors (see Figure 9).



Figure 9. Frequency of the risk factors mentioned in screening requests for all sectors.

Generally speaking, the five risk factors most frequently mentioned in the screening forms were, in descending order, workload (83%), time pressure (67.5%), organisational change (49.1%), work-life balance (44.5%) and loss of meaning at work (40.5%).

Although these results were more or less the same, there were differences in the frequency of psychosocial risk factors mentioned by sector.

Figure 10 shows the frequency of the psychosocial risk factors mentioned on the screening forms from the healthcare sector, while Figure 11 shows those from the banking sector.



Figure 10. Frequency of the risk factors mentioned in screening requests for the healthcare sector.



Figure 11. Frequency of the risk factors mentioned in screening requests for the banking sector.

Conflicts at work ranked 6th in the healthcare sector (35.8%), but 8th and to a lesser extent in the banking sector (17.8%). It is not surprising that this risk factor is becoming more frequent in the healthcare sector, where teamwork is a key element, but where there is a permanent shortage of staff and a heavy workload.

In contrast, job uncertainty was mentioned much more frequently in the banking sector (27.9%) than in the healthcare sector (11.8%). There was a noticeable difference in the way the "organisational change" risk factor was expressed, which may perhaps partly explain this discrepancy between the two sectors.

4.1.2.2. Missing resources mentioned in screening requests

Of the 1,421 screening forms received, 1,311 mentioned the lack of certain resources.

Generally speaking, the five missing resources most frequently mentioned in the screening forms were, in descending order, support from the hierarchy (60.2%), recognition (57.9%), participation in decision-making (37.4%), feedback (35%) and support from colleagues (27.9%) (see Figure 12).



Figure 12. Frequency of missing resources mentioned in screening requests.

Although the three missing resources most frequently mentioned in the screening forms were the same in the healthcare and banking sectors, there were several differences in terms of frequency (see Figures 13 and 14). Similarly, differences between sectors can also be observed in the order and frequency of expression of other missing resources.



Figure 13. Frequency of missing resources mentioned in screening requests by the healthcare sector.

Support from colleagues ranked 5th in the healthcare sector (30.1%), but 9th and to a lesser extent in the banking sector (17.4%).

Job security was a missing resource mentioned more frequently by workers in the banking sector (22.5%) than those in the healthcare sector (8.2%).



Figure 14. Frequency of missing resources mentioned in screening requests by the banking sector.

4.1.3. Screening forms received and decisions made by Fedris (Phase 1)

Of the 1,421 workers who submitted a screening form since the start of the project, 1,242 (87.4%) were able to access the diagnostic phase, while 179 workers (12.6%) did not meet the criteria to access the second phase of the pilot project.

The reasons for refusal were as follows:

- incapacity to work for more than two months: 63 cases (35.2%);
- the worker did not belong to a sector covered by the project: 76 files (42.5%);
- the worker did not complete the form: 16 cases (8.9%);
- the worker started another reintegration process: 20 cases (11.2%);
- the worker no longer wanted to participate in the project: 3 cases (1.7%);
- the worker had already participated in the project: 1 file (0.5%).

Of the 1,242 files of workers who accessed phase 2 of the pilot project, 1,064 screening reports (85.7%) were received, while 178 screening reports (14.3%) were not.

4.1.4. Screening reports and decisions made by Fedris (Phase 2)

A total of 1,064 screening reports were received by 31 December 2022. On the basis of these screening reports, Fedris opened up access to a support pathway for 865 workers (81.3%). Conversely, following an analysis of these reports by Fedris' psychologists, 199 workers (18.7%) did not access the support pathway (see Figure 15).



Figure 15. Distribution of screening reports according to Fedris' decision.

Of the refusals, 9 workers (4.5%) declined to take part in Fedris' support pathway, while 188 workers (94.5%) were not accepted because the support pathway was not suited to their situation. Non-suitability may, for example, have been due to the fact that the burn-out was too advanced for secondary prevention, that there was no predominant link with work, that there was another predominant pathology, or that there were significant private problems requiring comprehensive care. For two files (1%), the report was incomplete.

4.1.5. Support pathways in progress or completed (PHASE 3)

Of the 865 workers accepted onto the support pathway, 631 final reports were received, and 234 workers were still on the support pathway on 31 December 2022.

4.1.6. Processing times for pilot project requests

As previously mentioned, the requests received by Fedris were subject to two approvals: an administrative and a clinical approval.

Administrative approval gives access to the diagnostic phase (Phase 1). The deadline initially set in the Royal Decree of 7 February 2018 for this stage was 30 calendar days.

In practice, for 2022, for example, the average time taken to process a screening request was 9.5 calendar days (from the date Fedris received the documents to the date the decision letters were sent to the workers). While this average rose to 12 calendar days when a file was not accepted, the average processing time was seven calendar days for accepted files (see Table 1). This difference can mainly be explained by the need to contact workers for whom the screening forms were incomplete, which hampered the processing of the file.

		T1	T2	Т3	T4	2022	2019
Screening requests	Not accepted	1	13	9	8	12	22
5 1	Accepted	9	7	6	8	7	11
	TOTAL	5	10	7.5	8	9.5	13

Table 1. Average processing times for screening requests by quarter for 2022.

As shown in Table 1, there was a clear improvement in processing times between 2019 and 2022 for both accepted and not accepted files. The main reason for this was the continuous improvement of internal processes and tools for processing screening forms during the project.

Clinical approval gives access to the support pathway (Phase 2). The deadline set by Fedris at the start of the project was 15 calendar days. There was no deadline stipulated in the Royal Decree of 7 February 2018.

For 2022, the average time taken to process support requests was 15 calendar days (from the receipt of documents by Fedris to the dispatch of decision letters to workers) for both accepted and rejected applications (see Table 2).

		T1	T2	Т3	T4	2022	2019
Support requests	Not accepted	15	14	16	15	15	32
Support requests	Accepted	14	17	13	13	15	19
	TOTAL	14	17	14	14	15	22

Table 2. Average processing times for support requests by quarter for 2022.

Once again, there was an improvement in processing times between 2019 and 2022 for both accepted and not accepted files. This improvement in processing times for support requests can largely be explained by the recruitment of additional psychologists during the course of the project.

4.1.7. Impact of the Covid-19 crisis

Of 703 screening reports received by March 2020, 542 files (77.1%) mentioned the Covid-19 context.

Information on the type of Covid-19 impact was missing from three files. In all, 7.7% of the files did not mention the presence of any Covid-19 impact, while 23.7% mentioned the evaluation of this factor as not applicable to the worker's situation.

Lastly, of the 542 files that mentioned the Covid-19 impact, 459 (84.7%) indicated that it had a negative impact, potentially aggravating and/or triggering the burn-out.



Figure 16. Distribution of the number of files according to the Covid-19 impact mentioned in the screening reports, by sector and language used.

These results highlight the negative impact that the health crisis may have had on workers' functioning, particularly in the hospital sector, which was highly exposed. This finding fully justifies the project modifications proposed in 2020, which were implemented in 2021 following the publication of the Royal Decree of 28 December 2020. By December 2022, 185 sessions were used specifically to deal with the consequences of the health crisis. It should be noted that the lack of support providers in certain regions may have hampered access to these specific sessions. Nevertheless, this tends to show that the system as initially devised could be adapted to an unforeseen crisis, and above all to the needs of the workers affected by it. To successfully carry out this type of adaptation and train the network in these changes, Fedris recognises the benefits of having the necessary in-house expertise able, in the event of a crisis, to be proactive while guaranteeing the scientific quality and relevance of the proposed changes.

4.2. Scientific evaluation of the project

As explained above (see point 3.1. Determining an evaluation framework), the evaluation procedures were defined at the outset of the project, validated by the Management Committee for Occupational Diseases and included in the contract with the scientific experts. The report (see scientific report; Hansez & Braeckman, 2023) was submitted to the project team on 15 March 2023 and covered all the complete files collected (see point 3.3. Evaluation process), namely 223 files.

Hansez and Braeckman's (2023) analyses show the value of a coordinated system for early detection and providing support for burn-out. Repeated measures ANOVA highlighted not only a significant reduction in workers' scores on burn-out, stress, depression and anxiety scales but also a self-reported improvement in workers' physical and psychological health and overall well-being. These results held over time (six months), demonstrating the short and medium-term effectiveness of Fedris' support pathway on workers' health. The ongoing benefits over time of Fedris' support pathway for workers' health can also be seen in terms of healthcare use before and after the pathway. There has been a decline in workers' use of medication, consultations with a healthcare provider and other medical examinations.

With regard to the hypothesis of the effectiveness of Fedris' pathway in terms of remaining at and/or returning to work, this seems to be confirmed by a significant difference in workers' professional situation (e.g., sick leave, at work) before and after their participation in Fedris' support pathway. 81.9% of participants said they were at work after taking part in the pathway, compared with 45.3% before the start of the pathway. Furthermore, while a majority of workers pointed to changes in their own relationship to work, their perception of the actions implemented in terms of work organisation was more mixed, with, for example, 60% of workers believing that their organisation did not become aware of the problem at a more collective level.

Finally, Hansez and Braeckman's (2023) results also showed that participants were very satisfied with their support. Overall, participants rated their satisfaction with the pilot project at 8.01 out of 10 (σ = 1.79). They were satisfied with both the organisational and logistical aspects (e.g., appointment scheduling, premises, geographical distances) and the content (e.g., type of professionals involved; number, type and content of sessions; personalisation of the offer).

While these results underline the value of a mixed individual pathway addressing the organisational and individual components of burn-out, they also show the difficulties encountered by some workers, at a more organisational and collective level, regarding the implementation of concrete actions and changes by the organisation itself.

Hansez and Braeckman's (2023) results are complemented by Fedris' evaluation described below (see 4.3. Network evaluation and 4.4. Efficiency and organisational quality), showing the overall satisfaction of prevention actors and care providers involved in its burn-out pilot project.

4.3. Evaluation by the network

The composition of the network of support providers was dynamic, evolving from year to year. This was due to the arrival of new providers and to the departure of others. The most frequently cited reasons for non-renewal were lack of activity, resulting in support providers' demotivation and disengagement, the administrative burden of coordinating for the burn-out support providers, and Fedris' hourly rate, which is lower than the rates set by NIHDI regarding its offer for "first-line" psychological care. Other non-renewals or terminations of agreements were the result of a decision from Fedris following an assessment of the quality of the services provided by the providers concerned, which was deemed insufficient or inappropriate.

The main difficulties encountered by Fedris were as follows:

- a lack of role clarity;
- carrying out support sessions before Fedris gave the go-ahead;
- a lack of coordination between different roles;
- long-term absences of some support providers without notifying Fedris;
- the unavailability of support providers by email or phone within 48 hours, as stipulated in the agreement;
- the use of old templates for reports and other clinical documents.

The difficulties encountered by the network of support providers were as follows:

- omissions in the procedures, which appeared long and complicated, and concerned only a relatively small proportion of all consultations;
- role confusion;
- the feeling among some individual session support providers that they were not involved in the project, as they were not contacted very often;
- a heavy administrative workload (drawing up reports/forms, issuing invoices, mailing, etc.);
- mail losses;
- the complicated use of SharePoint and the need to consult it regularly to keep their access authorisation active.

These difficulties and their resolution were also the driving force behind the dynamic evolution of the administrative procedures associated with the burn-out pilot project. For example, these resolutions involved revising collaboration agreements or creating a guideline, as mentioned above.

4.4 Organisational efficiency and quality

Hansez and Braeckman (2023) analysed workers' satisfaction with their support pathway. Overall, they seemed satisfied to very satisfied with Fedris' support pathway. In addition to this evaluation, the project team carried out a qualitative evaluation based on feedback from the various field players involved at each stage of the project (prevention workers, providers and social partners).

The pilot project was evaluated in two stages by the network of Fedris-approved support providers, prevention actors and social partners. Initially, 71 support providers (clinical psychologists, occupational psychologists, physiotherapists, doctors; n_{FR} = 42 and n_{NL} = 29) took part in an online evaluation guestionnaire. Subsequently, 14 support providers, representing the two linguistic groups and the different support providing roles (BOSP, COSP, ISSP; n_{FR} = 8 and n_{NL} = 6), voluntarily agreed to take part in focus groups organised to deepen and enrich the survey results. The same applied for prevention actors (PAOPs, PAPAs and GPs). 102 prevention actors (n_{FR} = 36 and n_{NL} = 66) completed an evaluation questionnaire. Eight of them (n_{FR} = 3 and n_{NL} = 5) then voluntarily took part in focus groups. Lastly, as far as the social partners were concerned, 35 union representatives (n_{FR}= 33 and $n_{NL}= 2$) took part in an online evaluation questionnaire, and three Dutch-speaking employer representatives (HR) from the hospital and healthcare sector helped with the evaluation of the pilot project by taking part in a round-table discussion. HR representatives from the banking sector, contacted via Febelfin on the occasion of a social commission, stated that they did not receive any feedback from their companies and therefore did not take part in the roundtables. The following quantitative and qualitative data was therefore taken from these three groups.

4.4.1. Communication - Information - Training

Most participants in the evaluation questionnaire mentioned having learned about the project through various means (a colleague, the Internet, the press, etc.). The majority (88.1% of support providers; 83% of prevention actors; 100% of union representatives) agreed that Fedris' burn-out pilot project was not sufficiently well known among prevention actors (GPs, prevention advisors, HR staff, etc.), and particularly among GPs, who can play an important role in detecting and referring workers. Various reasons were given to explain this lack of awareness regarding Fedris' burn-out pilot project. The two main ones were insufficient communication from Fedris (80.3% of support providers; 73.1% of prevention actors; 100% of union representatives) and a lack of information about the project (55.9% of support providers; 64.5% of prevention actors; 48.5% of union representatives).

To solve the problem regarding the lack of awareness of such a project in the future, the support providers, prevention actors and HR staff who took part in the focus groups suggested improvements. One of the first suggestions made by the support providers was to run more "impactful" information campaigns by going directly into the field. For example, by taking part in company or trade associations meetings to explain the project in greater detail to create interest and hold the attention of the various protagonists. During the focus groups, participants reported an excess of information of all kinds (emails, leaflets, etc.). However, HR workers who took part in the roundtable indicated email or the newsletter as their preferred means of contact. The prevention actors suggested that Fedris should try to reach the stakeholders via umbrella or professional organisations and regularly repeat the information campaigns. As for the support providers, it was recommended that the project be presented directly at various events

and meetings. One union representative also suggested that this should be a mandatory item on the agenda of the Committee for Prevention and Protection at Work and that HR staff should be given greater and clearer communication about any changes to the project (via email/newsletter/ the website).

Lastly, with regard to the "Training" aspect, support providers who took part in information sessions, training seminars organised by Fedris and/or focus groups expressed the opinion that this type of activity favoured the exchange of experience concerning the pathway, as well as the creation of a network. This would contribute to a better information exchange and enable the support providers involved in this project to refer patients to each other and collaborate more closely. Support providers were in favour of organising meetings in the future, preferably by region, to facilitate contact between care providers and local actors.

4.4.2. Evaluation of administrative aspects

Support providers, prevention actors and social partners also had the opportunity to give their opinion on the more administrative aspects of the burn-out pilot project, thanks to the evaluation questionnaire they completed online, while HR workers were able to give their views on these aspects during the round-table discussions. Many participants did not wish to comment on some of these aspects (around 30% of support providers, 30% of prevention actors and 40% of union representatives). Of the latter, some felt that the questions did not apply to their situation, while others were neutral (neither agreeing nor disagreeing). The following results take these participants into account and should therefore be treated with caution.

4.4.2.1. Administrative tools

Information about the burn-out pilot project was rated as clear (59.7% of support providers; 63.1% of prevention actors; 56% of union representatives), useful and complete (41.9% of support providers; 61.5% of prevention actors; 56% of union representatives), or easily accessible on Fedris' website (59.7% of support providers; 65% of prevention actors; 40% of union representatives). Furthermore, the different partners who responded to the questionnaire were also satisfied with all the tools made available to them (templates, brochures, flyers, etc.), which they found easy to access via Fedris' website (53% of prevention actors; 40% of union representatives) or via the SharePoint created for them (40.3% of support providers).

More specifically, as far as these tools are concerned, the support providers in the focus groups said they felt well informed by Fedris about the pilot project thanks to the resources available. They were satisfied with the various administrative tools made available to them, including guidelines outlining and explaining the project (75.4%), the collaboration agreement (80.3%), the brochures for workers (68.2%), the emails and/or letters from Fedris concerning the burn-out pilot project (72.1%). Similarly, the prevention actors were generally satisfied with the brochures for workers (53%), the brochures for professionals (50.6%), the emails and/or letters from Fedris concerning the burn-out pilot project (40.9%). A number of participants from different groups also took advantage of the focus groups to ask that information intended for workers in difficulty be clear and concise (but complete, for example with regard to confidentiality) at the risk of them not reading it. Lastly, 72% of the union representatives questioned said they were satisfied with the brochures for project, compared with 58.3% for the information brochures for workers.

4.4.2.2. Administrative procedures

Both network of support providers and prevention actors had the opportunity to evaluate the administrative procedures associated with the burn-out pilot project. Considering, as previously mentioned, respondents who preferred not to give an opinion on the subject (+/- 30%), the results that follow were rather encouraging. However, despite the overall satisfaction of the network of support providers and prevention actors with the administrative procedures, they did suggest areas for improvement that could be considered in the future.

As a result, 57% of prevention actors were satisfied with the use and processing of the different forms, while 47% were satisfied with the processing times for the screening forms submitted to Fedris. They did, however, mention a number of areas for improvement. For example, sending documents by post is seen as a cumbersome method that can lead to delays and loss of documents. One of the requests made by respondents was to be able to send them securely by electronic means. Another area for improvement, partly related to the previous one, was the reduction in waiting times between receipt of the screening form and access to the pathway. This point was also made during the roundtable discussion with HR staff. Although this measure complies with General Data Protection Regulation (GDPR) and the professional secrecy of support providers entrusted, by law, with a mission of trust, sometimes not mentioning the worker's name (file number and national register number (NISS)) on documents sent led to difficulties. In some cases, the recipient was unable to determine which worker was involved. It would therefore be important for the future to work with prevention actors and a network of support providers to find a way of proceeding that could not only comply with GDPR rules but also solve the problems of the current system.

The support providers in the network were satisfied with Fedris' administrative management, particularly in terms of payment times (60.6%). 40.6% were also satisfied with the use and processing of the various forms, while 26.2% were dissatisfied with the documents sent to Fedris concerning workers' support.

4.4.2.3. Contact with Fedris' burn-out unit

Generally speaking, support providers who had been in contact with Fedris' burn-out unit showed satisfaction with the ease of contacting the unit, email response time and quality of responses provided at 79.02%. For example, one of the burn-out support providers commented that "in this respect, everything was perfect, I really liked the availability, kindness and professionalism [...]."

Overall, most of the people involved were satisfied with their contact with the burn-out unit, although some HR staff said they were not always satisfied with the content. It is also important to note that there was little contact between prevention actors and the burn-out unit, or between social partners, HR staff and the burn-out unit. One idea put forward by the prevention actors for staying informed was to send out a periodic newsletter. In particular, they felt poorly informed at several times, such as when the project was extended, when waiting times increased temporarily, or with regard to updates of the list of Fedris-approved support providers in response to the temporary unavailability of some of them.

4.4.3. Evaluation of clinical tools

4.4.3.1. Evaluation by prevention actors

The majority of prevention actors, who were able to evaluate the quality of the "screening form, considered the information requested in this form to be relevant (80.6%), and were satisfied with the management and follow-up of screening requests submitted to Fedris (64.6%).

With regard to the transmission sheets, the information they contained was considered relevant by 51.8% of the prevention actors concerned. However, while 33.9% felt that the transmission sheets had been useful to them in the course of their work, 30.4% thought the opposite, and 35.7% remained neutral on this question. Furthermore, only 26.3% of the prevention actors who responded felt that the transmission sheets had helped them to act in primary prevention, compared with 42.1% of the prevention actors concerned, who were of the opposite opinion. Although they saw applications for this form at the individual and organisational levels, most of the prevention actors who took part in the focus groups said they did not actively use it, and described the information it contained as "succinct.

Lastly, 35.1% of the prevention actors concerned felt that the pilot project had helped to raise awareness of the burn-out problem in companies (at a more collective level), while 28.1% took the opposite view. Despite these results, which may raise questions regarding the usefulness of transmitting these documents, 70% of the prevention actors considered that receiving these transmission sheets could be useful. In fact, both the focus groups and the survey revealed a demand for information exchange.

4.4.3.2. Evaluation by providers

The administrative side (reporting and liaison) was mainly handled by the burn-out support providers in charge of coordination. So these were mainly the ones who used the clinical tools. For those who were able to evaluate the quality of the "screening report", a majority considered that the information requested was sufficient to decide on the suitability of the pathway proposed by Fedris for a worker (68.75%), and that the screening report made it possible to identify the worker's support needs (80.6%). For 45.16%, the screening report made it easier to put together a personalised support pathway.

Furthermore, the majority of those involved found the clinical exchanges with Fedris' psychologists relevant and useful to the diagnostic process (88.2%) and enriching in terms of developing mutual knowledge of burn-out (91.7%).

However, despite general satisfaction, points for improvement were also mentioned with regard to reporting to Fedris. Delays in sending documents by post were highlighted in the focus groups. Regarding the workload involved in reporting to Fedris, a number of participants expressed the view that, on the whole, the administrative burden did not seem too heavy. On the other hand, it was pointed out that the administrative burden was not always proportional to the time allocated and paid for by Fedris. As a point for improvement, some argued, for example, that a fee equivalent to the cost of a session was insufficient to write a quality final report.

Lastly, for 60% of those involved, the information shared via the transmission sheets was relevant. However, while 43.3% of participants suggested that the information sheets

had enabled prevention actors to contact them, 26.7% suggested the opposite. Similarly, while 43.3% seemed to feel that the transmission sheets had enabled workers to contact their prevention actors, 30% were of the opposite opinion. In practice, however, a number of support providers wondered how the transmission sheet was used by those who received it. In the focus groups, for example, a number of support providers mentioned that doctors did not contact them when they recommended a consultation with a doctor.

4.4.4. Evaluation of the support pathway

The majority of support providers (91.6%) and 44.7% of the prevention actors involved agreed that the opportunity for focusing on both the organisational and individual dimensions of burn-out was useful. During the focus groups, participants also expressed satisfaction with the support pathway, which they described as "valuable", "comprehensive" and "intensive". Furthermore, 62.2% of support providers felt that the number of sessions suited the workers' needs. Similarly, the total number of sessions devoted to the support pathway was considered appropriate by 78.2% of the prevention actors concerned.

For 81.3% of those involved, the division of the pathway into different modules was beneficial and gave structure to the support of a worker in burn-out. The modular pathway made it possible to offer customised care. Not everyone shared this view, however. On this subject, for example, one support provider commented that "the division into different modules is, in fact, artificial".

As far as prevention actors are concerned, 75.4% found it beneficial to have a pathway made up of different modules to structure the support of a worker in burn-out. In fact, some prevention actors went so far as to say that this was one of the added values of the support pathway proposed by Fedris. During the focus groups, they also expressed their satisfaction with the availability of this pathway and the fact that it was free of charge for workers. One PAPA, for example, mentioned that *"it's a good thing that this initiative was offered, it was really needed."* Others spoke of the need to extend the project to other sectors. Similar comments about the pathway were also made during the roundtable discussion with HR staff.

Both support providers (73.1%) and prevention actors (94.7%) considered that having different types of support providers (BOSP, COSP, ISSP) was an added value in supporting workers in burn-out. They also seemed generally satisfied with the combination of cognitive-emotional and physical approaches (83.3% of support providers; 60.4% of prevention actors). For example, 76.5% of the providers who took part in the evaluation questionnaire saw the link between support providers with skills in work organisation and support providers with skills in clinical psychology as an added value for the support of a worker in burn-out, as well as the fact of having support providers from different professions (doctors, psychologists, physiotherapists; 92.3%), or having a network of support providers could facilitate the coordination of pathways and collaborative work (76.9%). The importance of having well-trained, pre-selected professionals within Fedris' network was also pointed out by some HR staff at the round-tables.

Although collaboration with other professionals or disciplines was seen as beneficial, in practice contact was not always frequent. Given the limited number of "individual sessions", a number of support providers underlined that they felt they had to choose between the physical and psychological approaches for these sessions, even though it would be more beneficial to combine these two complementary approaches. Some

individual sessions support providers observed that few workers were referred to them. The physiotherapists wondered whether the psychologists focused too much on the mental aspect (i.e. cognitive rather than physical), or whether they understood what the physiotherapy sessions could be used for in the context of the pathway. It seems that greater awareness is needed on this subject. Some also wondered whether the burn-out support provider was taking too much control of the support. One individual session support provider, for example, expressed surprise at "having worked almost only with one burn-out support provider so far. Did the others not feel it necessary to consider/offer the mind-body approach?". Other support providers would like to see more collaboration or multidisciplinarity but rarely had the opportunity to enact it due to the limited number of support providers in the same region. As possible changes, with regard to the content of the pathway, some participants of the focus groups suggested a reintegration module or an extension of the follow-up module (as part of the returnto-work process). Lastly, a number of proposals were put forward, such as providing more time and/or resources for consultation, providing an online platform enabling different practitioners to track the progress of a given worker, providing a document listing, for a given worker, the contact details of those involved in the support pathway, or having Fedris organise meeting times for support providers/actors.

With regard to the possibility of contact with the burn-out support provider, prevention actors involved were rather divided. While 29.5% of prevention actors seemed satisfied with their contacts with the burn-out support provider, 29.5% felt that these contacts had been insufficient. For example, some prevention actors reported that they were rarely contacted after the pathway had begun. According to one PAOP, "in all the transmission sheets received (cf. page 23, point 2.8.5., phase 3: the end of the support pathway), a consultation with the occupational physician was never deemed necessary, nor was a multidisciplinary consultation! This was a missed opportunity to bring together the key actors involved in supporting the worker". As a result, they felt this was an area for future improvement.

Likewise, although just over half of support providers (56.7%) were satisfied with the opportunity of holding a multidisciplinary meeting with the prevention services, in practice very few of such meetings took place. During the focus groups, support providers indicated that they did not know exactly why these meetings were rarely held in practice. They suggested three reasons that seemed more likely: it was too early for the worker, the worker thought the employer would not be open to the idea, or the worker thought they would find themselves facing a kind of "tribunal". Several support providers would find it beneficial to attend such a meeting to support the worker. More follow-up sessions or a reintegration module were also suggested. They also considered that employers needed to be made more aware of the burn-out problem. The union representatives interviewed for the survey concurred with this view. They considered that difficulties linked to work pressure and organisation should be tackled more collectively and that the employer should carry out better risk analyses.

It was also clear from the questionnaire that only 23.9% of prevention actors seemed satisfied with the possibility of organising a multidisciplinary meeting with the prevention services. It should be noted that few "multidisciplinary meeting" modules were carried out throughout the project. This result should be treated with caution, as more than half the sample (63.4%) did not give an opinion. Furthermore, according to some of the prevention actors present at the focus groups, it was not clear who should initiate the meeting. Some would find it useful if a person could be designated for this purpose. Given their knowledge of the worker's situation, they considered the burn-out

support provider to be the most appropriate person. The prevention actors also saw their role as bringing the various stakeholders within the organisation to the table. Other ideas were also put forward, such as the possibility of having a clear overview of the practitioners involved in the worker's pathway; planning a time when the burn-out support provider could give feedback to the prevention actors in the workplace at the end of the pathway; planning meeting times between support providers and prevention actors to facilitate the creation of networks. The use of a digital platform for secure information sharing between practitioners and the prevention department was also suggested.

Lastly, despite the fact that over 40% had no definite opinion on the matter, a significant proportion of union representatives agreed that the burn-out pilot project helped improve mental well-being at work (47.6%), keep workers in the early stages of burn-out at work or improve their return to work (50%), and raise awareness of the burn-out problem and its consequences for workers at a collective level (57.1%). However, they seemed more divided regarding the impact of the burn-out pilot project on the employer's prevention services and internal bodies, with 33.3% suggesting that there had been more interaction versus 38.1% reporting the opposite.

4.4.5. Evaluation of training activities

At the start of the project, Fedris set up continuous information and training actions for the network of Fedris-approved support providers and prevention actors. Each action was developed based on questions asked by the network, and on the team's own questions and reflections throughout the project. A systematic evaluation of these actions was carried out to guarantee the quality and constant improvement of the information and continuous training actions for the network of Fedris-approved support providers.

4.4.5.1. Objectives

The information and training initiatives for the network's supports providers and prevention actors had a number of objectives. The aim was both to enable participants to understand and use the system set up by Fedris (e.g., conceptual framework, tools created, roles and missions) and to offer them a place to reflect on and share clinical experience about the support pathway (e.g., good practices, transmission of knowledge and observations). It was also an opportunity to work towards consolidating a network of professionals active in burn-out prevention. Lastly, these meetings with professionals in the field also enabled Fedris to maintain an overview of the project, which was a prerequisite for adapting to the ever-changing reality.

4.4.5.2. Interactive webinars/seminars

Several one-day, face-to-face seminars were held between 2019 and 2020. Evaluation questionnaires for these seminars showed a high level of satisfaction from both Frenchand Dutch-speaking participants. Seminar participants unanimously considered that the seminars met their expectations and they expressed their desire to see this type of training repeated.

The format of information and training initiatives had to be adapted due to the health crisis. From 2020, webinars took place in interactive or ex-cathedra mode, with time for questions and answers. Participants seemed to enjoy the interactive webinars, with an average of 95.5% saying that they met expectations. 94.1% would like to see this type of

training repeated, while 100% mentioned that the webinars were useful in terms of knowledge acquisition and project follow-up (including 55.1% who said they were very useful). While the ex-cathedra webinars met the expectations of 66.2% of participants on average, 87.5% wanted this type of training to be repeated. Lastly, 78.4% of participants found the webinars useful in terms of knowledge acquisition and project follow-up (including 41.5% who found them very useful).

4.4.5.3. Information sessions

The information sessions were also a great success, with an average of 93.3% of participants saying that the sessions met expectations. They were deemed useful by 92.8% of participants (including 64.1% who found them very useful). Of these, 89.5% said they would like to see this type of action repeated.

5. DISCUSSION AND RECOMMENDATIONS

The objective of the pilot project for the secondary prevention of burn-out was to confirm the feasibility and validity of a support pathway for workers at risk of or at an early stage of burn-out. In particular, it aimed to help people stay at work or return to work. Although at this time there are no strict guidelines for the management of occupational burn-out (Ahola et al., 2017), the results presented by Hansez and Braeckman (2023) and by Fedris tend to demonstrate the effectiveness of a secondary burn-out prevention support pathway as offered by Fedris.

This discussion considers the different evaluations carried out (Hansez & Braeckman, 2023; Fedris, 2023). It identifies the main lessons at each stage of the pathway and makes recommendations for the future of the pilot project, and for reflections on prevention policy.

5.1. Identification

The results of the study associated with the pilot project and carried out by Hansez and Braeckman (2023) suggest that a majority of workers were informed about Fedris' burnout pilot project by work-related sources, while identification and referral to the project were largely carried out by PAOPs or PAPAs. This trend in identification and referral also seems to be confirmed when considering all the participants in the pilot project (see Figure 8). The general practitioner was involved in almost 30% of cases and seems to have been contacted mainly by workers who learned about the pilot project through channels other than their prevention services (PAOP and/or PAPA).

These results tend to show the importance of having actors in the workplace able to detect burn-out and initiate care for workers in distress. A identification by the PAOP or PAPA also enables an evaluation of the psychosocial risk factors and organisational resources lacking for the worker. This initial evaluation not only reveals the organisational reality that the worker is experiencing but also determines whether they are exposed to a high-risk occupational context. This information is crucial for assessing the possible link between a worker's complaints and the risk of burn-out. Early detection in the workplace also opens up the possibility of longer-term follow-up of the worker, both on an individual level and in terms of working conditions on a more collective level. It can be assumed that the early involvement of these prevention actors will enable them to act at secondary but also primary levels. Beyond identification of the potential problem, the structured follow-up of the worker by prevention advisors, appears to be a prerequisite for a successful return to work, particularly when returning to work involves reviewing the working conditions (e.g., modifying work-related tasks, reviewing schedules; Perski et al., 2017). Furthermore, given the negative association between long work stoppages (more than six months) and return to work (Kärkkäinen et al., 2017), as well as the high risk of burn-out relapse mentioned in recent studies (Savic, 2023), this follow-up constitutes a challenge not only in terms of preventing relapse and the onset of comorbid disorders (anxiety and depressive disorders, for example), but also more globally in terms of maintaining an active life.

Furthermore, the role played by doctors (GPs, psychiatrists, etc.) in identifying workplace suffering should not be minimised. The stigma surrounding mental health often complicates access to care (Corrigan & Watson, 2004). It complicates talking about psychological difficulties, particularly at work, due to workers' fear of potential negative consequences for their careers (EU-OSHA et al., 2022). Many individuals prefer to turn

to their GP when seeking tangible, informative support regarding their health (Reavley & Jorm, 2011). The GP's position outside the workplace can be a factor that facilitates help-seeking. The value of consulting the GP is all the greater as GPs are in a position to rule out certain diagnoses, thanks to overall knowledge of the worker, and they can also inform the worker of available resources and help the worker mobilise those resources.

Detecting burn-out requires a good understanding of the problem (and, more broadly, of suffering at work) and the resources that can be mobilised. In view of Hansez and Braeckman's (2023) results, and for all the reasons mentioned above, Fedris confirms the importance of identification by prevention actors at work (PAOP and PAPA) and local actors (GPs). Fedris also notes the fact that the project may have been referred to by other actors who should be in a position to receive any useful information that could facilitate referring workers to key prevention actors.

Recommendation 1: Reinforce the detection of mental distress at work

- Improve information for workers and prevention professionals on the resources available in the event of psychological difficulties encountered at work;
- Enhance training of prevention actors at all levels of prevention on detection of mental distress at work;
- Support prevention actors in their mission to identify mental suffering at work (in terms of human and logistical resources);
- Initiate early follow-up of workers at risk of burn-out, to enable them to stay at work or return to work under good conditions.

5.2. Diagnosis

Diagnosing burn-out in workers who are experiencing it requires clinical expertise and a sound knowledge of work and organisational psychology so that both the etiological and symptomatologic aspects can be taken into consideration in supporting these workers. This is why Fedris decided to use recognised professionals with different and complementary training (psychologists, psychiatrists and doctors). The recruitment procedure established as part of this pilot project proved its relevance in terms of recruiting trained, experienced and qualified professionals.

Hansez and Braeckman's (2023) results show that at the end of the pathway, the burnout support providers confirmed their initial evaluation establishing the link between the complaints stated by the worker and burn-out (in 90% of cases), at an early stage (70%), and as the main disorder at the origin of the symptomatology observed (80%). For 5% of the project participants, the burn-out support provider believed that the burn-out led to other psychological disorders, and for 12.5% that it was the consequence of previous difficulties or disorders. This in-depth clinical assessment in the diagnostic phase may explain the effectiveness of the pathway on workers' mental and physical health, as demonstrated by Hansez and Braeckman (2023). In fact, these results tend to show that the pathway was used wisely, in compliance with the established criteria (target audience, secondary prevention), and that it produced the desired effects. In addition, the quality of the differential diagnosis enabled workers suffering from severe burn-out (tertiary prevention) or presenting other difficulties to be redirected to the appropriate care (e.g., first-line psychological care or specialist consultations) and enabled the project to meet its objective of linking up with tertiary prevention.

In view of data collected, Fedris confirms its initial choice of using psychologists, psychiatrists and doctors for the clinical evaluation of workers experiencing complaints of occupational burn-out. It stresses the importance of their knowledge and experience in both clinical and occupational psychopathology. It also recommends closer links between the different institutions responsible for prevention in order to improve the visibility of the existing support offer and coordinate their respective actions. Regardless of the point of entry to care, it is important to facilitate the workers' journey to preclude therapeutic wandering. The federal Mental Health and Work network could be a valuable tool in this respect.

Recommendation 2: Entrust the diagnosis of mental suffering at work to professionals with the necessary expertise.

- Identify professionals with knowledge, skills and experience in clinical psychopathology and in occupational and organisational psychology;
- Ensure that these professionals are part of a network that lets them consider the worker as a whole and, where necessary, to refer the workers for specific treatment.

5.3. Pathway management and coordination

One of the strengths of the proposed pathway was to offer the opportunity to work on both the organisational and individual components of burn-out, while also taking into account the psychological and physical impact of burn-out in terms of therapeutic approaches. The appointment of a burn-out coordinator was also an important feature of the project.

The principles of support according to the different phases or the severity of the complaints associated with occupational burn-out often mention the role that doctors, psychologists and/or psychotherapists can play at different times (Mikolajczak et al., 2020; Delbrouck et al., 2017). Although a significant improvement in workers' physical and psychological health was confirmed at the end of the pathway and seemed to hold over time (for three to six months afterwards), it is interesting to note that most of the pathways involved only one (58.9%) or two support providers (31.8%). In addition, the use of the body approach by a physiotherapist or doctor seems to have been relatively infrequent (16% and 2% respectively). Yet, in general, workers reported physical, emotional, cognitive and behavioural symptoms. While the number of symptoms at the time of identification, even in cases of early-stage burn-out (stages 1 and 2 according to Hansez, 2018; Dendoncker and Lebrun, 2022).

According to data from the focus groups, some of the obstacles to a multidisciplinary approach may be inherent in the system proposed. The fact that the burn-out support providers had only one module of seven "individual sessions" at their disposal, which could be divided between the cognitive-emotional and body approaches, could paradoxically have led them to favour one approach over another. Having to divide these sessions between two support providers affected their ability to take in-depth actions in their respective fields. Although psychologists trained in mind-body techniques (e.g., yoga, relaxation, mindfulness) are able to address certain somatic aspects in their support, the skills of physiotherapists would undoubtedly benefit the overall support of the worker, mainly in terms of fitness, adapted physical activity, management of musculoskeletal disorders or stress-related pain, which were regularly mentioned in diagnostic reports.

One solution might be to give each dimension (psychological and physical) its own place in the pathway, with dedicated sessions for each. These additional sessions would not only mean that the burn-out support provider would no longer have to choose between these two approaches anymore but, in addition and more importantly, they would also make workers feel supported by a balanced support system capable of recognising, thinking about and treating all their complaints, wherever the manifestation (body or psyche) and whatever the intensity of those complaints. On the other hand, in some regions, the under-utilisation of physiotherapists was linked to a lack of physiotherapists available to offer specific treatment for somatic complaints. Increasing supply and networking could solve this difficulty.

Recommendation 3: Promote a multidisciplinary approach to comprehensive care for complaints related to occupational burn-out

- Identify professionals with knowledge, skills and experience in the treatment of physical disorders linked to stress and burn-out;
- Adapt the pathway so that the physical dimension is taken more into account in the support of workers;
- Study the effect of multidisciplinarity on the effectiveness of Fedris' pathway.

5.4. Network

A well-established, operational network facilitates access to early diagnosis and support of mental distress at work. By discouraging workers' therapeutic wandering there is less risk of worsening a disorder at the start or of the development of comorbid disorders that could result.

5.4.1. Proximity

The results of the study showed that participants in the pilot project particularly appreciated the possibility of finding support providers close to where they lived or worked (92.4% satisfaction). Although a network in place enables workers and support providers to contact each other and, according to the support providers in the network, this facilitates recourse to other professionals, the network must also be sufficiently extensive to meet this demand for proximity. Although Fedris is active in a large part of Belgium, its network does not yet cover all regions uniformly. The geographical data presented by Hansez and Braeckman (2023) could be partly explained by a lack of support providers in certain regions. Some support providers made this observation to the project team. Another explanation could be linked to the way workers are directed to Fedris' project. Some prevention services and/or GPs have been major referrers, making intensive use of this new resource available to them; this may explain the higher number of requests from certain regions and the fact that some providers may, at times, have had longer lead times for new cases. On the other hand, in the absence of demand, some initially motivated contributors gradually withdrew and, in some cases, left the network.

In addition, the Covid-19 crisis opened the way to new support methods, including remote sessions (teleconsultation). Fedris is not opposed to these new practices. Nevertheless, data collected as part of the evaluation, particularly in terms of satisfaction, underlines that proximity and the opportunity for face-to-face meetings have an added value for both workers and support providers. While remote practice may have helped in times of crisis, further thought needs to be given to the use of teleconsultation so as to ensure that it does not become the practice by default, sometimes to the detriment of the needs expressed by workers.

5.4.2. Attractiveness

Smooth running of a network depends in part on its attractiveness to the professionals who comprise and operate it. The evaluation Fedris did with prevention actors and its contractual support providers (see point 4.4.4. Evaluation of the support pathway) showed that these actors were very satisfied with the availability of a coordinated multidisciplinary network and professionals skilled in clinical psychology and in work organisation. The importance of having well-trained and pre-selected practitioners within Fedris' network was also stressed by social partners.

The attractiveness of a network also depends on the satisfaction of those who use it. The results of this project show a very high percentage of participants satisfied with the support pathway, with an average score of 8 out of 10 (see Table 9.3.1.; Hansez & Braeckman, 2023). This applies to both logistic aspects and the various features of the pathway (modular structure, content, coordination, multidisciplinarity). Furthermore, almost 95.9% of participants would recommend Fedris' pathway to other workers (see Table 9.3.3; Hansez & Braeckman, 2023).

On the other hand, this pilot project shows just how difficult it is to maintain a local network that is solid, accessible and evenly distributed throughout Belgium. Regular updates and recruitments of new support providers to strengthen the existing network are therefore essential. In addition, to maintain and expand an existing network, it is crucial to consider the suggestions made by the present network (harmonisation of remuneration packages for the various projects, recognition of coordination and reporting time, etc.). The question of the support providers' remuneration (fixed by royal decree and indexed on 1 January of each year) has been at the heart of a recurring debate, given the changes in the provision of psychological support that have taken place since the pilot project was launched. Despite their motivation and satisfaction with the pilot project, some support providers chose to terminate or not renew their agreement in favour of a more lucrative activity linked to other projects. This may have exacerbated the disparity between regions that already existed.

Furthermore, in view of the "polycrisis" context that the Belgian population is increasingly experiencing, there is a risk of saturation of the healthcare offer. It is important to be attentive to this as workers may face a saturated healthcare offer due either to a shortage of professionals involved in the project or to a lack of availability of professionals active in multiple projects or overloaded by an increasingly demanding population. Fedris suggests connecting its network of support providers with existing healthcare offers by means of inter-institutional collaboration and coordination while taking care to avoid saturation of available resources. Recommendation 4: Consolidate and strengthen the network of professionals trained in the diagnosis and support of mental distress at work.

- Maintaining a procedure of calling for applications to identify professionals competent in the field of mental suffering at work;
- Strengthening territorial coverage by organising regular calls for support provider applications and coordinating with existing healthcare services;
- Harmonising remuneration of contractual professionals for projects financed by social security institutions.

5.5. Linking secondary prevention and primary prevention

The results of the pilot project suggest that the pathway as currently offered improved balance at the individual level, but has less impact on the organisation itself. While a significant proportion of workers, off work at the time of their application, returned to work, almost a quarter (24%) returned to work with a burn-out diagnosis still present. It is therefore important to consider how these workers are supported in their return to work.

The "multi-disciplinary meeting" module included in the pathway was designed to initiate contact between the worker and different actors at work who could help improve their working conditions (prevention actors, managers, HR, etc.). However, this module was seldom used. This under-utilisation was also confirmed by burn-out support providers during the project evaluation, as well as by prevention actors (see point 4.4.4. Evaluation of the support pathway). In addition, few burn-out support providers mentioned that they were in contact with prevention actors, despite the tools developed as part of the project (transmission sheet). According to EU-OSHA (2022) and support providers in the pilot project, resistance to these contacts often originated with the workers themselves, who did not feel ready to take the step or by fear of repercussions on their working lives. According to Hansez and Braeckman (2023), although the multidisciplinary meeting provided for in the pathway did not take place, or took place only to a limited extent, a discussion on adapting working conditions with prevention actors or company stakeholders probably took place more informally, without activating Fedris' multidisciplinary meeting. These results are in line with Mélon et al. (2022), who highlighted the use of informal routes within companies for returning to work after a long-term absence. According to them, an informal route would offer more room for manoeuvring and flexibility, encouraging exchanges between the different protagonists and generating less pressure with regard to the prospect of dismissal on medical grounds (Mélon et al., 2022).

In practice, interdisciplinarity and combining primary/secondary prevention do not seem easy to implement, despite the advantages for the worker, particularly when they return to work (Delhaye, 2022). According to Perski et al. (2017), the most effective long-term interventions would incorporate advice from work experts and enable workers to initiate a dialogue with the employer. This is probably the role played by the burn-out support provider in helping workers learn new coping strategies, gain a better understanding of the professional issues that led them to develop burn-out and regain the autonomy they need to identify and deal with certain dysfunctions. According to the project results, when workers themselves have approached their hierarchy or human resources, organisations sometimes took action, although this was true in a minority of situations (35%; Hansez & Braeckman, 2023). These figures are in line with feedback from some social partners regarding workers' perception that their employer does little and that it is up to them to constantly adapt to a difficult environment. This is not just an issue for workers. The impact for prevention actors and care providers in terms of wear and burnout, of being involved in continually recovering the balance of individuals systematically abused by organisational factors must not be underestimated. (Dendoncker and Lebrun, 2022).

While this project cannot draw conclusions on an effective way to improve return to work, the results of the evaluation tend to be in line with studies advocating the combination of individual and organisational approaches in the management of burn-out (cf. Ahola et al., 2017) for a successful long-term return to work (Pijpker et al. 2019). In terms of getting people with work-related mental health problems back to work, other studies tend to go even further, advocating multidisciplinary interventions comprising a psychotherapeutic aspect (health aspect), a work aspect (involving communication with the employer to implement changes at work) and stress reduction programmes (Nowrouzi-Kia et al., 2023). With this in mind, Fedris proposes to develop a system whereby mental health and occupational health professionals can interact more effectively. The aim is to capitalise on the effects of a pathway that has certainly enabled individual reflection and a return to a certain personal equilibrium, but that needs to be reflected in the organisation of work. Adapting the current system and creating complementary tools could therefore formalise and optimise possible interactions with the world of work, in order to increase the effect on the collective aspect (see point 5.6. Project adaptations).

Lastly, Fedris proposes to help strengthen the network dynamic between prevention actors at work and care providers, for example by organising actions that create opportunities for the various actors to meet, exchange views on the burn-out issue and develop synergies to better coordinate their actions. Fedris' participation in the coordination of the federal Mental Health and Work network also contributes greatly to this objective.

Recommendation 5: Promote coordination between healthcare and prevention professionals to ensure combined action at individual and organisational levels.

- Confirm the burn-out support provider's role as coordinator of the support pathway;
- Adapt the support pathway by creating a meeting dedicated to liaison and coordination between healthcare professionals and prevention advisors at work;
- Develop liaison tools between mental health professionals and prevention advisors at work;
- Organise joint actions between workplace prevention advisors and mental health professionals to create synergies in the fight against mental suffering at work.

5.6. Adaptations of the project

5.6.1. Adaptations following the Covid-19 crisis

As the acute crisis that led to adaptation of the pathway (COVID-19 Starterkit and COVID-19 Module) is no longer relevant, deployment of additional resources dedicated to it no longer seems necessary. Workers who had a disorder resulting from the Covid-19 crisis (excluding burn-out) would be facing a disorder today for which another type of treatment would probably be appropriate before accessing to the burn-out support pathway. Fedris therefore advocates removing the crisis mechanism and returning to normal (cf. Vaiva et al., 2005). Nevertheless, it has learned from this experience that its system is capable of evolving in the event of another crisis increasing workers' exposure to specific psychosocial risks.

5.6.2. Transition from pilot project to programme

Since 2021, the maximum number of sessions available for any one individual is 25. On average, participants in the burn-out pilot project used around 12 sessions (Hansez & Braeckman, 2023). These results could in part be explained by the "Responsive regulation model" (Stiles et al., 2015), which suggests that patients have varied goals and/or expectations and each evolve at his/her own pace. The therapist takes these variations into account and adjusts the duration of treatment so that the end of the treatment corresponds to an improvement considered as sufficient from the point of view of the patient, who assesses the situation in terms of costs and benefits (Stiles et al., 2015). Workers tend not to extend their follow-up indefinitely once a satisfactory balance has been found.

In view of those findings, Fedris recommends transforming the burn-out pilot project into a permanent programme. It does, however, recommend adjusting the current system. Given Hansez and Braeckman's (2023) results, and although the modular structure remains relevant, Fedris proposes simplification by distinguishing four modules: "Work", "Individual", "Work/Health Articulation" and "Follow up". Each module represents specific focus, but flexibility is introduced into the use of the sessions (see Figure 17).



Figure 17. Proposed changes to the support pathway.

While a flexible approach is encouraged, the number of sessions must continue to be adapted to the needs of each individual. Considering the recommendations made by Hansez and Braeckman (2023) and the lessons learned from the pilot project, Fedris proposes a programme consisting of eight work-oriented sessions, 13 individual-oriented

sessions divided into ten sessions focusing on the psychological dimension (psychoeducation and cognitive-emotional approach) and three sessions with a physiotherapist focusing on the physical dimension (see Figure 17). In addition to these "Work" and "Individual" modules, Fedris wants to take advantage of the feedback from its network which feels that it would be pertinent to offer two follow-up sessions, for example three to six months after the end of the support pathway. These follow-up sessions would respond to the workers' request to get back in touch with their support provider after the end of the support pathway for a post-return assessment or to consolidate certain skills. Those two sessions would also take account of and offer longer-term support to the 24% of workers who returned to work despite being still diagnosed with burn-out.

Although initiating a dialogue with the employer is one of the recommendations made in the scientific literature regarding returning to work for people experiencing workrelated mental health problems (Nowrouzi-Kia et al., 2023), the "multidisciplinary meeting" module, as previously mentioned, has been used rarely or not at all. On the basis of its evaluation with actors in the field, Fedris recommends using the "Health/Work Connection" module (see Figure 17) to organise a time for transmission and connection between healthcare providers and prevention actors involved in worker support pathway (GP, PAOP, PAPA, Fedris-approved support providers). This kind of consultation would provide better coordination between work and health, to ensure comprehensive support and treatment for the worker, while preserving confidentiality of the information exchanged. In a second phase, this complementary tool could prove useful to prevention advisors in the follow-up of workers experiencing work-related mental suffering. This would be an initial contact that would then encourage a dialogue between worker and employer. With the worker's consent, the support provider in charge of the "work aspect" would contact the prevention actors (in this case, the signatory(ies) of the screening form). The aim of this coordination between support providers and referrers would be to link the work carried out at individual level during the pathway and the more organisational aspects of primary prevention and protection at work. In this way, prevention actors would have the keys to understanding the worker's condition and needs for remaining at or returning to work durably over the long term. At the same time, they could draw general lessons that would benefit primary prevention within the company. This recommendation by Fedris is in line with the best practices issued by the National Labour Council (NLC), as recalled by Hansez and Braeckman (2023, p. 56). However, before implementing this adaptation, both prevention actors and healthcare providers must be contacted to confirm its relevance and feasibility.

Lastly, as recommended by Hansez and Braeckman (2023), Fedris proposes extending access to a future secondary prevention programme to other sectors. Like in the banking sector (Giorgi et al., 2017), many sectors have been impacted by organisational or structural changes in recent years, with new technologies leading to New Ways of Working. Yet these changes tend to have a considerable impact on working conditions and workers' lives (Giorgi et al., 2017).

Recommendation 6: Transition from a pilot project to Fedris' secondary prevention programme of burn-out

 \circ Adapting the support pathway, ensuring that it remains a mixed "Work" and "Individual" pathway and allowing greater flexibility;

- Holding a consultation meeting to improve coordination between prevention advisors
- at work and healthcare professionals involved in Fedris' support pathway;
- Confirming the transition of the burn-out pilot project into a secondary prevention programme of burn-out;
- Broadening the target groups.

5.7. Information, training and development of expertise

Results (see points 4.4.1. Communication - Information - Training and 4.4.5. Evaluation of training activities) confirm that information and training for prevention actors and support providers are essential to the success of a project such as Fedris' burn-out pilot project. Feedback on these actions and joint thinking have continually improved the system, based on experience of the field of the professionals involved and committed to the project, the needs of the public for whom it is designed, and the day-to-day lessons learned by the project team. In view of these results, it seems clear that information and training initiatives for the network's prevention actors and support providers need to be stepped up and structured to optimise impact.

The various exchanges with the network (evaluation questionnaires, clinical consultations and focus groups) show that it is important for healthcare professionals to be able to maintain contact and joint thinking with each other (peer supervision) or with a centre of expertise (Fedris, for example). The majority of support providers found the clinical exchanges with Fedris' psychologists relevant and useful to the diagnostic process (88.2%). On both sides, these contacts were a guarantee of quality, thanks to the theoretical perspective, ongoing development of clinical practice and development of burn-out knowledge they provided (91.7%).

Fedris learned from this empirical experience throughout the project. These lessons have enabled Fedris to adapt its system and contribute to the development of knowledge regarding mental suffering at work. The present evaluation helps it pass on the knowledge gained through feedback, and thus contributes to the discussion on work and its interaction with mental health.

Recommendation 7: Actively participate in the development of knowledge regarding mental health at work

- Share the lessons learned from the pilot project with prevention advisors at work and mental health professionals;
- Support joint reflection with prevention and healthcare professionals by organising peer supervision/intervision sessions;
- Participate in a national and European reflection on work and its interaction with mental health.

5.8. Communication and information

With regard to the communication and information aspect of the pilot project, Fedris wants to act on the feedback from participants, prevention actors and social partners regarding the lack of communication and information on the pilot project, which led to a lack of awareness and the probable under-utilisation of the project by prevention actors and the target audiences. The success of a nationwide support pathway such as the one offered by Fedris depends to a large extent on communication and information on the project, as well as on the resulting word-of-mouth. The results presented in this report suggest the need for more targeted, sustained and recurrent communication, using a variety of channels specific to the professionals and/or audiences targeted.

Furthermore, as the vast majority of requests for the pilot project came from the Dutchspeaking side of the country, the reasons for this should be investigated. Several factors could explain this linguistic disparity. One is the information campaign on the project, which may have been more effective in the northern part of the country for a reason yet to be identified. Cultural differences could also exist in terms of how a topic such as work-related stress is approached, and therefore how risk is perceived and assessed (Giorgi et al., 2017). However, while the notions of stress in the workplace, prevention and use of psychological care may be perceived and approached differently depending on the cultural characteristics and linguistic groups addressed, this is not enough to explain the linguistic disparity in the use of the project. A better understanding of the processes involved would enable more appropriate communication and information.

Lastly, it is also possible that better communication would lead to greater awareness of the project among prevention actors. This would result in an increase in requests sent to Fedris. This increase would, de facto, have an impact on Fedris' network and referrals to other healthcare networks, whether for severe burn-out or another problem identified during the identification or diagnostic phase. It is therefore important to ensure that these networks are not saturated and have sufficient resources to process these requests within reasonable timescales.

Recommendation 8: Intensify communication and information on projects aimed at preventing and/or providing support against mental suffering at work.

- Study and understand the reasons behind the linguistic disparity observed in the use of Fedris' burn-out pilot project;
- Implement a more targeted, sustained and recurring communication plan, using a variety of channels specific to professionals and/or audiences targeted;
- Identify and provide information on the resources available at different levels of prevention.

6. LIMITATIONS

Hansez and Braeckman (2023) highlighted a number of limitations associated with the burn-out pilot project. To these can be added the difficulties associated with data collection. While 1,421 workers applied to take part in the burn-out pilot project, the samples used for the statistical analysis included 223 workers (post-test 2 sample) and 312 workers (post-test 1 sample). Although workers were informed that a study was associated with Fedris' burn-out pilot project, deciding whether or not to participate in this research did not determine a worker's access to the pathway. As a result, it was not surprising to lose a number of workers between the times of various measurements.

On the other hand, while social desirability bias may have affected participants' responses on different self-reported online questionnaires, selection bias may also have affected the results presented in this report. Results must therefore be treated with caution. Although a power analysis was carried out, the current sample may not be considered representative of the target populations it represents at national level. To determine whether a sample of 223 workers is representative, this would have to be compared with the overall number of workers in the healthcare and banking sectors. Consequently, given the potential selection bias, care must be taken to avoid making hasty generalisations.

Furthermore, although Professors Hansez and Braeckman pre-defined the framework of the support pathway (content and therapeutic approaches), Fedris chose to use recognised healthcare professionals with a degree of autonomy in their practice. This autonomy is necessary for the practitioner, who adapts to the needs of the worker being treated, but it also leads to heterogeneity in the treatments provided. This diversity of treatments makes standardisation impossible and limits the generalisation of these results.

Lastly, some data would benefit from further analysis or the development of other studies. As an institution working to protect workers and prevent occupational risks, the issue of mental health cannot be excluded from Fedris' concerns. This being the case, it would be advantageous to continue the reflection initiated with the burn-out pilot project, by means of longitudinal research projects, both on the causes underlying the development of work-related mental suffering, and on the effectiveness of secondary prevention programmes on these issues.

7. CONCLUSION

Preventing burn-out is a major challenge for our society. While burn-out is far from the only manifestation of mental suffering at work, it undeniably directly questions society's relationship with work and, by the same token, the consequences of this relationship on health. Prevention and/or early treatment are all the more important given the damaging long-term effects it can have on workers' health (e.g., Burned-out brain, Sandic, 2023).

Given the effectiveness of a mixed support pathway (Individual-Work) as offered by Fedris, and the fact that burn-out is the consequence of "chronic workplace stress that has not been successfully managed" (ICD-11; WHO, 2019), the results show that the support pathway proposed by Fedris acts at the earliest possible stage, at the source of burn-out, i.e. on work-related stress problems. By preventing these problems from becoming chronic and/or worse, leading to other co-morbidities, Fedris fully assumes its mission of secondary prevention of work-related mental suffering.

These results made it possible to identify ways of improving the support pathway offered by Fedris. Based on the findings highlighted in this report and its recommendations, a more macro-level awareness of the needs of workers in burn-out situations and, more generally, in situations of work-related psychological suffering, is and remains indispensable. The results of the burn-out pilot project highlight the need to restore balance "*en abyme*", first at individual level, then at organisational level, and finally at societal level. The lessons learned from this project highlighted the key role that such a system can play in helping workers suffering from burn-out to stay at work or return to work. They also showed that a link between healthcare providers and prevention actors can facilitate action at a more collective level, on the structural and organisational components generating suffering at work. In this respect, Fedris must continue to examine the interactions between work and mental health in the context of occupational diseases and accidents at work.

Ultimately, in addition to the lessons it learned, Fedris also hopes to help create a dynamic for the (inter-)institutional transmission of the knowledge acquired regarding burn-out and its management. This transmission is, according to Fedris, essential to the implementation of a "collective intelligence" (Delbrouck, 2017, p. 257) and the gradual construction of a genuine culture of prevention of work-related mental suffering. Developing tools and systems able to understand and act on the individual reality of burn-out, as well as and above all on the organisational and societal reality, is a major challenge for the next ten years.

8. REFERENCES

- Ahola. K., Toppinen-Tanner. S., & Seppänen. J. (2017). Interventions to alleviate burn-out symptoms and to support return to work among workers with burn-out: Systematic review and meta-analysis. *Burnout Research*, 4, 1-11. https://doi.org/https://doi.org/10.1016/j.burn.2017.02.001
- Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16-20.
- Delbrouck, M. (2017). Comment traiter le burn-out: Principes de prise en charge du syndrome d'épuisement professionnel (4ème édition). De Boeck Supérieur.
- Demerouti E., Bakker A.B., Vardako I., & Kantas A. (2003). The convergent validity of two burnout instruments. *European Journal of Psychological Assessment*, 19(1),12-23.
- Dendoncker, C. & Lebrun, F. (2022). Adaptations d'un dispositif de prise en charge du burn-out professionnel: une question d'équilibre. End-of-course work for the University Certificate "Diagnostic et prise en charge clinique des burn-outs professionnel et parental ". Louvain-la-Neuve: UCLouvain.
- Desart, S., Schaufeli, W.B., & De Witte, H. (20 février 2017). Op zoek naar een nieuwe definitie van burn-out [Blog post]. https://kuleuvenblogt.be/2017/02/20/op-zoek-naar-een-nieuwe-definitie-van-burn-out
- Eurofound (2018). Burnout in the workplace: A review of data and policy responses in the EU, *Publications Office of the European Union*, Luxembourg. https://www.eurofound.europa.eu/publications/report/2018/burnout-intheworkplace-a-review-of-data-and-policy-responses-in-the-eu
- European Agency for Safety and Health at Work, Leclerc, C., De Keulenaer, F., Belli,
 S. (2022). OSH pulse: occupational safety and health in post-pandemic workplaces: report, *Publications Office of the European Union*.
- https://data.europa.eu/doi/10.2802/478476
- Eurostat (2021). Self-reported work-related health problems and risk factors key statistics, Statistics Explained.
 https://ec.europa.eu/eurostat/statisticsexplained/index.php?title=Self-reported_workrelated_health_problems_and_risk_factors_-_key_statistics
- Hansez, I. (2019, January). Les stades du burnout et prévention [PowerPoint].
- https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_the me_file /121219
- Hansez, I., & Braeckman, L. (2023, 31 March). *Evaluation d'un programme de prise en charge de travailleurs en burnout précoce (prévention secondaire)*. Scientific report on the pilot project implemented by the Federal Agency for Occupational Risks (Fedris). Brussels: Belgium
- IBM Corp. Released (2022). *IBM SPSS Statistics for Windows, Version 29.0.* Armonk, NY: IBM Corp.
 Kärkkäinen, R., Saaranen, T., Hiltunen, S., Ryynänen, O.P., & Räsänen, K. (2017). Systematic review: Factors associated with return to work in burnout. *Occupational Medicine*, *67*(6), 461-468, https://doi.org/10.1093/occmed/kqx093
- Lovibond. S.H., & Lovibond. P.F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney: Psychology Foundation.
- Mélon, L., Bingen, A., Sepulchre, D., Vanroelen, C. & De Schampeleire, J., (2022, December). *Recueil de bonnes pratiques au sein d'entreprises en matière de retour*

au travail. Federal Public Service Employment, Labour and Social Dialogue. Brussels: Belgium

- Mikolajczak, M., Zech, E., & Roskam, I. (2020). Burn-out professionnel, parental et de l'aidant. Comprendre, prévenir et intervenir. De Boeck Supérieur.
- Nowrouzi, B., Garrido, P., Gohar, B., Yazdani, A., Chattu, V. K., Bani-Fatemi, A., Howe, A., Duncan, A., Riquelme, M. P., Abdullah, F., Jaswal, S., Lo, J., Fayyaz, Y., & Alam, B. (2023). Evaluating the Effectiveness of Return-to-Work Interventions for Individuals with WorkRelated Mental Health Conditions: A Systematic Review and Meta-Analysis. *Healthcare*, *11*(10), 1-18.
- https://doi.org/10.3390/healthcare11101403
- Perski, O., Grossi, G., Perski, A., & Niemi, M. (2017). A systematic review and metaanalysis of tertiary treatments in clinical burn-out. Scand J Psychol, 58(6), 551-561. https://doi.org/10.1111/sjop.12398
- Pijpker. R.. Vaandrager. L.. Veen. E. J.. & Koelen. M. A. (2019). Combined Interventions to Reduce Burn-out Complaints and Promote Return to Work: A Systematic Review of Effectiveness and Mediators of Change. International Journal of Environmental Research and Public Health, 17(1), 1-20. https://doi.org/10.3390/ijerph17010055
- Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: Findings from an Australian national survey of mental health literacy and stigma. *Australian & New Zealand Journal of Psychiatry*, 45(11), 947-956. https://doi.org/10.3109/00048674.2011.621060
- Savic, I. (2023, 17 March). The burned-out brain. In M. Mikolajczak & I. Roskam (Chairs). *Burnout in the 21st century* [Symposium]. Biennial Symposium of the Psychological Committee of the Royal Academies for Science and the Arts of Belgium, Brussels, Belgium.
- Schaufeli, W.B., De Witte, H. & Desart, S. (2019). *Handleiding Burnout Assessment Tool (BAT)*. KU Leuven, België: Intern rapport. With the aid of Securex.
- Thil L., Vanmarcke S., Szekér L., Lenaerts K., Vandekerckhove S., Deschacht N., Detilleux C., De Witte H., Babic A., Montagnino C., Pierrot M., Tojerow I., Verdonck M., Bosmans K., Van Aerden K., Vanderleyden J. & Vanroelen C. (2023). La qualité de l'emploi et du travail en Belgique en 2021 : Analyse sur la base de l'enquête européenne sur les conditions de travail (EWC(T)S) 2021 - résumé analytique. HIVA KU Leuven.
- https://emploi.belgique.be/sites/default/files/content/documents/Welzijn%20op %20het%20werk/Onderzoeksprojecten/Rapport%20EWCS_EIND.pdf
- World Health Organization (2019). International Classification of Disease, Eleventh Revision (ICD11). WHO. https://icd.who.int/
- Vaiva, G., Lebigot, F., Ducrocq, F., Goudemand M. (2005). *Psychotraumatismes* : prise en charge et traitements. Mass

9. APPENDICES

Appendix 1: Typical support provider profiles

A. BURN-OUT SUPPORT PROVIDER



BURN-OUT SUPPORT PROVIDER as part of a burn-out prevention project organised by FEDRIS

FEDRIS is looking for self-employed or complementary self-employed work clinic professionals with both clinical expertise and experience of organisational reality, to provide support to workers/patients at high risk of burn-out.

As part of a pilot project in the hospital, healthcare and banking sectors, FEDRIS offers a programme for the secondary prevention of suffering at work, aimed at preventing the development of burn-out or helping those threatened by burn-out.

The project includes a screening phase, followed by a consultation phase in the work clinic, coupled with individual support sessions (using a cognitive-emotional or physical approach) and a review of working conditions in conjunction with the stakeholders involved in wellbeing at work.

Mission description:

- To carry out a diagnostic assessment of the worker confronted with burn-out
- To realise a full medical history (including differential diagnosis and clinical assessment into the specific aetiology of work-related mental disorders).
- To provide work clinic consultations to provide support to workers/patients in burn-out, monitor their stay at work/return to work and make recommendations to the employer/occupational physician/general practitioner.
- To compose and coordinate a pathway adapted to the worker's needs, in conjunction with the different parties involved in the project.

Training or equivalent European diploma:

- Master's degree in Psychology, specialised Clinical Psychology
- Master's degree in Psychology, specialised in Occupational and Organisational Psychology
- Master's degree in Medicine, specialised in Occupational Medicine
- Master's degree in Medicine, specialised in Psychiatry
- Master's degree in Medicine, specialised in General Medicine

A Master's degree in Risk Management and Well-being at Work or an equivalent Master's degree, as well as further training in work-related clinical or occupational psychopathology would be an asset.

Experience:

- 3 years of experience in the target field
- Extensive experience in providing support to patients confronted with work-related problems (work clinic)
- Clinical experience in general psychopathology
- · Experience in providing support in remaining at work/returning to work

Avenue de l'Astronomie 1, 1210 Bruxelles • www.fedris.be Joignable les lundi, mardi et jeudi de 9h à 16h et les mercredi et vendredi de 9h à 13h

.be

- · Experience in intervention at work on issues of well-being at work
- Experience in interdisciplinary collaboration with prevention advisors, union representatives and healthcare professionals involved in the process of remaining at work/returning to work
- Experience of supervision or peer-review process

Language:

Thorough knowledge (spoken and written) in one of Belgium's three national languages (French, Dutch, German)

Knowledge:

- Knowledge of organisational reality and psychosocial risk factors
- Knowledge of the regulatory framework relating to well-being at work, health insurance, unemployment, social security, occupational medicine, reintegration of workers unable to work
- Knowledge of the concepts of incapacity, disability, compensation, support providers and stages in sick leave and its follow-up, return to work, etc.

Asset:

Be part of a multidisciplinary care structure or network

Documents required:

- Cover letter
- Detailed CV
- Copies of diplomas and training certificates
- · For psychologists: certificate of registration with the Commission of Psychologists
- For clinical psychologists: accreditation issued by FPS Public Health
- Detailed description of experience matching the profile sought (specify duration of experience, number of patients involved, originality/added value of the experience, link with regulatory framework).

Please contact us by email (burnout@fedris.be) or telephone (02 272 21 70) if you require any further information.

If you are interested, please send your application to burnout@fedris.be.

If your application is accepted, the Burn-out unit will contact you to arrange an interview with the team's psychologists.

B. INDIVIDUAL SESSIONS SUPPORT PROVIDER



INDIVIDUAL SESSIONS SUPPORT PROVIDER

as part of a burn-out prevention project organised by FEDRIS

FEDRIS is looking for freelance or complementary freelance professionals with a Master's degree in clinical psychology and a Bachelor's degree in physiotherapy or equivalent qualifications to provide psychological support and guidance to workers at high risk of burn-out, using cognitive-emotional and/or mind-body approaches.

As part of a pilot project in the hospital, healthcare and banking sectors, FEDRIS offers a programme for the secondary prevention of suffering at work, aimed at preventing the development of burn-out or helping those threatened by burn-out.

The project includes a screening phase, followed by a consultation phase in the work clinic, coupled with individual support sessions (using a cognitive-emotional or physical approach) and a review of working conditions in conjunction with the stakeholders involved in well-being at work.

This call is for individual support sessions.

Mission description:

- Provision of individual psycho-educational sessions on well-being at work, including stress management, healthy lifestyle (diet, physical activity, sleep) and energy recovery.
- Provision of psychological support and guidance sessions using a cognitiveemotional approach
- · Provision of support and guidance sessions using a physical approach

Training or equivalent European diploma:

- Master's degree in Psychology, specialised in Clinical Psychology with certificate in psychotherapy (accreditation possible for all three activities)
- Bachelor's degree in physiotherapy or equivalent diplomas with training (accreditation possible only for support and guidance sessions using the physical approach).

Experience:

• 3 years of experience in the target field



Language:

 Thorough knowledge (spoken and written) of one of Belgium's three national languages (French, Dutch, German)

Knowledge:

- Knowledge of health psycho-education and, more specifically, stress management
- Knowledge of individual support techniques
- · Knowledge of suffering at work and, more specifically, burn-out

Documents required:

- Cover letter
- Detailed CV
- · Copies of diplomas and training certificates
- · For psychologists: certificate of registration with the Commission of Psychologists
- Detailed description of experience matching the profile sought (specify the exact nature and duration of experience, number of patients involved).

Avenue de l'Astronomie 1, 1210 Bruxelles • Ouvert de 9 à 16 heures et sur rendez-vous • www.fedris.be

62

.be

C. COVID-19 SUPPORT PROVIDER



COVID-19 SUPPORT PROVIDER

as part of the burn-out prevention project organised by FEDRIS

FEDRIS is looking for self-employed or complementary self-employed work clinic professionals with both clinical expertise and experience of organisational reality, to provide support to workers/patients at high risk of burn-out.

As part of a pilot project in the hospital, healthcare and banking sectors, FEDRIS offers a programme for the secondary prevention of suffering at work, aimed at preventing the development of burn-out or helping those threatened by burn-out.

The project includes a screening phase, followed by a consultation phase in the work clinic, coupled with individual support sessions (using a cognitive-emotional or physical approach) and a review of working conditions in conjunction with the stakeholders involved in wellbeing at work.

Following the health crisis (COVID-19), the programme now includes an additional module dedicated to assess and manage the direct repercussions of the COVID crisis on workers.

This call concerns the specific sessions to be carried out in this module.

Mission description:

- Evaluation of the consequences of the health crisis on the personal and professional functioning of the person referred to the burn-out project.
- Assessment of the onset or aggravation of psychological difficulties and/or disorders following the health crisis
- In conjunction with the burn-out support provider (coordinator of the support pathway), setting up of a system for the early support of these disorders prior to the continuation of the burn-out-focused support pathway.

Training or equivalent European diploma:

- Master's degree in Psychology, specialised in Clinical Psychology
- Master's degree in Medicine, specialised in Psychiatry
- · Ongoing training in psychotraumatology and/or crisis intervention is an asset.

Experience:

 At least 3 years of experience in providing support for psychotraumatic and related disorders (depression, anxiety and addiction)

Avenue de l'Astronomie 1, 1210 Bruxelles • Ouvert de 9 à 16 heures et sur rendez-vous • www.fedris.be

- Clinical experience in general psychopathology
- Experience of supervision or peer-review process
- · Experience in crisis intervention in collective emergencies is an asset.

Language:

 Thorough knowledge (spoken and written) of one of Belgium's three national languages (French, Dutch, German)

Knowledge:

- Knowledge of the characteristics of different traumatic experiences, their consequences and the possible clinical manifestations
- Knowledge of the links between traumatic symptomatology and the onset of other psychological disorders
- Knowledge of organisational reality and psychosocial risk factors in a crisis situation
- Knowledge of evidence-based individual techniques for dealing with stress and trauma

Asset:

· Be part of a multidisciplinary care structure or network

Flexibility is required to accommodate workers outside their working hours.

Documents required:

- Cover letter
- Detailed CV
- · Copies of diplomas and training certificates
- For Psychologists: certificate of registration with the Commission of Psychologists
- Detailed description of experience matching the profile sought (specify duration of experience, number of patients involved, originality/added value of the experience, link with regulatory framework).

Avenue de l'Astronomie 1, 1210 Bruxelles + Ouvert de 9 à 16 heures et sur rendez-vous + www.fedris.be

.be

Appendix 2: Support scheme

FEDERAL AGENTSCHAP VOOR BEROEPSRISICO'S ADENCE PÉDÉRALE DES RISQUES PROFESSIONNELS

Scheme of Fedris' support pathway



Appendix 3: List of experts involved

<u>Reflection and development of a support pathway for the secondary prevention of burn-out</u>

Scientific supervision

- Professor Isabelle Hansez, University of Liège (ULiège), Faculty of Psychology, Logopaedics and Educational Sciences, Department of Psychology, Human Resources Development Unit.
- Professor Lutgart Braeckman, Ghent University, Faculty of Medicine and Health sciences, Department of Public Health and Primary Care

Expert group (2017)

- Mrs. Sofie Balduyck, Prevention advisor for psychosocial aspects, IDEWE,
- Dr. Kristien Bauwens, General practitioner, in training in occupational medicine,
- Mr. Koen Boonen, Prevention advisor for psychosocial aspects, UZ Leuven,
- Mrs. Véronique Brouette, Clinical psychologist, ULiège collaborator,
- Mrs. Véronique Crutzen, Psychologist, FPS Employment, Labour and Social Dialogue, DG Humanisation of Work
- Mrs. Tine Daeseleire, Clinical psychologist, The Human Link,
- Mrs. Anne Dumbruch, Prevention advisor for psychosocial aspects, PROVIKMO,
- Mrs. Myriam Pauwels, Prevention advisor for psychosocial aspects, ING,
- Dr. Olivier Poot, Occupational physician, Fedris
- Mrs. Mélanie Straetmans, Occupational psychologist, FPS Employment, Labour and Dialogue, DG Humanisation of Work
- Mrs. Marthe Verjans, Prevention advisor for psychosocial aspects, IDEWE.

Board members

- Mrs. Elena Dupont, Occupational psychologist, Fedris,
- Mrs. Elodie Stas, Occupational psychologist, Fedris.

Pilot project management and evaluation

Scientific supervision and evaluation

- Professor Isabelle Hansez, ULiège.
- Professor Lutgart Braeckman, Ghent University.

Internal clinical expertise at Fedris, Studies and Development Department:

- Mrs. Caroline Dendoncker, Clinical psychologist
- Mrs. Karolien Kerckhofs, Clinical psychologist
- Dr. Florence Lebrun, Clinical psychologist
- Mrs. Déborah Mennecier, Clinical psychologist
- Mrs. Shana Vranken, Clinical psychologist