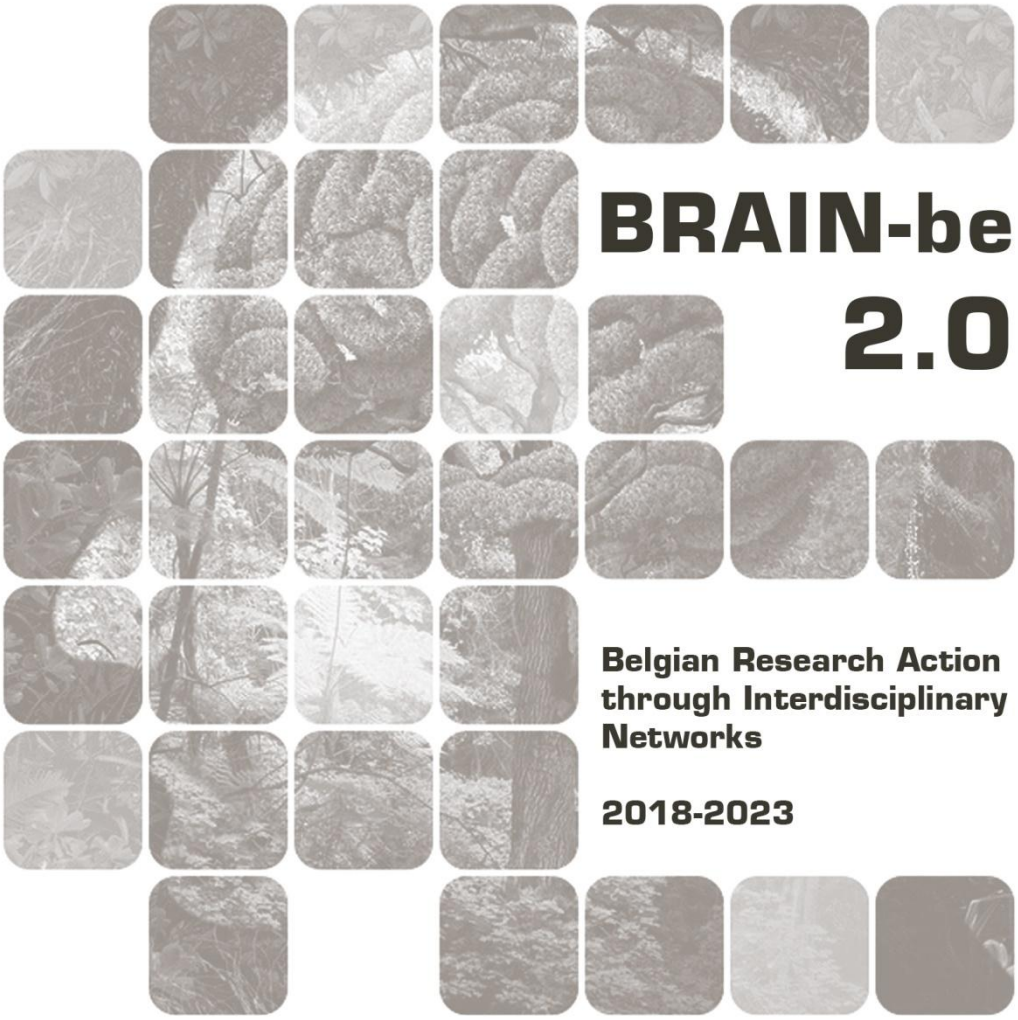

RE-BOrn

REturn to Work after BurnOut

ROOMAN, C., LEHAEN, C., BRAECKMAN, L., HANSEZ, I, & DEROUS, E.

Pillar 3: Federal societal challenges

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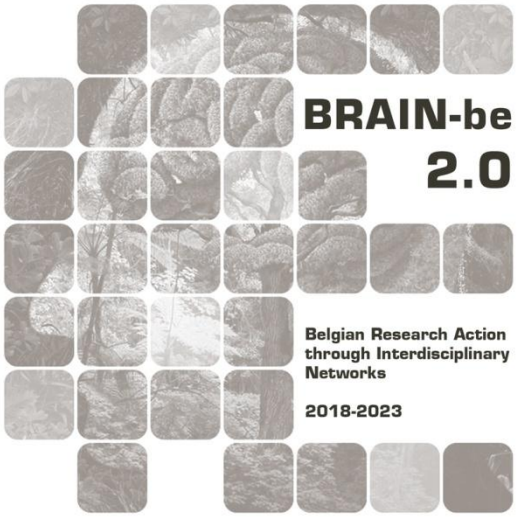

NETWORK PROJECT

RE-BOrn
REturn to Work after BurnOut

Contract - B2/223/P3/RE-BOrn

FINAL REPORT

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TABLE OF CONTENTS

ABSTRACT

Context

Burnout is a major public health challenge in Belgium, particularly within the Federal Administration (FA), where stress-related disorders account for over 40% of sick days. While primary prevention has received considerable attention, evidence-based strategies for reintegration after burnout remain scarce. The RE-BOrn project addresses this gap through multidisciplinary research and practical interventions.

Objectives

The project aimed to (1) evaluate current reintegration policies and practices in the Federal Administration (FA), (2) implement and assess an adapted Burnout Treatment Program (FA-BOTP) for recovery (i.e., secondary prevention), and (3) develop and validate the Burnout Reintegration Monitor (FA-BRM) to track reintegration quality and prevent relapse (i.e., tertiary preventions). A mixed-methods approach combined literature reviews, qualitative benchmarking, intervention testing, and longitudinal surveys.

Conclusions

Findings show that the FA-BOTP significantly reduces burnout, depression, and stress symptoms, though uptake remained limited. FA-BRM demonstrates strong reliability and identifies key predictors of successful reintegration, including job autonomy, meaning of work, and reduced emotional load. Policy recommendations emphasize sustained investment, certified professionals, organizational culture change, and integration of evidence-based tools, such as the FA-BOTP and the FA-BRM, into a comprehensive well-being strategy at the Federal Administration.

Keywords

Burnout, reintegration, public sector, prevention, FA-BOTP, FA-BRM, job demands-resources, well-being policy.

1. INTRODUCTION

Burn-out is an important public health issue with prevalence rates up to 69% in certain occupation groups and large costs for workers, organizations and society. Burn-out alone accounts for 7.14% of all workers in invalidity of which 71.12% are women (National Institute for Sickness and Disability Insurance, 2021). In 2024, the general sickness absence percentage among federal civil servants slightly decreased to 6.42%, after having reached its highest level since 2019 in 2023 (i.e., 6.71%). Conversely, the proportion of civil servants without any absence days improved to 35%, compared to its lowest point of 31.7% in 2023 since 2019. The number of long-term absentees, i.e., those for 30 working days or more than 30 working days absent, increased with a 12.8% compared to 2023 (from 7,589 to 8,560). According to the 2024 Medex report on sickness absence among federal civil servants (Medex, 2024), stress-related psychological disorders remain the leading cause of sickness absence, accounting for 43.7% of all sick days. These stress-related psychological disorders include burnout and stress. Together, burnout and stress represent the largest share of all stress-related psychological disorders in the Belgian federal government (45.8%), and they increased compared to 2023 (40,0%), while depression accounted for 34.1% (2023: 36.7%).Notably, whereas most attention in literature goes to primary prevention of burn-out, much less is known about re-integration after burnout (both secondary prevention and tertiary prevention). The Re-BOrn project aims to address this gap. The RE-BOrn project focuses specifically on promoting better re-integration after burn-out, hence its title 'RE-BOrn' which stands for 'REturn to work after Burn-Out'. First, re-integration after burn-out can be improved by (a) implementing an intervention for better recovery and (b) monitoring the quality of re-integration and acting upon it to prevent relapse. Relapse prevention sharpens insights in potential risk/helping factors and, in that way, helps to reduce the numbers of burn-outs (Rooman et al., 2021). Second, RE-BOrn aims contributing to a more inclusive society by improving access to and participation in the labour market for people struggling with mental illness. This holds especially for women who are over-represented among the workers on invalidity for burn-out. This project investigates whether different socio-demographic groups (e.g., gender) experience different barriers in the re-integration process. The RE-BOrn project consists of practice- and policy-oriented strategic research in 3 work packages (WP's): (1) an evaluation (SWOT-analysis) of current re-integration policies and practices, (2) the implementation of an intervention for burn-out recovery, and (3) the implementation of a self-assessment tool for re-integration, all adapted to the needs/context of the federal administration (FA). The project follows a mixed-methods approach, combining quantitative data with in-depth qualitative content analyses, and is concluded with practical recommendations for relevant stakeholders. The RE-BOrn project, first, mobilises a wide range of disciplines with project partners from the psychological, labour economic, and medical field. This multidisciplinary approach is a unique asset given that burn-out is mostly studied from a psychological point of view. RE-BOrn also mobilises researchers from the two largest linguistic regions of Belgium to assure their representation in our scientific advice towards national labour market re-integration policy. As an international benchmark, the Belgian Ministers of Employment look primarily to the Scandinavian employment model. Hence why a Scandinavian expert, Prof. Riitta Kärkkäinen, is one of the members of our follow-up committee. The Scandinavian 'flexicurity' model is based on intensive guidance towards employment. RE-BOrn will also strengthen the participation of a wide range of stakeholders, as this project aims to elevate successfully implemented burnout interventions/tools from the local to the national governmental level.

2. STATE OF THE ART AND OBJECTIVES

Literature describes three types of burn-out prevention: primary (eliminating/reducing antecedents of burn-out), secondary (promoting burn-out symptom reduction and retention in employment), and tertiary (promoting return-to-work after burn-out and preventing relapse) (Truchot, 2004). The 'REturn to work after Burn-Out' (RE-BOrn) project encompasses stages of recovery (secondary prevention) and re-integration (tertiary prevention). The overall project goals are to improve (a) burn-out recovery, (b) work-related well-being since re-integration after burn-out, and (c) prevention of relapse in the Federal Administration (FA). The project has a broad scope, as it is not tailored to specific federal public services but rather aimed at the entire FA to have more impact. The leading theoretical framework is the Job Demands-Resources model (Demerouti et al., 2001) for all Work packages (WP's).

2.1. State of the Art and Objectives of WP1

Research Objective 1 aims to evaluate current practices and policies on return-to-work after burn-out in the FA (realized in WP1). A literature review summarizes the best available scientific evidence (*top-down approach*) on (interventions for) secondary and tertiary burn-out prevention. The state of the art regarding scientific evidence is that most articles cover primary prevention. There is much less research on recovery from burn-out (secondary prevention) and re-integration after burn-out (tertiary prevention) (Kärkkäinen et al., 2017; Rooman et al., 2021). Yet, this topic is a large societal challenge as burn-out and related absenteeism numbers are high and still rising (343.151 salaried workers in invalidity for burn-out in Belgium in 2023 compared to 23.821 in 2016; National Institute for Sickness and Disability Insurance, 2023). Interest for burn-out was also growing as part of the Relance Strategy for societal and economic recovery after the COVID-19 crisis. Therefore, focus is on effective interventions to reduce burn-out symptoms prior to workplace re-integration (Aim 1: building block for WP2) and once employees are re-integrated at work (Aim 2: building block for WP3). Secondly, document analysis and in-depth interviews were used for internal benchmarking. We mapped actions the federal administration (FA) is undertaking already, on what aspects these actions could still be improved, and in what legislative framework they operate regarding re-integration (*bottom-up approach*). The state of the art is that attention for psychosocial well-being at work is growing and many projects on primary prevention are being set up in the FA. Yet, with growing numbers of long-term absenteeism/invalidity (National Institute for Sickness and Disability Insurance, 2023), especially since the pandemic, a specific approach to improve re-integration is needed.

2.2. State of the Art and Objectives of WP 2

Research Objective 2 evaluates the effectiveness of a BurnOut Treatment Program (BOTP) for secondary burn-out prevention among workers in the FA (realized in WP2). Interventions for secondary prevention could be at the individual (1) or the organizational (2) level (Maslach & Goldberg, 1998). First, Individual-centered interventions aim (a) to modify the relationship between individuals and their job, (b) to optimize their personal resources or (c) to work on personality characteristics (Jonckheer, 2011). The most investigated individual-centered intervention is cognitive behavioural therapy (CBT; Corazon et al., 2018; Smoktunowicz et al. 2021), together with mind-body approaches like relaxation and mindfulness (Korczak et al., 2012; Smoktunowicz et al. 2021). Second, organization-centered interventions relate to work arrangements (Jonckheer, 2011). Burn-Out (BO)

interventions are often combined and thus focus on both individual and organizational aspects appeared to be most effective (Pijpker et al., 2019). BO combined interventions can (a) have a (direct) positive effect on facilitating rehabilitation (secondary prevention) among employees at work or on sick leave due to BO (Pijpker et al., 2019), and (b) have an (indirect) reducing impact on absenteeism and promoting effect on return-to-work (tertiary prevention) (Kärkkäinen et al., 2019). Addressing these recommendations, Braeckman and Hansez (2019) developed the BOTP (FEDRIS, 2019), which is adapted to the FA and evaluated in the RE-Born project. Given the lack of literature and insights in the effectiveness of BO interventions (Ahola et al., 2017; Perski et al., 2017), WP2 has three main aims: First, to create an adapted BOTP(FA-BOTP) with both person- and organization-centered interventions tailored to the FA. Second, to evaluate the FA-BOTP, in terms of effectiveness on BO symptoms and absenteeism on the one hand, and in terms of participants' satisfaction on the other. Third, to draft recommendations aimed at implementing (future) BOTP's. WP2 is innovative as it adds value to both the scientific literature and practice, in two ways. First, WP2 responds to the BELSPO (BRAIN-BE 2.0 [6] request) to consider combined instead of single interventions, as typically has been done. Second, the effectiveness of combined interventions is tested, which is typically not done but may provide guidelines for further improvements.

2.3. State of the Art and Objectives of WP3

Research Objective 3 concentrates on workplace re-integration (realized in WP3), the phase subsequent to burn-out recovery/ treatment (see WP2). WP3 specifically focuses on prevention of relapse into burn-out among workers who recently resumed their activities in the FA, by implementing a newly developed and short questionnaire tool, named the Burnout Reintegration Monitor (BRM). BRM monitors how well one feels re-integrated at work and finds ways to act upon it. The tool gives workers the autonomy and agency to take control of their own re-integration process; to assess their well-being and work on it if needed, which fits the self-activation vision characterizing HR 2.0. The tool not only captures risk factors in the workplace (e.g., perceived workload) but, importantly, also helping factors in the workplace (e.g., perceived social support) for successful re-integration after burn-out, departing from the Job Demands-Resources model (Demerouti, 2001), a well-known theoretical framework on burn-out prevention (cf., supra for link with primary and secondary prevention). For person-related factors, the extended Job Demands-Resources model (Schaufeli & Taris, 2014) serves as the theoretical basis. Hence, the Burnout Reintegration Monitor (BRM) aims are twofold, namely to measure (1) one's overall perceived quality of re-integration to give workers insights into their level of re-integration quality (low/medium/high) and (2) to give the FA a general overview on how well their workers feel re-integrated after burn-out. In addition, the BRM-tool includes the major, most proximal determinants of quality of re-integration, stemming from prior PhD-research (Rooman et al., 2021). The BRM is innovative in three ways: First, the limited body of existing studies on re-integration is largely qualitative in nature; there is not yet a general scale to measure/monitor quality of re-integration before, which we develop and validate (Rooman et al., 2022). Second, the BRM highlights the direct antecedents of re-integration quality on which concrete actions can be taken. Third, the BRM is contextualized to the FA: The original risk and helping factors are finetuned according to the needs/specificity of the FA. Combining the above, the RE-BOrn project sets out a self-assessment tool that encourages FA employees to monitor their own psychosocial well-being at work, which is –to the best of our knowledge– not done before. This implementation and practical valorisation in the FA are focused on 2 pillars: (1) diagnosis, or measuring the success of re-integration trajectories after burn-

out in the FA, and (2) remediation, or improving successful re-integration by giving workers the means to do so. In that way, the RE-BOrn project contributes to a strong relapse prevention policy concerning stress, burn-out, and long-term sick leave, which serves the psychosocial well-being of the workers and contributes to a sustainable career management policy in the FA. Note that the current project, particularly WP3, focuses on the development and first empirical tests of the BRM monitor for the federal agencies, named FA-BRM.

3. METHODOLOGY

3.1. Ethics and Data Management

The Ethics Committee of the Faculty of Psychology, Speech Therapy and Educational Sciences of Liège University provided their approval (file reference 2223-029) for all data collection in the ReBorn project on 02/01/2023 (approval letter for application no. 2223-029)

The Ethics Committee of the Faculty of Psychology and Educational Sciences of Ghent University provided their approval for all data collection in the ReBorn project in which Ghent University is involved, on 20/11/2023 (approval letter for application no. 2023-078).

To comply with GDPR guidelines, a data processing agreement was constructed between Ghent University and FPS BOSA in which the FPS BOSA was the responsible data processor given that the data collection executed by the Ghent University researchers was commissioned by FPS BOSA (reference no A24-TT-0256 N Ugent DPO Verwerker REBORN).

3.2. Methodology of WP1

Work Package 1 (**WP1**) concerns two work packages, namely **WP 1.1,** i.e., setting the stage with a literature review, and **WP 1.2**, a document analysis and in-depth interviews for internal benchmarking.

3.2.1. Methodology of WP1.1

WP1.1 is an **integrative literature review** (top-down approach), which contributes to the body of knowledge on a particular topic by reviewing, critiquing, and synthesizing representative literature on this topic. The ultimate aim is to create new relevant frameworks based on the integration of literature (Torraco, 2016).

Scoping review protocol. A **protocol** describing the methodology was written and registered on Open Science Framework (OSF). The scoping review methodology consists of 3 steps. Firstly, an initial limited search of Medline (Ovid) and PsycINFO (Ovid) was performed to collect articles on the topic. Secondly, the words contained in the titles and abstracts of relevant articles, and the index terms used to describe the articles were utilized to develop a full search strategy for Medline (Ovid), PsycINFO (Ovid), Embase (Elsevier) and CENTRAL (Ovid). Following the search, all identified citations were uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicates were removed. Following a pilot test, titles and abstracts were then screened by two independent reviewers for assessment against the study's inclusion criteria. The full text of selected citations was retrieved and assessed in detail against the inclusion criteria by two independent reviewers. Any disagreement between reviewers at each stage of the selection process has been resolved by discussion or with an additional reviewer. Data were then extracted from the included articles by two independent

reviewers, dr Nancy Durieux (researcher at Liège University) and Cloé Lehaen, using a data extraction tool, developed by the reviewers. The extracted data contains information relevant to answering the questions raised: terminology used to name them, evaluation method, characteristics,... Any disagreements between evaluators were resolved by discussion or by the intervention of an additional evaluator. If necessary, the authors of the articles were requested to provide missing or additional data. Thirdly, the reference list of all included studies and of all relevant reviews identified during the search process were screened for additional studies. The study selection was then reported in a PRISMA flowchart to increase transparency and reproducibility. All articles were screened based on pre-defined criteria: (1) language: English or French; (2) published studies and protocols reporting quantitative, qualitative or mixed-methods data, (3) study population: employees either at risk of burnout or suffering from burnout (4) study scope: studies investigating combined burnout interventions, their characteristics and their assessment and containing a burnout measure/evaluation. The extraction, using a table developer by the reviewers, and analysis of data from the studies included were completed by the same two independent reviewers.

Federal Agency literature review. The protocol was registered in PROSPERO (International Prospective Register of Systematic Reviews). The review was conducted in compliance with the PRISMA-guidelines for systematic reviews (Liberati et al., 2009) and consisted of 4 main phases: (a) search in relevant databases, (b) deduplication, (c) a first screening based on title and abstract, and (d) a full-text evaluation of the remaining articles for eligibility. The search (a) was wide to increase sensitivity and was thus conducted in the databases Web of Science, Scopus, Medline, Embase, PsychINFO, Cochrane Database of Systematic Reviews and Google Scholar. The time range started with articles no older than 2010. Grey literature like government websites was not included, as all information from the FA was captured in the document analysis (see WP1.2, next stage). The study selection (c, d) was reported in the PRISMA flowchart to increase transparency and reproducibility. All articles were screened based on pre-defined criteria: (1) language: English, French or Dutch; (2) published, peer-reviewed scientific article (both primary studies and systematic reviews with or without meta-analysis; including both quantitative and qualitative research designs according to the projects' multi-method approach), (3) study population: working age (18y-65y) and working in governmental organizations, (4) study scope: antecedents/interventions related to 2 outcomes: (a) burn-out treatment/symptom reduction (secondary prevention) and/or (b) re- integration after burn-out (tertiary prevention), like for instance duration of sick leave and work-related well-being since re-integration (Cancelliere et al., 2016).

3.2.2. Methodology of WP1.2

WP1.2 is a **combination of a document analysis and internal benchmarking interviews** (i.e., *bottom-up approach*). Document analysis is a qualitative systematic procedure to review or evaluate documents to gain understanding and empirical knowledge (Bowen, 2009). It is a commonly used technique to create a good overview of organizational or institutional data (text, numbers, images) gathered earlier without any researchers' intervention. The goal of this phase is to increase understanding in the specific context of the federal public services and what the challenges are when it comes to burn-out and re-integration. Important to note is that document analysis, as a qualitative technique, aims to elicit meaning and gain understanding. This stage, therefore, does not yet serve to evaluate re-integration practices in the FA but rather understand these better. The data was grouped into themes/categories via content/thematic analysis (Bowen, 2009). Afterwards, three interviews were conducted for internal benchmarking (Baker et al., 2012). These were semi-structured in-depth

interviews with an estimated duration of 1 hour (Kallio et al., 2016). The interview guideline was based on findings of the integrative literature review (WP1.1) and the document analysis. The target audience were psychosocial prevention advisors in the FA. They were asked to describe current practices and policies on re-integration (after burn-out) and evaluate these in their effectiveness, while paying specific attention to the aspects that could still be improved. All sessions were recorded and transcribed, as in the focus groups hereafter (see WP2). Data analysis of the transcripts was done by grouping the information into categories via membership categorization analysis (MCA; Kärkkäinen et al., 2018), a qualitative analysis technique based on thematic analysis (the technique used in the document analysis described above) (Braun & Clarke, 2006), but with some specificities relevant for the RE-BOrn project. MCA is fitted to study practices that members in a certain community, like the FA, deploy. This approach was also adopted by a recent interview study with occupational physicians and re-integration coordinators to investigate how supervisors can offer support in the return to work of employees with burn-out (Kärkkäinen et al., 2018).

3.3. Methodology of WP2

Work Package 2 (**WP2**) is divided into three methodological phases, namely **WP2.1** (focus groups), **WP2.2** (test of FA-BOTP), and **WP2.3** (Delphi-method).

3.3.1. Methodology of WP2.1

The creation of the Federal Agency Burnout Treatment Program (FA-BOTP) is based on a pre-existing tool, the Burnout Treatment Program (BOTP; Fedris 2019), which uses a mixed intervention focused on the individual but also on the organization. A preliminary step concerned the organization of several focus groups with federal agents to adjust the BOTP to the needs and context of federal agencies. 4 two-hour long focus groups have taken place on 23, 24, 26 and 27 January 2023. Two focus groups were conducted in French by the University of Liège researchers (Groups 1 & 3) and two focus groups were conducted in Dutch by the Ghent University researchers (Groups 2 & 4). In total, 36 participants coming from FPS Policy and Support, FPS Employment, Labour and Social Dialogue, FPS Home Affairs, FPS Mobility and Transport, and RIZIV/INAMI, attended the focus groups (18 in French & 18 in Dutch). Each session started with an introductory presentation including: a presentation of the research team, information on the confidentiality of data exchanged (Ethical committee documents), the course and purpose of the session, the context of the RE-BOrn project, the presentation of the BOTP (FEDRIS, 2019) as well as different points to be addressed in order to adapt the BOTP to the Federal Agencies Burnout Treatment Program (FA-BOTP). Afterwards, each session was followed by a lunch to continue the exchange in a more informal way. The focus groups were recorded and then transcribed. The transcriptions were anonymized, and the recordings destroyed as soon as the transcription had been completed. The collected data was analyzed using a thematic analysis (Braun & Clarke, 2006) to create a Burnout Treatment Program adapted to the context of the federal agencies.

3.3.2. Methodology of WP2.2

Procedure of WP2.2. In this stage, the developed FA-BOTP (see further for the content of the FA-BOTP) was tested with 23 federal agents who had to complete a Pre-test and a Post-test. The multiple data points per participant were connected via an anonymous, personal code. Recruitment communications containing a link to a screening form have been launched in the same five federal

agencies as used for the focus groups, and the research team has examined these requests to ensure that the participants met the inclusion criteria. If participants met the inclusion criteria (i.e., early-stage work-related burnout, no relapse, no absence of more than two months), they received a link to the Pre-test as well as a list of health professionals set up by the research team. Participants then had to choose their burnout treatment provider and attend up to two diagnostic sessions to confirm or deny the early stage of burnout. A diagnostic report drawn up by the burnout treatment provider was then sent to the research team, which took the final decision on their inclusion based on this report. Participants who did not meet the inclusion criteria were redirected by their burnout treatment provider towards other solutions, both external and internal to the federal public services. Participants who met the inclusion criteria then began the program.

At the end of the FA-BOTP, once the final report drafted by the burnout treatment provider was sent, the participant received the link to complete the Post-test. Three reminders emphasizing the importance of responding to the Post-test were sent, followed by a final fourth reminder for those who had not yet responded; however, to avoid being overly intrusive, it was decided not to send any additional reminders. The online questionnaires were administered and completed via the UDI-FAPSE platform, the online survey platform of the Faculty of Psychology, Speech Therapy and Educational Sciences at the University of Liège.

Measures of WP2.2. To assess the effectiveness of the FA-BOTP, each participant had to complete an online questionnaire before the FA-BOTP (Pre-test, see **Annex A**) and directly after the FA-BOTP (Post-test, see **Annex B**). The data from the reports completed by the burnout treatment providers was also analyzed (see **Annexes C, D**).

➔ Questionnaire

Socio-demographic data (i.e. age, gender, type of contract…) was collected during the Pre-test. During the Pre-test and Post-test, data was collected on:

- Employment status: job title, working week, working hours, federal agency (FPS BOSA, RIZIV-INAMI, etc.), etc.
- Physical and psychological state of health.
- Consultations with doctors, occupational physicians, psychologists/psychiatrists.
- Medication.
- Burnout risk via the Burnout Assessment Tool (BAT) (Schaufeli et al., 2020).
- Depression, stress and anxiety via the Depression, Stress and Anxiety Scale (DASS-21) (Lovibond & Lovibond, 1995).

Post-test 1 also included questions on:

(1) Participants' satisfaction with:

- The environment: proximity of care, accessibility of the venue, premises suitable for care, use of teleconsultations, times of consultations (during/outside working hours).
- Providers: ease of making appointments, flexibility, punctuality, coordination of FA-BOTP, satisfaction with sessions.
- Content of the program: variety of sessions, modularity/degree of personalization, length of journey, explanations given by the burnout treatment provider and the research team, dynamics of meetings with the occupational physician.
- Sessions: number of sessions, desire or need for more: work clinic sessions, starter kit, individual sessions, follow-up/reorientation sessions.
- Anonymity and confidentiality: preservation of anonymity and confidentiality.

- Overall assessment: overall assessment of FA-BOTP, recommendations to others, continuation of follow-up.

(2) Changes in the work situation

- Adaptations/workstation adjustments.
- Sick leave during FA-BOTP.
- Perception of the current situation within the organization: awareness of the problem, management style, relationships with superiors and colleagues, material support, etc.
- Perception of the current situation in relation to work: perception of positive aspects, distancing from work, expectations.
- Perception of the current situation at an individual level: general well-being, well-being in relation to work, quality of sleep, work-life balance and ease of completing tasks.

➔ Reports

The various reports provided by the burnout treatment provider were analyzed to obtain information on: the burnout diagnosis, the suitability of FA-BOTP for the participant's situation, the number and type of sessions attended, the presence of burnout at the end of the program, and the reduction in symptoms.

Sample of WP2.2. In total, 109 federal agents expressed an interest in the FA-BOTP. Of these 109 federal agents, 54 met the inclusion criteria. 44 participants then completed the pre-test. 29 participants took part in the obligatory diagnostic sessions to confirm burnout with a health professional and 23 participants met the criteria. Of the 23 end-of-treatment reports received, only 14 participants responded to the post-test. Thus, for these 14 participants, we analyzed both the data from the post-test and those from the end-of-treatment reports, while for the nine participants who did not respond to the post-test, only the data from the report were analyzed. The 14 participants were predominantly female, Dutch-speaking, and aged between 35y and 55y. Most of these employees held A-level positions and were statutory.

The envisioned number of 40 participants has not been reached despite efforts to maximize participant numbers through frequent reminders and integrating individuals from the waiting list, and thus extending the timeframe to allow them to complete the FA-BOTP. Several participants who met the inclusion criteria did not proceed to contact a burnout treatment provider. The limited timeframe and the nine-month duration of the FA-BOTP program prevented the inclusion of the initially planned 40 participants.

Analyses of WP2.2. We performed a one-sided paired-sample Student's t-test to check whether there was a decrease in BAT and DASS-21 before and after the FA-BOTP. For the evaluation of satisfaction and changes in work situation, descriptive analyzes were carried out to assess the frequency with which each response was given using SPSS (Version 29.0.2.0).

3.3.3. Methodology of WP 2.3

Procedure of WP2.3. To obtain recommendations based on expert opinion, a DELPHI method was then implemented. This method aims to reach a consensus among an independent group of experts via several rounds. This anonymous process can be carried out either by interview or by questionnaire, possibly online (Spiral, n.d.). While there are different ways of defining or reporting consensus, systematic reviews (Diamond et al., 2014; Foth et al., 2016) suggest that the most common way of defining consensus is based on the percentage of agreement with a specific response. Still

according to these authors, while the threshold for percentage agreement varies widely, the median threshold is 75% agreement between participants. With this in mind, each recommendation with 75% agreement or more (score 4 or 5) was not represented in the next round, and recommendations with less than 75% agreement were represented in the next round.

The first round (see **Annex E**) took place from March 26 to April 9, 2025, giving participants two weeks to complete the questionnaire. One week was then dedicated to analyzing the responses and creating a new questionnaire. The second round (see **Annex F**) took place from April 16 to April 30, 2025, again giving participants two weeks to respond. At the end of the second round, two items had not yet reached the consensus threshold. These two items were the subject of a third (see **Annex G**), shorter round, which began on May 9, 2025, and ended on May 19, 2025. By the end of these third rounds, all items had reached the 75% consensus threshold. At the end of the third round, participants who had completed all rounds of the Delphi study received a compensation of €300. To track which participants had completed all rounds, everyone was assigned a personal code by the researcher. Participants were required to enter this code at the end of each questionnaire. The researcher was the only person who knew which code corresponded to which participant, and participants were unaware of the identities of the other members of the panel.

Measures of WP2.3. Each recommendation was developed through a structured evaluation process. Initially, contextual findings were presented to provide participants with the necessary background information. This approach ensured that all participants had a clear understanding of the situation and the rationale behind the proposed action. Following this, a specific recommendation was formulated, tailored to the context previously described. Participants were then asked to assess the recommendation using a five-point Likert scale, where 1 indicated strong disagreement and 5 indicated strong agreement. In addition to assigning a numerical score, participants were required to justify their rating. This qualitative input was crucial for gaining insight into the reasoning behind their evaluations and for identifying any concerns, suggestions, or areas of support related to the recommendation.

The recommendations were organized into 4 themes:

1. The FA-BOTP inclusion process: this category covers the various elements of the participant recruitment process, as well as the inclusion criteria.
2. FA-BOTP content: this category refers to the sessions and number of sessions included in the FA-BOTP.
3. Organizational approach in the FA-BOTP: this category refers to the involvement of the organization.
4. Consultation logistics: this category covers the practical aspects of setting up the FA-BOTP.

Sample of WP2.3. The experts were contacted individually by e-mail and were part of the respective professional networks of the University of Liège and of Ghent. 14 experts (2 men, 50% French-speaking experts) were involved in the DELPHI method. The experts were either occupational physicians, clinical or occupational psychologists, or psychosocial prevention advisors. Five participants were also familiar with the context of federal public services and how they operate. N = 13 participants took part in the first round (n = 7 French-speaking and n = 6 Dutch-speaking). From this group, n = 12 participants took part in the second round (n = 7 French-speaking and n = 5 Dutch-speaking) and n = 12 participants took part in the final round (n = 6 French-speaking and n = 6 Dutch-speaking).

Analyses of WP2.3. For the evaluation of the recommendation, descriptive analyses were carried out to assess the frequency with which each response was given. The justifications were subjected to

a thematic content analysis. This analysis made it possible to identify points of convergence and divergence to adjust the recommendations for subsequent rounds of the DELPHI process. The aim was to foster a move towards consensus among the participants.

3.4. Methodology of WP3

Work Package 3 (**WP3)** is divided into two methodological phases, namely **WP3.1** (cross-sectional survey) and **WP 3.2** (longitudinal survey).

3.4.1. Procedure of WP 3.1 and WP 3.2

WP3.1. WP3.1 concerned a cross-sectional survey (i.e., sent out once) which was administered online among workers in the FA who resumed work in the meantime after a recent period of sick leave for burn-out. To this end, the FA-BRM was widely deployed within the FA (minimum 150-200 participants) at Time 1 (T1 = first measurement moment). This one-time questionnaire serves construction and validation purposes. Specifically, the plan was to conduct factor analyses in SEM with lavaan (R) to see if adjustments (e.g., item selections) are needed for the target group of FA-workers.

WP3.2. In the next stage (WP3.2), the adapted FPS-BRM was administered throughout a three-wave longitudinal study (online survey). We theoretically argued that quality of re-integration does not fluctuate strongly on a (two-)weekly basis as it captures rather an overall perception of the re-integration which is more a long-term process. Consequently, the gap between the 3 measurement points was 3 months to ensure sufficient fluctuation (data-collection spread over 9 months in total). The scales were adapted to the longitudinal design, meaning that participants had to reflect each time on the past month. Items therefore started with “the past month” instead of the more general instruction “since my return to work”. All variables measured in WP3.1 were measured again at each time point (3x) (except for socio-demographics) as they were expected to fluctuate over the course of the study period. For efficiency reasons, we aimed to take a subsample of participants who already participated in WP3.1 (T1= baseline condition). The number of total participants we target at Time 3 (T3) was 40. The multiple data points per participant were connected via an anonymous, personal code following the example of Xanthopoulou et al. (2009). The time-varying determinants were taken into account through multilevel analyses because these are crucial to understand dynamic processes like re-integration (Carlier et al., 2013; Xanthopoulou et al., 2009).

3.4.2. Measures of WP3.1 and WP 3.2

The **primary outcome** of this study was **Work Resumption Quality (WRQ)**, measured using the scale developed by Rooman et al. (2022). Based on the state-of-the-art in the literature, Rooman (2023) defined work resumption quality as the workers’ subjective perception of how qualitative their work resumption process has been since return to work, after their sick leave due to burnout. In other words, workers who experience a high work resumption quality feel like they are well reintegrated and resuming work goes smoothly upon their return from burnout. This re-employment experience starts when the person first resumes work duties (i.e., since the return to work) and can keep evolving as the person seeks their place again at work. Workers’ subjective experiences on reintegration are relevant for their general well-being as they constitute their momentary feeling and mental health (Rooman et al., 2022). They deserve further monitoring after burnout given the risk of relapse (Flemish Government, 2021) when workers are confronted with job demands again (JD-R; Bakker & Demerouti, 2017).

In terms of **determinants of WRQ**, the study first considered **general factors** that appeared important for work resumption quality (WRQ) after burnout in previous research across various sectors (i.e., both the private and the public sector) (Rooman, 2023). These factors are included in a practical tool to assess Work Resumption Quality (WRQ) and its most important determinants, named the 'Burnout Reintegration Monitor' (BRM) ('Re-integratiebalans' in Dutch; 'Bilan de réintégration' in French). The tool specifically considers the following determinants:

1. Job Autonomy & Workload (Copenhagen Psychosocial Questionnaire; Berthelsen et al., 2018; Burr et al., 2019)
2. Supervisor Support (Social Support Scale of Caplan, 1980)
3. Resilience (Campbell-Sills & Steins' [2007] version of the Connor-Davidson Resilience Scale)
4. Perfectionistic Striving & Concerns (Perfectionism Scale of the Work Reintegration Questionnaire; Vendrig, 2005)

To account for ongoing effects of burnout, Residual Burnout Symptoms were included as a **control variable**. These were assessed using the work-related version of the Burnout Assessment Tool (Schaufeli et al., 2020).

Secondly, the study considered the following determinants which are more **specific to the governmental context** and were selected based on preparatory interviews with federal agents reintegrated after burnout (*N* = 6; all women; *M* age = 54.50 years old; 4 French-speaking, 2 Dutch-speaking; representing the FPS Public Health, RSVZ/INASTI, BOSA; educational level minimal bachelor). Most of them were at increased risk of relapsing into burnout. The average duration of the interviews was about 1 hour. The interviewer was a 28 year old woman. The interviews were held online with audio recording and automatic transcription via Microsoft Teams. The transcripts were analyzed using thematic analysis (Braun & Clarke, 2006), a method for identifying, analyzing, and reporting patterns (themes) within data, which involves a flexible yet systematic process of coding and theme development to capture meaningful insights.

Based on the interview findings, additional elements to consider in reintegration after burnout in the governmental context are (a) feelings of injustice vs. fair treatment, (b) top-down decision-making and 'not feeling heard', (c) a conflict vs. fit of personal and work values; (d) interpersonal conflicts, harassment and discrimination; (e) the alignment between Medex and Empreva in the reintegration process. Concerning the latter, the landscape of institutions involved in reintegration at the federal agencies is often difficult to navigate for workers reintegrating after burnout. One central point of contact could be helpful to make the reintegration process easier for them. The other factors should be followed up when the federal agents have resumed work, making them valuable to consider in an extended version of the 'Burnout Reintegration Monitor' (Burnout Reintegration Monitor for the Federal Administration; FA-BRM). The factors to be considered further in the survey were therefore grouped into four themes, that represent potentially important mechanisms to promote qualitative reintegration after burnout in the Federal Administration:

1. **Personal Fit with the Job** – This theme assesses the degree to which employees feel aligned with their job, organization, and work environment.
2. **Negative Interactions with Others at Work** – This theme examines interpersonal challenges that may hinder reintegration, like workplace conflicts or negative behaviors from colleagues.
3. **Job Aspects Typical to the Governmental Context** – This theme captures structural and procedural factors specific to governmental workplaces that impact reintegration.
4. **Fair Treatment by the Employer Upon Reintegration** – This theme assesses perceptions of fairness and transparency in how employees are treated during their return to work.

Departing from these themes identified in the preparatory interviews, the following factors are considered in the survey (structured per theme):

1. **Personal Fit with the Job**:
    a. Person-Job Fit, using the scale for general person-job fit of Kim et al. (2020), which measures to what degree people experience a match between themselves and their job, in general.
    b. Person-Organization Fit, using the subscale for person-organization fit of the person-job fit scale of Cable and DeRue (2002), which measures how one's values fit with the values of the organization they work for.
    c. Demands-Abilities Fit, using the subscale for demands-abilities fit of the person-job fit scale of Cable and DeRue (2002), which measures how one's abilities align with job expectations.
    d. Needs-Supply Fit, using the subscale for needs-supply fit of the person-job fit scale of Cable and DeRue (2002), which measures how what the job offers, aligns with what the worker seeks in a job.
2. **Negative Interactions with Others at Work**:
    a. Internalized Burnout Stigma (Adapted from the SOSS-D; Clough et al., 2019), measuring to what degree people think they will be stigmatized for their burnout.
    b. Task and Relational Conflict (Jehn, 1995), measuring to what degree people experience conflicts in the workplace, either concerning work-related issues (e.g., how a task should be handled) –named task conflict, or concerning issues on a more personal level –named relational conflict.
    c. Negative Behaviors from Others (Short Negative Acts Questionnaire; Notelaers et al., 2009), measuring several kinds of negative behaviors people experience from other people at work (e.g., their colleagues, supervisor, etc.), like feeling excluded, bullied or ignored in the workplace.
3. **Job Aspects Typical to the Governmental Context**
    a. Top-down decision-making, using a selection of items for procedural interactions based on a classification of multi-level decision-making in a governmental context from Popering, van et al. (2016), which captures to what degree decisions in the organization are implemented top-down.
    b. Ability to adapt procedures, using the 'Possibility to adapt prescribed work' scale from the 'Psychodynamics of work' measure (Leclercq et al., 2022), which measures to which extent workers have the ability to adapt prescribed work or procedures when they deem this necessary.
    c. Meaning in work, using a scale for meaning from the Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019), which measures the degree to which workers find their job meaningful.
    d. Emotional load, using a scale for emotional job demands from the Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019), which measures the degree to which workers find their job emotionally demanding.
4. **Fair Treatment by the Employer Upon Reintegration**.
    a. Burnout Stigma by Medex Doctor (Scale of Occupational Stigma in Doctors (SOSS-D) by Clough et al., 2019), capturing whether workers felt stigmatized by the

occupational physician of Medex upon their reintegration after burnout (therefore measured at T1 only).

b. Interpersonal & Informational Justice (derived from the procedural justice scale by Colquitt et al., 2001) – assessing different aspects of fairness upon reintegration after burnout (therefore measured at T1 only). Interpersonal justice evaluates fairness in interpersonal treatment, while informational justice assesses how transparently the employer communicated about the reintegration process and how much information they provided to the worker throughout this process.

Table I provides an overview of the key study variables, their measurement instruments, the timepoints at which they were assessed, and the subgroup to which they belong (outcome, control variable, determinants from the general 'Burnout Reintegration Monitor' i.e. BRM factors, and government-specific determinants, clustered per theme based on thematic analysis of the preparatory interviews).

Table I

Overview of measurement scales and timepoints.

Variable	Subgroup	Reference	Example item	Timepoint of measurement		
				T1	T2	T3
Work resumption quality (WRQ)	Outcome	Rooman et al. (2022)	I have taken up my work again in a qualitative manner	X	X	X
Residual burnout symptoms	Control variable	Burnout Assessment Tool (Schaufeli et al., 2020); work-related version	At work, I felt mentally exhausted	X	X	X
Job autonomy	BRM factors	Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019)	I had a large degree of influence on the decisions concerning my work	X	X	X
Workload	BRM factors	Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019)	I often did not have the time to complete all my tasks	X	X	X
Supervisor Support	BRM factors	Social Support Scale of Caplan (1980)	How much could your supervisor be relied on when things got tough at work?	X	X	X
Resilience	BRM factors	Campbell-Sills and Steins' (2007) version of the Connor-Davidson Resilience Scale (Connor & Davidson, 2003)	I had a tendency to get back up after setbacks	X	X	X
Perfectionistic striving	BRM factors	Perfectionism Scale of the Work Reintegration Questionnaire (Vendrig, 2005)	I set high standards for myself in my work	X	X	X
Perfectionistic concerns	BRM factors	Perfectionism Scale of the Work Reintegration	I blamed myself if I made a mistake	X	X	X

		Questionnaire (Vendrig, 2005)				
Person-job fit	Government factors Theme 1	Kim et al. (2020)	All things considered, this job suited me	X	X	X
Person-organization fit	Government factors Theme 1	Subscale of the person-job fit scale of Cable & DeRue (2002)	My personal values matched my organizations' values and culture	X	X	X
Demands-abilities fit	Government factors Theme 1	Subscale of the person-job fit scale of Cable & DeRue (2002)	The match was very good between the demands of my job and my personal skills	X	X	X
Needs-supply fit	Government factors Theme 1	Subscale of the person-job fit scale of Cable & DeRue (2002)	There was a good fit between what my job offers me and what I am looking for in a job	X	X	X
Task conflict	Government factors Theme 2	Jehn (1995)	How much conflict about the work you did was there in your work unit?	X	X	X
Relational conflict	Government factors Theme 2	Jehn (1995)	How much were personality conflicts evident in your work unit?	X	X	X
Internalized burnout stigma	Government factors Theme 2	Adapted from the SOSS-D (scale occupational stress stigma in doctors); Clough et al. (2019)	Due to my burnout, I felt I was more likely to experience discrimination or prejudice	X	X	X
Negative behaviors from others	Government factors Theme 2	Selection of the 3 highest loading items of Short Negative Acts Questionnaire (S-NAQ-R) (Notelaers et al., 2009)	How often have you experienced the following interactions? Getting insulting or hurtful comments about your person, views or private life	X	X	X
Top-down decision-making	Government factors Theme 3	Items based on classification of multilevel decision-making in governmental context in Popering et al. (2016); items for 'procedural interactions' (vs. 'informal interactions')	Decision-making in my organization was based on hierarchy where decisions were implemented from the top-down	X	X	X
Ability to adapt procedures	Government factors Theme 3	'Possibility to adapt prescribed work' from the 'Psychodynamics of	I could deviate from work procedures when I deemed it necessary	X	X	X

		work' measure (Hansez et al., in press)				
Meaning in work	Government factors Theme 3	Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019)	I felt the work I did was important	X	X	X
Emotional load	Government factors Theme 3	Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018; Burr et al., 2019)	My work was emotionally demanding	X	X	X
Burnout stigma Medex doctor	Government factors Theme 4	Adapted from the SOSS-D (scale occupational stress stigma in doctors); Clough et al. (2019)	Upon my reintegration, the Medex doctor considered my burnout as a sign that I was not right for my profession	X		
Interpersonal justice	Government factors Theme 4	Subscale of the procedural justice scale of Colquitt et al. (2001)	My employer has treated me with dignity	X		
Informational justice	Government factors Theme 4	Subscale of the procedural justice scale of Colquitt et al. (2001)	My employer has been candid in their communication with me	X		

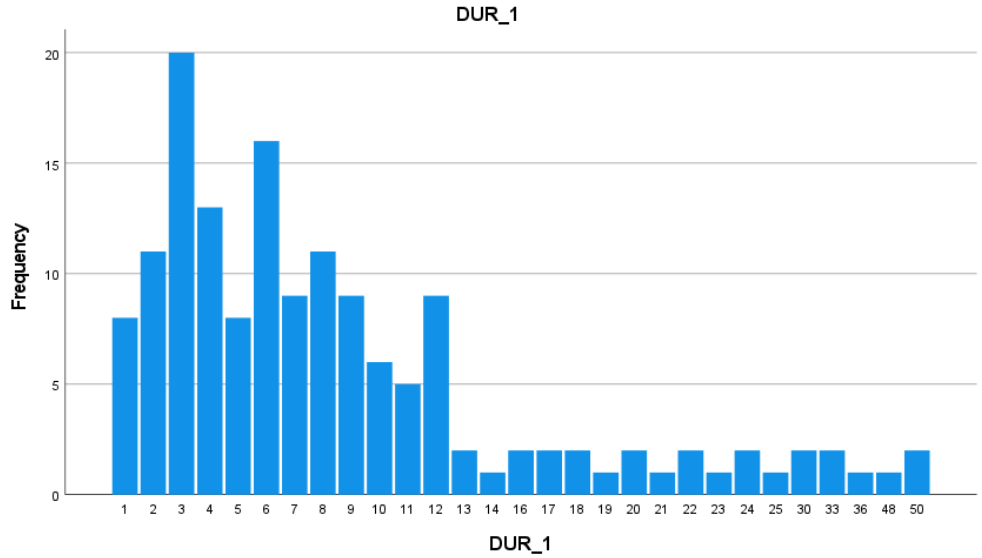
Samples of WP3.1 and WP3.2. The data collection consisted of a questionnaire in three waves, with 3 months in between each wave (T1: February 2024, T2: June 2024, T3: October 2024). Participants completed the questionnaire via Qualtrics, a survey tool provided by Ghent University (i.e., external to the Federal Administration). To recruit federal agents reintegrated in the Federal Administration after burnout, the research team sent out a communication plan to the BOSA Manager HR Policy Preparation. In this way, the call to participate was launched on the BOSA website and via various HR- and well-being networks within the Federal Administration (e.g., Network for Well-being at work).

The study aimed to collect data from a targeted sample size of *N* = 150 at Time 1 (T1). The actual number of respondents at T1 was *N* = 152. Over the course of the study, participation evolved as follows: at Time 2 (T2), *N* = 119 participants completed the survey, and at Time 3 (T3), *N* = 102 completed the survey. All participants confirmed their voluntary participation by completing an informed consent beforehand. Given that some individuals dropped out while others joined in the second or third wave, these numbers do not always reflect the same participants. In total, *N* = 226 participants completed at least one wave of the survey. To maximize the available data points (and power), some analyses were conducted using the grand means per person (*N* = 226) instead of limiting the analyses to those who participated at T1 (*N* = 152).

Demographics were collected at T1 and are therefore based on *N* = 152. The participants were on average 46.58 years old and had on average 8 years 10 months tenure in their function and 14 years 11 months tenure in the organization. The sample consisted of 71.10% women, in line with earlier statistics showing that women are overrepresented among workers on long-term absence due to burnout. 10.60% of the participants belonged to an ethnic minority group. The mean duration of burnout absence in the sample was 9.24 months. However, the distribution was skewed (skewness = 2.42; kurtosis = 7.00, *N* = 152) due to outliers (i.e., individuals absent for > 1 year). The distribution has a long tail on the right side, meaning that relatively few people with very long absence periods impact

the mean calculation (see **Figure 1**). Therefore, the median (6.5 months) can provide a more accurate representation of the typical absence duration in this case. **Figure 1** also shows that reintegration is most frequent after either 3, 6 or 12 months of absence. 82.20% of the sample resumed work within the first year of absence.

Figure 1 *Distribution of burnout absence duration (in months)*



Participants were employed in various federal public services, with the most represented institutions listed below (**Table II**; *N* = 152):

Table II

Representation of Federal Public Services (FPS) in the WP3 sample (N = 152).

Federal Public Service (FPS)	Number of Participants
FPS Finance	25
FPS Home Affairs	16
National Employment Service (RVA)	15
Federal Agency for Safety of the Food Chain (FAVV)	14
FPS Public Health	11
FPS Policy & Support (BOSA)	11

Preparatory analyses of WP3. Several preparatory analyses were conducted to evaluate the reliability and underlying structure of the measures. First, internal consistency, which reflects the degree to which items within a scale measure the same construct, was assessed using Cronbach's alpha (α) for all variables across three measurement points (T1, T2, T3) using SPSS v.27. Second, test-retest reliability, which indicates the stability of the measure over time, was assessed using the intraclass correlation coefficient (ICC). The ICC was calculated in lavaan for maximal data use (*N* = 226) using full information maximum likelihood (FIML). Subsequently, an exploratory factor analysis (EFA[1]) was conducted to examine the factor structure of the scales. The EFA was conducted using Principal Components Analysis using SPSS v.27. The extraction of factors was based on Eigenvalues > 1. No

[1] Note that factor loadings of all items (EFA) and correlations of all study variables can be found in **Annexes K – N.**

rotation was applied. The EFA analysis was applied on the grand means, i.e., the item scores across timepoints (*N* = 226) (See **Annex K**).

Reliability assessment. The measurement scales for all variables show at least good reliability (>.70; **Table III**). Many scales even demonstrated high internal consistency, with α values exceeding .80 - .90. For instance, work resumption quality (WRQ) (α = .90-.91), residual burnout symptoms (BAT) (α = .91–.92), and various dimensions of person-environment fit (α = .88–.96) displayed strong internal consistency across all timepoints. However, internalized burnout stigma exhibited consistently low reliability (α = .34-.44), as did top-down decision-making (α = .57-.70). These low α values suggest a weaker internal structure for these scales, indicating that their items may not be measuring a single underlying construct as effectively. Given the low reliability of these scales, the variables 'internalized burnout stigma' and 'top-down decision-making' could not be considered in further analyses.

Table III

Reliability assessment

Variable	Internal consistency reliability (α)			Test-retest reliability (ICC)
	T1	T2	T3	
Work resumption quality (WRQ)	.90	.90	.91	.83
Residual burnout symptoms (BAT)	.92	.91	.91	.92
Job autonomy	.89	.87	.82	.78
Workload	.95	.90	.86	.78
Supervisor Support	.95	.96	.94	.91
Resilience	.73	.78	.77	.84
Perfectionistic striving	.83	.84	.85	.87
Perfectionistic concerns	.76	.74	.71	.88
Person-job fit	.96	.96	.96	.91
Person-organization fit	.93	.96	.93	.88
Demands-abilities fit	.92	.88	.89	.89
Needs-supply fit	.94	.95	.94	.91
Task conflict	.92	.91	.92	.83
Relational conflict	.92	.96	.94	.85
Internalized burnout stigma	.34	.36	.44	.83
Negative behaviors from others	.89	.84	.83	.95
Top-down decision-making	.57	.70	.65	.87
Ability to adapt procedures	.85	.87	.81	.86
Meaning in work	.88	.86	.89	.89
Emotional load	.86	.85	.89	.91
Burnout stigma Medex doctor	.73	--	--	--
Interpersonal justice	.98	--	--	--
Informational justice	.89	--	--	--

Exploratory factor analysis of WP3. EFA showed evidence for 1 component in all variables (**Table IV**). For residual burnout symptoms (i.e., Burnout Assessment Tool), the scree plot showed evidence for 1 major component (Eigenvalue = 6.32). In addition, there were 3 components with an Eigenvalue around 1 (C2: 1.12; C3: 1.004; C4: .96) adding marginal explained variance (C2: 9.37%; C3:

8.36%; C4: 8.03%). However, based on the scree plot and difference in Eigenvalues, we consider BAT as 1 factor in any further analysis. **Annex L** shows per variable the factor loadings for each item.

Table IV
Exploratory factor analysis.

Variable	# items	# components	Eigenvalue	% variance explained
Work resumption quality (WRQ)	3	1	2.55	84.97%
Residual burnout symptoms (BAT)	12	1	6.34	53.55%
Job autonomy	4	1	3.04	75.99%
Workload	3	1	2.58	85.96%
Supervisor Support	4	1	3.48	87.00%
Resilience	3	1	2.14	71.22%
Perfectionistic striving	6	1	3.45	57.55%
Perfectionistic concerns	5	1	2.71	54.15%
Person-job fit	4	1	3.56	88.98%
Person-organization fit	3	1	2.73	90.75%
Demands-abilities fit	3	1	2.53	84.25%
Needs-supply fit	3	1	2.69	89.68%
Task conflict	4	1	3.35	83.83%
Relational conflict	4	1	3.59	89.68%
Internalized burnout stigma	5	1	2.90	58.06%
Negative behaviors from others	3	1	2.46	81.90%
Top-down decision-making	3	1	1.76	58.59%
Ability to adapt procedures	4	1	2.83	70.65%
Meaning in work	2	1	1.81	90.47%
Emotional load	3	1	2.41	80.38%
Burnout stigma Medex doctor	3	1	1.95	64.83%
Interpersonal justice	3	1	2.86	95.34%
Informational justice	4	1	3.02	75.47%

4. SCIENTIFIC RESULTS AND RECOMMENDATIONS

4.1. WP1

4.1.1. WP 1.1

Firstly, regarding the scoping review on combined burnout interventions, following the launch of the strategies, 4257 references were identified. After removing duplicates, we screened 2734 references, reviewed 175 full-texts, and finally included 36 documents: 32 studies and 4 protocols. These ranged from 1983 to 2024 and were mostly conducted in Europe. Sample sizes varied, from 17 to over 1,500 participants, with the healthcare sector being the most represented. Most participants were still employed, indicating a strong focus on secondary prevention.

We identified 143 individual interventions, with frequent approaches including Improving competencies/knowledge (individual-related), Mental health support and Improving competencies/knowledge (work-related). We also found 155 organizational interventions, mostly related to Policy development, Work organization, and Improving interpersonal relations at work. Many interventions were tailor-made, either at the individual level, by adapting sessions to personal

needs or diagnostic profiles, or at the organizational level, by addressing specific workplace challenges and supporting structural changes. Few studies were explicitly labelled as 'combined' and terminology varied greatly with use of terms such as ‘multi-level’, ‘multistrategy’, ‘multi-component’, etc. Internal professionals (like managers or hierarchical line) and external ones (such as psychologists or physicians) were often involved, but 12 studies did not clearly state who delivered the interventions.

Designs included Randomized Controlled Trials (RCT), quasi-experimental studies, and used a pre-post evaluation with at least one follow-up. However, some studies didn’t report their methodology clearly.

Burnout evaluation was often based on the Maslach Burnout Inventory (MBI) (Maslach et al., 1996), but other questionnaires were also used. Other outcomes primarily concerned mental health aspect such as depression and anxiety or work-related measures such as job demands, resources, job control, etc. Finally, two major gaps reported by the authors of the included articles were identified. A first gap related to treatment efficacy (*n = 31*), revealing a lack of knowledge on the effectiveness of interventions to treat stress-related disorders and a second gap (*n = 15*) related to a lack of focus on organizational interventions.

Most studies focused on employees who were still at work, reflecting a strong emphasis on secondary rather than tertiary prevention. Many interventions were tailored, either to individual needs or to specific organizational issues. This individualization is considered crucial in burnout prevention. According to authors like Shanafelt and Noseworthy (2017) and Nielsen (2022), listening to employees and adapting interventions to their reality significantly increases relevance and impact.

What’s new in this review is the balance: combined interventions typically include both individual and organizational components, a shift from earlier, more individual-focused strategies. There’s no consensus on terminology, we found labels like 'multi-level', 'multi-modal', or no label at all. This can be explained by the fact that individual and organizational interventions can be conceptualized in different ways, depending on the framework chosen by the authors to classify their intervention. For instance, some consider training to be an individual intervention, while others frame it as organizational if it improves job resources. Several studies lacked key details, such as design or the professionals involved, which matches past findings by Ahola et al. (2017) and Awa et al. (2010).

Lastly, high heterogeneity in outcomes, tools, and methods makes comparison and synthesis very difficult.

This review extended the scope of previous reviews by including intervention protocols. In addition, the terms used in the search strategy explicitly refer to the combined characteristics of interventions, whether directly or indirectly. Still, limitations exist. Some interventions may have been missed if not properly labelled in titles or abstracts. Selection also depended on our chosen definition for individual and organizational interventions, which may differ from other interpretations. Finally, only French and English studies were included, meaning relevant work in other languages could have been excluded.

Moving forward, we recommend enriching search strategies to make them more exhaustive, harmonizing definitions and terminologies to ensure that everybody is referring to the same concepts, and standardizing intervention descriptions to better understand the methodology used but also to enhance their potential for replica. There’s also a need to explore tertiary prevention, an area still under looked in most studies.

Secondly, the systematic review titled "Return-to-work interventions for sick-listed employees with burnout" by Lambreghts et al., published in Occupational and Environmental Medicine in September 2023, examines the effectiveness of various interventions aimed at facilitating

the return to work (RTW) for employees on sick leave due to burnout. The study synthesizes existing research to identify which strategies are most beneficial in supporting employees' reintegration into the workplace. The authors analyzed multiple studies focusing on different RTW interventions, including psychological therapies, physical activities, and combined approaches. Their findings suggest that interventions incorporating cognitive-behavioral therapy (CBT) and those that combine psychological and physical components tend to be more effective in reducing burnout symptoms and promoting successful RTW outcomes. However, the review also highlights the variability in study designs and intervention implementations, which poses challenges in drawing definitive conclusions. The review underscores the need for well-structured, high-quality research to better understand the specific elements that contribute to the success of RTW interventions for burnout. It emphasizes the importance of personalized approaches that consider individual employee needs and workplace contexts to enhance the effectiveness of these interventions.

4.1.2. WP 1.2

In our study among federal agents who reintegrated after burnout in the federal administration (*N* = 152; see WP3 for description of the sample), we examined the uptake of employer-provided reintegration initiatives (see **Table V** and **Annex H**). It should be noted that the numbers (*N* used) do not represent unique cases: some people used multiple initiatives, while others used none. 61.18% used none of the initiatives mentioned. The most frequently used initiative was guidance from an occupational physician, either through an external service or Empreva, with 15.13% of respondents (*N* = 23) making use of this support. Reimbursement of work-related psychological care by BOSA was utilized by 7.89% (*N* = 12), followed by guidance from a confidential counsellor (7.24%, *N* = 11) and Lumen burnout coaching (6.58%, *N* = 10). Career advice consultations with a Talent+ coach and the BOSA e-learning on burnout were each used by 5.92% (*N* = 9). Guidance from a psychosocial prevention advisor (PAPA) was reported by 3.29% (*N* = 5), while the BOSA e-learning on reintegration was used by 2.63% (*N* = 4). Fewer participants made use of the competence benchmark for internal mobility (1.97%, *N* = 3) or guidance from a disability manager (0.66%, *N* = 1). Notably, some available initiatives, such as the RIZIV/INAMI inventory for mapping functional capacities in mental disorders and the FPS Employment, Labour and Social Dialogue website with risk analysis tools and a reintegration checklist, were not used by any participants. These findings highlight varying levels of engagement with reintegration resources, suggesting potential areas for increased awareness or accessibility improvements. The rather low use of these initiatives can have various reasons. First, most initiatives were introduced rather recently (i.e., in the past year), whereas an important share of the study participants reintegrated longer ago. As a result, some initiatives may not have been available at the time of their return, or participants may not recall having used them. Additionally, a lack of awareness about these initiatives could have played a role-employees might not have known where to find the necessary information or may not have been sufficiently informed about the support available to them. Another possible explanation is a lack of trust in employer-provided initiatives, particularly if employees perceive them as insufficiently independent or fear potential repercussions for their career. These factors highlight the importance of improving communication, ensuring transparency, and fostering trust to enhance the uptake of reintegration support measures.

Table V

Overview of the mapped initiatives related to burnout and their use in the FA (N = 152)

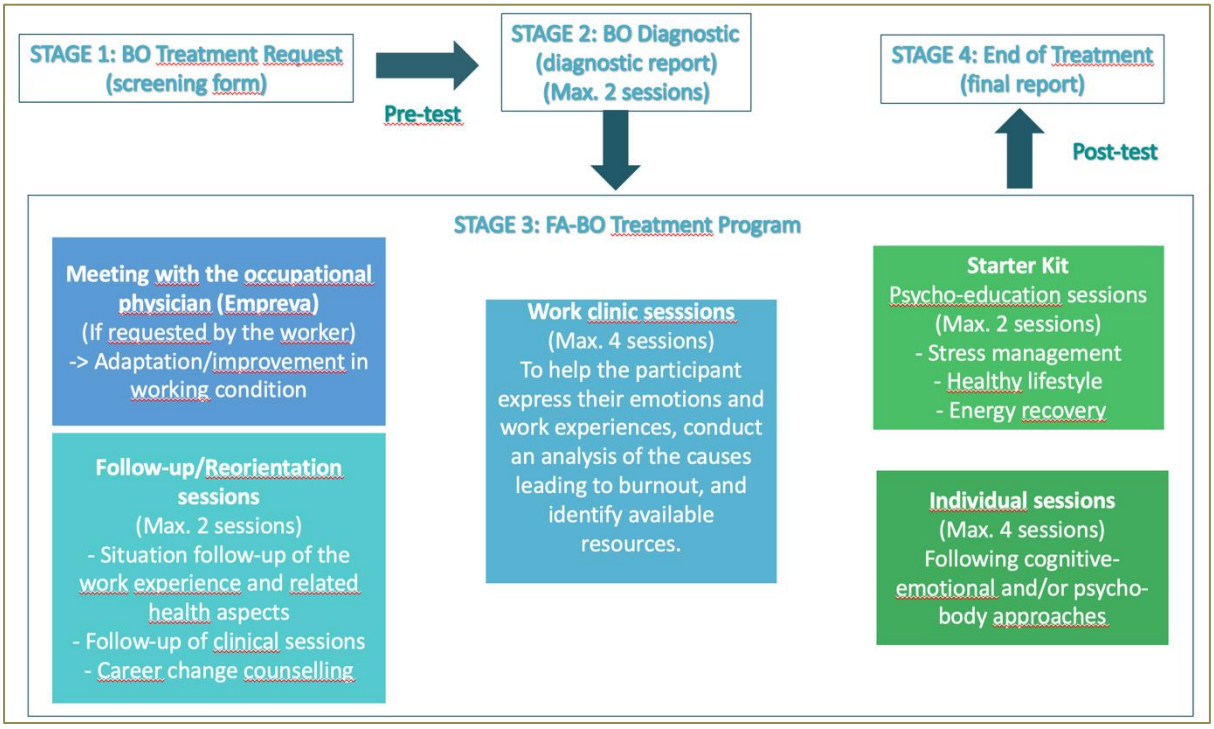
Mapped initiative	% used	N used
Guidance from an occupational physician from external service or Empreva	15.13%	23
Reimbursement of work-related psychological care by BOSA	7.89%	12
Guidance from confidential counsellor (confidant)	7.24%	11
Lumen burnout coaching	6.58%	10
Career advice consultation with Talent+ coach	5.92%	9
BOSA e-learning burnout	5.92%	9
Guidance from psychosocial prevention advisor (PAPA) from Empreva or external prevention service	3.29%	5
BOSA e-learning reintegration	2.63%	4
Administering competence benchmark for internal mobility in the FA ('competentiebilan')	1.97%	3
Guidance from disability manager	0.66%	1
Inventory RIZIV/INAMI for mapping of functional capacities in mental disorders	0%	0
FPS WASO website with risk analysis tools & reintegration checklist	0%	0

4.2. WP 2

4.2.1. WP 2.1

Data collected during the focus groups were transcribed and analyzed, and the FEDRIS BOTP was adapted to the FA-BOTP. The FA-BOTP (see **Figure 2**) consists of several stages, which have been discussed in the focus groups to map which changes were necessary from the FEDRIS BOTP. This resulted in the following stages:

Figure 2 *The FA-BOTP*



Stage 1: Request (screening form). A first communication was sent directly to federal agents via the communications teams within the federal agencies. The well-being teams in the federal agencies received a second communication so they could spread information on the FA-BOTP to potential participants to inform them about the initiative and to promote participation. A screening form (see **Annex I**) had to be completed to enter the FA-BOTP. This screening form was processed by the research team to assess if inclusion is possible. If the participant did not meet the criteria, he/she was referred to an internal (Empreva, Lumen, etc.) or external (clinical or work psychologist, etc.) initiative of the federal public services. If the participant met the inclusion criteria, he/she received (a) a list of health professionals involved in the FA-BOTP that they could choose from as their burnout treatment provider throughout the program, and (b) a link to the pre-test (see **Annex A**), which was to be completed before the burnout diagnosis stage of the FA-BOTP.

Stage 2: Burnout diagnostic. Participants chose a burnout treatment provider to make the burnout diagnosis. Maximum 2 diagnostic sessions were held with this health professional to confirm or refute the burnout diagnosis. The pre-test data was also transmitted to the selected burnout treatment provider to combine their clinical judgement of the participant with the participants' self-reported data on burnout (i.e., score on the Burnout Assessment Tool and DASS-21). When confirmed, the burnout treatment provider sent the research team a report (see **Annex C**) justifying the diagnosis and a request for treatment if the burnout diagnosis was confirmed. The research team then analyzed the report to determine whether the participant met the inclusion criteria. Participants who did not meet inclusion criteria were redirected to other sources of professional help and support, internally (e.g., the prevention advisor, the psychosocial advisor or other "law of well-being 2014" related actors or the Lumen and Talent+ networks) or external to the FPS (e.g., clinical or work psychologist, etc.). Participants who met the inclusion criteria then began the FA-BOTP sessions.

Stage 3: FA-BOTP (Federal Agencies Burnout Treatment Program). The treatment program consisted of 12 sessions, starting with a maximum of 2 diagnosis sessions, and the following sessions could be chosen from different session types (see **Figure 2**). Participants were able to take part in face-to-face, online or hybrid sessions. The program was established by the burnout treatment provider (i.e., selected health professionals) based on consultation with the participant, according to his/her needs:

- **"Work stress clinic"** sessions (max. 4): the aim of these sessions was to help the participants to express their emotions, their reality, and their experience of work, to take an overall view of the causes that led to the burnout, to list the resources available, etc.
- **"Starter kit"** sessions (max. 2): these sessions covered topics such as stress management, healthy lifestyle, and energy recovery.
- **"Individual" sessions** (max. 4): these sessions, given by the individual sessions' treatment provider, were based on a mind-body and/or cognitive-emotional approach.
- **"Follow-up"/"Reorientation" sessions** (max. 2): these sessions were designed to monitor the progress of the participant and/or to discuss possible reorientation in their jobs.
- **Meeting with the occupational physician:** If, and only if, the participant agreed to remove their anonymity, they could also request a meeting with the occupational physician (Empreva). The purpose of this meeting was to consider adaptations or adjustments to working conditions within the organization.

Stage 4: End of FA-BOTP: At the end of the program, the burnout treatment provider wrote a final report (see **Annex D**) and sent it to the research team. The participants were asked to complete a post-test (see **Annex B**) directly after the treatment has ended to evaluate their progress.

4.2.2. WP2.2

Given the small sample size (*n* = 14), the results observed should be viewed with caution, as they may not accurately reflect effects on a larger population. The results below relate to the 14 participants who completed the post-test at the end of their program.

Regarding mental health indicators (see **Table VI**), the FA-BOTP proved to be effective in reducing burnout (*p* =.008), depression (*p* = .046) and stress (*p* = .002). However, no significant change was observed in anxiety (*p* = .135).

Table VI

Mental health indicators

Indicators	*Pre-test (M)*	*Pre-test (SD)*	*Post-test (M)*	*Post-test (SD)*	*t(13)*	*p*
Burnout (BAT)	3.49	.46	2.86	.75	2.78**	.008
Depression(DASS-21)	22.14	7.90	16.43	11.50	1.81	.046
Anxiety (DASS-21)	16.00	10.28	12.86	10.22	1.15*	.135
Stress (DASS-21)	23.71	7.14	12.86	10.51	3.45**	.002

Note. M = Mean; *SD* = Standard Deviation. Items on BAT were scored on a 5 -point Likert-type scale. Items on DASS-21 were scored on a 4-point Likert-type scale. For the DASS-21, raw sub-subscale were multiplied by two, as recommended, to ensure comparability with the full DASS-42, the means presented therefore reflect adjusted scores.** $p < .01$, * $p < .05$. $N = 14$.

The FA-BOTP (see **Table VII**) also demonstrated its effectiveness in improving general well-being, well-being at work, quality of life, and work-life balance. The results also tend to suggest an improvement in sleep. However, the results concerning ease of accomplishing tasks reveal more inter-individual differences in perceptions.

Table VII
Perceptions at the individual level

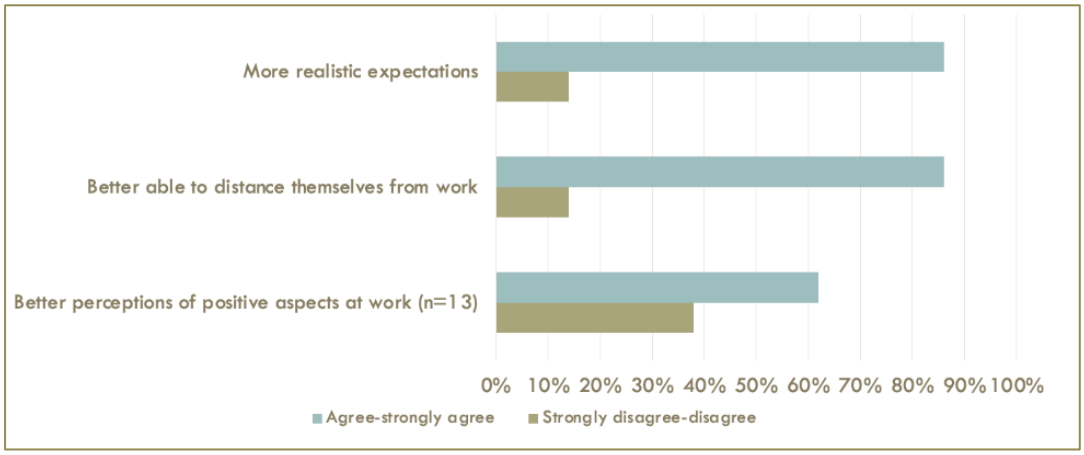
Indicators	*n*	*Agree-Strongly agree*	*Strongly disagree-disagree*
General well-being	14	11	3
Well-being at work	14	11	3
Quality of life	14	10	4
Work-life balance	14	12	2
Improvements in sleep	12	8	4
Ease of accomplishing tasks	14	7	7

Note. n = number of respondents to each item. Items were scored on a 4-point Likert-type scale (1 = *strongly disagree* to 4 = *strongly agree*).

While almost 60% of workers were absent during FA-BOTP (less than 15 days, *n* = 3; less than two months, *n* = 3, between two- and six-months, *n* = 2), all returned to work after the program. Currently, almost 80% of participants are working full-time and nearly 80% of participants have kept their job within the same organization.

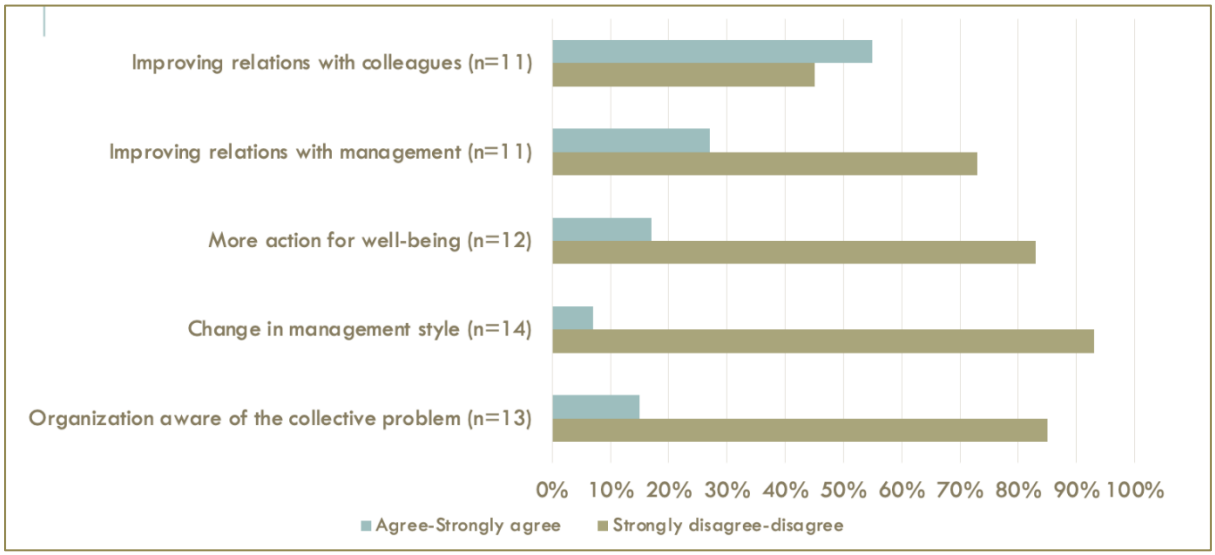
Regarding participants' relationship to work improvements (see **Figure 3**), the majority reported having developed more realistic expectations and an increased ability to emotionally distance themselves from work-related stressors. Additionally, most participants indicated a greater tendency to recognize and appreciate the positive aspects of their work environment.

Figure 3 *Relationship to work improvements*



As far as *work organization* is concerned (see **Figure 4**), the results are less conclusive, particularly as regards collective awareness of the problem, a change in managerial style, as well as an increase in actions to promote well-being and an improvement in relations with supervisors. As far as improving relations with colleagues is concerned, there is more variability in the responses.

Figure 4 *Organizational-level improvements*



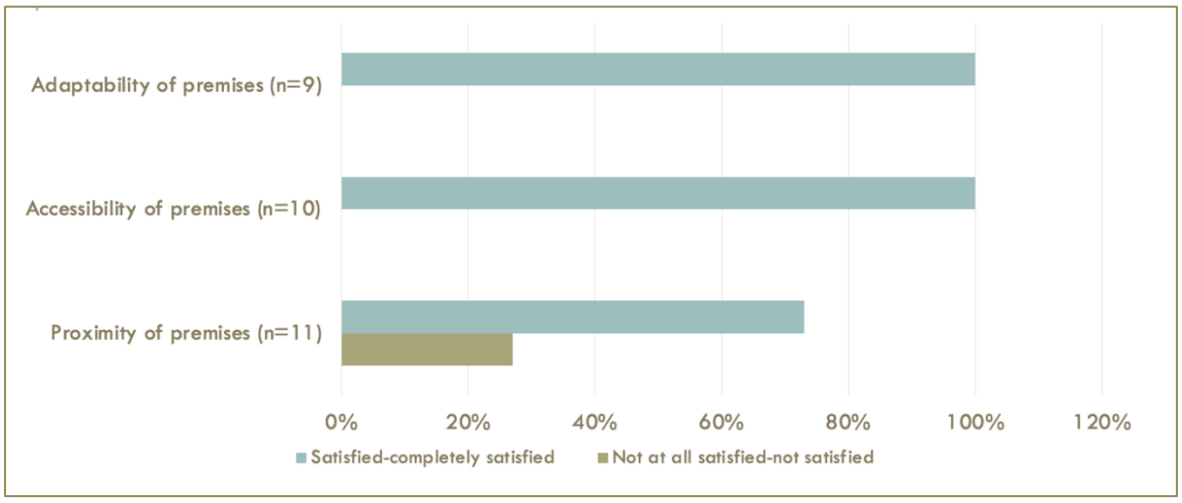
Around four participants out of 14 have benefited from changes introduced by their organization, whether ergonomic adaptations (e.g., balance cushions) or modifications to tasks or workstations. Six out of 14 participants have initiated adjustments themselves, to improve the separation between their professional and private lives (e.g., not installing work emails on their phone, switching off their phone after working hours) or to modify their work organization (e.g., requesting that they no longer take on certain tasks).

Anonymity (*n* = 14) and confidentiality (*n* = 13), which were major concerns expressed by federal agents during the focus groups, were generally respected for the majority of participants who attended the FA-BOTP (14 respondents).

Eight participants attended the FA-BOTP close to home and two halfway between home and work (10 respondents). Six participants attended the FA-BOTP during working hours, five attended FA-BOTP during and outside working hours and two attended outside working hours (13 respondents). Ten participants had teleconsultations several times and three never had any (13 respondents).

Regarding satisfaction with the environment (see **Figure 5**), most participants were satisfied/very satisfied with the adaptability of the premises, the proximity of the place of care and the ease of access/accessibility of the place of care.

Figure 5 *Satisfaction with the environment*



Most participants were satisfied/very satisfied with the provider's services (see **Figure 6**). All 14 participants were satisfied with the ease with which they could make an appointment with the providers, with the providers' punctuality, with the coordination of the FA-BOTP, and with their satisfaction with the sessions. Almost all participants (n=13) were satisfied with the flexibility of the providers' timetables (14 respondents).

Regarding the content of the FA-BOTP (see **Figure 7**), 12 out of 13 participants were satisfied with the diversity of the sessions. All 14 participants were satisfied with the degree of personalization/modularity of the FA-BOTP. Concerning the duration of the FA-BOTP, 11 out of 13 participants were satisfied. All 14 participants were satisfied with the explanations provided by the burnout treatment providers and 12 out of 14 were satisfied with the explanations provided by the research team. In addition, 7 out of 8 participants were satisfied with the possibility of having several professionals involved.

Figure 6 *Satisfaction with provider's services*

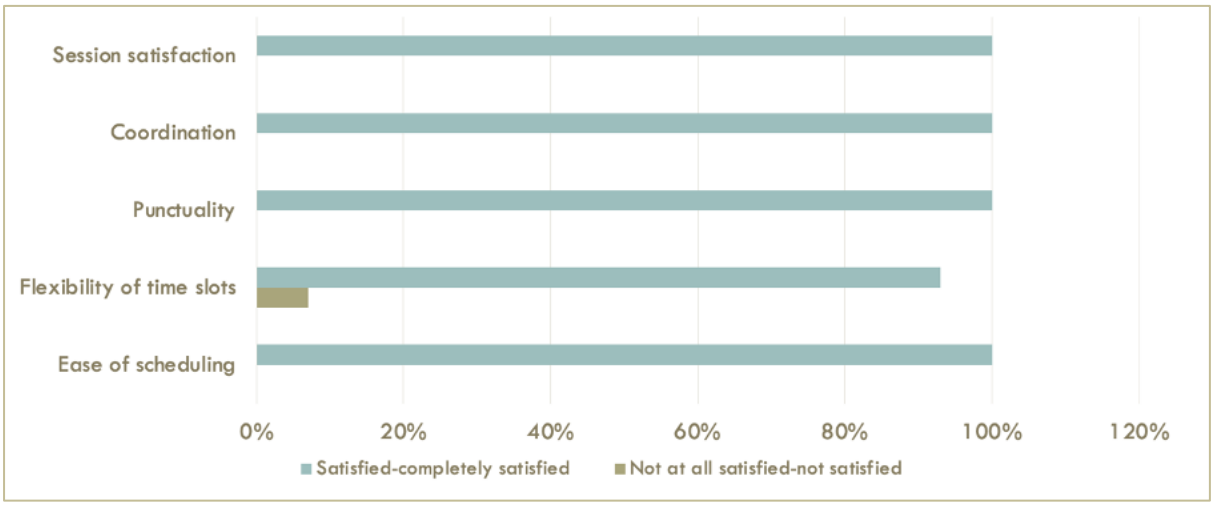
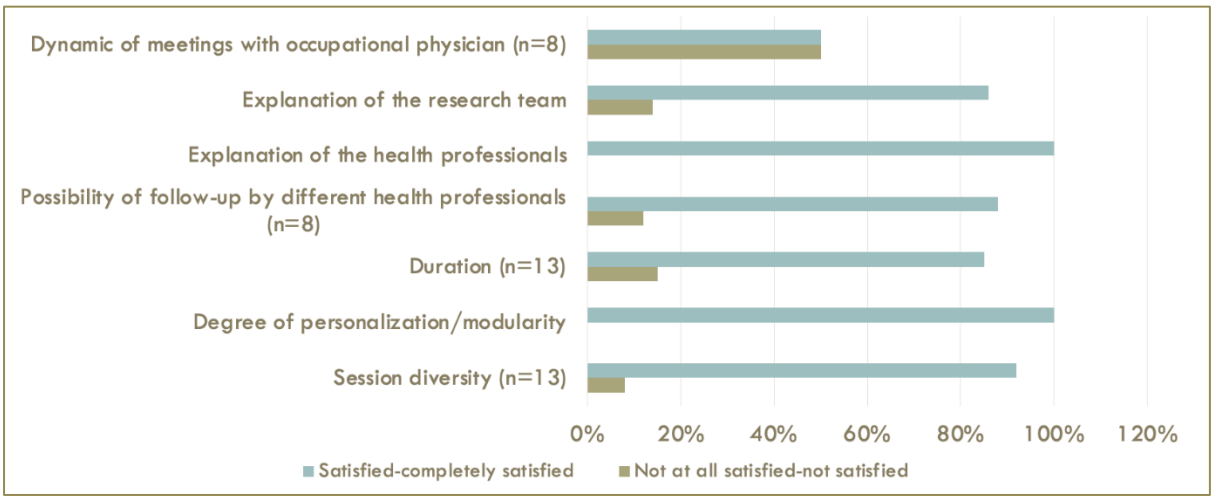


Figure 7 *Satisfaction with FA-BOTP content*



10 participants out of 14 were satisfied with the number of sessions offered. They would all recommend FA-BOTP (*n* = 14) to other workers and the average evaluation of the program was slightly above **8/10**.

The following results concern the 23 participants involved in the FA-BOTP and are based on reports submitted by healthcare professionals. The maximum number of sessions was 12. The average number of sessions attended was 8.87. The sessions most frequently used by participants were "work clinic sessions", "starter kit sessions", "follow-up/reorientation sessions" and then "individual sessions". In half the cases, the diagnosis of burnout was still present after the program but in most cases, severity and number of burnout symptoms improved.

4.2.3. WP2.3

Based on the promising outcomes of the FA-BOTP initiative, we recommend its implementation within federal public services, provided that a few key recommendations are considered. These recommendations, derived through the *Delphi method* involving expert input, reflect those that reached the predefined consensus threshold of 75% agreement among participants.

Recommendations regarding the inclusion process

1. **Strengthening communication**: It was recommended to raise awareness among the well-being networks (e.g. Lumen, Empreva, etc.) within federal administrations to improve the flow of information about FA-BOTP and other well-being initiatives. A structured communication plan should specify the roles and responsibilities of each actor involved in well-being communication and adapt messages to different target audiences (management, employees, HR, wellness players) to ensure that the right information reaches the right people.
2. **Accessibility of information:** It was deemed essential to make information available via the digital channels already in use (i.e. intranet, dedicated websites, etc.), while providing additional formats adapted to different realities (paper, etc.), so as not to leave any group of staff less connected out.
3. **Improving the screening form** (see **Annex J**): Adapt the screening form to improve clarity and accessibility by using structured, concise questions and visual elements (e.g., checkboxes, conditional logic) that help identify key symptoms and contextual factors without overwhelming the participant. Where possible, include simple examples and questions about the work environment. Ensure the form remains easy to complete, respects confidentiality, and clearly positions itself as a first step, not a diagnostic tool.
4. **Support in filling in the different form**:
    a. Offer participants the option to complete the screening form with the support of a healthcare professional or qualified internal point of contact for the FA-BOTP (e.g., occupational physician), especially if there are difficulties in understanding or completing the form. This support should aim to clarify questions and ensure better alignment between the participant's needs and the program. If the form is completed independently and uncertainties arise, a follow-up consultation should be proposed. The process should remain accessible, flexible, and adapted to the participant's situation.
    b. If the pre-test is maintained: Provide participants with the option to receive an automated reminder followed, if necessary, by personalized contact by a professional bound by professional secrecy (healthcare professional or qualified internal point of

contact). The communication should remain non-intrusive, confidential, and clearly state that participation is voluntary. The participant can refuse this follow-up at any time, thus guaranteeing a balance between support and autonomy.

c. If the pre-test is maintained: A professional, bound by professional secrecy (healthcare professional or qualified internal point of contact), can be freely contacted by participants to help them overcome obstacles and move forward with the program, according to a mode of contact (active or passive) chosen by the participant.

5. **Opening the program to workers who have relapsed**: FA-BOTP will be accessible to people who have experienced a relapse, and specific awareness-raising sessions will be envisaged to address the causes of the initial burnout and the relapse as well as their experience of work resumption or the evolution of the work situation.

Recommendations regarding the program content

1. **Individualized number of sessions**: It has been decided to offer up to 16 sessions, including maximum 2 diagnostic sessions, with the possibility of adapting this number according to the needs of each participant. The burnout treatment provider will assess progress and adjust the duration of the support in consultation with the participant. This flexible approach enables to respond to a variety of situations, depending on the severity of the burnout, the professional context and the pace of recovery.
2. **Extension of work clinic sessions**: The availability of work clinic sessions should be extended to 6, reinforcing the support linked to the professional aspects of burnout.
3. **Individual sessions**:
    a. Offer up to 6 additional individual sessions, depending on the needs identified by the burnout treatment provider. This flexibility is designed to avoid overload, while ensuring therapeutic follow-up tailored to the pace and progress of each participant.
    b. Reinforcing communication around individual sessions: It was recommended that awareness of the benefits of these sessions be improved, by healthcare professionals or by the program coordinator (i.e., FA-BOTP point of contact). Messages should emphasize their complementarity with other program components (work clinic and starter kit sessions) and highlight the possibility of adjustments over time based on the individual's needs and the individual sessions provider/burnout treatment provider's assessment. Better information should also be provided on the possibility of consulting the occupational physician to consider professional adjustments.
4. **Clarification of the occupational physician's role**: The healthcare professional's communication about the occupational physician's role should be improved, particularly regarding job adaptation possibilities. This professional will help the participant identify the most appropriate person to contact in this respect.
5. **Post-program follow-up:**
    a. Two follow-up sessions (e.g., after three and six months after the end of the program) will provide an opportunity to discuss the participant's professional situation (reintegration, adjustments, persistent needs) with their burnout treatment provider. These sessions are designed to reinforce the sustainability of the program's effects and support adjustments over time.
    b. Offer participants the voluntary option of continued support for up to one year after completing the FA-BOTP, through professionally moderated peer groups or secure

online platforms. These support options should be evidence-based, clearly framed, and provided by trusted professionals to ensure safety and quality. As an alternative or complement, participants could access a toolkit with self-guided resources (e.g., relaxation exercises, theoretical frameworks) to support long-term recovery.

Recommendations regarding the organizational approach

1. **Strengthening communication around psychosocial risks**: It was recommended that managers, employees and wellness stakeholders should be better informed and made aware of psychosocial risks, particularly in organizations where these risks are highly reported. This measure is aimed at preventing the onset of burnout at an early stage.
2. **Mandatory training in stress management and burnout prevention**: Training sessions are to be set up for managers and employees, to develop a shared understanding of stress mechanisms and protective factors. Their compulsory nature ensures that the skills needed for prevention are widely disseminated.
3. **Proactive involvement of managers in detection and prevention**: Managers must be encouraged to identify signs of overload or malaise within their teams, and to implement concrete actions such as adjusting workloads or creating a supportive climate.
4. **Leadership training on mental health**: Specific training in mental health management is also recommended for managers, to reinforce the supportive culture within the organization and give managers the tools to act effectively.
5. **Creation of communities of practice**: The organization of focus groups or communities of practice will enable stakeholders to be involved in identifying primary prevention solutions, in a participative approach. This will encourage the field to take command of its own actions.
6. **Implementing a comprehensive workplace well-being policy**: A structured policy integrating burnout prevention was deemed essential. This should include:
    a. monitoring and evaluation of preventive actions,
    b. adjusting work organization, if necessary,
    c. regular monitoring of the effectiveness of measures and their continuous improvement.
7. **Developing a culture of professional reintegration**: It is recommended to promote an organizational culture that actively supports the return to work after a burnout. This includes upstream preparation, the necessary job adaptations, and a benevolent attitude towards those returning to work.

Recommendations regarding consultation logistics

1. **Clear, structured initial communication:** We recommend that participants are explicitly informed at the outset of the program about its general course, objectives and planned procedures. This transparency must be accompanied by flexibility in organization, considering the participant's personal and professional constraints.
2. **Individualized negotiation of the schedule**: The healthcare professional will need to co-construct, with each participant, an adapted support schedule. This includes the frequency, duration and pace of sessions, adapting to the progress of recovery and any necessary adjustments along the way.
3. **Choice of progression pace**: It is accepted that participants can opt for a shorter or more spread-out pace, depending on their abilities and situation. This respect for personal pace is designed to avoid pressure and maximize the benefits of each stage of the program.

4. **Timing:** Allow federal agents to attend FA-BOTP consultations either during or outside working hours, based on personal preference. Participation should be voluntary and guided by mutual agreements to ensure respect for confidentiality and team organization, without adding undue pressure on the participant.
5. **Hybrid follow-up methods:** The option of choosing between teleconsultation and face-to-face sessions must be maintained, to ensure fair and appropriate access, particularly for people with geographical, mobility or scheduling constraints.

An estimation of the maximum budget required for 50 participants can be calculated based on the reimbursement rates provided by FEDRIS for the BOTP. The reimbursed cost per session is €90. If each participant receives the maximum number of 16 sessions, and that both the diagnostic and end-of-treatment reports are maintained (2 additional billable items), this amounts to a total of 18 billable items per participant. The maximum budget can therefore be estimated as follows: 18 items × 50 participants × €90 = €81,000.

This figure represents the upper limit of the potential budget. However, it is important to note that not all participants are expected to require the full set of 16 sessions. Some individuals will likely complete the program with fewer sessions, which would reduce the overall cost.

4.3. WP 3

4.3.1. WP3.1 - Burnout Reintegration Monitor: Diagnosis

Work resumption quality (WRQ) is a critical factor in understanding the reintegration of employees following burnout. This section provides an overview of WRQ scores across three measurement points (T1, T2, and T3) and compares them to a broader reference sample of reintegrated workers with a history of burnout. Additionally, an analysis of WRQ distribution across different quality levels is presented.

Table VIII presents the mean (*M*) and standard deviation (*SD*) of WRQ across three time points. The average WRQ scores across all time points remain relatively stable, with values ranging between 3.23 and 3.26 on a 5-point Likert-type scale- These scores are comparable to the general burnout sample (*M* = 3.20; *SD* = 0.84; *N* = 1054), which includes reintegrated workers from various sectors. However, the standard deviation in the current sample is larger (*SD* = 1.08 at T1, *SD* = 0.99 at T2, and *SD* = 1.05 at T3) compared to the general burnout sample (*SD* = 0.84), indicating greater variability in work resumption experiences after burnout in the federal government sample.

Table VIII

Work Resumption Quality: State-of-the-Art Analysis (Part 1)

	T1	T2	T3
***M* WRQ**	3.23	3.26	3.26
***SD* WRQ**	1.08	.99	1.05
N	152	119	102

Table IX shows the number of participants in each WRQ zone at different time points. The categorization is based on the general burnout sample (*N* = 1054), where WRQ scores below 2.92/5 fall into the red zone (low WRQ), scores between 2.92 and 3.48/5 are classified as the orange zone (mid WRQ), and scores above 3.48/5 belong to the green zone (high WRQ). The color zones for WRQ are delineated based on the mean and the variance in the sample on which the tool is based, i.e., *N* = 1054 (general burnout sample). The middle zone is designated as orange (intermediate). The lower

boundary of this orange zone is defined as *M* – 1/3 *SD* in the reference sample. This marks the transition from orange to red. The upper boundary of the orange zone is defined as *M* + 1/3 *SD* in the reference sample. This marks the transition from orange to green. The choice of 1/3 SD as the cut-off point is based on the distribution of WRQ scores within the general burnout sample (*N* = 1054). This threshold ensures an approximately equal distribution of participants across the different color zones. In other words, while the orange zone may appear visually smaller in the feedback report, the number of participants falling into this category remains relatively stable and comparable to the other zones.

The number of individuals in the low WRQ (red zone) decreases over time (from 49 at T1 to 30 at T3) **(Table IX)**. The number of individuals in the mid WRQ (orange zone) remains relatively stable between T1 and T2 but decreases at T3, while the high WRQ (green zone) also shows a decline from T1 to T3. Although it might be tempting to interpret some changes as an improvement in work resumption quality, the decrease in frequencies within the red, orange, and green zones can be driven by attrition effects. This pronounced effect for the red and green zones (being the largest groups) may suggest that individuals from these two groups were more likely to drop out over time, rather than indicating a substantial shift in WRQ distribution, for which a within-person analysis is needed (see further).

Table IX

Work Resumption Quality: State-of-the-Art Analysis (Part 2)

N	T1	T2	T3
Low WRQ (red zone)	49	36	30
Mid WRQ (orange zone)	32	32	25
High WRQ (green zone)	71	51	47
Total	152	119	102

4.3.2 - Burnout Reintegration Monitor: Remediation

4.3.2.1 General factors

For the remediation part, a confirmatory factor analysis (CFA) model[2] was fitted to examine the importance of the general factors identified in previous research within a governmental context. First, a measurement model was estimated in which individual items were specified as indicators of their respective latent factors, ensuring an adequate representation of the construct structure. Next, a structural model was fitted by adding regression paths to assess how well these latent factors relate to WRQ, based on their regression coefficients. This analysis does not imply causality but rather evaluates the relative importance of these factors in explaining variance in WRQ within this specific context.

Results overview

Table X specifies the fit measures for each model as well as regression coefficients for the general factors in the federal government sample at T1 (Sample B; *N* = 152) and across timepoints (Sample C; *N* = 226), and compares these to the regression coefficients of these factors for WRQ in previous research (Sample A; Rooman, 2023; *N* = 1054). For the T1 model (*N* = 152), the fit was χ^2 (329) = 450.89,

[2] Note that correlations of all study variables can be found in **Annexes K – N**.

$p < .001$, CFI = .95, TLI = .95, RMSEA = .051 (90% CI [.039, .063]), SRMR = .07. These values suggest a good model fit, with CFI and TLI above .95, RMSEA below .06, and SRMR somewhat higher but still within acceptable limits. For the model across timepoints ($N = 226$), the fit was χ^2 (329) = 641.90, $p <$ .001, CFI = .92, TLI = .91, RMSEA = .067 (90% CI [.059, .074]), SRMR = .07. The fit remains acceptable but slightly weaker than the T1 model, particularly in CFI and RMSEA values, which indicate a slightly less optimal but still reasonable fit.

1. **Job autonomy** is consistently positively associated with WRQ across all samples, with the effect being particularly strong in the Federal Government samples. However, a potential random effect may be present in sample B ($N = 152$) due to its smaller sample size. It is therefore more appropriate to interpret the sample C effect, which aligns better with previous research ($\beta = .32$ vs. $\beta = .20$).
2. **Workload** shows mixed results across samples. While workload is significantly related toWRQ in the general burnout sample A, it is less consistent in the Federal Government samples B and C, with weaker or non-significant effects. This discrepancy may be due to power issues, as the Federal Government sample has fewer data points. The fact that sample C (with a larger $N = 226$) shows a marginally significant effect at p = 0.05 supports this idea.
3. **Supervisor support** is significantly related to WRQ in the general burnout sample A but does not show a significant relation in the Federal Government samples B and C, either at T1 or across timepoints. This could also be related to sample size, given that the regression coefficients in samples A($\beta = .21$) and C ($\beta = .13$) are relatively similar.
4. **Resilience** is positively associated with WRQ in the general burnout sample A but shows mixed results in the federal government samples B and C. It is not significantly related to WRQ at T1 (probably due to limited power) but it does have a significant effect across timepoints ($\beta = .18$).
5. **Perfectionism** plays a similar role in the Federal Government samples B and C as in the general burnout sample A. The coefficient for perfectionistic striving is somewhat lower in the B and C samples (sample B: $\beta = .28$; sample C: $\beta = .32$) but remains consistently significant across all three samples. The coefficient for perfectionistic concerns remains largely unchanged. However, due to limited power, its effect is not significant in sample B, but it becomes significant in sample C, where more data points are considered ($\beta = -.25$, $N = 226$).

Conclusion

Supplementary analyses (longitudinal in WP3.2) will further investigate the importance of the BRM determinants to promote WRQ after absence due to burnout, accounting for their evolution over time. This will provide a more comprehensive view of their impact, as the significance of the estimated coefficients in this analysis appears to be strongly dependent on sample size, which is smaller in the Federal Government samples compared to prior research across various sectors.

Policy implications

To improve work resumption quality after burnout (WRQ), policies should prioritize job autonomy. **Encouraging flexible work arrangements and autonomy in decision-making** can support successful reintegration after absence due to burnout. The **effect of workload was mixed** but this is probably due to limited power (i.e., sample size) and potential variability in workload and its impact on well-being across different federal organizations. **Reducing excessive workloads** remains important to prevent relapse into burnout, especially in high-pressure environments. Furthermore, also **supervisor support showed mixed effects**, although its non-significance in the federal government samples is probably related to limited power as well. Although supervisor support may

be insufficient on its own to support successful reintegration, policies should still ensure supervisors are trained to offer targeted support for employees returning from burnout. Finally, the findings show that – next to organizational aspects – also **personal strengths and risk factors** play an important role in defining one's reintegration experience after burnout. *Psychological support* in the preparation or follow-up of reintegration processes after burnout should therefore focus on building resilience and *addressing maladaptive aspects of perfectionism, like excessive worrying (i.e. perfectionistic concerns).*

4.3.2.2 Government-specific factors

In addition to general factors, the importance of government-specific determinants was investigated. These determinants were identified through qualitative interviews and analyzed using Confirmatory Factor Analysis (CFA) models, structured according to the themes presented above in this report (see 3.4.2 Measures). An overview of the results is provided in **Table XI.**

Table X

Test of the regression weights for the Burnout Reintegration Monitor (BRM)

	A. General burnout sample (Rooman, 2023) (N=1054)		***B. Federal government sample T1 (N=152)***		***C. Federal government sample; across timepoints (N=226)[3]***	
BRM determinants	***β***	***p***	***β***	***p***	***β***	***p***
Job autonomy	***.20*****	***< .001***	***.39*****	***< .001***	***.32*****	***.001***
Workload	***-.12*****	***.005***	*-.10*	*.135*	***-.12(*)***	***.05***
Supervisor Support	***.21*****	***< .001***	*.19*	*.064*	*.13*	*.124*
Resilience	***.28*****	***< .001***	*.14*	*.138*	***.18****	***.024***
Perfectionistic striving	***.41*****	***< .001***	***.28****	***.012***	***.32*****	***.001***
Perfectionistic concerns	***-.29****	***.013***	*-.22*	*.094*	***-.25****	***.021***
Fit Measures	*χ^2 (329) = 1070.83, p < .001; CFI = .95, TLI = .94, RMSEA = .05, SRMR = .05*		*χ^2 (329) = 450.89, p < .001; CFI = .95, TLI = .95, RMSEA = .05, SRMR = .07*		*χ^2 (329) = 641.90, p < .001; CFI = .92, TLI = .91, RMSEA = .07, SRMR = .07*	

Table XI

Test of the regression weights for the government specific determinants per theme

Government-specific determinants		**Federal government sample; across timepoints (*N* = 226)**	
Theme	**Determinants**	***β***	***p***
Theme 1: Personal fit with the job	*Person-job fit*	.17	.213
	Person-organization fit	**.22****	**<.001**
	Demands-abilities fit	**.19***	**.041**
	Needs-supply fit	.21	.076
Model fit Theme 1: χ^2 (94) = 280.66, p < .001 CFI = .95, TLI = .94, RMSEA = .09, SRMR = .05			
Theme 2: Negative interactions with others at work	***Task conflict***	**-.43***	**.023**
	Relational conflict	.25	.187
	Negative behaviors from others	**-.28****	**.002**

[3] The results of sample C with grand means per person are added to maximize the number of data points (*N* = 226), increasing the stability of the regression weights.

Model fit Theme 2: χ^2 (71) = 175.83, p < .001 CFI = .97, TLI = .96, RMSEA = .08, SRMR = .04			
Theme 3: Job aspects typical to the government context	***Ability to adapt procedures***	**.17***	**.019**
	Meaning of work	**.45****	**<.001**
	Emotional load	**-.26****	**<.001**
Model fit Theme 3: χ^2 (66) = 1830.28, p < .001 CFI = .97, TLI = .96, RMSEA = .07, SRMR = .05			
Theme 4: Fair treatment by employer upon reintegration	*Burnout stigma by Medex doctor*	-.13	.145
	Interpersonal justice	.18	.089
	Informational justice	.17	.121
Model fit Theme 4: χ^2 (59) = 185.47, p < .001 CFI = .93, TLI = .90, RMSEA = .12, SRMR = .09			

Note. The factors for each theme were fitted into a separate CFA structural model. *N* = 226. For the theme 'fair treatment by employer upon reintegration', *N* = 152 as these variables were only measured at T1 so the grand mean equals the T1 measure.

Results overview

1. **Theme 1: Personal fit with the job.** The fit of this model was χ^2 (94) = 280.66, p < .001, CFI = .95, TLI = .94, RMSEA = .094 (90% CI [.081, .10]), SRMR = .05. The chi-square test is significant, which is common in larger samples and should be interpreted with caution. The CFI and TLI values indicate an acceptable to good fit, while the RMSEA suggests a moderate fit. – Person-organization fit (β = .22, p < .001) and demands-abilities fit (β = .19, p = .041) are significant predictors of work resumption quality after burnout, while person-job fit (p = .213) and needs-supply fit (p = .076) are not.
2. **Theme 2: Negative interactions with others at work.** The fit of this model was χ^2 (71) = 175.83, p < .001, CFI = .97, TLI = .96, RMSEA = .081 (90% CI [.066, .096]), SRMR = .04. The chi-square test is significant, likely due to sample size. The CFI and TLI values indicate a good fit, while RMSEA suggests an acceptable fit. – Task conflict (β = -.43, p = .023) and negative behaviors from others (β = -.28, p = .002) significantly reduce work resumption quality after burnout, while relational conflict (p = .187) does not.
3. **Theme 3: Job aspects typical to the government context.** The fit of this model was χ^2 (66) = 1830.28, p < .001, CFI = .97, TLI = .96, RMSEA = .069 (90% CI [.049, .088]), SRMR = .05. The chi-square test is significant but should be interpreted cautiously due to sensitivity to sample size. The CFI and TLI values suggest a good fit, and the RMSEA falls within the acceptable range. – Ability to adapt procedures (β = .17, p = .019), meaning of work (β = .45, p < .001), and emotional load (β = -.26, p < .001) are significant determinants of work resumption quality after burnout.
4. **Theme 4: Fair treatment by employer upon reintegration.** The fit of this model was χ^2 (59) = 185.47, p < .001, CFI = .93, TLI = .90, RMSEA = .119 (90% CI [.100, .138]), SRMR = .09. The chi-square test is significant, but given its sensitivity to sample size, other indices are more informative. The CFI and TLI values indicate a marginal fit, while the RMSEA suggests a poor fit. This is probably because none of the determinants considered in this model appeared significantly important for WRQ. – Burnout stigma by Medex doctor (p = .145), interpersonal justice (p = .089), and informational justice (p = .121) do not show significant effects on work resumption quality after burnout.

Conclusion

Based on the findings, the most relevant themes for work resumption quality after burnout (WRQ) in the federal government sample are Theme 3: Job aspects typical to the government context and Theme 2: Negative interactions with others at work. Specifically, **meaning of work** (β = .45, p < .001) and **emotional load** (β = -.26, p < .001) in the job context were highly significant correlates of WRQ, indicating that factors related to the job's emotional demands and sense of purpose are crucial. Additionally, **task conflict** (β = -.43, p = .023) and **negative behaviors from others** (β = -.28, p = .002) were significant negative correlates of WRQ, highlighting the detrimental impact of interpersonal issues at work. Theme 1: Personal fit with the job showed some relevance, especially **person-organization fit** (β = .22, p < .001), but person-job fit and needs-supply fit were less influential. This suggests that *alignment with the organization's values and culture* is more critical than other fit aspects when considering WRQ. Theme 4: Fair treatment by employer upon reintegration did not show significant effects on WRQ, which suggests that while fairness is important, it may not be as directly impactful in this context as factors related to job characteristics and interpersonal dynamics.

Policy Implications

1. **Job Autonomy:** To enhance work resumption quality after burnout within the federal government, it is crucial to allow employees sufficient *autonomy in organizing their work and time.* Rigid procedures may hinder a smooth reintegration process and should be adapted where possible to provide flexibility.
2. **Workload:** Additionally, addressing excessive workload is essential when applicable. This can be achieved through *job crafting or open discussions about work modifications* to ensure that tasks are manageable and sustainable for returning employees.
3. **Supervisor support:** Supervisors play a key role in supporting employees after burnout, both in terms of instrumental and emotional support. They should be trained to implement necessary *work modifications and to address negative interpersonal interactions*, such as team conflicts, which could otherwise undermine reintegration efforts.
4. **Addressing personal factors:** Beyond workplace adjustments, personal risk factors should also be considered. Employees at risk of relapse could benefit from resources such as *the Lumen burnout coach* or *access to a psychologist reimbursed through BOSA*, ensuring they receive tailored guidance and support.
5. **Person-job fit:** Improving person-job fit is another crucial aspect of effective reintegration. This involves ensuring that *job demands align with employees' abilities (demands-abilities fit)* and that their values *align with the organization's mission (person-organization fit*). A preventive approach could involve screening for these aspects during the selection stage, while job crafting could help tailor work to individual strengths and needs upon reintegration.
6. **Meaning and emotional load:** Furthermore, *enhancing the meaningfulness of work* can significantly contribute to employees' motivation and recovery. At the same time, *reducing excessive emotional load* is necessary to prevent future burnout risks.
7. **"Red Button":** The 'red button' that integrates all kind of well-being initiatives at the FA needs to be promoted.
8. **SPOCs:** Single Points of Contact (SPOCs) need to be appointed, who can guide for the help one needs

Note that **several initiatives within the Federal Administration** already support these factors, such as through training programs, leadership development pathways, the internal mobility program/reorientation trajectory, and services provided by the career center (and Talent+ career coach). For instance, the BOSA Career Center may support internal career reorientation to work on several of these factors. Hence, by mapping all initiatives (see **Annex H**) and by addressing these factors systematically, workplace policies can support employees in sustaining their return to work while reducing the risk of burnout recurrence.

4.3.2.3 Integrated model

As a final step, an integrated CFA structural model was fitted in which the general factors from previous research (Rooman, 2023) were added together with the added government-specific factors that appeared significant in the previous analyses (see 4.3.2.2 Government-specific factors).

Results overview

For the **integrated model (Table XII)**, the fit was χ^2 (1079) = 1838.73, $p < .001$, CFI = .91, TLI = .90, RMSEA = .057 (90% CI [.053, .062]), SRMR = .07. The chi-square test is significant, but given the model complexity and sample size, alternative fit indices provide more insight. The CFI and TLI values

indicate an acceptable fit, while the RMSEA remains within an acceptable range. The SRMR suggests an acceptable level of residual error.

In terms of the correlates, **perfectionistic striving** and **demands-abilities fit** emerged as significant predictors, with β = .27 (p = .022) and β = .18 (p = .012), respectively. *Job autonomy* and *resilience* approached significance (β = .22, p = .082; β = .17, p = .059) at .05 level. However, other factors such as *workload, supervisor support, perfectionistic concerns, and various government-specific determinants* (e.g., person-organization fit, task conflict, negative behaviors from others, etc.) did not show significant effects (all p > .05). The limited number of significant results is due to the complexity of the model, which includes multiple factors to enhance informational value, compared to the relatively small number of data points (N = 226). Therefore, regression weights were primarily derived from theme-specific analyses (i.e., less complex models; see **Table XI**), while the integrated model (**Table XII**) is included mainly for informational and transparency purposes.

Table XII

Test of the regression weights for the integrated model (FA-BRM; Burnout Reintegration Monitor for the federal administration, consisting of both the BRM determinants and the significant government specific determinants)

			Federal government sample; across timepoints (*N*=226)	
Category	**Determinants**	**# items**	***β***	***p***
BRM	*Job autonomy*	4	.22	.082
BRM	*Workload*	3	-.10	.124
BRM	*Supervisor Support*	4	.08	.338
BRM	*Resilience*	3	.17	.059
BRM	***Perfectionistic striving***	**6**	**.27***	**.022**
BRM	*Perfectionistic concerns*	5	-.22	.074
Government	*Person-organization fit*	3	.07	.278
Government	***Demands-abilities fit***	**3**	**.18***	**.012**
Government	*Task conflict*	4	-.03	.655
Government	*Negative behaviors from others*	3	-.12	.130
Government	*Ability to adapt procedures*	4	-.07	.359
Government	*Meaning*	2	.02	.822
Government	*Emotional load*	3	-.02	.844
Model fit integrated model: χ^2 (1079) = 1838.73, p < .001 CFI = .91, TLI = .90, RMSEA = .06, SRMR = .07				

Note. The total number of items in the FA-BRM is 46. The integrated model includes modelled error covariances between items within constructs, to model specific variance not captured by their latent constructs (perfectionistic striving 5-6; perfectionistic concerns 1-4; task conflict 1-3; demands-abilities fit 1-3; supervisor support 1-2). The covariances to add were selected based on the modification indices (MI > 10). Adding the error covariances resulted in a significantly improved model fit ($\Delta\chi^2$ = 79.103; df = 5; p < .001).

4.3.2.4 Longitudinal analysis of the determinants using RICLPM

To analyze the correlates of work resumption quality (WRQ) in a longitudinal manner, a random intercept cross-lagged panel model (RICLPM) was fitted to the federal government sample across timepoints (N = 226). The model was estimated using full information maximum likelihood (FIML) to maximize the number of available data points by accounting for missing data.

RICLPM allows for a clear distinction between between-person effects and within-person effects, offering deeper insights into how determinants influence WRQ over time:

1. **Between-person effects** are captured through random intercepts, which represent stable individual differences across measurement points. A significant covariance between the random intercepts of a determinant (e.g., meaning in work) and WRQ indicates a between-person effect. This means that federal agents who generally experience higher levels of meaning in their work also tend to report better reintegration outcomes on average (**Figure 8**).
2. In contrast, **within-person effects** reflect changes within individuals over time and are captured through lagged and cross-lagged regression relationships. A lagged effect examines whether a variable at an earlier timepoint predicts itself at a later timepoint (i.e., whether WRQ at T1 predicts WRQ at T2). A cross-lagged effect, on the other hand, assesses whether a factor at one timepoint influences WRQ at the next timepoint while accounting for prior levels of WRQ. A significant cross-lagged within-person effect, for instance, would indicate that when a federal agent experiences a temporary increase in meaningful work, they are more likely to report improved WRQ at the next measurement moment (i.e., controlled for WRQ at the previous measurement moment).

Given the complexity of RICLPM and potential power issues, a separate model was estimated for each determinant of WRQ. Each model included both the between-person effect (random intercept covariance) and the within-person effect (lagged and cross-lagged relationships). This approach ensured a comprehensive examination of how different determinants influence WRQ at both the individual and group levels.

Figure 8 *Visual representation of the between-effects*

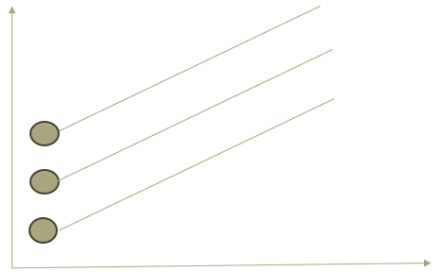
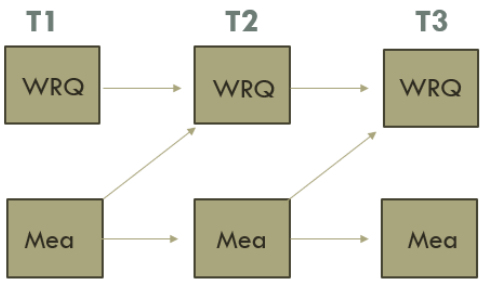


Figure 9 *Visual representation of the within-effects.*



Note. WRQ = Work Resumption Quality. Mea = Meaning of Work

Table XIII

Random intercept cross-lagged panel model for the factors included in the FA-BRM

Category	***Determinants***	***Federal government sample across timepoints (N = 226)***					
		Within-effect (cross-lagged)				***Between-effect***	
		b	***β***		***p***	***covar RI***	***p***
BRM	***Job autonomy***	*-.05*	*T1-T2*	*-.08*	*.781*	***2.00*****	***.006***
			T2-T3	*-.07*			
BRM	*Workload*	*.32*	*T1-T2*	*.51*	*.069*	*-2.36*	*.187*
			T2-T3	*.50*			
BRM	***Supervisor Support***	*-.22*	*T1-T2*	*-.24*	*.187*	***.61*****	***<.001***
			T2-T3	*-.17*			
BRM	***Resilience***	*.38*	*T1-T2*	*.32*	*.105*	***.50****	***.018***
			T2-T3	*.30*			
BRM	***Perfectionistic striving***	*.19*	*T1-T2*	*.11*	*.397*	***.43*****	***<.001***
			T2-T3	*.12*			
BRM	***Perfectionistic concerns***	*.19*	*T1-T2*	*.15*	*.341*	***-.24****	***.024***
			T2-T3	*.12*			
Gov	***Person-organization fit***	***-.46*****	***T1-T2***	***-.44*****	***.004***	***.57*****	***<.001***
			T2-T3	***-.42*****			
Gov	***Demands-abilities fit***	*-.01*	*T1-T2*	*-.009*	*.951*	***.68*****	***<.001***
			T2-T3	*-.008*			
Gov	***Task conflict***	***.32****	***T1-T2***	***.30****	***.032***	***-.54*****	***<.001***
			T2-T3	***.29****			
Gov	***Negative behaviors***	***.42****	***T1-T2***	***.31****	***.035***	***-.50*****	***<.001***
			T2-T3	***.33****			
Gov	***Ability to adapt procedures***	*-.06*	*T1-T2*	*-.04*	*.751*	***.55*****	***<.001***
			T2-T3	*-.04*			
Gov	***Meaning***	*-.03*	*T1-T2*	*-.02*	*.873*	***.71*****	***<.001***
			T2-T3	*-.02*			
Gov	***Emotional load***	***.44*****	***T1-T2***	***.32*****	***.006***	***-.35*****	***<.001***
			T2-T3	***.40*****			

Note. BRM = Burnout Reintegration Monitor. Gov = Federal Government. T1-T2-T3 = Time 1, Time 2, Time 3

Results overview

First, all **between-effects** (i.e., covariance of the random intercept) were significant, except for workload (*β* = -2.36, *p* = .187). The significant between-effects include: job autonomy (*β* = 2.00, *p* = .006), supervisor support (*β* = .61, *p* < .001), resilience (*β* = .50, *p* = .018), perfectionistic striving (*β* = .43, *p* < .001), person-organization fit (*β* = .57, *p* < .001), demands-abilities fit (*β* = .68, *p* < .001), task conflict (*β* = -0.54, *p* < .001), negative behaviors from others (*β* = -0.50, *p* < .001), ability to adapt procedures (*β* = 0.55, *p* < .001), meaning (*β* = 0.71, p < .001), and emotional load (*β* = -0.35, *p* < .001). Workload (*β* = -2.36, *p* = .187) was not significant. The next section (see **4.3.2.5 Additional analyses**) will consider additional analyses investigating the effect of workload over time on WRQ after burnout, with less demanding (complex) analyses that might have affected non-significant findings.

Secondly, several **within-effects** (i.e., cross-lagged regression relationships over timepoints) were significant: person-organization fit (T1-T2: *β* = -0.44, *p* = .004; T2-T3: *β* = -0.42, *p* = .004), task conflict (T1-T2: *β* = 0.30, *p* = .032; T2-T3: *β* = 0.29, *p* = .032), negative behaviors from others (T1-T2: *β* = 0.31, *p* = .035; T2-T3: *β* = 0.33, *p* = .035), and emotional load (T1-T2: *β* = 0.32, *p* = .006; T2-T3: *β* =

0.32, p = .006). However, the directions of these effects were opposite to what was hypothesized. This may be a statistical artefact -highly likely- due to suppression effects (i.e., the significant between-effects soaking up the explained variance in these variables and changing the direction of effects). To investigate this further, the next section will consider additional, less complex analyses, investigating the effect of these variables over time on WRQ after burnout **(Table XIII).**

4.3.2.5 Additional analyses

Some unexpected findings from the previous analyses related to workload, person-organization fit, task conflict, negative behaviors and emotional load warranted further investigation. Specifically, it was suspected that certain factors, such as workload, were not statistically significant due to a lack of statistical power. Additionally, within-person effects appeared to be in the opposite direction, likely due to suppressor effects-where strong between-person effects in the expected direction absorbed much of the explained variance, thereby distorting the within-person coefficients of the same variables. To further examine these variables, a less complex and more straightforward analytical approach was applied.

Two analytical options were considered: (a) repeated measures ANOVA and (b) linear mixed models (LMM). Linear mixed models were chosen because repeated measures ANOVA has two critical limitations: (1) it requires the assumption of sphericity, which is often violated in longitudinal data, and (2) it relies on listwise deletion, which is problematic given the objective of maximizing the use of all available data points. Therefore, linear mixed models, with one model fitted per factor, were deemed the most appropriate supplementary analysis. These analyses were executed using SPSS v.27. These models were estimated using an autoregressive covariance structure (AR1), which assumes that later time points depend on earlier ones. The AR(1) structure was selected as it balances model fit and parsimony by assuming a structured correlation pattern over time.

Results overview

Table XIV presents the results. Overall, time did not have main effects nor interaction effects with the considered factors. Concretely, this means that the factors itself did not significantly change over the course of the study period (i.e., main effect of time) nor did the effect of the factors on WRQ change over time (i.e., interaction effect between the considered factor and time). Furthermore, the main effects of all considered factors were significant, in the theoretically hypothesized direction. The detailed results of the linear mixed models are presented below:

1. **Workload:** A significant negative relationship with WRQ was observed (β = -0.354, t = -4.394, p < .001). This suggests that higher workload is associated with a lower WRQ score.
2. **Person-Organization Fit:** A significant positive relationship with WRQ was found (β = 0.359, t = 4.349, p < .001), indicating that higher person-organization fit is associated with higher WRQ.
3. **Task Conflict:** A small but significant negative relationship with WRQ was identified (β = -0.083, t = -1.991, p = .047), meaning that greater task conflict is associated with a lower WRQ score.
4. **Negative Behaviors from Others:** A significant negative relationship with WRQ was found (β = -0.302, t = -2.871, p = .004), suggesting that experiencing more negative behaviors from others at work is linked to lower WRQ.
5. **Emotional Load:** A significant negative relationship with WRQ was observed (β = -0.145, t = -2.036, p = .043), indicating that emotionally demanding work following reintegration is associated with lower WRQ.

Conclusion

The results of the linear mixed models confirm that these factors (i.e., workload, person-organization fit, task conflict, negative behaviors from others, emotion load) are indeed relevant for WRQ and align with expectations based on the hypotheses derived from the Job Demands-Resources (JD-R) model and insights from the qualitative interviews. These findings underscore the importance of considering these factors when examining reintegration quality after burnout.

Table XIV

Linear mixed models for factors requiring further investigation

Model	**Variable**	***F* (df_N, df_D)**			***p***
		F	***Numerator df***	***Denominator df***	
Workload	*Intercept*	671.096	1	366.54	<.001
	Workload	40.450	1	356.35	<.001
	Time	1.052	2	201.08	.351
	*Time * Workload*	.580	2	207.84	.561
Person-organization fit	*Intercept*	192.613	1	349.75	<.001
	Person-organization fit	38.844	1	358.94	<.001
	Time	.358	2	208.72	.699
	*Time * Person-organization fit*	.247	2	215.26	.781
Task conflict	*Intercept*	1339.942	1	307.67	<.001
	Task Conflict	16.972	1	357.92	<.001
	Time	.040	2	204.44	.961
	*Time * Task Conflict*	.564	2	258.65	.570
Negative behaviors	*Intercept*	912.350	1	305.89	<.001
	Negative behaviors	31.149	1	345.68	<.001
	Time	.312	2	208.08	.732
	*Time * Negative behaviors*	1.024	2	247.45	.361
Emotional load	*Intercept*	490.351	1	326.19	<.001
	Emotional load	12.419	1	344.12	<.001
	Time	.684	2	176.08	.506
	*Time * Emotional load*	1.490	2	185.59	.228

5. Dissemination and Valorization

5.1. WP 1

About the scoping review on combined burnout interventions, an initial presentation of the preliminary results was made at the “Association Internationale de Psychologie du Travail de Langue Française” (AIPTLF) 2023 congress in Montreal (Canada). A second presentation, once the review had been finalized, was given at the “European Association of Work and Organizational Psychology” (EAWOP) 2025 congress in Prague (Czech Republic). In addition, a scientific article resulting from this scoping review has been submitted for publication in a specialist journal.

The results of the mapping of well-being initiatives in federal public services were presented at the “European Academy of Occupational Health Psychology” (EAHOP) 2024 congress in Granada (Spain).

5.2. WP 2

The results of the focus groups were presented at the EAHOP 2024 congress in Granada (Spain). The results of the FA-BOTP and DELPHI methods will also be the subject of a scientific article and may be presented at conferences (e.g. European Academy of Occupational Health Psychology 2026 in Helsinki, Finland). The entire WP2, as well as the exploratory study, will be included in the doctoral thesis of C. Lehaen currently in progress, thereby contributing to the scientific and academic value of the project. The results of WP2 are promoted in the form of a burnout management program tailored to the context of federal public services and improved following recommendations made by a panel of experts, as discussed in the previous sections.

Adapted FA-BOTP – Federal Agencies Burnout Treatment Program

Stage 1: Request (Screening Form)

A first communication will be sent directly to federal agents via the communications teams within the federal agencies. In addition, awareness will be raised among the well-being networks (e.g., Lumen, Empreva, etc.) within federal administrations to improve the flow of information about the FA-BOTP and other well-being initiatives. A structured communication plan will specify the roles and responsibilities of each actor involved in the communication chain and will adapt messages to different target audiences (management, employees, HR, well-being stakeholders, etc.) to ensure that the right information reaches the right people. The well-being teams in the federal agencies will receive a second communication so they can promote the FA-BOTP among potential participants. Information will also be made accessible through existing digital channels (intranet, dedicated websites, etc.), as well as via alternative formats (e.g., paper), to ensure inclusiveness for all groups, including less connected staff.

Participants will receive clear and structured initial communication about the program's content, procedures, and objectives. This communication will be paired with organizational flexibility to accommodate individual constraints. A screening form (see **Annex G**) will have to be completed to enter the FA-BOTP. This form will be improved to be clearer and more accessible by using concise, structured questions, visual elements (e.g., checkboxes, conditional logic), and simple examples where relevant. It will also include questions about the work environment while remaining easy to complete, confidential, and clearly defined as a first step—not a diagnostic tool. Participants will be offered the option to complete the screening form with the support of a healthcare professional or qualified internal FA-BOTP contact to be determined. In case of independent completion, a follow-up consultation with a healthcare professional or a qualified internal FA-BOTP contact will be offered if uncertainties arise. The screening form will then be processed by a program manager (to be determined), preferably bound by professional secrecy, to assess whether inclusion in the program is possible. If the participant does not meet the criteria, they will be referred to an internal (Empreva, Lumen, etc.) or external (clinical or work psychologist, etc.) initiative of the federal public services. If the participant meets the inclusion criteria, they will receive:

- A list of health professionals involved in the FA-BOTP (burnout treatment provider + individual session provider) from which they can choose their burnout treatment provider.
- A link to the pre-test, if the pre-test is maintained, which will have to be completed before the burnout diagnosis stage.

Participants will receive automated reminders to complete the pre-test and, if needed, personalized follow-up from a professional bound by confidentiality. They will also be able to refuse such follow-up at any time. Participants will have the option to contact a professional (healthcare provider or internal point of contact) freely and choose the method of communication (active or passive) to receive support during the inclusion process.

The program will also be accessible to individuals who have experienced a relapse. Specific awareness-raising sessions will be planned to address both the causes of the initial burnout and the relapse, including their experience of returning to work or changes in their work situation.

Stage 2: Burnout Diagnostic

Participants will choose a burnout treatment provider who will carry out up to two diagnostic sessions to confirm or refute the diagnosis. If applicable, the pre-test data will also be transmitted to the selected provider so he/she can combine clinical judgment with the participant's self-reported data (e.g., Burnout Assessment Tool, DASS-21). If the diagnosis is confirmed, the burnout treatment provider will send the program manager (preferably bound by professional secrecy) a report justifying the diagnosis and a request for treatment. The program manager will then analyze the report to determine whether the participant meets the inclusion criteria. Participants who do not meet the criteria will be redirected to other sources of internal or external support (e.g., prevention advisor, psychosocial advisor, occupational physician, Lumen or Talent+ networks, clinical psychologists, etc.). Participants who meet the inclusion criteria will then proceed with the full FA-BOTP program.

Stage 3: FA-BOTP Program Content

The FA-BOTP will consist of up to 16 sessions, including a maximum of 2 diagnostic sessions. Each participant will co-create the number and type of sessions as well as their session schedule (frequency, rhythm) with the burnout treatment provider, according to their needs and their recovery progress. Both teleconsultation and in-person sessions will be available to ensure equal access for participants facing geographical, mobility, or scheduling constraints. Permission to attend FA-BOTP consultations during or outside working hours, according to personal preference, should be offered to participants, provided that participation is voluntary and guided by mutual agreements to ensure confidentiality and team organization, without adding undue pressure on the participant. Types of sessions include:

- **"Work stress clinic" sessions (max. 6) – burnout treatment provider**: Focused on expressing emotions and experiences related to work, analyzing causes of burnout, identifying personal resources, and initiating recovery.
- **"Starter kit" sessions (max. 2) – burnout treatment provider or individual session provider**: Focused on stress management, healthy lifestyle, and energy recovery.
- **"Individual sessions" (up to 6) – individual session provider**: Based on a mind-body and/or cognitive-emotional approach. The benefits of these sessions will be better communicated to participants, emphasizing their complementarity with other sessions and their flexibility over time. Participants will also be informed of the possibility to consult the occupational physician for potential work-related adaptations.
- **"Follow-up" / "Reorientation" sessions (max. 2) – burnout treatment provider**: To monitor recovery and discuss any necessary career or job reorientation.
- **"Additional follow-up" sessions (max. 2) – burnout treatment provider**:
    - These two sessions will be offered at three and six months after the end of the program to discuss reintegration, remaining needs, or any necessary adjustments.
    - Offer, as a voluntary option, ongoing support for up to a year after completing FA-BOTP, through professionally moderated peer groups or secure online platforms. Participants

could access a toolbox of self-guided resources (e.g. relaxation exercises, theoretical frameworks) to support long-term recovery.

- **Meeting with the occupational physician**: If, and only if, the participant agrees to lift their anonymity, they may also request a meeting with the occupational physician (Empreva) to discuss potential work adaptations. The role of the occupational physician will be clearly explained by the burnout treatment provider beforehand, who will help identify the most appropriate point of contact for these discussions.

Stage 4: End of Program

At the end of the FA-BOTP, the burnout treatment provider will write a final report and send it to the program manager. If applicable, the participant will also be asked to complete a post-test to evaluate progress and outcomes.

Complementary Measures: Organizational Level

1. Awareness about psychosocial risks could be strengthened among managers, employees, and well-being stakeholders, especially in departments where such risks are high.
2. Stimulating training on stress management and burnout prevention for both managers and employees.
3. Managers will be encouraged to proactively detect early signs of burnout and take preventive measures, such as adjusting workloads and improving work climate.
4. Specific leadership training on mental health could be supported to provide managers with tools to support staff effectively.
5. Communities of practice or focus groups could be supported to involve staff in identifying solutions for primary prevention in a participatory way.
6. A comprehensive workplace well-being policy could be implemented, including:
    a. Monitoring and evaluation of preventive actions
    b. Adjustments in work organization where needed
    c. Regular evaluation and continuous improvement of measures
7. An organizational culture supporting professional reintegration after burnout could be actively promoted, including advance planning, necessary job adjustments, and a compassionate approach to return-to-work.

5.3. WP 3

The findings of WP3 are valorized by means of a practical tool. Specifically, an existing tool that has been developed based on previous research (BRM) was further refined and expanded with factors based on the findings within the context of the Federal Administration (FA-BRM), which were discussed in detail above. In addition, the preliminary FA-BRM results were presented at the EAHOP 2024 congress in Granada, Spain and have been discussed with researchers at the Academy of Management meeting in Copenhagen, July 2025 (Denmark).

5.3.1. Burnout Reintegration Monitor (BRM)

Previous research (Rooman, 2023) laid the basis to develop a measurement instrument to assess the quality of reintegration (i.e., measurement) and identified factors that can promote quality reintegration at work after burnout (i.e., remediation). The measurement instrument and factors are included in a practical e-tool (“Re-integratiebalans” or Burnout Reintegration Monitor), which can be found on the website https://www.re-integratiebalans.be/nl (in a Dutch version only).

In this way, the BRM helps, first, to make a scientifically sound assessment of the quality of reintegration and, secondly, to promote awareness around the promoting and risk factors identified based on empirical research. This awareness can be a first step towards concrete actions that help to improve reintegration trajectories after burnout (i.e., remediation). As mentioned earlier in this report (see Methodology), the tool considers the following determinants:

1. Job Autonomy;
2. Workload;
3. Supervisor Support;
4. Resilience;
5. Perfectionism, where the dimensions of perfectionistic striving versus perfectionistic concerns are differentiated.

After completing the questionnaire, participants automatically receive a personalized feedback rapport providing them insights into (a) their level of work resumption quality, and (b) their score on important risk and promoting factors. Score bars with color zones to represent one's risk level are used (red = high risk; orange = moderate risk; green = low risk). For WRQ, this represents the risk of relapse into burnout (i.e., a green score represent a high WRQ and thus low risk of burnout relapse).

For the determinants considered, the color zone (red/orange/green) represents the risk level that this factor entails for the person in question (e.g., a red score for workload shows that workload appears to be an important risk factor for WRQ for this person). In other words, the score bars with color zones help to situate the participants' score on work resumption quality and its defining factors, relative to the sample from the research that laid the basis for the tool development.

5.3.2. Burnout Reintegration Monitor for the Federal Administration (FA-BRM)

For the present project, the Burnout Reintegration Monitor (BRM) is expanded containing not only generally important factors for qualitative reintegration after burnout (see higher on 'Burnout Reintegration Monitor' for an overview of these factors), but also factors that appeared specifically important in the governmental context, based on research within the Federal Administration among federal agents who reintegrated in the workplace after a period of absence due to burnout. Based on the WP3 results (see **Table XI**), the following government-specific factors were added to the tool:

1. Person-organization fit;
2. Demands-abilities fit;
3. Task conflict;
4. Negative behaviors from others;
5. Ability to adapt procedures;
6. Meaning of work;
7. Emotional load.

5.3.3. Back-end calculation principles behind the feedback report

The calculations in the back-end of the website adopt the following principle: the color zones are delineated based on the mean and the variance in the sample on which the tool is based, namely *N* = 1054 (general burnout sample) for the general factors, *N* = 226 for the government-specific factors (federal government sample). The scores for determinants are calculated using a compensatory approach. This means that an individual's scale score for a determinant (i.e., the average score across all items related to this determinant) is multiplied by the corresponding regression weight of that determinant, derived from prior research (see the fourth column with β in the table below). The resulting value is then compared to M * β in the reference sample from previous research. This

comparison determines whether the participant's score is higher or lower than the product of the mean scale score in the reference sample multiplied by the regression weight.

The **classification into color zones** also considers the distribution of scores:

1. The **middle zone** is designated as **orange (intermediate)**.
2. The **lower boundary** of this orange zone is defined as ***M * β* – 1/3 *SD*** in the reference sample. This marks the transition from orange to red for WRQ and for positive factors and from orange to green for risk factors.
3. The **upper boundary** of the orange zone is defined as ***M * β* + 1/3 *SD*** in the reference sample. This marks the transition from orange to green for WRQ and for positive factors and from orange to red for risk factors.

The choice of 1/3 SD as the cut-off point is based on the distribution of scores within the general burnout sample (*N* = 1054). This threshold ensures an approximately equal distribution of participants across the different color zones. In other words, while the orange zone may appear visually smaller in the feedback report, the number of participants falling into this category remains relatively stable and comparable to the other zones. The calculations behind the lower and upper bounds for WRQ are described in **Table XV** and **Table XVI.**

Table XV

Means, standard deviations and regression weights for all variables in the FA-BRM

Category	Variables	*M*	*β*	*M* β*	*ABS (M* β)*	*SD*	*1/3 SD*
BRM	*Work resumption quality (outcome)*	3.20	1.00	3.20	3.20	0.84	0.28
BRM	*Job autonomy*	2.94	0.20	0.59	0.59	0.79	0.26
BRM	*Workload*	2.65	-0.12	-0.32	0.32	0.81	0.27
BRM	*Supervisor Support*	3.15	0.21	0.66	0.66	1.01	0.34
BRM	*Resilience*	3.30	0.28	0.92	0.92	0.74	0.25
BRM	*Perfectionistic striving*	3.28	0.41	1.35	1.35	0.70	0.23
BRM	*Perfectionistic concerns*	3.38	-0.29	-0.98	0.98	0.71	0.24
Gov	*Person-organization fit*	2.95	0.22	0.65	0.65	1.04	0.35
Gov	*Demands-abilities fit*	3.51	0.19	0.67	0.67	0.97	0.32
Gov	*Task conflict*	2.28	-0.43	-0.98	0.98	0.99	0.33
Gov	*Negative behaviors*	1.77	-0.28	-0.50	0.50	1.05	0.35
Gov	*Ability to adapt procedures*	3.06	0.17	0.52	0.52	0.85	0.28
Gov	*Meaning*	3.51	0.45	1.58	1.58	1.00	0.33
Gov	*Emotional load*	3.14	-0.26	-0.82	0.82	1.10	0.37

Note. The *M* and *SD* are based on a 5-point Likert scale. The BRM factors are based on the general burnout sample (*N* = 1054; Rooman, 2023), whereas the governmental factors are based on the federal government sample (*N* = 226).

Table XVI

Lower and upper bounds for color zones per determinant in the FA-BRM.

Category	Variables	Lower bound = ABS (*M* * *β*) - ABS (1/3 *SD*)	Upper bound = ABS (*M* * *β*) + ABS (1/3 *SD*)
BRM	*Work resumption quality (outcome)*	2.92	3.48
BRM	*Job autonomy*	0.33	0.85
BRM	*Workload*	0.05	0.59
BRM	*Supervisor Support*	0.32	1.00
BRM	*Resilience*	0.67	1.17
BRM	*Perfectionistic striving*	1.11	1.58
BRM	*Perfectionistic concerns*	0.75	1.22
Gov	*Person-organization fit*	0.30	1.00
Gov	*Demands-abilities fit*	0.34	0.99
Gov	*Task conflict*	0.65	1.31
Gov	*Negative behaviors*	0.15	0.85
Gov	*Ability to adapt procedures*	0.24	0.80
Gov	*Meaning*	1.25	1.91
Gov	*Emotional load*	0.45	1.18

Note. The *M* and *SD* are based on a 5-point Likert scale. ABS = absolute value.

5.3.4. Implementation of the FA-BRM

Implementing the FA-BRM tool[4] in the landscape of reintegration after burnout in the Federal Administration allows for further follow-up over time, both on *an individual level* as well as on an *organizational level (upon request)*. Participants completing the FA-BRM upon their reintegration after burnout will receive an invitation to complete it again after 3 and 6 months. This will allow them to track any progress they made by acting upon risk and promoting factors, potentially with the help of a career coach within the Federal Administration (e.g., Lumen burnout coaches). On the organizational level, such a follow-up can help HR-professionals and occupational physicians to improve the policies on reintegration after burnout by addressing the difficulties that play a significant role for many federal agents, beyond the individual level. To maximize the adoption of the tool, its implementation should be as accessible as possible. We recommend a system where federal agents reintegrating after burnout are broadly informed about the tool and encouraged to use it on their own initiative (e.g., through a general newsletter). This approach is preferable to a system where a government well-being professional personally invites them to use the tool (e.g., via HR), for the following reasons:

a) It requires a time investment from HR / well-being professionals, and the continuity of usage may be at risk if they do not immediately perceive its added value or only recognize it in the long term.
b) Being asked to complete a questionnaire during reintegration may feel invasive, particularly if the request comes from a superior, such as a direct manager.

Beyond self-initiated use, clear and sensitive communication about data handling is crucial for successful implementation. Before completing the tool, participants will be asked to provide their email address to enable the linking of their data points over time. This may raise privacy and GDPR-related concerns. To address this, it is essential to communicate clearly that only the external research team will have access to individual data, including email addresses. The employer (in this case, the Federal Administration) will have access only to anonymized, group-level data for the purpose of improving their reintegration policies.

Before completing the tool, participants will be asked to choose their level of consent regarding the use of their email address for:

a) Linking their data points over time for further validation and follow-up research.
b) Follow-up invitations to complete the tool again at three and six months after the initial completion.

This approach ensures both user autonomy and privacy protection, while also fostering long-term research and policy improvements.

5.4. Additional implementation and policy recommendations

In addition to the recommendations made throughout the project, on October 10, 2025, the findings and final tools were presented to stakeholders and considered during roundtable sessions. Four key questions were considered, leading to additional implementation and policy recommendations:

- **Question 1 - Tools (FA-BOTP/FA-BRM):** Evaluation of the tools and what is still needed to move towards an integrated well-being policy at the Federal Agencies?
- **Question 2 – Organization:** What will be the role of the different organizations (BOSA – EMPREVA – MEDEX…) in implementing the FA-BOTP and FA-BRM?

[4] The FA-BRM tool can be filled-out in Dutch (https://www.re-integratiebalans.be/nl) or in French (https://www.re-integratiebalans.be/fr).

- **Question 3 – Organization:** How to improve organizational involvement for secondary and tertiary prevention of burnout in the FA, more in general (touching upon policy)?
- **Question 4 – Policy:** How to improve organizational involvement for secondary and tertiary prevention of burnout in the FA, more in general (touching upon policy)?

Below, we report the main outcomes of the roundtable discussions, including general recommendations for practice and policy.

5.4.1. Question 1

- **General remarks**
  - For WP2 & WP3: Self-evaluation tools are valuable because they capture the individual's perspective. *Proactive follow-up is recommended* that also include the context. To realize this, meetings can be formalized with disability managers (or similar roles) to connect individual results with organizational awareness. Links with the BOSA Career Center are also relevant in the reintegration context, though short-term budget cuts may be a hinderance.
- **WP1: Mapping**
  - There are currently many well-intended initiatives (see **Annex H**), but these initiatives remain *fragmented*. This also leads to fragmented well-being data. Empreva is well positioned to capture this information and plays a key role in: (a) linking primary, secondary, and tertiary prevention;
- linking the individual and organizational level.
  - For instance, data from psychosocial risk analyses could be matched with data from the FA-BRM at the organizational level, providing valuable input for supervisors and policymakers. This is complementary to the more individual focus of WP3.
  - There is concern about *"quaternary prevention*", i.e., the prevention of unnecessary or potentially harmful interventions when untrained professionals intervene without the necessary qualifications, such as uncertified coaches. This highlights the need for *quality control* and *certification* of anyone offering support, e.g., when working with the FA-BOTP. In times of budget restrictions, *priority should go to evidence-based tools (like FA-BOTP and FA-BRM) and qualified professionals with proper evidence-based training*, who can work with relevant tools. Quality assurance should be the foundation for cost-saving measures.
  - To increase engagement, the *communication strategy around these tools and initiatives* should be part of a continuous communication plan tailored to different stakeholders. It should also reach external professionals who support federal employees (e.g., psychologists). It should be made clear that both tools are evidence-based.
  - *Privacy concerns* must also be addressed: people may fear that their data will be used by AI systems, so clear reassurance about data protection is essential.
  - **To conclude**: fragmented initiatives could be consolidated, evaluated for evidence based design and implementation, and prioritized accordingly. The ReBorn project is pioneering in this regard. Communication about FA-BRM and FA-BOTP could clarify who refers employees to which tool and how, while actors should receive training on the tools' purposes and use, enabling them to provide proper follow-up. Collecting data remains essential, as it allows a stronger link to primary prevention through psychosocial risk analyses and supports organizational action plans for well-being.

- **WP2 – FA-BOTP (Burnout Treatment Program for Federal Agents)**
  - Further *validation through implementation* in the FA is important. However, *continuity* remains a recurring concern: Who will conduct the intake for WP2 once the project ends, and how can Belspo ensure sustained implementation?
  - *Linking with primary prevention* is essential. The occupational physician plays a key role by involving supervisors and policymakers to drive organizational change alongside the program's individual focus.
  - It is recommended *to keep initiatives in-house, standardize and certify professionals involved,* and *ensure continuity of partners*. For example, the FA-BOTP framework contract relies on a limited number of trained professionals who can conduct intakes, but this requires policy buy-in and support from well-being teams to advocate for such resources.
  - *Considering an assistance budget* is advisable, although training budgets are limited. Moreover, budgets are fixed per legislature, meaning that once allocated resources are exhausted, no additional funds are available. Special attention should be given to high-risk professions or jobs with a high emotional load. A higher budget per person should be allocated for those facing higher psychosocial risks.
  - *Implementation processes for interventions take time* and should *not be evaluated or discontinued too quickly*. Informing stakeholders within the Federal Administration about new initiatives and adopting new tools requires time. Low participation rates should therefore not be interpreted as failure but as part of the natural adoption process. Slow uptake is partly due to the challenging target group, i.e., employees recovering from burnout often have limited energy or resources to engage (i.e., reverse job crafting), and partly due to the public sector context, where building engagement and trust among all actors takes time (e.g., concerns about data confidentiality). Therefore, implementation and evaluation should be carried out over several years.
  - Resources should be redistributed across organizations with the greatest needs, and investments in retention are necessary. Succession planning could help by mapping needs and resources with a focus on future sustainability. Clarity is needed on where to focus to prioritize efforts and which trade-offs to make.
- **WP3 – FA-BRM (Burnout Reintegration Monitor for Federal Agents)**
  - The *"Red Button" system is customized per organization*, as every organization enters its own contact persons. Due to this customization, it is technically challenging to create a general link from the FA-BRM to the Red Button, since the system operates on each organization's intranet. It is therefore recommended *to advise users to search on their intranet for their prevention advisor and to also refer employees to their direct supervisor for questions related to the work organization*. All information on follow-up steps and coaching trajectories should be added to the intranet, with a link to the external FA-BRM.
  - *Communication is key to making people aware of the FA-BRM and its purpose.* For instance, occupational physicians, coaches, and similar professionals, can refer employees to the website and subsequently to care. However, BOSA cannot receive management rights due to GDPR restrictions (no access to sensitive personal data of federal agents).

- *FA-BRM results can lead to reorientation in case of difficult reintegration*. However, reorientation does not always succeed because the original organization may not be able to release the employee. One potential solution is job exchange between organizations ("externships"), where one organization temporarily sends out an employee and receives another employee in return. This approach has already been implemented for older employees seeking new challenges, but budget cuts have halted such programs. The Talent Exchange Program, intended for short-term learning experiences, may not be used to compensate for staffing shortages. Moreover, budget is needed to retain employees who thrive in a new position (e.g., after burnout), rather than forcing them back to their old job. It is important to collect data on such cases to inform policymakers about the resources and the effectiveness of reintegration policies.

5.4.2. Question 2

Ensuring continuity requires coordination among the main actors:

- MEDEX is not formally within scope, as burnout is not recognized as an occupational disease, although it does play a role in reducing the number of long-term sick employees.
- Empreva is essential for connecting different prevention levels as well as the statistical monitoring of consultations and reintegration (see Question 1).
- Whereas Persopoint may develop tools for tracking absenteeism, BOSA may more directly promote the FA-BOTP and FA-BRM tools via the Workplace Mental Health Network and the 'Je me sens bien au travail' website via awareness-rising, information and the provision of training.

For long-term sustainability, adequate resources, including both immaterial and material support, need to be guaranteed.

5.4.3. Question 3

Many initiatives aimed at supporting employees recovering from burnout or seeking professional reorientation within the public sector have been discontinued due to budgetary constraints (see **Annex H**). Training for supervisors and managers, raising awareness about well-being at work and (changing) organizational culture, are crucial to improving involvement. Support from higher political levels is also required to ensure follow-up on psychosocial risk analyses and the implementation of concrete actions derived from them. Without such sustained commitment, efforts in secondary and tertiary prevention risk losing momentum.

5.4.4. Question 4

- *Automation and AI* can help reduce workload by optimizing task distribution and making better use of human resources. Efforts should also continue to reactivate long-term sick employees, but only with adequate support and follow-up.
- *Job crafting* can be a useful approach but also has side effects when redistributed tasks increase pressure on colleagues, so it must be applied carefully.
- *Upcoming waves of retirements* without replacement will further intensify workload, making the prioritization of core tasks essential.
- *Supervisors play a key role* in communicating realistic expectations: They must align objectives, key performance indicators (KPIs), and available resources. It is important to acknowledge that not all KPIs can be achieved under restricted budgets and to value employees' efforts, nonetheless.

- *Communication* is crucial. Initiatives should not appear as "band-aids" to compensate for budget cuts but should be framed as genuine, structural commitments to well-being. System limitations must also be recognized, such as the shortage of occupational physicians and the imbalance between the number of disability managers and the total number of employees. These constraints should be considered when designing feasible and sustainable well-being policies.

6. PUBLICATIONS AND PRESENTATIONS

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ANNEXES

Annex A: Pre-test

French

SD	**Informations de participation**	
SD1	Numéro de participation :	
SD2	**Informations générales vous concernant**	
SD31	Qui vous a informé(e) du trajet de prise en charge FA-BOTP ?	1 @L'équipe de recherche 2@Conseiller en prévention aspects psychosociaux 3@Personne de confiance 4@Chef/Responsable 5@Service ressources humaines (RH) 6@ Collègues 7@Syndicat 8@Réseau Lumen 9@Réseau Talent+ 10@Empreva 11@Medex 12@ Autre
SD311	Précisez:	
SD4	Quel est votre âge ?	
SD5	Vous êtes :	1@Un homme 2@Une femme 3@ Autre
SD6	Quel est votre niveau au sein de votre organisation ?	1@Niveau A 2@Niveau B 3@Niveau C 4@Niveau D 5@Autre
SD61	Précisez :	
T	**Les questions suivantes portent sur votre travail, plus précisément, l'emploi pour lequel vous êtes rémunéré(e).**	

T1	Votre organisation :	1@SPF Stratégies et Appui (BOSA) 2@SPF Mobilité et Transports 3@SPF Emploi, Travail et Concertation sociale 4@SPF Intérieur 5@INAMI 6@Autre
T11	Précisez :	
T2	Quel statut avez-vous au sein de votre organisation ?	1@Statutaire 2@Contractuel 3@Autre
T21	Précisez :	
T4	Depuis combien de temps exercez-vous cette fonction au sein de votre organisation ?	1@Moins de 1 an 2@Entre 1 et 5 ans 3@Entre 6 et 10 ans 4@Entre 11 et 15 ans 5@Entre 16 et 20 ans 6@Plus de 20 ans
T51	Vous avez un :	1@Horaire fixe 2@Horaire flexible
T52	Effectuez-vous un travail de jour uniquement, de nuit uniquement ou les deux ?	1@Uniquement de jour 2@Uniquement de nuit 3@De jour et de nuit
T6	Combien d'heures effectives de travail réalisez-vous par semaine environ (y compris les éventuelles heures supplémentaires, le télétravail, ...) ?	
T9	En ce moment, vous êtes :	1@Actif(ve) à temps plein 2@Actif(ve) à temps partiel 3@En pause carrière 4@En arrêt maladie ou situation équivalente 5@Autre
T91	Précisez :	
A1	**Votre état de santé (physique et psychologique) au travail au cours des 3 derniers mois (= entre aujourd'hui et il y a 3 mois)**	
A2	Vous êtes-vous absenté(e) de votre travail au cours des 3 derniers mois en raison de problèmes de santé liés au travail ?	1@Oui 2@Non
A21	Combien de fois ? (ex: 4)	

A22	Votre plus longue période d'absence en raison de problèmes de santé liés au travail a duré (en nombre de jours ex: 10):		
A3	Au cours des 3 derniers mois, y a-t-il eu des jours où vous avez été gêné(e) au travail par des problèmes de santé liés au travail?	1@Oui 2@Non	
S	**Votre état de santé général (physique et psychologique) aujourd'hui**		
S1	Nous aimerions savoir comment vous évaluez votre état de santé AUJOURD'HUI. Deux échelles axées sur l'état physique et l'état psychologique sont numérotées de 0 (le pire état ressenti) à 100 (le meilleur état ressenti)		
S2	Votre état physique	*(0 - 100)*	
S3	Votre état psychologique	*(0 - 100)*	
BAT1	**Les affirmations suivantes concernent votre expérience du travail. Veuillez indiquer à quelle fréquence chaque affirmation s'applique à vous.**		
BAT 2	@Jamais@Rarement@Parfois@Souvent@Toujours		
BAT3	Au travail, je me sens épuisé (e) mentalement.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT4	Tout ce que je fais au travail me demande beaucoup d'efforts.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT5	Après une journée au travail, il m'est difficile de retrouver mon énergie.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT6	Au travail, je me sens épuisé(e) physiquement.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT7	Quand je me lève le matin, je manque d'énergie pour commencer une nouvelle journée de travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT8	Je veux être actif/ve au travail, mais il m'est impossible d'y arriver.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT9	Quand je fais beaucoup d'efforts au travail, je me fatigue plus que d'habitude.	@Jamais @Rarement @Parfois	@Souvent @Toujours

BAT10	A la fin de ma journée de travail, je me sens épuisé (e) et vidé (e) mentalement.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT11	J'ai du mal à être enthousiaste à propos de mon travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT12	Au travail, je ne réfléchis pas à ce que je fais et je fonctionne en pilote automatique.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT13	Je ressens une profonde aversion pour mon travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT14	Je ressens de l'indifférence à propos de mon travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT15	Je ne pense pas que les autres accordent de l'importance à mon travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT16	Au travail, je me sens incapable de contrôler mes émotions.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT17	Je ne me reconnais pas dans mes réactions émotionnelles au travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT18	Quand je suis au travail, je deviens irritable quand les choses ne se passent pas comme je voudrais.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT19	Il m'arrive d'être en colère ou triste au travail sans vraiment savoir pourquoi.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT20	Au travail, il m'arrive de réagir avec excès sans en avoir l'intention.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT21	Au travail, j'ai du mal à rester attentif/ve.	@Jamais @Rarement @Parfois	@Souvent @Toujours

BAT22	Au travail, il m'est difficile de penser de manière claire.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT23	J'oublie des choses et je suis distrait(e) au travail.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT24	Quand je travaille, j'ai du mal à me concentrer.	@Jamais @Rarement @Parfois	@Souvent @Toujours
BAT25	Je fais des erreurs dans mon travail car mon esprit est ailleurs.	@Jamais @Rarement @Parfois	@Souvent @Toujours

D	**Votre état général au cours de la dernière semaine**		
D0			
D1	J'ai trouvé difficile de décompresser.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
D2	J'ai été conscient(e) d'avoir la bouche sèche.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
D3	J'ai eu l'impression de ne pas pouvoir ressentir d'émotion positive.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
D4	J'ai eu de la difficulté à respirer (par exemple : respiration excessivement rapide, essoufflement sans effort physique).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
D5	J'ai eu de la difficulté à initier de nouvelles activités.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps	

		@S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D6	J'ai eu tendance à réagir de façon exagérée.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D7	J'ai eu des tremblements (par exemple : des mains).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D8	J'ai eu l'impression de dépenser beaucoup d'énergie nerveuse.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D9	Je me suis inquiété(e) en pensant à des situations où je pourrais paniquer et faire de moi un(e) idiot(e).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D10	J'ai eu le sentiment de ne rien envisager avec plaisir.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D11	Je me suis aperçu(e) que je devenais agité(e).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D12	J'ai eu de la difficulté à me détendre.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D13	Je me suis senti(e) triste et déprimé(e).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps

D14	Je me suis aperçu(e) que je devenais impatient(e) lorsque j'étais retardé(e) de quelque façon que ce soit (par exemple : dans les ascenseurs, aux feux de circulation, lorsque je devais attendre).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D15	J'ai eu le sentiment d'être pris(e) de panique.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D16	J'ai été incapable de me sentir enthousiaste au sujet de quoi que ce soit.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D17	J'ai eu le sentiment de ne pas valoir grand-chose comme personne.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D18	Je me suis aperçu(e) que j'étais irritable.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D19	J'ai été conscient(e) des palpitations de mon coeur en l'absence d'effort physique (sensation d'augmentation de mon rythme cardiaque ou impression que mon coeur venait de sauter).	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D20	J'ai eu peur sans bonne raison.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
D21	J'ai eu l'impression que la vie n'avait pas de sens.	@Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps
U	**Utilisation des soins de santé au cours des 3 derniers mois :**	
U1	*A. Consultations chez le médecin généraliste*	

U11	Au cours des 3 derniers mois, avez-vous consulté un médecin généraliste en raison de problèmes de santé liés au travail?	1@Oui 2@Non	
U12	Combien de fois avez-vous consulté un médecin généraliste ?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 ou plus
U13	Raison(s) de cette/ces visite(s) :		
U2	*B. Consultations chez le médecin du travail*		
U21	Au cours des 3 derniers mois, avez-vous consulté le médecin du travail en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U211	Combien de rendez-vous avez-vous eus ?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 ou plus
U212	Raison(s) de cette/ces visite(s) :		
U3	*C. Consultations chez un psychologue ou psychiatre*		
U31	Au cours des 3 derniers mois, avez-vous consulté un psychologue ou psychiatre en raison de problèmes de santé liés au travail?	1@Oui 2@Non	
U311	Combien de rendez-vous avez-vous eus ?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 ou plus
U312	Raison(s) de cette/ces visite(s) :		
U4	*D. Médication*		
U40	Au cours des 3 derniers mois, avez-vous pris des médicaments en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U41	Quel(s) type(s) de médicaments avez-vous pris pour vos problèmes de santé liés au travail ?	@Tranquillisants @Antidépresseurs @Antidouleurs @Somnifères @Médicaments pour les maladies cardiovasculaires @Médicaments pour les troubles gastriques @Anti-inflammatoires	

		@Autre(s)...

Dutch

SD	**Deelnemersinformatie**	
SD1	Deelnemersnummer	
SD2	**Algemene persoonlijke informatie**	
SD31	Wie informeerde u over de FA-BOTP?	1 @ Het onderzoeksteam (via e-mail) 2@ Preventieadviseur psychosociale aspecten 3@ Vertrouwenspersoon 4@ Leidinggevende 5@ Afdeling Human Resources (HR) 6@ Collega's 7@ Vakbond 8@ Lumen netwerk 9@Talent+ netwerk 10@Empreva 11@Medex 12@ Andere
SD311	Verduidelijk wie:	
SD4	Wat is uw leeftijd?	
SD5	U bent:	1@Een man 2@Een vrouw 3@ Andere
SD6	Wat is uw niveau in uw organisatie?	1@Niveau A 2@Niveau B 3@Niveau C 4@Niveau D

		5@Andere
SD61	Specificeer:	
T	**De volgende vragen hebben betrekking op uw werk, meer bepaald het werk waarvoor u een salaris ontvangt.**	
T1	Uw organisatie :	1@FOD Beleid en Ondersteuning (BOSA) 2@FOD Mobiliteit en Vervoer 3@FOD Werkgelegenheid, Arbeid en Sociaal Overleg 4@FOD Binnenlandse Zaken 5@RIZIV 6@Andere
T11	Specificeer:	
T2	Welke statuut heeft u in uw organisatie?	1@Statutair 2@Contractueel 3@Andere
T21	Specificeer:	
T4	Hoe lang bekleedt u deze functie al binnen uw organisatie?	1@Minder dan 1 jaar 2@ 1-5 jaar 3@ 6-10 jaar 4@ 11-15 jaar 5@ 16-20 jaar 6@Meer dan 20 jaar
T51	U heeft een:	1@Vaast uurrooster 2@Flexiebeluurrooster
T52	Werkt u overdag, 's nachts of beide?	1@Enkel overdag 2@Enkel ‘s nachts 3@Overdag en ‘s nachts
T6	Hoeveel uren werkt u ongeveer per week (inclusief eventuele overuren, telewerk, ...)?	
T9	U bent op dit moment:	1@ Voltijds werkzaam 2@ Deeltijds werkzaam 3@ In loopbaanonderbreking 4@ In ziekteverlof of gelijkwaardig 5@Andere
T91	Specificeer :	
A1	**Uw gezondheidstoestand (psychologisch en fysiek) op het werk <u>gedurende de laatste 3 maanden</u> (= tussen vandaag en 3 maanden geleden)**	

A2	Bent u de afgelopen 3 maanden afwezig geweest op het werk wegens werkgerelateerde gezondheidsproblemen?	1@Ja 2@Nee	
A21	Hoeveel keer (vb: 4)		
A22	Uw langste periode van afwezigheid door werkgerelateerde gezondheidsproblemen duurde (in aantal dagen *vb: 10*):		
A3	Zijn er in de afgelopen 3 maanden dagen geweest waarop u last ondervond van gezondheidsproblemen die volgens u te wijten zijn aan werkgerelateerde situaties?	1@Ja 2@Nee	
S	**Uw gezondheidstoestand (fysiek en psychologisch) <u>vandaag</u>**		
S1	We willen graag weten hoe u uw gezondheidstoestand **VANDAAG** beoordeelt. Twee schalen met betrekking tot uw **fysieke toestand** en uw **psychologische toestand** zijn genummerd van 0 (de slechtste toestand die u ooit ervaren heeft) tot 100 (de beste toestand die u ooit ervaren heeft).		
S2	Uw **fysieke** toestand:	*(0 - 100)*	
S3	Uw **psychologische** toestand:	*(0 - 100)*	
BAT1	**De volgende uitspraken hebben betrekking op hoe u uw werk beleeft en hoe u zich daarbij voelt. Wilt u aangeven hoe vaak iedere uitspraak op u van toepassing is?**		
BAT 2	@Nooit@Zelden@Soms@Vaak@Altijd		
BAT3	Op het werk voel ik me geestelijk uitgeput.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT4	Alles wat ik doe op mijn werk kost mij moeite.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT5	Ik raak maar niet uitgerust nadat ik gewerkt heb.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT6	Op het werk voel ik me lichamelijk uitgeput.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT7	Als ik ‘s morgens opsta, mis ik de energie om aan de werkdag te beginnen.	@Nooit @Zelden @Soms	@Vaak @Altijd

BAT8	Ik wil wel actief zijn op het werk, maar het lukt mij niet.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT9	Als ik me inspan op het werk, dan word ik snel moe.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT10	Op het einde van de werkdag voel ik mentaal uitgeput en leeg.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT11	Ik kan geen belangstelling en enthousiasme opbrengen voor mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT12	Op mijn werk denk ik niet veel na en functioneer ik op automatische piloot.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT13	Ik voel een sterke weerzin tegenover mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT14	Mijn werk laat mij onverschillig.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT15	Ik ben cynisch over wat mijn werk voor anderen betekent.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT16	Op mijn werk heb ik het gevoel geen controle te hebben over mijn emoties.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT17	Ik herken mezelf niet in de wijze waarop ik emotioneel reageer op mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT18	Tijdens mijn werk raak ik snel geïrriteerd als de dingen niet lopen zoals ik dat wil.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT19	Ik word kwaad of verdrietig op mijn werk zonder goed te weten waarom.	@Nooit @Zelden @Soms	@Vaak @Altijd

BAT20	Op mijn werk kan ik te sterk emotioneel reageren, terwijl ik dat niet wou.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT21	Op mijn werk kan ik mijn aandacht moeilijk behouden.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT22	Tijdens mijn werk heb ik moeite om helder na te denken.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT23	Ik ben vergeetachtig en verstrooid tijdens mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT24	Als ik aan het werk ben, kan ik me moeilijk concentreren.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT25	Ik maak fouten tijdens mijn werk omdat ik er met mijn hoofd niet goed bij ben.	@Nooit @Zelden @Soms	@Vaak @Altijd

D	**Uw algemene toestand van <u>de laatste week</u>**		
D0			
D1	Ik vond het moeilijk mezelf te kalmeren.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D2	Ik merkte dat mijn mond droog aanvoelde.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D3	Ik was niet in staat om ook maar enig positief gevoel te ervaren.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	

D4	Ik had moeite met ademhalen (bv.: overmatig snel ademen, buiten adem zijn zonder me in te spannen, ...).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D5	Ik vond het moeilijk om initiatief te nemen om iets te gaan doen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D6	Ik had de neiging om overdreven te reageren op situaties.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D7	Ik merkte dat ik beefde (bv.: met de handen).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D8	Ik was erg opgefokt.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D9	Ik maakte me zorgen over situaties waarin ik in paniek zou raken en mezelf belachelijk zou maken.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D10	Ik had het gevoel dat ik niets had om naar uit te kijken.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D11	Ik merkte dat ik erg onrustig was.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D12	Ik vond het moeilijk me te ontspannen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing

D13	Ik voelde me somber en zwaarmoedig.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D14	Ik had geen geduld met dingen die me hinderden bij iets dat ik wilde doen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D15	Ik had het gevoel dat ik bijna in paniek raakte.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D16	Ik was niet in staat om over iets enthousiast te worden.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D17	Ik had het gevoel dat ik als persoon niet veel voorstel.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D18	Ik merkte dat ik nogal lichtgeraakt was.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D19	Ik was me bewust van mijn hartslag terwijl ik me niet fysiek inspande (bv.: het gevoel van een versnelde of overslaande hartslag).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D20	Ik was angstig zonder enige reden.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D21	Ik had het gevoel dat mijn leven geen zin had.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing

U	**Gebruik van gezondheidszorg tijdens <u>de laatste 3 maanden</u>**		
U1	***<u>A. Consultatie bij de huisarts</u>***		
U11	Heeft u uw huisarts geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** in de afgelopen 3 maanden?	1@Ja 2@Nee	
U12	Hoe vaak heeft u uw huisarts geconsulteerd?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 of meer
U13	Reden(en) van deze consultatie(s):		
U2	***<u>B. Consultatie bij de arbeidsarts</u>***		
U21	Heeft u uw arbeidsarts geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** in de afgelopen 3 maanden?	1@Ja 2@Nee	
U211	Hoe vaak heeft u uw arbeidsarts geconsulteerd?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 of meer
U212	Reden(en) van deze consultatie(s):		
U3	***<u>C. Consultatie bij een psycholoog of psychiater</u>***		
U31	Heeft u uw psycholoog of psychiater geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** in de afgelopen 3 maanden?	1@Ja 2@Nee	
U311	Hoe vaak heeft u uw psycholoog of psychiater geconsulteerd?	@1 @2 @3 @4 @5	@6 @7 @8 @9 @10 of meer
U312	Reden(en) van deze consultatie(s):		
U4	***<u>D. Geneesmiddelen</u>***		
U40	Heeft u medicatie genomen omwille van **werkgerelateerde gezondheidsproblemen** in de afgelopen 3 maanden?	1@Ja 2@Nee	
U41	Welke soort medicatie heeft u genomen voor uw **werkgerelateerde gezondheidsproblemen**?	@Kalmeermiddelen @Antidepressiva @Pijnstillers	

		@Slaapmiddelen @ Medicatie voor hart- en vaatziekten @Medicatie voor maagklachten @Ontstekingsremmers @Andere...

Annex B: Post-test

French

SD	**Informations de participation**	
SD1	Numéro de participation	
BCOM	**Évolution de votre situation professionnelle**	
B1	En ce moment, vous êtes :	1@Actif(ve) à temps plein 2@Actif(ve) à temps partiel 3@En pause carrière 4@En arrêt maladie ou situation équivalente 5@Sans emploi 6@Autre
B11	Précisez :	
B2	Actuellement, …	1@Vous avez toujours le même emploi dans la même organisation 2@Vous avez un emploi différent, mais toujours dans la même organisation 3@Vous avez le même emploi dans une autre organisation 4@Vous avez un emploi différent dans une autre organisation
B3	Vous avez un:	1@Horaire fixe 2@Horaire flexible
B4	Effectuez-vous un travail de jour uniquement, de nuit uniquement ou les deux ?	1@Uniquement de jour 2@Uniquement de nuit 3@De jour et de nuit
B5	Combien d'heures effectives de travail réalisez-vous par semaine environ (y compris les éventuelles heures supplémentaires, le télétravail, ...) ?	
B6	Est-ce que des adaptations de votre poste de travail ou des aménagements de votre travail ont été effectués par votre organisation ?	1@Oui 2@Non
B61	Quels sont les adaptations et/ou les aménagements effectués ?	
B7	Est-ce vous avez vous-même procédé à des adaptations de votre poste de travail ou des aménagements de votre travail ?	1@Oui 2@Non
B71	Quels sont les adaptations et/ou les aménagements effectués ?	
ACOM	**Évolution de votre situation personnelle**	

A1	Êtes-vous actuellement en arrêt maladie pour des raisons de santé liées à votre situation de travail ?	1@Non 2@Oui, depuis moins de 15 jours 3@Oui, depuis moins de 2 mois 4@Oui, depuis une durée comprise entre 2 et 6 mois 5@Oui, depuis plus de 6 mois	
A2	Au cours du trajet de prise en charge FA-BOTP avez-vous été en arrêt maladie pour des raisons de santé liées à votre situation de travail ?	1@Non 2@Oui, moins de 15 jours 3@Oui, moins de 2 mois	4@Oui, entre 2 et 6 mois 5@Oui, plus de 6 mois
A21	Avez-vous bénéficié d'un trajet de réintégration après votre absence de longue durée ?	1@Oui 2@Non 3@Non, mais je me suis renseigné sur les modalités d'un tel trajet	
A211	Précisez le trajet suivi :		
A3	Avez-vous été en arrêt maladie durant l'entièreté de votre trajet de prise en charge FA-BOTP ?	1@Oui 2@Non	
A4	Au cours du trajet d'accompagnement FA-BOTP avez-vous pris rendez-vous et rencontré le conseiller en prévention aspects psychosociaux ?	1@Oui, une fois 2@Oui, plusieurs fois 3@Non	
A5	Au cours du trajet d'accompagnement FA-BOTP, avez-vous pris rendez-vous et rencontré le médecin du travail ?	1@Oui, une fois 2@Oui, plusieurs fois 3@Non	
A6	Au cours du trajet d'accompagnement FA-BOTP, avez-vous pris rendez-vous et rencontré la personne de confiance ?	1@Oui, une fois 2@Oui, plusieurs fois 3@Non	
A7	Au cours du trajet d'accompagnement FA-BOTP, avez-vous pris rendez-vous et rencontré le réseau Lumen (un coach burnout interne) ?	1@Oui, une fois 2@Oui, plusieurs fois 3@Non	
A9	Au cours du trajet d'accompagnement FA-BOTP, avez-vous entamé un trajet de réorientation (Talent+ ou autre) (en dehors du trajet FA-BOTP) ?	1@Oui 2@Non	
S	**Votre état de santé général (physique et psychologique) aujourd'hui :**		
S1	Nous aimerions savoir comment vous évaluez votre état de santé AUJOURD'HUI. Deux échelles axées sur l'état physique et l'état psychologique sont numérotées de 0 (le pire état ressenti) à 100 (le meilleur état ressenti).		

S2	Votre état physique :	100@0@5@50@Le meilleur état@Le pire état@1	
S3	Votre état psychologique :	100@0@5@50@Le meilleur état@Le pire état@1	
BAT1	**Les affirmations suivantes concernent votre expérience du travail. Veuillez indiquer à quelle fréquence chaque affirmation s'applique à vous.**		
BAT2	@Jamais@Rarement@Parfois@Souvent@Toujours		
BAT3	Au travail, je me sens épuisé (e) mentalement.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT4	Tout ce que je fais au travail me demande beaucoup d'efforts.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT5	Après une journée au travail, il m'est difficile de retrouver mon énergie.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT6	Au travail, je me sens épuisé (e) physiquement.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT7	Quand je me lève le matin, je manque d'énergie pour commencer une nouvelle journée de travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT8	Je veux être actif/ve au travail, mais il m'est impossible d'y arriver.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT9	Quand je fais beaucoup d'efforts au travail, je me fatigue plus que d'habitude.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT10	A la fin de ma journée de travail, je me sens épuisé (e) et vidé (e) mentalement.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT11	J'ai du mal à être enthousiaste à propos de mon travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours

BAT12	Au travail, je ne réfléchis pas à ce que je fais et je fonctionne en pilote automatique.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT13	Je ressens une profonde aversion pour mon travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT14	Je ressens de l'indifférence à propos de mon travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT15	Je ne pense pas que les autres accordent de l'importance à mon travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT16	Au travail, je me sens incapable de contrôler mes émotions.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT17	Je ne me reconnais pas dans mes réactions émotionnelles au travail.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT18	Quand je suis au travail, je deviens irritable quand les choses ne se passent pas comme je voudrais.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT19	Il m'arrive d'être en colère ou triste au travail sans vraiment savoir pourquoi.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT20	Au travail, il m'arrive de réagir avec excès sans en avoir l'intention.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT21	Au travail, j'ai du mal à rester attentif/ve.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT22	Au travail, il m'est difficile de penser de manière claire.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT23	J'oublie des choses et je suis distrait/e au travail.	~Jamais @Rarement	@Souvent @Toujours

		@Parfois	
BAT24	Quand je travaille, j'ai du mal à me concentrer.	~Jamais @Rarement @Parfois	@Souvent @Toujours
BAT25	Je fais des erreurs dans mon travail car mon esprit est ailleurs.	~Jamais @Rarement @Parfois	@Souvent @Toujours
DA	**Votre état général au cours de la dernière semaine**		
DA0	@Ne s'applique pas du tout à moi@S'applique un peu à moi, ou une partie du temps@S'applique beaucoup à moi, ou une bonne partie du temps@S'applique entièrement à moi, ou la grande majorité du temps		
DA1	J'ai trouvé difficile de décompresser.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
DA2	J'ai été conscient(e) d'avoir la bouche sèche.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA3	J'ai eu l'impression de ne pas pouvoir ressentir d'émotion positive.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA4	J'ai eu de la difficulté à respirer (par exemple : respiration excessivement rapide, essoufflement sans effort physique).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA5	J'ai eu de la difficulté à initier de nouvelles activités.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique entièrement à moi, ou la grande majorité du temps	
DA6	J'ai eu tendance à réagir de façon exagérée.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps	

		@S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA7	J'ai eu des tremblements (par exemple : des mains).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA8	J'ai eu l'impression de dépenser beaucoup d'énergie nerveuse.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA9	Je me suis inquiété(e) en pensant à des situations où je pourrais paniquer et faire de moi un(e) idiot(e).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA10	J'ai eu le sentiment de ne rien envisager avec plaisir.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA11	Je me suis aperçu(e) que je devenais agité(e).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA12	J'ai eu de la difficulté à me détendre.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA13	Je me suis senti(e) triste et déprimé(e).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA14	Je me suis aperçu(e) que je devenais impatient(e) lorsque j'étais retardé(e) de quelque façon que ce soit (par exemple : dans les ascenseurs, aux feux de circulation, lorsque je devais attendre).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps
DA15	J'ai eu le sentiment d'être pris(e) de panique.	~Ne s'applique pas du tout à moi

		@S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA16	J'ai été incapable de me sentir enthousiaste au sujet de quoi que ce soit.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA17	J'ai eu le sentiment de ne pas valoir grand-chose comme personne.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA18	Je me suis aperçu(e) que j'étais irritable.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA19	J'ai été conscient(e) des palpitations de mon coeur en l'absence d'effort physique (sensation d'augmentation de mon rythme cardiaque ou impression que mon coeur venait de sauter).	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA20	J'ai eu peur sans bonne raison.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DA21	J'ai eu l'impression que la vie n'avait pas de sens.	~Ne s'applique pas du tout à moi @S'applique un peu à moi, ou une partie du temps @S'applique beaucoup à moi, ou une bonne partie du temps @S'applique enti•èrement à moi, ou la grande majorité du temps	
DCONSIGNE	**Questionnaire de satisfaction**		
DCONSIGNE2			
DCOM	**Environnement**		
DMOD	@Pas du tout satisfait@Pas satisfait@Satisfait@Tout à fait satisfait@Pas concerné		
D1	La proximité du/des lieu(x) de prise en charge	1~Pas du tout satisfait (*Helemaal niet tevreden*) 2@Pas satisfait (*Niet tevreden*)	4@Tout à fait satisfait (*Helemaal tevreden*)

		3@Satisfait (*Tevreden)*	5@Pas concerné (*Niet van toepassing*)
D2	L'accessibilité du/des lieu(x) de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
D3	Locaux adaptés à la prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
D4	Où avez-vous suivi le trajet de prise en charge ?	1@Près de chez vous 2@Près de votre lieu de travail 3@A mi-chemin	
D5	Quand avez-vous suivi le trajet de prise en charge ?	1@Pendant les heures de travail 2@En-dehors des heures de travail 3@Pendant les heures de travail et en-dehors des heures de travail	
D6	Avez-vous eu des téléconsultations ?	1@Oui, une ou deux fois 2@Oui, plusieurs fois 3@Non, jamais	
ECOM1	**Votre satisfaction quant à votre/vos intervenant(s)**		
E1	Comment évaluez-vous votre satisfaction par rapport à votre/vos intervenant(s) burnout ?		
EMOD1	@Pas du tout satisfait@Pas satisfait@Satisfait@Tout à fait satisfait@Pas concerné		
E12	La facilité dans les prises de rendez-vous avec l'intervenant	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
E13	La flexibilité des plages horaires de l'intervenant	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
E14	La ponctualité de l'intervenant	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
E15	La coordination du trajet d'accompagnement par l'intervenant	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
E16	Votre satisfaction des séances menées par l'intervenant	1~Pas du tout satisfait	4@Tout à fait satisfait

		2@Pas satisfait 3@Satisfait	5@Pas concerné
FCOM	**Contenu du trajet de prise en charge**		
FMOD	@Pas du tout satisfait@Pas satisfait@Satisfait@Tout à fait satisfait@Pas concerné		
~~F1~~	~~Le nombre de séances~~	~~1~Pas du tout satisfait~~ ~~2@Pas satisfait~~ ~~3@Satisfait~~	~~4@Tout à fait satisfait~~ ~~5@Pas concerné~~
F2	La diversité des séances du trajet de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F3	La modularité/le degré de personnalisation du trajet de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F4	La durée du trajet de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F5	Les explications données par l'intervenant burn-out durant le trajet de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F6	Les explications données par l'équipe de recherche ULiège durant le trajet de prise en charge	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F7	La possibilité d'un suivi par des personnes ayant des disciplines/des spécialisations différentes	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
F8	La dynamique de la réunion avec le médecin du travail	1~Pas du tout satisfait 2@Pas satisfait 3@Satisfait	4@Tout à fait satisfait 5@Pas concerné
GCOM1	**Votre satisfaction quant aux séances de prise en charge**		
G1	Avez-vous été satisfait(e) du nombre de séances ?	1@Oui 2@Non	
G2	Auriez-vous souhaité bénéficier de plus de séances de clinique du travail ?	1@Oui 2@Non	

G21	Combien ?		
G22	Pour quelle(s) raison ?		
G3	Auriez-vous souhaité bénéficier de plus de séances starter kit ?	1@Oui 2@Non	
G31	Combien ?		
G32	Pour quelle(s) raison(s) ?		
G4	Auriez-vous souhaité bénéficier de plus de séances individuelles ?	1@Oui 2@Non	
G41	Combien ?		
G42	Pour quelle(s) raison(s) ?		
G5	Auriez-vous souhaité bénéficier de plus de séances de suivi et/ou réorientation ?	1@Oui 2@Non	
G51	Combien et pour quelle(s) raison(s) ?		
G52	Pour quelle(s) raison(s) ?		
HCOM	**Anonymat et confidentialité**		
H1	Estimez-vous que la confidentialité a été préservée durant le FA-BOTP ?	1@Oui 2@Non	
H11	Pour quelle(s) raison(s) estimez-vous que la confidentialité n'a pas été préservée ?		
H2	A part lors de la réunion avec le médecin de travail, avez-vous dû lever l'anonymat durant le FA-BOTP ?	1@Oui 2@Non	
H21	Si oui, pour quelle(s) raison(s) avez-vous dû lever l'anonymat ?		
ICOM	**Evaluation globale**		
I1	Votre évaluation globale du trajet de prise en charge (1 = Pas du tout satisfait à 10 = Tout à fait satisfait)	10@0@1@5@Tout à fait satisfait @Pas du tout satisfait@1	
I2	Est-ce que vous recommanderiez le trajet à d'autres personnes ?	1@Oui 2@Non	
I3	Continuez-vous ou allez-vous continuer un suivi avec votre intervenant burn-out ?	1@Oui 2@Non	
I31	Continuez-vous ou allez-vous continuer un suivi avec votre intervenant individuel ?	1@Oui 2@Non	
JREM	Vous pouvez nous laisser vos éventuels commentaires sur votre trajet dans l'espace ci-dessous :		

KCONSIGNE	**Votre perception de la situation actuelle.**		
KCONSIGNE2			
K1	Au niveau de l'organisation du travail Depuis le début de votre prise en charge :		
K10	@Pas du tout d'accord@Pas d'accord@D'accord@Tout à fait d'accord@Pas concerné		
K11	L'organisation a pris conscience de la problématique à un niveau plus collectif	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K12	Le style de management a changé	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K13	L'organisation agit davantage pour le bien-être des travailleurs	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K21	Votre relation avec votre hiérarchie s'est améliorée	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K22	Votre relation avec vos collègues s'est améliorée	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K23	Vous avez davantage de support matériel au travail	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K3	**Au niveau de votre rapport au travail Depuis le début de votre prise en charge :**		
K30	@Pas du tout d'accord@Pas d'accord@D'accord@Tout à fait d'accord@Pas concerné		
K31	Vous percevez davantage d'aspects positifs dans votre travail	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K32	Vous avez pris de la distance vis-à-vis de votre travail	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné

K33	Vos attentes vous paraissent plus réalistes	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K4	Au niveau individuel Depuis le début de votre prise en charge :		
K40	@Pas du tout d'accord@Pas d'accord@D'accord@Tout à fait d'accord@Pas concerné		
K41	Votre bien-être général s'est amélioré	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K412	Votre bien-être au travail s'est amélioré	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K42	Vous réalisez vos tâches de travail avec plus de facilité	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K43	Votre sommeil s'est amélioré	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K44	Votre qualité de vie s'est améliorée	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
K45	Votre conciliation vie privée-vie professionnelle s'est améliorée	1~Pas du tout d'accord 2@Pas d'accord 3@D'accord	4@Tout à fait d'accord 5@Pas concerné
U	**Utilisation des soins de santé depuis le début de votre prise en charge**		
U1	**A. Consultations chez le médecin généraliste**		
U11	Depuis le début de votre prise en charge, avez-vous consulté un médecin généraliste en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U12	Combien de fois avez-vous consulté un médecin généraliste ?	1@2@3@4@5@6@7@8@9@10 ou plus	
U13	Raison(s) de cette/ces visite(s) :		
U2	**B. Consultations chez le médecin du travail**		

U21	Depuis le début de votre prise en charge, avez-vous consulté le médecin du travail en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U211	Combien de rendez-vous avez-vous eus ?	1@2@3@4@5@6@7@8@9@10 ou plus	
U212	Raison(s) de cette/ces visite(s) :		
U3	**C. Consultations chez un psychologue ou psychiatre**		
U31	Depuis le début de votre prise en charge, avez-vous consulté un psychologue ou un psychiatre en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U311	Combien de rendez-vous avez-vous eus ?	1@2@3@4@5@6@7@8@9@10 ou plus	4@4 5@5 ou plus
U312	Raison(s) de cette/ces visite(s) :		
U5	**E. Médication**		
U50	Depuis le début de votre prise en charge, avez-vous pris des médicaments en raison de problèmes de santé liés au travail ?	1@Oui 2@Non	
U51	Quel(s) type(s) de médicaments avez-vous pris pour vos problèmes de santé liés au travail ?	@Tranquillisants @Antidépresseurs @Antidouleurs @Somnifères @Médicaments pour les maladies cardiovasculaires @Médicaments pour les troubles gastriques @Anti-inflammatoires @Autre(s)...	
U52	Depuis le début du trajet, votre recours à des médicaments est :	1@Diminué 2@Resté le même 3@Augmenté	

Dutch

SD	**Deelnemersinformatie**	
SD1	Deelnemersnummer	
BCOM	**Evolutie van uw professionele situatie**	
B1	U bent op dit moment:	1@ Voltijds werkzaam 2@ Deeltijds werkzaam

		3@ In loopbaanonderbreking 4@ In ziekteverlof of gelijkwaardig 5@ Werkloos 5@Andere	
B11	Specificeer:		
B2	Op dit moment:	1@U hebt nog steeds dezelfde baan in dezelfde organisatie 2@U hebt een andere baan, maar nog steeds in dezelfde organisatie 3@U hebt dezelfde baan in een andere organisatie 4@U hebt een andere baan in een andere organisatie	
B3	U heeft een:	1@Vast uurrooster 2@Flexiebel uurrooster	
B4	Werkt u overdag, 's nachts of beide?	1@Enkel overdag 2@Enkel 's nachts 3@Overdag en 's nachts	
B5	Hoeveel uren werkt u ongeveer per week (inclusief eventuele overuren, telewerk, ...)?		
B6	Zijn er door uw organisatie aanpassingen op uw werkplek of werkafspraken gemaakt?	1@Ja 2@Nee	
B61	Wat zijn deze aanpassingen?		
B7	Heeft u zelf aanpassingen op uw werkplek of werkafspraken gemaakt?	1@Ja 2@Nee	
B71	Wat zijn deze aanpassingen?		
ACOM	**Evolutie van uw toestand op het werk**		
A1	Bent u momenteel in ziekteverlof omwille van werkgerelateerde gezondheidsproblemen?	1@Nee 2@Ja, minder dan 15 dagen 3@Ja, minder dan 2 maanden 4@Ja, tussen 2 en 6 maanden 5@Ja, meer dan 6 maanden	
A2	Was u tijdens het begeleidingstraject FA-BOTP op een gegeven moment in ziekteverlof omwille van werkgerelateerde gezondheidsproblemen?	1@Nee 2@Ja, minder dan 15 dagen 3@ja, minder dan 2 maanden	4@Ja, tussen 2 en 6 maanden 5@Ja, meer dan 6 maanden

A21	Heeft u een reïntegratietraject opgestart na uw langdurige afwezigheid?	1@Ja 2@Nee 3@ Nee, maar ik heb mij wel geïnformeerd over zo'n traject
A211	Specificeer:	
A3	Was u gedurende de <u>complete duur</u> van uw begeleidingstraject FA-BOTP in ziekteverlof?	1@Ja 2@Nee
A4	Heeft u tijdens het begeleidingstraject FA-BOTP een afspraak gehad met uw preventieadviseur psychosociale aspecten?	1@Ja, één keer 2@Ja, meerdere keren 3@Nee
A5	Heeft u tijdens het begeleidingstraject FA-BOTP een afspraak gehad met uw arbeidsarts?	1@Ja, één keer 2@Ja, meerdere keren 3@Nee
A6	Heeft u tijdens het begeleidingstraject FA-BOTP een afspraak gehad met uw vertrouwenspersoon?	1@Ja, één keer 2@Ja, meerdere keren 3@Nee
A7	Heeft u tijdens het begeleidingstraject FA-BOTP een afspraak gehad met het Lumen netwerk (een interne burn-out coach)?	1@Ja, één keer 2@Ja, meerdere keren 3@Nee
A9	Heeft u tijdens het begeleidingstraject FA-BOTP een loopbaanbegeleidingstraject (Talent + of ander) gevolgd (buiten het traject FA-BOTP)?	1@Ja 2@Nee
S	**Uw gezondheidstoestand (fysiek en psychologisch) <u>vandaag</u>:**	
S1	We willen graag weten hoe u uw gezondheidstoestand **VANDAAG** beoordeelt. Twee schalen met betrekking tot uw **fysieke toestand** en uw **psychologische toestand** zijn genummerd van 0 (de slechtste toestand die u ooit ervaren heeft) tot 100 (de beste toestand die u ooit ervaren heeft).	
S2	Uw **fysieke** toestand:	100@0@5@50@De beste toestand@De slechtste toestand@1
S3	Uw **psychologische** toestand:	100@0@5@50@De beste toestand@De slechtste toestand@1

BAT1	De volgende uitspraken hebben betrekking op hoe u uw werk beleeft en hoe u zich daarbij voelt. Wilt u aangeven hoe vaak iedere uitspraak op u van toepassing is?	

BAT 2	@Nooit@Zelden@Soms@Vaak@Altijd		
BAT3	Op het werk voel ik me geestelijk uitgeput.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT4	Alles wat ik doe op mijn werk kost mij moeite.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT5	Ik raak maar niet uitgerust nadat ik gewerkt heb.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT6	Op het werk voel ik me lichamelijk uitgeput.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT7	Als ik 's morgens opsta, mis ik de energie om aan de werkdag te beginnen.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT8	Ik wil wel actief zijn op het werk, maar het lukt mij niet.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT9	Als ik me inspan op het werk, dan word ik snel moe.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT10	Op het einde van de werkdag voel ik mentaal uitgeput en leeg.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT11	Ik kan geen belangstelling en enthousiasme opbrengen voor mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT12	Op mijn werk denk ik niet veel na en functioneer ik op automatische piloot.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT13	Ik voel een sterke weerzin tegenover mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT14	Mijn werk laat mij onverschillig.	@Nooit	@Vaak

		@Zelden @Soms	@Altijd
BAT15	Ik ben cynisch over wat mijn werk voor anderen betekent.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT16	Op mijn werk heb ik het gevoel geen controle te hebben over mijn emoties.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT17	Ik herken mezelf niet in de wijze waarop ik emotioneel reageer op mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT18	Tijdens mijn werk raak ik snel geïrriteerd als de dingen niet lopen zoals ik dat wil.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT19	Ik word kwaad of verdrietig op mijn werk zonder goed te weten waarom.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT20	Op mijn werk kan ik te sterk emotioneel reageren, terwijl ik dat niet wou.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT21	Op mijn werk kan ik mijn aandacht moeilijk behouden.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT22	Tijdens mijn werk heb ik moeite om helder na te denken.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT23	Ik ben vergeetachtig en verstrooid tijdens mijn werk.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT24	Als ik aan het werk ben, kan ik me moeilijk concentreren.	@Nooit @Zelden @Soms	@Vaak @Altijd
BAT25	Ik maak fouten tijdens mijn werk omdat ik er met mijn hoofd niet goed bij ben.	@Nooit @Zelden @Soms	@Vaak @Altijd

D	**Uw algemene toestand van <u>de laatste week</u>**	

D0		
D1	Ik vond het moeilijk mezelf te kalmeren.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D2	Ik merkte dat mijn mond droog aanvoelde.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D3	Ik was niet in staat om ook maar enig positief gevoel te ervaren.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D4	Ik had moeite met ademhalen (bv.: overmatig snel ademen, buiten adem zijn zonder me in te spannen, ...).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D5	Ik vond het moeilijk om initiatief te nemen om iets te gaan doen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D6	Ik had de neiging om overdreven te reageren op situaties.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D7	Ik merkte dat ik beefde (bv.: met de handen).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D8	Ik was erg opgefokt.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing

D9	Ik maakte me zorgen over situaties waarin ik in paniek zou raken en mezelf belachelijk zou maken.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D10	Ik had het gevoel dat ik niets had om naar uit te kijken.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D11	Ik merkte dat ik erg onrustig was.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D12	Ik vond het moeilijk me te ontspannen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D13	Ik voelde me somber en zwaarmoedig.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D14	Ik had geen geduld met dingen die me hinderden bij iets dat ik wilde doen.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D15	Ik had het gevoel dat ik bijna in paniek raakte.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D16	Ik was niet in staat om over iets enthousiast te worden.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing
D17	Ik had het gevoel dat ik als persoon niet veel voorstel.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing

		@ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D18	Ik merkte dat ik nogal lichtgeraakt was.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D19	Ik was me bewust van mijn hartslag terwijl ik me niet fysiek inspande (bv.: het gevoel van een versnelde of overslaande hartslag).	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D20	Ik was angstig zonder enige reden.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
D21	Ik had het gevoel dat mijn leven geen zin had.	@Helemaal niet of nooit van toepassing @ Een beetje of soms van toepassing @ Behoorlijk of vaak van toepassing @Zeer zeker of meestal van toepassing	
DCONSIGNE	**Tevredenheidsvragenlijst**		
DCONSIGNE2			
DCOM	**Omgeving**		
DMOD	@Helemaal niet tevreden@Niet tevreden@Tevreden@Helemaal tevreden@Niet van toepassing		
D1	Nabijheid van de plaats(en) waar begeleiding gegeven werd	1~Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@ Helemaal tevreden 5@ Niet van toepassing
D2	De toegankelijkheid van de plaats(en) waar begeleiding gegeven werd	1~Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@ Helemaal tevreden 5@ Niet van toepassing
D3	Aangepaste lokalen voor begeleiding	1~Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@ Helemaal tevreden 5@ Niet van toepassing
D4	Waar heb je de FA-BOTP bijgewoond?	1@Nabij uw huis	

		2@Nabij uw werkplek 3@Halfweg	
D5	Wanneer heb je de FA-BOTP gedaan?	1@Tijdens werktijd 2@Buiten werktijd 3@Tijdens werktijd en buiten werktijd	
D6	Heeft u online consulten gehad? Heeft u online consulten gehad?	1@Ja, een of twee keer 2@Ja, verschillende keren 3@Nee	
ECOM1	**Uw tevredenheid in verband met uw begeleider(s)**		
E1	Hoe beoordeelt u uw tevredenheid over uw burn-out begeleider(s)?		
EMOD1	@Helemaal niet tevreden@Niet tevreden@Tevreden@Helemaal tevreden@Niet van toepassing		
E12	Het gemak van het maken van afspraken met deze begeleider	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
E13	De flexibiliteit in beschikbare uren van deze begeleider	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
E14	De stiptheid van deze begeleider	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
E15	De coördinatie van uw begeleidingstraject door deze begeleider	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
E16	Uw tevredenheid van de sessies bij deze begeleider	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
FCOM	**Uw tevredenheid met betrekking tot de inhoud van uw begeleidingstraject**		
FMOD	@Helemaal niet tevreden@Niet tevreden@Tevreden@Helemaal tevreden@Niet van toepassing		
F2	De variatie van sessies in het begeleidingstraject	1@Helemaal niet tevreden 2@Niet tevreden	4@Helemaal tevreden 5@Niet van toepassing

		3@Tevreden	
F3	De mate van persoonlijke aanpassing van uw begeleidingstraject	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
F4	De duur van uw begeleidingstraject	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
F5	De uitleg van de burn-outbegeleider tijdens uw begeleidingstraject	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
F6	De uitleg van het onderzoeksteam van de ULiège tijdens uw begeleidingstraject	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
F7	Begeleiding door professionals uit verschillende disciplines	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
F8	De dynamiek van het gesprek met de arbeidsarts	1@Helemaal niet tevreden 2@Niet tevreden 3@Tevreden	4@Helemaal tevreden 5@Niet van toepassing
GCOM1	**Uw tevredenheid over de zorgsessies**		
G1	Was u tevreden over het aantal sessies?	1@Ja 2@Nee	
G2	Had je meer werk kliniek sessies gewild?	1@Ja 2@Nee	
G21	Hoeveel?		
G22	Om welke reden(en)?		
G3	Had u graag meer starter kit sessies gehad?	1@Ja 2@Nee	
G31	Hoeveel?		
G32	Om welke reden(en)?		
G4	Had u graag meer individuele sessies gehad?	1@Ja 2@Nee	
G41	Hoeveel?		

G42	Om welke reden(en)?		
G5	Had u meer follow-up en/of heroriëntatiesessies gewild?	1@Ja 2@Nee	
G51	Hoeveel?		
G52	Om welke reden(en)?		
HCOM	**Anonimiteit en vertrouwelijkheid**		
H1	Hebt u het gevoel dat de vertrouwelijkheid tijdens de FA-BOTP is gehandhaafd?	1@Ja 2@Nee	
H11	Zo niet, waarom vindt u dat de vertrouwelijkheid niet is gehandhaafd?		
H2	Moest u, afgezien van het gesprek met de bedrijfsarts, de anonimiteit opheffen tijdens de FA-BOTP?	1@Ja 2@Nee	
H21	Zo ja, om welke reden(en) moest u uw anonimiteit opheffen?		
ICOM	**Algemene beoordeling**		
I1	Uw algemene beoordeling van het begeleidingstraject (1 = Helemaal niet tevreden tot 10 = Helemaal tevreden)	10@0@1@5@Volledig tevreden @Helemaal niet tevreden@1	
I2	Raadt u het begeleidingstraject FA-BOTP aan andere mensen aan?	1@Ja 2@Nee	
I3	Gaat u verder met de begeleiding bij uw burn-outbegeleider?	1@Ja 2@Nee	
I31	Gaat u verder met de begeleiding bij uw individuele begeleider(s)?	1@Ja 2@Nee	
JREM	U kan uw opmerkingen over uw begeleidingstraject in het tekstvlak hieronder neerschrijven:		
KCONSIGNE	**Uw perceptie van uw huidige situatie.**		
KCONSIGNE2			
K1	Op het niveau van de organisatie van uw werk *Sinds de start van uw begeleidingstraject:*		
K10	@Helemaal niet akkoord@Niet akkoord@Akkoord@Helemaal akkoord @Niet van toepassing		

K11	Uw organisatie is zich op een meer collectief niveau bewust geworden van het probleem	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K12	De managementstijl is veranderd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K13	De organisatie doet meer voor het welzijn van zijn werknemers	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K21	Uw relatie met uw leidinggevende(n) is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K22	Uw relatie met uw collega's is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K23	U heeft meer materiële ondersteuning gekregen op het werk	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K3	**Op het niveau van uw relatie met uw werk** ***Sinds de start van uw begeleidingstraject:***		
K30	@Helemaal niet akkoord@Niet akkoord@Akkoord@Helemaal akkord @Niet van toepassing		
K31	U ziet meer positieve aspecten in uw werk	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K32	U heeft meer afstand kunnen nemen van uw werk	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K33	Uw verwachtingen lijken realistischer	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K4	**Op individueel niveau** ***Sinds de start van uw begeleidingstraject:***		

K40	@Helemaal niet akkoord@Niet akkoord@Akkoord@Helemaal akkord @Niet van toepassing		
K41	Uw welzijn is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K412	Uw welzijn op het werk is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K42	U kan uw taken op het werk met meer gemak uitvoeren	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K43	Uw slaap is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K44	Uw levenskwaliteit is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
K45	Uw balans tussen werk en privéleven is verbeterd	1@Helemaal niet akkoord 2@Niet akkoord 3@Akkoord	4@Helemaal akkord 5@Niet van toepassing
U	**Gebruik van gezondheidszorg <u>sinds de start van uw begeleidingstraject</u>:**		
U1	**A. Consultatie bij de huisarts**		
U11	Heeft u uw huisarts geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** sinds de start van uw begeleidingstraject?	1@Ja 2@Nee	
U12	Hoe vaak heeft u uw huisarts geconsulteerd?	1@2@3@4@5@6@7@8@9@10 of meer	
U13	Reden(en) van deze consultatie(s):		
U2	**B. Consultatie bij de arbeidsarts**		
U21	Heeft u uw arbeidsarts geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** sinds de start van uw begeleidingstraject?	1@Ja 2@Nee	
U211	Hoe vaak heeft u uw arbeidsarts geconsulteerd?	1@2@3@4@5@6@7@8@9@10 of meer	
U212	Reden(en) van deze consultatie(s):		

U3	**C. Consultatie bij een psycholoog of psychiater**	
U31	Heeft u buiten het traject FA-BOTP uw psycholoog of psychiater geconsulteerd omwille van **werkgerelateerde gezondheidsproblemen** sinds de start van uw begeleidingstraject?	1@Ja 2@Nee
U311	Hoe vaak heeft u uw psycholoog of psychiater geconsulteerd?	1@2@3@4@5@6@7@8@9@10 of meer
U312	Reden(en) van deze consultatie(s):	
U5	**E. Geneesmiddelen**	
U50	Heeft u medicatie genomen omwille van **werkgerelateerde gezondheidsproblemen** sinds de start van uw begeleidingstraject?	1@Ja 2@Nee
U51	Welke soort medicatie heeft u genomen voor uw **werkgerelateerde gezondheidsproblemen**?	@Kalmeermiddelen @Antidepressiva @Pijnstillers @Slaapmiddelen @ Medicatie voor hart- en vaatziekten @Medicatie voor maagklachten @Ontstekingsremmers @Andere...
U52	Sinds de start van uw begeleidingstraject is uw medicatiegebruik:	1@Verminderd 2@Hetzelfde gebleven 3@Vermeerderd

Annex C: Diagnostic report

RAPPORT DE DIAGNOSTIC - BURN-OUT

Numéro de dossier : _____

Nombre de séances: ☐ 1 ☐ 2

Date(s) des séances: / / et / /

I. DÉPISTAGE

1. Eléments déclencheurs ou précipitants
   Etablissez la chronologie afin de déterminer les éléments/évènements /tâches critiques du travail qui ont généré chez le travailleur un risque avéré de burn-out.

2. Antécédents psychologiques
   Le travailleur a-t-il déjà été confronté à des difficultés ou à des troubles psychologiques ? Précisez.

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3. Diagnostic différentiel
   Précisez en fonction de votre évaluation clinique et psychométrique les éléments vous permettant d'exclure d'autres pathologies présentant des symptômes proches du burn-out.

4. Symptomatologie
   Décrivez les troubles physiques, cognitifs et affectifs, ainsi que les troubles du comportement résultant du burn-out. Situez dans le temps l'apparition de ces symptômes.

5. Etiologie
   Expliquez les causes de la symptomatologie que vous venez de détailler et décrivez les:
   - facteurs professionnels *qui permettent une analyse de la situation de travail*
   - facteurs de risque *qui favorisent ou aggravent un burn-out*
   - facteurs protecteurs *qui permettent d'amortir l'intensité du burn-out*

6. Traitement médicamenteux ou autre
   Y-a-t-il eu recours à un traitement ? Si oui lequel ? Depuis quand?

II. CONCLUSION

Est-ce que les symptômes observés sont en relation avec le travail? ☐ Oui ☐ Non

Est-ce que les symptômes observés sont en relation avec :

☐ stress post-traumatique ☐ violence ☐ harcèlement ☐ conflit/hyperconflit
☐ autres

Est-ce qu'un diagnostic de burn-out peut être envisagé ? ☐ Oui ☐ Non

Si oui : - précisez le stade : ☐ Stade 1 ☐ Stade 2 ☐ Stade 3

- **précisez votre hypothèse de processus :**

☐ Le burn-out est le trouble principal à l'origine de la symptomatologie observée.

☐ Le burn-out est à l'origine d'un (ou de plusieurs) autre(s) trouble(s) psychologique(s).

☐ Le burn-out est la conséquence de difficultés et/ou d'un (ou de plusieurs) trouble(s) antérieur(s).

Le trajet d'accompagnement FA-BOTP est-il toujours adapté à la situation du travailleur ? ☐ **Oui** ☐ **Non**

Si oui, précisez en quoi :

Dans le cas où le trajet de prise en charge FA-BOTP n'est pas adapté, vers qui avez-vous réorienté le travailleur ?

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Rapport complété par (nom et fonction) :

……

Date et signature ……/……/……

DEMANDE DE PRISE EN CHARGE

Numéro de dossier : _____

III. COORDONNÉES DE L'INTERVENANT BURNOUT

NOM :

PRÉNOM :

IV. AVIS DE L'INTERVENANT BURNOUT

7. Dépistage

Burnout en relation avec le travail ? ☐ Oui ☐ Non

Le travailleur est-il à un stade précoce de burnout ? ☐ Oui ☐ Non

Quel est le stade du burnout ? ☐ 1-2 (prévention secondaire) ☐ 3-4 (prévention tertiaire)

Le trajet de prise en charge FA-BOTP est-il adapté au burnout du travailleur ?

☐ Oui ☐ Non

8. En cas de diagnostic de burn-out confirmé, le demandeur confirme-t-il sa demande de participer à la prise en charge ?

☐ Oui ☐ Non

Si non, pourquoi ?

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Rapport complété par (nom et fonction intervenant) :

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Date et signature ...../...../.....

Rapport complété par (travailleur) :

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Date et signature ...../...../.....

DIAGNOSEVERSLAG – BURN-OUT

Dossiernummer:

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Aantal sessies: ☐ 1 ☐ 2

Datum van de sessies: / / en / /

DIAGNOSE

9. Uitlokkende of bevorderende elementen
   Stel de chronologische volgorde vast van de elementen/gebeurtenissen/kritieke factoren die een verhoogd risico op burn-out teweeg gebracht hebben bij de werknemer.

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10. Psychologische voorgeschiedenis
Werd de werknemer in het verleden reeds geconfronteerd met psychologische moeilijkheden? Specifieer.

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11. Differentiële diagnose
Specifieer, op basis van uw klinische evaluatie en psychometrische testen, de elementen die u in staat stellen om andere pathologieën uit te sluiten die vergelijkbare symptomen vertonen met burn-out.

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12. Symptomatologie
Beschrijf de lichamelijke, cognitieve, affectieve en gedragsmatige symptomen die voortvloeien uit burn-out.
Situeer de verschijning van deze symptomen in de tijd.

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13. Etiologie

Beschrijf de oorzaken van bovengenoemde symptomen en beschrijf de:

- beroepsfactoren *die een analyse van de werksituatie mogelijk maken*
- risico factoren *die een burn-out kunnen bevorderen of verergeren*
- beschermende factoren *die kunnen bijdragen tot een verlichting van de burn-out*

14. Medicatie of ander type behandeling

Heeft de werknemer een behandeling gevolgd? Zo ja, welke? Sinds wanneer?

CONCLUSIE

Zijn de geobserveerde symptomen werkgerelateerd? ☐ Ja ☐ Nee

Vertonen de geobserveerde symptomen een relatie met:

☐ post-traumatische stress ☐ geweld ☐ pesterijen ☐ conflict/hyperconflict
☐ andere

Kan er gesproken worden van de diagnose burn-out? ☐ Ja ☐ Nee

Indien ja: - specificeer het stadium: ☐ Stadium 1 ☐ Stadium 2 ☐ Stadium 3

- specificeer uw hypothese van het proces:

☐ De burn-out is de voornaamste aandoening die aan de oorsprong van de geobserveerde symptomatologie ligt.

☐ De burn-out ligt aan de oorsprong van één of meerdere psychologische problemen.

☐ De burn-out is het gevolg van andere moeilijkheden en/of achterliggende psychologische problemen.

Past de situatie van de werknemer binnen de scope van het pilootproject burn-out? ☐ Ja ☐ Nee

Indien ja, op welke manier is het begeleidingstraject FA-BOTP angepast aan de situatie van de werknemer?

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Naar wie heeft u de werknemer doorverwezen indien het begeleidingstraject FA-BOTP niet aangepast is?

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Verslag ingevuld door (naam en functie):

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Datum en handtekening ……/……/……

VERZOEK VOOR BEHANDELING

Dossiernummer:_____

V. CONTACTGEGEVENS VAN DE BURN-OUT BEGELEIDER

NAAM :

VOORNAAM :

VI. ADVIES VAN DE BURN-OUT BEGELEIDER

15. Screening

Werkgerelateerde burn-out? ☐ Ja ☐ Nee

Is de werknemer in een vroeg stadium van burnout? ☐ Ja ☐ Nee

Wat is het burn-out stadium? ☐ 1-2 (secundaire preventie) ☐ 3-4 (tertiaire preventie)

Is het FA-BOTP begeleidingstraject aangepast aan burn-out? ?

☐ Ja ☐ Nee

16. Bevestigt de eiser in het geval van een bevestigde diagnose van burn-out zijn/haar verzoek om deel te nemen aan de begeleidingstraject?

☐ Ja ☐ Nee

Zo nee, waarom niet?

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Rapport ingevuld door (naam en functie van de begeleider):

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Datum en handtekening ……/……/……

Rapport ingevuld door (werknemer):

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Datum en handtekening ……/……/……

Annex D: Final report

CONFIDENTIEL - RAPPORT FINAL DE PRISE EN CHARGE – FA-BOTP

Numéro de dossier :

_____

VII. DESCRIPTION DU TRAJET DE PRISE EN CHARGE

a. Coordination du trajet

Comment avez-vous composé le trajet d'accompagnement ? Quelles interactions avec les partenaires de soins ont eu lieu ? Comment avez-vous suivi le travailleur durant son trajet ? Comment vous êtes-vous coordonné avec les autres intervenants durant le trajet ?

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b. Feedback des séances

- *Séance(s) clinique du stress et du travail :* ☐ *Séance(s) individuelle(s)* ☐ *Séance(s) en groupe*

Décrivez les séances, les thèmes abordés, les techniques et outils utilisés, abordez également l'utilité ou non de l'organisation d'une réunion multidisciplinaire et, le cas échéant, sa préparation avec le travailleur.

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- *Séance(s) du starterkit:* ☐ *Séance(s) individuelle(s)* ☐ *Séance(s) en groupe*

Décrivez le déroulement des séances, les besoins du travailleur en psychoéducation et les outils utilisés.

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- *Séance(s) individuelle(s):* ☐ *Séance(s) individuelle(s)* ☐ *Séance(s) en groupe*

Précisez le profil de l'intervenant (psychologue clinicien et/ou kinésithérapeute). Décrivez les approches et/ou les outils utilisés, et les thèmes abordés.

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c. Déroulement du trajet

- Le trajet d'accompagnement du travailleur a été : ☐ Complet ☐ Interrompu

Raison(s) d'interruption :

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- Fréquence des séances réalisées par l'intervenant burn-out :
  ☐ plusieurs fois par semaines ☐ toutes les semaines ☐ toutes les deux semaines
  ☐ autre, précisez : .....

VIII. SITUATION PROFESSIONNELLE

Le travailleur a-t-il changé d'emploi ou de poste : ☐ Oui ☐ Non
☐ Autre ……..

Le travailleur a-t-il changé de secteur d'activité : ☐ Oui ☐ Non

a. *Réunion avec le médecin du travail* :☐ Oui, ……(date) ☐ Non

Décrivez la préparation de cette réunion et les éléments dont vous avez eu connaissance : *le travailleur était-il demandeur ? quelle était la raison principale de cette rencontre* ? (résolution de conflits, adaptation des fonctions, manque de soutien, implémentation de solutions, …) *? Le travailleur a-t-il pu aborder ce qu'il voulait ? Quels partenaires ont été sollicités lors de la préparation de cette réunion ? Des changements ont-ils pu être observés suite à la réunion ? Si oui, lesquels ? Si non, pourquoi ?*

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b. Séances de réorientation professionnelle *(si pertinent):*

- Quelles sont les raisons qui vous ont amené à proposer ces sessions au travailleur ?
  ☐ En vue d'un changement d'organisation
  ☐ En vue d'un changement de profession

☐ En vue d'un changement de poste

☐ En raison de doutes vis-à-vis du travail actuellement exercé

Raison(s) de choix :

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- Décrivez les dispositifs mis en place :

Comment le travailleur est-il accompagné dans la démarche de réorientation professionnelle ?

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IX. EVOLUTION DU TRAVAILLEUR SUR LE LIEU DE TRAVAIL ET DIAGNOSTIC

a. Des actions ont-elles été mises en place sur le lieu de travail pour améliorer la situation du travailleur suite au trajet d'accompagnement (avec ou sans tenue de la réunion avec le médecin du travail) ?

☐ Oui ☐ Non

Précisez :

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b. Fonctionnement du travailleur

Un changement du fonctionnement du travailleur sur le lieu de travail est-il rapporté ? ☐ Oui ☐ Non

Précisez :

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c. Diagnostic

- Est-ce qu'à l'heure actuelle, en disposant des éléments cliniques dont vous avez eu connaissance durant les séances avec le travailleur, vous confirmez votre diagnostic initial ?

☐ Oui ☐ Non

- Veuillez cocher les éléments qui vous auraient été plus adaptés au diagnostic initial:

Un burn-out ☐ de stade précoce (1 ou 2)
☐ de stade avancé (stade 3)
☐ avec un lien prépondérant au travail

☐ Pas un burn-out (autre problématique)

Justifiez le fait d'avoir cocher ou non les propositions :

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- Les informations complémentaires dont vous avez eu connaissance tout au long du trajet vous permettent aujourd'hui de revoir l'hypothèse initiale posée lors de la phase de dépistage (si pertinent) :

  ☐ Oui ☐ Non

  Hypothèse revue (si pertinent) :

  ☐ Le burn-out est le trouble principal à l'origine de la symptomatologie observée.
  ☐ Le burn-out est à l'origine d'un (ou de plusieurs) autre(s) trouble(s) psychologique(s).
  ☐ Le burn-out est la conséquence de difficultés et/ou d'un (ou de plusieurs) trouble(s) antérieur(s).

- Un diagnostic de burn-out est toujours actuellement présent ? ☐ Oui ☐ Non
  - Si oui, précisez le stade : ☐ Stade 1 ☐ Stade 2 ☐ Stade 3
  - La symptomatologie s'est améliorée : ☐ Oui ☐ Non

- D'autres difficultés psychologiques sont-elles apparues ? ☐ Oui ☐ Non

Précisez :

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X. CONCLUSION

a. Si vous avez à nouveau confirmé le diagnostic de burn-out précoce lié au travail, et dans le cadre d'un trajet de prévention, est-ce que le trajet d'accompagnement était adapté pour le travailleur ?

☐ Oui ☐ Non

Précisez en quoi et si le type et le nombre de séances étaient adaptés.

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b. La poursuite d'un suivi est envisagée avec un intervenant conventionné par l'équipe de recherche ULiège :

☐ Oui, avec un(e) (*préciser la fonction*) …… ☐ Non

c. Le travailleur a été orienté vers un autre professionnel :
☐ Oui, vers un(e) (*préciser la fonction*)…… ☐ Non

Rapport rédigé par l'intervenant burn-out : _____ (nom)

Date et Signature:

CONFIDENTIEL – DATES DE SÉANCES DU TRAJET D'ACCOMPAGNEMENT – BURN-OUT

Numéro de dossier : _____

XI. DATES DES SÉANCES (MAXIMUM 12)

	Intervenant (nom + coordonnées)	*Dates des séances effectives*	*Dates des séances annulées (si pertinent)*
Séance(s) de diagnostic			
Séance(s) clinique du stress et du travail			
Starterkit			
Séance(s) individuelle(s)			
Séance(s) de suivi et/ou de réorientation			

VERTROUWELIJK – EINDVERSLAG BEGELEIDINGSTRAJECT – FA-BOTP

Dossiernummer :

_____

XII. BESCHRIJVING VAN HET BEGELEIDINGSTRAJECT

d. Coördinatie van het traject

Hoe heeft u het traject van de werknemer samengesteld? Welke interacties heeft u gehad met zorgpartners? Hoe heeft u het hele traject van de werknemer opgevolgd? Hoe heeft u samengewerkt met de andere begeleiders van het traject?

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e. Feedback over de sessies

- *Voor de sessies werkkliniek:* ☐ *Individuele sessie(s)* ☐ *Groepssessie(s)*

Beschrijf de sessies, de besproken thema's, de gebruikte technieken en gebruikte tools. Beschrijf alsook het nut van het al dan niet organiseren van een vergadering met de arbeidsarts, indien van toepassing, de voorbereiding met de werknemer.

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- *Voor de sessies starterkit:* ☐ *Individuele sessie(s)* ☐ *Groepssessie(s)*

Beschrijf het verloop van de sessies, de behoeften van de werknemer inzake psycho-educatie en de gebruikte tools.

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- *Voor de individuele sessies:* ☐ *Individuele sessie(s)* ☐ *Groepssessie(s)*

Verduidelijk het profiel van de begeleider (klinisch psycholoog en/of kinesitherapeut). Beschrijf de benadering(en) en/of gebruikte tools, en de besproken thema's.

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f. Verloop van het traject

- Het begeleidingstraject van de werknemer was: ☐ Compleet ☐ Onderbroken

Reden(en) voor de onderbreking(en):

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- Frequentie van de sessies uitgevoerd door de burn-outbegeleider:
  - ☐ meerdere malen per week ☐ elke week ☐ elke twee weken
  - ☐ andere, specificeer : .....

XIII. PROFESSIONELE SITUATIE

Is de werknemer van functie of dienst veranderd: ☐ Ja ☐ Nee
☐ Andere .....

Is de werknemer van sector veranderd: ☐ Ja ☐ Nee

a. Vergadering met de arbeidsarts: ☐ Ja, ...(datum) ☐ Nee

Beschrijf de voorbereiding van deze vergadering en de elementen waarvan u op de hoogte werd gebracht: was de werknemer de vragende partij voor deze vergadering? Wat was de belangrijkste reden voor deze bijeenkomst? (oplossen van conflicten, aanpassing van functie, gebrek aan steun, implementatie van oplossingen,…)? Heeft de werknemer kunnen bespreken wat hij wou? Welke partners heeft u gecontacteerd voor de voorbereiding van deze vergadering? Zijn er veranderingen waargenomen na de vergadering? Zo ja, dewelke? Zo nee, waarom?

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b. Loopbaanheroriëntatie sessies *(indien van toepassing):*

- Wat waren de redenen om deze sessies voor te stellen aan de werknemer?
  - ☐ Met het oog op een verandering van werkgever
  - ☐ Met het oog op een verandering van beroep
  - ☐ Met het oog op een verandering van functie
  - ☐ Wegens twijfels over het werk dat de werknemer momenteel uitvoert

Reden(en) voor de keuze(s):

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- Beschrijf de genomen maatregelen:

Hoe wordt de werknemer begeleid in het kader van een loopbaanheroriëntatie?

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XIV. EVOLUTIE VAN DE WERKNEMER OP DE WERKPLAATS EN DIAGNOSTIEK

d. Werden er op de werkplek maatregelen genomen om de situatie van de werknemer na het ondersteuningstraject te verbeteren (met of zonder overleg met de arbeidsarts)?

☐ **Ja** ☐ **Nee**

Specificeer :

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e. Functioneren van de werknemer

Wordt een verandering in het functioneren van de werknemer op de werkplek gerapporteerd? ☐ Ja ☐ Nee

Specificeer:

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f. Diagnostiek

- Bevestigt u op dit moment, op basis van de klinische elementen waarvan u kennis genomen heeft tijdens alle sessies met de werknemer, de diagnose die u stelde aan het begin van het begeleidingstraject?

  ☐ Ja ☐ Nee

- Duid de elementen aan die met de huidige kennis geschikter blijken te zijn in de initiële diagnose :

  Een burn-out ☐ vroegtijdig stadium (1 of 2)
  ☐ gevorderd stadium (3)
  ☐ hoofdzakelijk werkgerelateerd

☐ geen burn-out (andere problematiek)

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Motiveer waarom u al dan niet de bovenstaande suggesties aanduidde:

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- De complementaire informatie die u verzameld heeft tijdens het gehele begeleidingstraject staat u toe om uw initiële hypothese tijdens de diagnosefase te herzien (indien van toepassing):
  ☐ Ja ☐ Nee

Nieuwe hypothese (indien van toepassing) :

- ☐ De burn-out is de voornaamste aandoening die aan de oorsprong van de geobserveerde symptomatologie ligt.
  ☐ De burn-out ligt aan de oorsprong van één of meerdere psychologische problemen.
  ☐ De burn-out is het gevolg van andere moeilijkheden en/of achterliggende psychologische problemen.

- Is de diagnose van een burn-out op dit moment nog steeds aanwezig? ☐ Ja ☐ Nee
  - Zo ja, specificeer het stadium: ☐ Stadium 1 ☐ Stadium 2 ☐ Stadium 3
  - De symptomatologie is verbeterd: ☐ Ja ☐ Nee

- Zijn er andere psychologische problemen aan het licht gekomen? ☐ Ja ☐ Nee

Specificeer:

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XV. CONCLUSIE

a. Was het begeleidingstraject aangepast aan de situatie van de werknemer indien u de diagnose van een vroegtijdig stadium van een werkgerelateerde burn-out opnieuw heeft kunnen bevestigen?

☐ Ja ☐ Nee

Specificeer of het type en aantal sessies geschikt zijn en waarom:

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b. Een verderzetting van begeleiding door een begeleider van het onderzoeksteam van ULiège wordt overwogen na dit project:

☐ Ja, met de (specificeer de functie) ..... ☐ Nee

c. De werknemer is doorverwezen naar een andere professional:

☐ Ja, naar een (specificeer de functie)..... ☐ Nee

Verslag geschreven door de burn-outbegeleider: _____ (naam)

Datum en handtekening:

VERTROUWELIJK - DATA VAN DE SESSIES VAN DE BEHANDELING - BURN-OUT

Dossiernummer: _____

XVI. DATA VAN DE SESSIES (MAXIMAAL 12)

	Begeleider (naam + gegevens)	*Data van de effectieve sessies*	*Data van de geannuleerde sessies*
Diagnosesessies			
Work and stress clinic sessies			
Starterkit			
Individuele sessies			

Opvolgsessies en/of Loopbaanheroriëntatie sessies			

Annex E: DELPHI-Tour 1

As part of the research project REturn to work after BurnOut (Re-Born) funded by Belspo and supervised by Prof. I. Hansez of the University of Liège and Professors E. Derous and L. Braeckman of the University of Ghent, we had the opportunity to test a burnout treatment program, the Federal Agencies Burnout Treatment Program (FA-BOTP), with federal agents in the early stages of burnout.

109 agents expressed an interest in the FA-BOTP. Of these 109 agents, 54 met the inclusion criteria. 44 participants then completed the pre-test. 29 participants took part in the obligatory diagnostic sessions to confirm burnout with a health professional and 23 participants met the criteria. 23 end-of-treatment reports were received, and 14 participants responded to the post-test at the end of the treatment.

The results below relate to the 14 participants who completed the post-test at the end of their traject.
The FA-BOTP showed effectiveness in reducing burnout, depression, and stress, but no significant change in anxiety. It improved general well-being, work well-being, quality of life, and work-life balance, with a tendency for better sleep.

Although almost 60% of workers were absent during the program, all returned to work, and 80% remained in the same organization. Participants developed more realistic work expectations and learned to distance themselves from work. Work organization results were less conclusive, especially regarding collective awareness, managerial changes, and improved relations with supervisors.

Around 30% benefited from organizational changes, while 40% initiated their own adjustments, such as improving work-life separation.

Anonymity and confidentiality were respected, with participants expressing satisfaction with the program's logistical aspects, sessions, and content.

They rated the program slightly above 8/10 and would recommend it.

The results below relate to the 23 involved in the FA-BOTP and are based on reports submitted by healthcare professionals.
Regarding session attendance, the average was 8.87 out of a maximum of 12. Work clinic, starter kit, and follow-up sessions were the most attended. In half the cases, burnout diagnosis remained, but symptoms generally improved, and burnout severity was reduced.It's important to note that the sample size is small, so these findings should be taken with caution.

Based on these results, preliminary recommendations have been formulated and will be presented to you for your feedback. These recommendations are organized into 4 categories:

1. The FA-BOTP inclusion process: this category covers the various elements of the participant recruitment process, as well as the inclusion criteria. 2. FA-BOTP content: this category refers to the sessions and number of sessions included in the FA-BOTP. 3. Organizational approach in the FA-BOTP: this category refers to the involvement of the organization. 4. Consultation logistics: this category covers the practical aspects of setting up the FA-BOTP. You will review each proposed recommendation. For each one, you will note whether you agree or disagree with these proposals on a scale from 1 to 5, 1 being "Completely disagree" and 5 being "Completely agree". After rating, provide justification for your rating and, if applicable, suggest any improvements or additional comments. This process will help us refine the recommendations and improve the burnout treatment and prevention approach.You will also have the opportunity to give your opinion or make additional proposals. The questionnaire is in English. Answers are expected in your native language, French or Dutch.	
1. Inclusion procedure in the FA-BOTP	
1.1. Improvement of Communication Channels To communicate about the project, information was disseminated via a number of channels: the human resources department in each federal institution, the intranet used by the federal public services, the various networks of well-being actors present in the organisation, as well as via the research team, thanks to contacts established beforehand. *Finding:* Human Resources department in each public institution was the main channel used to communicate information about FA-BOTP. Other sources, such as the research team, the intranet, the psychosocial prevention adviser, and information about the FA-BOTP from colleagues, also played a role. However, some channels such as confidential advisor, superior, trade union as well as the different well-being networks present in the Federal agencies were never mobilized	
Recommendation 1: Raise awareness among the various well-being networks presents in the Federal agencies to improve information flow about FA-BOTP and other well-being initiatives.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Recommendation 2: Develop a communication plan that outlines clear roles and responsibilities for each actor in the communication process. This should also include targeted communication strategies for different groups (e.g., management, employees, HR, well-being actors) to ensure the right information reaches the right people.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:

Recommendation 3: Consider using digital tools already existing in the federal agencies to centralize information about the FA-BOTP (how to access it, content,...)	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
1.2. Optimizing the Inclusion Procedure *Finding*: To ensure the autonomy and anonymity of participants, the screening form was self-completed rather than being filled out with healthcare professionals. For your information, a copy of the screening form was included in the e-mail containing the link to this questionnaire. However, this approach led to several issues: • The origin of the complaint was not always clear (e.g., whether it stemmed from personal life, work-related stress, or both). • The symptoms described were often incomplete or vague, making it difficult to determine whether the participant was experiencing burnout or another condition. • The work context was not always sufficiently detailed, preventing a proper understanding of the participant's professional situation and challenges. As a result, the inclusion process was less effective, as the lack of clarity made it harder to assess the suitability of participants for the program.	
Recommendation 1: Improve the precision and structure of the screening form by: • Adding clear and structured questions to differentiate between personal and work-related complaints. • Including more detailed symptom descriptions (e.g., checkboxes for common burnout symptoms, severity scale, duration of symptoms). • Incorporating specific questions about the work environment (e.g., job role, workload, relationships with colleagues and management, recent changes at work). • Providing brief examples or explanations to guide participants in filling out the form more accurately.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
	Other points to be added:
Recommendation 2: Optimize the inclusion procedure by ensuring that the screening form is completed with a healthcare professional during an initial consultation with the participant.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
1.3. Inclusion procedure of relapsing workers in the FA-BOTP	

Finding: Of the 109 applications, 20 (18.3%) were from workers who had relapsed into burnout. Although relapsing workers were not included due to the experimental nature of the project, the question of their inclusion arises in the event of a future implementation of FA-BOTP within the federal public services.	
Recommendation 1: Open up the FA-BOTP to workers who have relapsed.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Consider creating sensibilization sessions tailored to relapsing workers, to address the factors that led to the burnout and then the relapse, talk about the evolution of the work situation, discuss their first experience of work resumption, etc.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
1.4. Encouraging contact for diagnostic sessions *Finding*: Several participants did not contact a burnout consultant to start the diagnostic sessions after receiving authorization.	
Recommendation 1: Consider automated reminders to encourage participants to continue the program.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Provide a dedicated support person (e.g. a case manager or program coordinator) to encourage participants to contact the burnout consultant for diagnostic sessions. This would help overcome barriers to FA-BOTP participation, such as scheduling or logistical issues.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Do you have any additional comments or suggestions about **the inclusion procedure**?	
2. Content of the FA-BOTP	
2.1. Number of sessions Participants could attend a maximum of 12 sessions in total, to be chosen with the burnout consultant from the following sessions:	What do you think of the number of sessions?

• A minimum of 1 and a maximum of 2 diagnostic sessions; • A maximum of 4 work clinic sessions; • A maximum of 4 individual sessions; • A maximum of 2 reorientation/follow-up sessions; • In addition, possibility of a consultation with the occupational physician. <u>2.2. Work clinic sessions</u> These sessions, conducted by a burnout consultant, aim to support workers by acknowledging their struggles, raising awareness of personal and professional limits, identifying resources, redefining work's meaning, and providing psychological and career guidance. A maximum of 4 work clinic sessions were scheduled. 87% of participants attended 3 or 4 sessions and the average number of sessions was 3.43. *Finding*: Several participants expressed the need for additional work clinic sessions.	What do you think of the type of sessions on offer?
Recommendation: Extend to 6 the availability of work clinic sessions.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
<u>2.3. Individual sessions</u> The individual sessions followed either the cognitive-emotional or psycho-corporeal approach. In the cognitive-emotional approach, conducted by an individual sessions consultant or a burnout consultant who are clinical psychologist, the worker could, for example, transform stressful thoughts into positive ones, or work on irrational work-related thoughts. In the psycho-corporal approach, conducted by an individual sessions consultant, who may be a physiotherapist or a clinical psychologist, the worker was guided through relaxation and movement therapies to release tension and enhance awareness. *Finding*: A maximum of 4 individual sessions were planned. Only 30.4% of participants attended 3 or 4 individual sessions and the average number of sessions was 1.39, making individual sessions the least used.	
Recommendation 1: Improve communication and awareness of the benefits of individual sessions by the health professional to encourage participation.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Improve communication and awareness of the benefits of individual sessions by the program manager to encourage participation.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree

	Justification:
Recommendation 3: Increase the number of available individual sessions to 6, as this type of support requires time to be effective.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
2.4. Consultation with the occupational physician Consultations with the occupational physician in order to consider adjustments to the work. *Finding*: Only a minority of participants had an official consultation with the occupational physician	
Recommendation 1: Improve communication from the health professional on the role of the occupational physician in terms of work adaptations.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: The health professional works with the participant to identify the most appropriate person to meet in order to adapt working conditions.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
2.5. Post-program follow-up sessions Two follow-up/reorientation sessions were included in the FA-BOTP. The aim of these sessions was to redirect the worker towards other career paths (job changes, organizational changes, etc.) if appropriate, or to review the progress of the FA-BOTP with the participant. *Finding*: Several participants expressed the wish to have follow-up sessions after the end of the FA-BOTP in order to be able to discuss their work situation with their health professional after the FA-BOTP has ended.	
Recommendation 1: Include two follow-up sessions (e.g. after three months and six months) to discuss the work situation (e.g. reintegration, adaptation, needs,…) after the program to help participants maintain long-term benefits.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Possibility to have an ongoing access to a support network (e.g., group discussions or online forums) at the end of the FA-BOTP.	1. @Completely disagree 2. @Disagree

	3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Do you have any additional comments or suggestions about **the content of the FA-BOTP**?	
3. Organizational approach in the FA-BOTP	
3.1. Raising awareness of psychosocial risks *Finding*: According to the screening form results, a number of psychosocial risks are reported: lack of recognition, lack of support from management, work overload, loss of meaning in work, time pressure, lack of fulfillment opportunity at work, organizational changes, and lack of definition of tasks.	
Recommendation 1: Improving communication and raising awareness of the psychosocial risks that are strongly reported within certain specific organizations, among managers, employees and well-being actors, in order to prevent the development of burnout.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Implement training sessions on stress management and burnout prevention that are mandatory for both managers and employees.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 3: Organizing communities of practice or reflective teams to define primary prevention solutions in a participative approach.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
3.2. Involvement of the organization in burnout prevention *Finding*: According to participants at the moment of the post-test, organizational actions such as collective awareness of the problem, changes in managerial style, increase in actions to promote well-being and improved relations with supervisors, were not sufficiently activated.	
Recommendation 1: Put in place a comprehensive policy for well-being at work, including a structured approach to preventing burnout. This should involve 1) monitoring and evaluating primary prevention actions, 2) adjusting work organization where	1. @Completely disagree 2. @Disagree

necessary and 3) ensuring regular monitoring to assess the effectiveness of these measures and make improvements where necessary.	3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Develop an organizational culture oriented towards work reintegration, covering preparation for the return to work as well as the necessary work adaptations.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 3: Encourage managers to be actively involved in identifying burnout risks within their teams and to take proactive measures (e.g., adjusting workloads or fostering a supportive work environment).	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 4: Leadership training on mental health management to enhance the organizational culture of support.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Do you have any additional comments or suggestions about **the organizational approach in the FA-BOTP**?	
4. Consultation logistics	
4.1. Extending program duration for flexibility The participant had 9 months to complete the FA-BOTP. *Finding*: Several participants took nine months or more to complete FA-BOTP, suggesting that the current duration may be insufficient for some individuals.	
Recommendation 1: Provide clear communication at the start of the program about the planned schedule via clear negotiation of time with the health professional.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Recommendation 2: Allow participants to choose longer or shorter timeline to suit their individual needs. This flexibility can help ensure that participants do not feel rushed and can truly benefit from each stage of the program.	1. @Completely disagree 2. @Disagree

	3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
4.2. Teleconsultation Several health professionals offered online consultations for greater flexibility. *Finding*: A majority of participants used teleconsultations, with no negative impact on their satisfaction with the FA-BOTP.	
Recommendation: Continue to allow participants to choose between teleconsultations and face-to-face sessions.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
4.3. Official recognition of consultation during working hours *Finding:* The majority of participants attended consultations during their working hours.	
Recommendation: Allow federal agents to attend FA-BOTP consultations during working hours to improve accessibility and communicate with them on this subject.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree
	Justification:
Do you have any additional comments or suggestions about **the consultation logistics**?	
5. General impression	
In general, what do you think of the FA-BOTP?	
Do you think the FA-BOTP is a good practice?	
What would you suggest/change to improve it?	
If you have any further comments, please leave them here:	

Annex F: DELPHI-Tour 2

In this questionnaire, you will find the recommendations for which a minimum level of agreement of 75% was not reached. Recommendations that received a level of agreement of 75% or more are not presented again here. However, all suggestions and comments made on these recommendations have been taken into account and will be incorporated into the final recommendations. For each recommendation presented, you will find the original version as well as the modifications and clarifications made as a result of the suggestions made in the first round. We ask you to rate each modified recommendation by indicating your level of agreement on a scale from 1 (strongly disagree) to 5 (strongly agree). You are also invited to justify your answer if you wish. If you don't wish to add a justification, you can simply indicate a bar (/) in the box provided. Your feedback is essential to refine and finalize these recommendations. Thank you for your participation!	
1. Inclusion procedure in the FA-BOTP	
1.1. Improvement of Communication Channels To communicate about the project, information was disseminated via a number of channels: the human resources department in each federal institution, the intranet used by the federal public services, the various networks of well-being actors present in the organisation, as well as via the research team, thanks to contacts established beforehand. *Finding:* Human Resources department in each public institution was the main channel used to communicate information about FA-BOTP. Other sources, such as the research team, the intranet, the psychosocial prevention adviser, and information about the FA-BOTP from colleagues, also played a role. However, some channels such as confidential advisor, superior, trade union as well as the different well-being networks present in the Federal agencies were never mobilized	
Original recommendation: Consider using digital tools (e.g., internal app) to centralize information and provide real-time updates. *Revised formulation*: Ensure that essential information is made easily accessible through appropriate digital channels already in use (e.g., intranet, dedicated websites, or platforms related to well-being), while also considering complementary formats (e.g well-being networks, management, HR,…) that are adapted to diverse work contexts and accessible to all staff, including those less connected to digital infrastructure.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
1.2. Optimizing the Inclusion Procedure *Finding*: To ensure the autonomy and anonymity of participants, the screening form was self-completed rather than being filled out with healthcare professionals. For your information, a copy of the screening form was included in the e-mail containing the link to this questionnaire. However, this approach led to several issues: • The origin of the complaint was not always clear (e.g., whether it stemmed from personal life, work-related stress, or both).	

• The symptoms described were often incomplete or vague, making it difficult to determine whether the participant was experiencing burnout or another condition. • The work context was not always sufficiently detailed, preventing a proper understanding of the participant's professional situation and challenges. As a result, the inclusion process was less effective, as the lack of clarity made it harder to assess the suitability of participants for the program.	
Original recommendation: Improve the precision and structure of the screening form by: • Adding clear and structured questions to differentiate between personal and work-related complaints. • Including more detailed symptom descriptions (e.g., checkboxes for common burnout symptoms, severity scale, duration of symptoms). • Incorporating specific questions about the work environment (e.g., job role, workload, relationships with colleagues and management, recent changes at work). • Providing brief examples or explanations to guide participants in filling out the form more accurately. *Revised formulation*: Adapt the screening form to improve clarity and accessibility by using structured, concise questions and visual elements (e.g., checkboxes, conditional logic) that help identify key symptoms and contextual factors without overwhelming the participant. Where possible, include simple examples and questions about the work environment. Ensure the form remains easy to complete, respects confidentiality, and clearly positions itself as a first step—not a diagnostic tool.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Original recommendation: Optimize the inclusion procedure by ensuring that the screening form is completed with a healthcare professional during an initial consultation with the participant. *Revised formulation*: Offer participants the option to complete the screening form with the support of a healthcare professional or qualified internal actor (e.g., occupational physician, counselor), especially if there are difficulties in understanding or completing the form. This support should aim to clarify questions and ensure better alignment between the participant's needs and the programme. If the form is completed independently and uncertainties arise, a follow-up consultation should be proposed. The process should remain accessible, flexible, and adapted to the participant's situation.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
<u>1.3. Inclusion procedure of workers in the FA-BOTP</u> *Finding*: Several participants did not contact a burnout consultant to start the diagnostic sessions after receiving authorization.	
Original recommendation: Consider automated reminders to encourage participants to continue the program.	1. @Completely disagree 2. @Disagree 3. @Neutral

Revised formulation: Provide participants with the option to receive one automated reminder, followed — if needed — by a single personalized follow-up from a professional subject to the obligation of professional secrecy. Participants will be informed of this process at the beginning of the program. If they prefer not to receive any personalized follow-up, they can opt out of this contact at any time. This two-step approach ensures autonomy while offering a gentle, supportive nudge for those who may benefit from encouragement. The communication should remain non-intrusive, confidential, and clearly state that participation is voluntary.	4. @Agree 5. @Completely agree Justification:
Original recommendation: Provide a dedicated support person (e.g. a case manager or program coordinator) to encourage participants to contact the burnout consultant for diagnostic sessions. This would help overcome barriers to FA-BOTP participation, such as scheduling or logistical issues. *Revised formulation*: Provide participants with the option to contact a professional subject to the obligation of professional secrecy. This contact person should be available to assist with overcoming barriers to move on the next stage of the FA-BOTP, and participants can reach out to them if needed. It should be made clear from the beginning that this support is voluntary and confidential. Participants should also have the option to initiate contact or to be contacted, depending on their preference.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Do you have any additional comments or suggestions about **the inclusion procedure**?	
2. Content of the FA-BOTP	
2.1. Sessions number Offer up to 16 sessions, with the option to adapt the number based on individual needs. Participants can receive fewer sessions if they feel they no longer require further support, or more sessions if additional assistance is needed to address their specific situation. The burnout consultant should assess each participant's progress and, in collaboration with them, determine the appropriate number of sessions. This flexibility ensures that the program can be tailored to different levels of burnout and individual circumstances, such as ongoing work commitments or recovery time.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
2.2. Individual sessions The individual sessions followed either the cognitive-emotional or psycho-corporeal approach. In the cognitive-emotional approach, conducted by an individual sessions consultant or a burnout consultant who are clinical psychologist, the worker could, for example, transform stressful thoughts into positive ones, or work on irrational work-related thoughts. In the psycho-corporal approach, conducted by an individual sessions consultant, who may be a physiotherapist or a clinical psychologist, the worker was guided through relaxation and movement therapies to release tension and enhance awareness. *Finding*: A maximum of 4 individual sessions were planned. Only 30.4% of participants attended 3 or 4 individual sessions and the average number of sessions was 1.39, making individual sessions the least used.	
Original recommendation: Improve communication and awareness of the benefits of individual sessions by the health professional to encourage participation. *Revised formulation*: Enhance communication and awareness of the benefits of individual sessions through the healthcare professional to encourage participation. Emphasize should be placed on the following points:	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree

• Individual sessions, such as cognitive-emotional or physical approach (i.e.psycho-corporal) sessions, fully complement the program's work clinic and starter kit sessions. • Clearly communicate the possibility of consultations with the occupational physician to explore potential workplace adjustments, which may positively impact the work component. • Highlight that, based on the individual's needs and as assessed by the healthcare professional, sessions can be revisited and adjusted over time. This ensures the approach remains flexible and tailored to each person's pace and needs, avoiding any risk of overwhelming them.	Justification:
Original recommendation: Improve communication and awareness of the benefits of individual sessions by the program manager to encourage participation. *Revised formulation*: Improve communication and awareness of the benefits of individual sessions through the program manager by: • Providing clear, descriptive information to participants about the sessions' value and how they complement the work clinic and starter kit sessions. • Emphasizing the flexible and complementary nature of these sessions with other support options, such as physical approaches (e.g., kinesiology, relaxation techniques). • Ensuring communication regarding consultations with the occupational physician to explore potential workplace adjustments. • Highlighting that the health professional should be responsible for assessing the specific needs of each participant and discussing the appropriateness of further sessions based on individual progress and pace.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Original recommendation: Increase the number of available individual sessions to 6, as this type of support requires time to be effective. *Revised formulation*: Offer the possibility of up to 6 individual sessions, based on the participant's needs and ongoing evaluation by the health professional. This flexible approach allows for an individualized therapeutic process, ensuring that participants receive the support they require without being overwhelmed. The number of sessions should be determined collaboratively, considering the participant's progress.	6. @Completely disagree 7. @Disagree 8. @Neutral 9. @Agree 10. @Completely agree Justification:
<u>2.3. Post-program follow-up sessions</u> Two follow-up/reorientation sessions were included in the FA-BOTP. The aim of these sessions was to redirect the worker towards other career paths (job changes, organizational changes, etc.) if appropriate, or to review the progress of the FA-BOTP with the participant.	

Finding: Several participants expressed the wish to have follow-up sessions after the end of the FA-BOTP in order to be able to discuss their work situation with their health professional after the FA-BOTP has ended.	
Original recommendation: Possibility to have an ongoing access to a support network (e.g., group discussions or online forums) at the end of the FA-BOTP. *Revised formulation*: Provide participants with the opportunity for ongoing support after completing the FA-BOTP through moderated group discussions or access to a peer support network. This network could include in-person group sessions or online platforms that are carefully monitored by professionals to ensure a safe, confidential, and supportive environment. These support sessions could be offered for up to one year after the program to help participants anchor the changes they've made and allow for continued exchange among participants.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Do you have any additional comments or suggestions about **the content of the FA-BOTP**?	
3. Consultation logistics	
3.1. Extending program duration for flexibility The participant had 9 months to complete the FA-BOTP. *Finding*: Several participants took nine months or more to complete FA-BOTP, suggesting that the current duration may be insufficient for some individuals.	
Original recommendation: Provide clear communication at the start of the program about the planned schedule via clear negotiation of time with the health professional. *Revised formulation*: Provide clear communication at the start of the program, outlining the general structure and objectives, while allowing for flexibility in scheduling based on the participant's individual needs, capacities, and constraints. The healthcare professional should negotiate a schedule that works for both the participant and the program, taking into consideration any work-related or personal limitations. Flexibility is crucial, as participants' progress may vary, and they may need more or fewer sessions or changes in the frequency of meetings as their recovery evolves.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
3.2. Official recognition of consultation during working hours *Finding:* The majority of participants attended consultations during their working hours.	
Original recommendation: Allow federal agents to attend FA-BOTP consultations during working hours to improve accessibility and communicate with them on this subject. *Revised formulation*: Allow federal agents to attend FA-BOTP consultations during and outside working hours based on their preference for privacy. Participation should be voluntary and managed with clear guidelines to prevent misuse, ensuring that it does not burden colleagues or disrupt team dynamics.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
Do you have any additional comments or suggestions about **the consultation logistics**?	

Annex G : DELPHI-Tour 3

In this questionnaire, you will find the recommendations for which a minimum level of agreement of 75% was not reached. Recommendations that received a level of agreement of 75% or more are not presented again here. However, all suggestions and comments made on these recommendations have been taken into account and will be incorporated into the final recommendations. For each recommendation presented, you will find the original version as well as the modifications and clarifications made as a result of the suggestions made in the first round. We ask you to rate each modified recommendation by indicating your level of agreement on a scale from 1 (strongly disagree) to 5 (strongly agree). You are also invited to justify your answer if you wish. If you don't wish to add a justification, you can simply indicate a bar (/) in the box provided. Your feedback is essential to refine and finalize these recommendations. Thank you for your participation!	
1. Content of the FA-BOTP	
1.1. Post-program follow-up sessions Two follow-up/reorientation sessions were included in the FA-BOTP. The aim of these sessions was to redirect the worker towards other career paths (job changes, organizational changes, etc.) if appropriate, or to review the progress of the FA-BOTP with the participant. *Finding*: Several participants expressed the wish to have follow-up sessions after the end of the FA-BOTP in order to be able to discuss their work situation with their health professional after the FA-BOTP has ended.	
Recommendation round 2: Provide participants with the opportunity for ongoing support after completing the FA-BOTP through moderated group discussions or access to a peer support network. This network could include in-person group sessions or online platforms that are carefully monitored by professionals to ensure a safe, confidential, and supportive environment. These support sessions could be offered for up to one year after the program to help participants anchor the changes they've made and allow for continued exchange among participants. *Recommendation round 3*: Offer participants the voluntary option of continued support for up to one year after completing the FA-BOTP, through professionally moderated peer groups or secure online platforms. These support options should be evidence-based, clearly framed, and provided by trusted professionals to ensure safety and quality. As an alternative or complement, participants could access a toolkit with self-guided resources (e.g., relaxation exercises, theoretical frameworks) to support long-term recovery.	1. @Completely disagree 2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:
2. Consultation logistics	
2.1. Official recognition of consultation during working hours *Finding:* The majority of participants attended consultations during their working hours.	
	1. @Completely disagree

Recommendation round 2: Allow federal agents to attend FA-BOTP consultations during and outside working hours based on their preference for privacy. Participation should be voluntary and managed with clear guidelines to prevent misuse, ensuring that it does not burden colleagues or disrupt team dynamics. *Recommendation round 3*: Allow federal agents to attend FA-BOTP consultations either during or outside working hours, based on personal preference. Participation should be voluntary and guided by mutuel agreements to ensure respect for confidentiality and team organizational, without adding undue pressure on the participant.	2. @Disagree 3. @Neutral 4. @Agree 5. @Completely agree Justification:

Annex H: Reintegration initiatives provided by the Federal Agencies

Initiative	Creator	Goal	Level of prevention	Target group: BO specific?	Target group: specific agencies?	Target group: specific jobs or levels?	Entry requirements	Materials	Level of intervention	On-/Offline	Progress of implementation	Relation to ReBorn	Link
Burnout pilot project	FEDRIS	Intervention trajectory for symptom reduction in an early stage of BO	Secondary prevention	Yes	No: focused on healthcare & banking sector	Yes but not in FA: healthcare & banking	Sector + early stage of BO: still at work or <1 month absent	Combination of work-focused & individual-focused sessions	Individual	Both	Implemented	Adapted to & implemented in FedGov in WP2	https://www.fedris.be/nl/pilootproject-burn-out
Platform common mental disorders	RIZIV/INAMI	Mapping all CMD that lead to sickness absence. Further info needed from Saskia.	Secondary & tertiary prevention	No: all common psy disorders	No	No							
Charge book mapping functional capacities in common psy disorders	RIZIV/INAMI	Mapping functional capacities in CMD: focus on tools that can offer support in this process	Secondary & tertiary prevention	No: all common psy disorders	No	No		Charge book with tools that can support in mapping functional capacities in workers with common psychological disorders	Group & individual	Online	Implemented		
Supporting first line psychological intervention for work issues	RIZIV/INAMI	Offer tools to psychologists & GP's to support those at risk of	Secondary prevention	No: BO but also broader	No	No							

		dropping out/dropped out											
Indicator tool for monitoring well-being factors	BOSA		Primary prevention	No: BO but also broader	No	No							
Training for confidential counsellors	BOSA		Secondary & tertiary prevention	No: BO but also broader	No	Yes: confidential counsellors							
E-learning on burnout	BOSA	Informing workers on stress & BO prevention	Primary prevention	Yes	No	No	None	Self-awareness, active stress management, job crafting, understanding burnout, stress and burnout coaching, mindfulness, etc	Individual	Both			https://bosa.belgium.be/nl/themas/werken-bij-de-overheid/welzijn-en-preventie/psychosociale-risicos/stress-en-burn-out
E-learning on reintegration	BOSA	Informing professionals dealing with RTW on reintegration after long-term sickness	Tertiary prevention	No: BO but also broader	No	Yes: HR, P&O agents, supervisors, PA, disability mgrs,…	Being a federal agent dealing with/interested in reintegration after long-term sick leave	Information on reintegration legislation, trajectories etc including practical cases	Individual	Online	Implemented	Alignment with BRM tool (WP3) to be checked	https://bosa.belgium.be/nl/trainings/reintegratie-na-langdurige-afwezigheid-e-learning
Evoluno app	BOSA	Mental resilience tool	Primary prevention	No: BO but also broader	No	No	None	Different scales on well-being & burnout (BAT)	Individual	Both: app can suggest sessions or expe	Implemented but might stop	Also risk monitoring tool (WP3) but for BO	

										rts to get help		prevention	
Lumen Burnout Coaching	BOSA	Network of recognized stress & BO coaches available for federal agents	Secondary prevention	Yes	No	No	Workers with psychological (stress/BO) complaints in early stage (no severe trauma or psy conditions)	5-10 sessions of 1-1.5h. Guidance to learn to cope with work stress to work on energy balance, increase vitality, also preventing relapse after reintegration	Individual	Both	Implemented	Also follow-up for workers in early BO stage (WP2): overlap vs differences with FABOTP to be mapped!	https://bosa.belgium.be/nl/trainings/stress-burn-outcoaching
Reimbursement of psychological care for work issues	BOSA	Costs for psychologist are reimbursed when the reason is work-related	Secondary prevention	Yes	No	No	Workers with psychological (stress/BO) complaints; only for recognized psychologists included in the Commission of Psychologists	Sessions by recognized psychologist (included in Commission of Psychologists); content is not managed in the FedGov: individual initative of the worker	Individual	Offline	Implemented		https://bosa.belgium.be/nl/themas/werken-bij-de-overheid/welzijn-en-preventie/psychosociale-risicos/plan-mentaal-welzijn-op
Career consultation with Talent+ career coach	BOSA		Primary prevention	No	No	No	All federal agents	1 session of 1.5-2h.					https://bosa.belgium.be/nl/trainings/loopbaangesprek-talent-plus

Community of Practice Reintegration (COP)	BOSA		Tertiary prevention	No: BO but also broader	No	Yes: HR, PA, physicians, supervisors, disability mgrs,…	Professionals with guiding or supporting role in reintegration trajectories (broader than BO alone)	Support group for reintegration professionals + access to relevant documents	Group & individual				https://bosa.belgium.be/nl/networks/cop-re-integratie-van-werknemers-na-een-afwezigheid-van-lange-duur
Professionalization Disability Managers (WIP)	BOSA	Training program by BOSA for agents from other FPS to become disability managers	Tertiary prevention	No: BO but also broader	No	No	TBC: the project is still work in progress. The number of participants will be limited due to budget constraints.	TBC: the project is still work in progress.	Individual	TBC: the project is still work in progress.	Work in progress		
Website for training, prevention & awareness	WASO	Different tools including risk analysis tool (5 A's/T's) + RTW checklist with best practices	Primary & tertiary prevention	No: BO but also broader	No	No: both reintegration professionals & workers themselves							www.sesentirbienautravail.be; for workers: www.jemesensbienautravail.be; more information on initiatives in general: www.beswic.be
Internal mobility program / reorientation trajectory	BOSA	Reorientation trajectory towards a new job upon reintegration	Tertiary prevention	No	No	No	(a) in reintegration trajectory, (b) >6 months sick leave, (c) declared permanently unfit for current job, (d) job lost	Reorientation trajectory = Competentiebilan: overview of competences based on individual meetings and tests + Reorientat	Individual	Offline	Implemented	Relevant to measure in WP3	https://bosa.belgium.be/nl/trainings/herorienteer-je-loopbaan

							due to restructuring	ion plan + Trying out up to 3 different departments for max. total period of 18 months					
Burnout workshop & game	BOSA	Supporting tool for implementing a burnout prevention policy	Primary & secondary prevention	Yes	No	Yes: PA, confidential counsellors, P&O agents	PA, confidential counsellors, P&O agents intereste d in how to build burnout preventi on policy & what actions to take to adress burnout						https://bosa.belgium.be/nl/services/workshop-burnout

Annex I: Screening form.

FORMULAIRE DE DEMANDE DE DÉPISTAGE

Préface

Sur la page qui suit, vous allez remplir votre demande de participation nous permettant de déterminer si vous répondez aux critères d'inclusion. **Ces critères d'inclusion visent à s'assurer que le trajet de prise en charge répondra à vos besoins de façon adéquate**. Dans le cas où vous êtes inclu.e, un mail contenant la liste des intervenants burnout ainsi qu'une invitation à remplir le pré-test avant de débuter la prise en charge vous sera envoyé. Vous pourrez alors choisir l'intervenant burnout et le contacter pour prendre rendez-vous afin de pouvoir débuter le suivi après avoir rempli le pré-test. S'agissant d'un projet de recherche, **il est important que vous répondiez au pré-test et au post-test**. Sans ces données, nous ne pourrons évaluer si le projet est pertinent et efficace pour les agences fédérales et s'il mérite d'être poursuivi.

Votre **participation à ce projet de prise en charge est volontaire**. Vous pouvez choisir de ne pas participer et si vous décidez de participer vous pouvez cesser de répondre aux questions à tout moment et fermer la fenêtre de votre navigateur sans aucun préjudice.

Vos **réponses seront confidentielles** et nous ne collecterons pas d'informations permettant de vous identifier, telles que votre nom, votre adresse e-mail ou votre adresse IP, qui pourraient permettre la localisation de votre ordinateur. Vos réponses seront transmises anonymement à une base de données. Votre participation implique que vous acceptez que les renseignements recueillis soient utilisés anonymement à des fins de recherche. Les résultats de cette étude serviront à des fins scientifiques uniquement.

Commencer

1. Coordonnées du travailleur

1.1. Nom : …
1.2. Prénom : …
1.3. Date de naissance: …
1.4. Langues de contact : FR-NL-FR/NL
1.5. Téléphone/GSM : …
1.6. E-mail de contact : …

2. Activité professionnelle

2.1. De quelle agence fédérale provenez-vous ?

SPF Stratégies et Appui (BOSA)

SPF Mobilité et Transports

SPF Emploi, Travail et Concertation Sociale

SPF Intérieur

INAMI

- Autre (Précisez) : …

2.2. Quelle est votre fonction au sein de votre agence fédérale ?...

3. Motif de la consultation

3.1. Décrivez les motifs pour lesquels vous souhaitez intégrer ce programme de prise en charge.

4. Situation professionnelle

4.1. Êtes-vous actuellement en arrêt de travail pour les plaintes évoquées ?

Oui-Non

- Si oui, date de début - date de fin présumée

4.2. Ces 12 derniers mois, avez-vous été en arrêt de travail pour les mêmes raisons ?

Oui-Non

- Nombre d'arrêt de travail
- Nombre total de jours d'arrêt

5. Avez-vous déjà commencé un trajet de réintégration professionnelle ?

Oui-Non

6. Le lien avec le travail :

6.1. Votre plainte porte principalement sur :

- Le travail
- Des éléments extérieurs au travail

6.2. Concernant votre travail, pouvez-vous identifier le(s) facteur(s) qui posent problème ?

- Surcharge de travail
- Contacts difficiles avec le client/patient/…
- Problèmes d'environnement (bruit,…)
- Souffrance relationnelle au travail (harcèlement, violence, conflit…)
- Pression temporelle
- Pénibilité physique
- Interférence ou conflit entre vie privée et professionnelle
- Changements organisationnels
- Incertitudes liées à l'emploi
- Perte de sens du travail
- Manque de travail

- Autres : …

6.3. Pouvez-vous identifier les ressources qui vous manquent dans votre travail ?

- Soutien de la hiérarchie
- Soutien des collègues
- Retour sur le travail effectué (feed-back)
- Reconnaissance
- Autonomie
- Possibilité d'épanouissement au travail
- Variété dans les compétences et les tâches à effectuer
- Définition des tâches
- Formation continue
- Équipement/matériel adéquat
- Participation liée aux décisions
- Sécurité liée à l'emploi

- Autres : …

7. Validation du formulaire de dépistage

En validant ce questionnaire, vous autorisez l'échange de données vous concernant entre votre intervenant burnout, votre intervenant séances individuelles ainsi que l'équipe de recherche. Ces données pourront également être transmises au médecin du travail **si, et seulement si,** vous sollicitez une rencontre avec lui.

Après la validation de ce questionnaire, l'équipe de recherche déterminera si vous répondez aux critères de recherche. Dans le cas où vous répondez aux critères, nous vous enverrons un mail contenant la liste des intervenants burnout ainsi qu'un lien pour répondre au pré-test à remplir directement avant de débuter la prise en charge. Dans le cas où vous ne répondez pas aux critères, nous vous le notifierons en vous réorientant vers les initiatives bien-être existantes au sein des organisations fédérales.

AANVRAAGFORMULIER VOOR SCREENING

Voorwoord

Op de volgende pagina vult u uw aanvraagformulier in om te bepalen of u aan de inclusiecriteria voldoet. **Deze inclusiecriteria zijn bedoeld om ervoor te zorgen dat het zorgpad adequaat op uw behoeften aansluit**. Als uw aanvraag wordt aanvaard, krijgt u een e-mail met de lijst van burn-outbegeleiders en een uitnodiging om de pre-test in te vullen voordat u met het begeleidingstraject begint. U kunt dan de burn-outbegeleider kiezen en contact met hem/haar opnemen om een afspraak te maken om met het traject te beginnen nadat u de pre-test hebt ingevuld. Aangezien dit een onderzoeksproject is**, is het belangrijk dat u de pre-test en post-test invult**. Zonder deze gegevens kunnen we niet beoordelen of het project relevant en effectief is voor de federale agentschappen en of het de moeite waard is om door te gaan.

Uw deelname aan dit begeleidingstraject is vrijwillig. U kunt ervoor kiezen niet deel te nemen en als u besluit wel deel te nemen, kunt u op elk moment stoppen met het beantwoorden van de vragen en het venster van uw browser zonder gevolgen afsluiten.

Uw antwoorden worden vertrouwelijk behandeld en wij verzamelen geen persoonlijk identificeerbare informatie, zoals uw naam, e-mailadres of IP-adres, die kan worden gebruikt om uw computer te lokaliseren. Uw antwoorden worden anoniem naar een database gestuurd. Uw deelname houdt in dat u ermee instemt dat de verzamelde informatie anoniem voor onderzoeksdoeleinden wordt gebruikt. De resultaten van dit onderzoek zullen uitsluitend voor wetenschappelijke doeleinden worden gebruikt.

Start

Contactgegevens van de werknemer

1. Naam: ...
2. Voornaam: ...
3. Geboortedatum: ...
4. Contacttalen: FR-NL-FR/NL
5. Telefoon/GSM: ...
6. Contact e-mail: ...

Professionele activiteit

1. Van welk federaal agentschap bent u?

a. FOD Beleid en Ondersteuning (BOSA)
b. FOD Mobiliteit en Vervoer
c. FOD Werkgelegenheid, Arbeid en Sociaal Overleg
d. FOD Binnenlandse Zaken
e. RIZIV
f. Andere (specificeer): ...

2. Wat is uw functie in uw federale agentschap?...

Reden voor raadpleging

Beschrijf de redenen waarom u wilt deelnemen aan dit begeleidingstraject.

Werkgelegenheid

1. Bent u momenteel arbeidsongeschiktomwille van de genoemde klachten?
Ja-Nee

a. Zo ja, begindatum - geschatte einddatum

2. Bent u in de afgelopen 12 maanden om dezelfde redenen afwezig geweest?
Ja-Nee

a. Aantal werkonderbrekingen
b. Totaal aantal ziektedagen

3. Bent u al begonnen met een professioneel reïntegratietraject?
Ja-Nee

4. De link met het werk:
a. Uw klacht gaat voornamelijk over :
    - Het werk
    - Factoren buiten het werk

b. Kunt u met betrekking tot uw werk de factor(en) aanwijzen die problemen veroorzaken?
    - Overbelasting door het werk
    - Moeilijke contacten met de cliënt/patiënt/...
    - Problemen door de werkomgeving (lawaai, enz.)
    - Relationele problemen op het werk (pesterijen, geweld, conflicten, enz.)
    - Tijdsdruk
    - Fysieke problemen
    - Inmenging of conflict tussen privé- en beroepsleven
    - Organisatorische veranderingen
    - Onzekerheid over de werkgelegenheid
    - Verlies van zin in het werk

- Gebrek aan werk
- Andere: ...

c. Kunt u vaststellen welke middelen u mist in uw werk?
   - Steun van de hiërarchie
   - Steun van collega's
   - Feedback over het verrichte werk
   - Erkenning
   - Autonomie
   - Mogelijkheid om te groeien op het werk
   - Verscheidenheid aan vaardigheden en uit te voeren taken
   - Definitie van taken
   - Voortgezette opleiding
   - Geschikte uitrusting/materialen
   - Deelname aan de besluitvorming
   - Werkzekerheid
   - Andere: ...

Validering van het screeningsformulier

Door deze vragenlijst te valideren, geeft u toestemming voor de uitwisseling van gegevens over u tussen uw burn-out begeleider, uw begeleider voor individuele sessies en het onderzoeksteam. Deze gegevens kunnen ook worden doorgegeven aan de arbeidstarts indien, en alleen indien, u een gesprek met hem aanvraagt.

Na validatie van deze vragenlijst zal het onderzoeksteam bepalen of u aan de onderzoekscriteria voldoet. Als u aan de criteria voldoet, sturen wij u een e-mail met de lijst van burn-out begeleider en een link naar de pre-test die u direct voor aanvang van de behandeling dient in te vullen. Als u niet aan de criteria voldoet, brengen wij u op de hoogte door u en verwijzen we u door naar de bestaande welzijnsinitiatieven binnen de federale organisaties.

Annex J: Adapted screening form.

FORMULAIRE DE DEMANDE DE DÉPISTAGE

Préface

Sur la page qui suit, vous allez remplir votre demande de participation nous permettant de déterminer si vous répondez aux critères d'inclusion. **Ces critères d'inclusion visent à s'assurer que le trajet de prise en charge répondra à vos besoins de façon adéquate**. Dans le cas où vous êtes inclu.e, un mail contenant la liste des intervenants burnout vous sera envoyé.

Votre **participation à ce projet de prise en charge est volontaire et vos réponses sont confidentielles**. Vous pouvez choisir de ne pas participer et si vous décidez de participer vous pouvez cesser de répondre aux questions à tout moment et fermer la fenêtre de votre navigateur sans aucun préjudice.

Dans le cas où vous souhaitez obtenir de l'aide pour remplir ce formulaire, vous pouvez contacter XXX à l'adresse suivante XXX ou au numéro de téléphone suivant XXX.

Commencer

Ce questionnaire est un premier pas pour comprendre votre situation. Il ne constitue pas un diagnostic médical. Vos réponses resteront confidentielles.

1. Coordonnées du travailleur

1.1. Nom : …
1.2. Prénom : …
1.3. Date de naissance: …
1.4. Langues de contact : FR-NL-FR/NL
1.5. Téléphone/GSM : …
1.6. E-mail de contact : …

2. Activité professionnelle

2.1. Mon organisation : ….
2.2. Ma fonction : …

3. Motif de la demande

Cette section nous aide à comprendre vos difficultés actuelles.

3.1. Votre plainte porte principalement sur :
- Le travail
- Des éléments extérieurs au travail

3.2. Pouvez-vous nous donner quelques exemples concrets de situations de travail qui vous posent problème ?
Ex : charge de dossiers trop importantes, conflit répété avec un/des collègue(s),…

3.3. Quels sont les principaux signes que vous ressentez ?
- Difficultés à se concentrer
- Pertes de mémoire

- Difficultés à penser clairement
- Perte de motivation
- Sentiment de ne plus avoir d'énergie
- Cynisme
- Fatigue persistante
- Troubles du sommeil
- Douleurs musculaires
- Maux de têtes fréquents
- Irritabilité
- Isolement
- Baisse de productivité
- Prise de distance par rapport aux collègues
- Autres : ….

3.4. Depuis combien de temps ressentez-vous ces difficultés ?

- Moins d'un mois
- 1 à 3 mois
- 3 à 6 mois
- Plus de 6 mois

3.5. Comment cela impact-t- 'il votre quotidien ?

Ex : difficulté à accomplir ses tâches au travail, moins de plaisir au travail, retentissement sur la vie privée,…

….

3.6. Pouvez-vous identifier le(s) facteur(s) qui posent problème ?

- Surcharge de travail
- Contacts difficiles avec le client/patient/…
- Problèmes d'environnement (bruit,…)
- Souffrance relationnelle au travail (harcèlement, violence, conflit…)
- Pression temporelle
- Pénibilité physique
- Interférence ou conflit entre vie privée et professionnelle
- Changements organisationnels
- Incertitudes liées à l'emploi
- Perte de sens du travail
- Manque de travail

- Autres : …

3.7. Pouvez-vous identifier les ressources qui vous manquent dans votre travail ?

- Soutien de la hiérarchie
- Soutien des collègues
- Retour sur le travail effectué (feed-back)
- Reconnaissance
- Autonomie
- Possibilité d'épanouissement au travail
- Variété dans les compétences et les tâches à effectuer
- Définition des tâches
- Formation continue
- Équipement/matériel adéquat
- Participation liée aux décisions
- Sécurité liée à l'emploi

- Autres : …

4. Situation professionnelle

4.1. Êtes-vous actuellement en arrêt de travail pour les plaintes évoquées ?

Oui-Non

- Si oui, date de début - date de fin présumée

4.2. Ces 12 derniers mois, avez-vous été en arrêt de travail pour les mêmes raisons ?

Oui-Non

- Nombre d'arrêt de travail :
- Nombre total de jours d'arrêt :

4.3. Avez-vous déjà commencé un trajet de réintégration professionnelle ?

En Belgique, un trajet de réintégration est une procédure officielle visant à réinsérer un travailleur en incapacité de travail (temporaire ou définitive) en lui trouvant un travail adapté à son état de santé.

Oui-Non- Je ne suis pas certain.e

- Pouvez-vous nous décrire les démarches entreprise ?

5. Préférences pour la suite du trajet

Afin de respecter vos souhaits, merci d'indiquer comment vous préférez être recontacté :

- Recevoir rappels par e-mail
- Recevoir un rappel et être ensuite contacté par un professionnel soumis au secret professionnel
- Être directement contacté par le responsable du programme (secret professionnel)
- Prendre moi-même contact avec le responsable

6. Validation du formulaire de dépistage

En validant ce questionnaire, vous autorisez l'échange de données vous concernant entre les professionnels soumis au secret professionnel impliqués dans le FA-BOTP. Ces données pourront également être transmises au médecin du travail **si, et seulement si,** vous sollicitez une rencontre avec lui.

Après la validation de ce questionnaire, le responsable du programme déterminera si vous répondez aux critères de recherche. Dans le cas où vous répondez aux critères, un mail contenant la liste des intervenants burnout vous sera envoyé. Dans le cas où vous ne répondez pas aux critères, il vous le sera notifié et vous serez réorienté vers les initiatives bien-être existantes au sein et en-dehors des organisations fédérales.

AANVRAAGFORMULIER VOOR SCREENING

Voorwoord

Op de volgende pagina vult u uw aanvraag tot deelname in, waarmee we kunnen bepalen of u voldoet aan de inclusiecriteria. Deze inclusiecriteria hebben tot doel ervoor te zorgen dat het zorgtraject op een adequate manier aansluit bij uw behoeften. Indien u wordt opgenomen, ontvangt u per e-mail een lijst van de burn-outbegeleiders.

Uw deelname aan dit begeleidingstraject is vrijwillig. U kunt ervoor kiezen niet deel te nemen en als u besluit wel deel te nemen, kunt u op elk moment stoppen met het beantwoorden van de vragen en het venster van uw browser zonder gevolgen afsluiten.

Uw antwoorden worden vertrouwelijk behandeld.

Indien u hulp wenst bij het invullen van dit formulier, kunt u contact opnemen met XXX via het volgende adres XXX of via het volgende telefoonnummer XXX.

Start

Deze vragenlijst is een eerste stap om uw situatie te begrijpen. Ze vormt geen medisch diagnostisch instrument. Uw antwoorden blijven vertrouwelijk.

1. Contactgegevens van de werknemer

1.1. Naam: …
1.2. Voornaam: …
1.3. Geboortedatum: …
1.4. Contacttalen: FR-NL-FR/NL
1.5. Telefoon/GSM: …
1.6. Contact e-mail: …

2. **Professionele activiteit**

2.1. Mijn organisatie: …
2.2. Mijn functie: …

3. **Reden voor raadpleging**

Dit gedeelte helpt ons uw huidige moeilijkheden beter te begrijpen.

3.1. Uw klacht gaat voornamelijk over:

- Het werk
- Factoren buiten het werk

3.2. Kunt u enkele concrete voorbeelden geven van werksituaties die u problemen bezorgen?
Bijv.: te hoge werkbelasting, herhaald conflict met collega('s), …

3.3. Wat zijn de voornaamste signalen die u ervaart?

- Moeilijkheden om zich te concentreren
- Geheugenverlies
- Moeilijkheden om helder te denken
- Verlies van motivatie
- Gevoel geen energie meer te hebben
- Cynisme
- Aanhoudende vermoeidheid
- Slaapproblemen
- Spierpijn

- Frequente hoofdpijn
- Prikkelbaarheid
- Isolement
- Productiviteitsdaling
- Afstand nemen van collega's
- Andere: …

3.4. Hoe lang ervaart u deze moeilijkheden al?

- Minder dan een maand
- 1 tot 3 maanden
- 3 tot 6 maanden
- Meer dan 6 maanden

3.5. Hoe beïnvloedt dit uw dagelijks leven?

Bijv.: moeilijkheden om taken op het werk uit te voeren, minder plezier in het werk, invloed op het privéleven, …

3.6. Kunt u de factor(en) aanwijzen die problemen veroorzaken?

- Overbelasting door het werk
- Moeilijke contacten met de cliënt/patiënt/...
- Problemen door de werkomgeving (lawaai, enz.)
- Relationele problemen op het werk (pesterijen, geweld, conflicten, enz.)
- Tijdsdruk
- Fysieke problemen
- Inmenging of conflict tussen privé- en beroepsleven
- Organisatorische veranderingen
- Onzekerheid over de werkgelegenheid
- Verlies van zin in het werk
- Gebrek aan werk
- Andere: …

3.7. Kunt u vaststellen welke middelen u mist in uw werk?

- Steun van de hiërarchie
- Steun van collega's
- Feedback over het verrichte werk
- Erkennin
- Autonomie
- Mogelijkheid om te groeien op het werk
- Verscheidenheid aan vaardigheden en uit te voeren taken
- Definitie van taken
- Voortgezette opleiding
- Geschikte uitrusting/materialen
- Deelname aan de besluitvorming
- Werkzekerheid
- Andere: …

4. Professionele situatie

4.1. Bent u momenteel arbeidsongeschikt omwille van de genoemde klachten?

Ja – Nee

Zo ja, begindatum – geschatte einddatum

4.2. Bent u in de afgelopen 12 maanden om dezelfde redenen afwezig geweest?

Ja – Nee

- Aantal werkonderbrekingen
- Totaal aantal ziektedagen

4.3. Bent u al begonnen met een professioneel reïntegratietraject?

In België is een re-integratietraject een officiële procedure die tot doel heeft een arbeidsongeschikte werknemer (tijdelijk of definitief) opnieuw in te schakelen door hem/haar aangepast werk te bezorgen.

Ja – Nee – Ik ben niet zeker

- Kunt u de ondernomen stappen beschrijven?

5. Voorkeuren voor het verdere traject

Om uw wensen te respecteren, gelieve aan te geven hoe u het liefst opnieuw gecontacteerd wordt:

- Herinneringen per e-mail ontvangen
- Een herinnering ontvangen en nadien gecontacteerd worden door een professional die aan het beroepsgeheim onderworpen is
- Rechtstreeks gecontacteerd worden door de verantwoordelijke van het programma (beroepsgeheim)
- Zelf contact opnemen met de verantwoordelijke

6. Validatie van het screeningsformulier

Door deze vragenlijst te valideren, geeft u toestemming voor de uitwisseling van gegevens over u tussen de professionals die betrokken zijn bij het FA-BOTP en aan het beroepsgeheim onderworpen zijn. Deze gegevens kunnen ook worden doorgegeven aan de arbeidsgeneesheer indien, en alleen indien, u een gesprek met hem aanvraagt.

Na validatie van deze vragenlijst zal de programmaverantwoordelijke bepalen of u aan de onderzoekscriteria voldoet. Als u aan de criteria voldoet, sturen wij u een e-mail met de lijst van burn-outbegeleiders. Als u niet aan de criteria voldoet, brengen wij u op de hoogte en verwijzen wij u door naar de bestaande welzijnsinitiatieven binnen en buiten de federale organisaties.

Annex K: Correlations within variables across timepoints

Variable	Correlations		
	T1-T2	T2-T3	T1-T3
Work resumption quality (WRQ)	.58	.66	.44
Residual burnout symptoms	.76	.82	.79
Job autonomy	.57	.52	.33
Workload	.64	.55	.46
Supervisor Support	.75	.81	.72
Resilience	.58	.61	.43
Perfectionistic striving	.66	.61	.75
Perfectionistic concerns	.62	.72	.68
Person-job fit	.77	.81	.72
Person-organization fit	.65	.70	.66
Demands-abilities fit	.68	.70	.68
Needs-supply fit	.81	.74	.77
Task conflict	.59	.48	.56
Relational conflict	.70	.48	.46
Negative behaviors from others	.80	.44	.67
Ability to adapt procedures	.60	.55	.72
Meaning in work	.68	.76	.68
Emotional load	.80	.76	.81
Burnout stigma Medex doctor	--	--	--
Interpersonal justice	--	--	--
Informational justice	--	--	--
Gender	--	--	--
Ethnicity	--	--	--
Duration of burnout absence	--	--	--
N	64	75	56

Note. All correlations in this table were significant on the $p < .01$ level.

Annex L: Factor loadings for all items in the Exploratory Factor Analysis (EFA).

Variable	# items	Item nr.	Factor loadings
Work resumption quality (WRQ)	3	1	.94
		2	.93
		3	.90
Residual burnout symptoms (BAT)	12	1	.81
		2	.71
		3	.69
		4	.74
		5	.74
		6	.72
		7	.77
		8	.77
		9	.59
		10	.78
		11	.75
		12	.71
Job autonomy	4	1	.86
		2	.85
		3	.92
		4	.86
Workload	3	1	.90
		2	.95
		3	.93
Supervisor Support	4	1	.93
		2	.93
		3	.95
		4	.93
Resilience	3	1	.83
		2	.84
		3	.86
Perfectionistic striving	6	1	.72
		2	.78
		3	.70
		4	.75
		5	.79
		6	.82
Perfectionistic concerns	5	1	.79
		2	.76
		3	.76
		4	.61
		5	.76
Person-job fit	4	1	0.94
		2	0.95
		3	0.95
		4	0.95
Person-organization fit	3	1	0.92
		2	0.97
		3	0.97
Demands-abilities fit	3	1	0.89

		2	0.94
		3	0.93
Needs-supply fit	3	1	0.94
		2	0.96
		3	0.94
Task conflict	4	1	0.89
		2	0.95
		3	0.91
		4	0.92
Relational conflict	4	1	0.95
		2	0.93
		3	0.96
		4	0.95
Internalized burnout stigma	5	1	0.76
		2	-0.77 (R)
		3	0.71
		4	0.79
		5	-0.77 (R)
Negative behaviors from others	3	1	0.90
		2	0.92
		3	0.90
Top-down decision-making	3	1	0.90
		2	0.80
		3	-0.55 (R)
Ability to adapt procedures	4	1	0.73
		2	0.89
		3	0.88
		4	0.84
Meaning in work	2	1	0.95
		2	0.95
Emotional load	3	1	0.91
		2	0.82
		3	0.95
Burnout stigma Medex doctor	3	1	0.74
		2	0.86
		3	0.81
Interpersonal justice	3	1	0.96
		2	0.98
		3	0.98
Informational justice	4	1	0.74
		2	0.92
		3	0.93
		4	0.88

Annex M: Correlations

Variable	WRQ	RBS	Auto	Workload	SupSup	Res	Perf Striving	Perf Concerns	PJ-fit	PO-fit	DA-fit	NS-fit
Work resumption quality	--	-.67**	.56**	-.38**	.52**	.45**	.30**	-.24**	.55**	.39**	.48**	.55**
Residual burnout symptoms		--	-.58**	.47**	-.46**	-.43**	-.17*	.48**	-.51**	-.45**	-.40**	-.49**
Job autonomy			--	-.30**	.69**	.30**	.14*	-.23**	.51**	.41**	.42**	.48**
Workload				--	-.29**	-.21**	-.07	.32**	-.22**	-.22**	-.15*	-.16*
Supervisor Support					--	.21**	.12	-.22**	.40**	.38**	.30**	.44**
Resilience						--	.24**	-.25**	.37**	.20**	.35**	.27**
Perfectionistic striving							--	.43**	.32**	.15*	.30**	.29**
Perfectionistic concerns								--	-.07	-.12	.02	-.05
Person-job fit									--	.35**	.73**	.80**
Person-organization fit										--	.24**	.43**
Demands-abilities fit											--	.61**
Needs-supply fit												--
Task conflict												
Relational conflict												
Negative behaviors from others												
Ability to adapt pocedures												
Meaning in work												
Emotional load												
Burnout stigma Medex doctor												
Interpersonal justice												
Informational justice												
Gender												
Ethnicity												
Duration of burnout absence												

Note. *N* = 226. * = *p* <.05; ** = *p* < .01. This correlation table relates the grand means of different variables (i.e., the average scale score per person across all timepoints), except for 'Burnout stigma Medex doctor', 'Interpersonal Justice', and 'Informational Justice' which were only measured at T1 and thus the T1 scale score is used to calculate correlations. WRQ = Work resumption quality; RBS = Residual burnout symptoms; Auto = Job autonomy; SupSup = Supervisor Support; Res = Resilience; Perf Striving = Perfectionistic striving; Perf Concerns = Perfectionistic Concerns; PJ-fit = Person-job fit; PO-fit = Person-organization fit; DA-fit = Demands-abilities fit; NS-fit = Needs-supply fit.

Annex M: Continued

Variable	TaskC	RelC	NegBeh	AAP	Meaning	EmLoad	BOstigma Medex	Interpers Justice	Inform Justice	Gender	Ethn	Dur
Work resumption quality	-.35**	-.31**	-.35**	.37**	.49**	-.28**	-.14	.30**	.31**	.05	-.15	.12
Residual burnout symptoms	.43**	.43**	.44**	-.42**	-.54**	.48**	.15	-.25	-.34*	-.003	.16*	-.22**
Job autonomy	-.45**	-.44**	-.41**	.58**	.55**	-.29**	-.20**	.37**	.34**	.04	.02	.06
Workload	.21**	.17**	.15*	-.13*	-.11	.47**	.07	-.15	-.23**	-.05	.13	-.14
Supervisor Support	-.42**	-.44**	-.46**	.41**	.41**	-.30**	-.08	.45**	.41**	.04	.12	.11
Resilience	-.10	-.10	-.005	.30**	.32**	-.01	-.23**	-.02	.06	.07	-.05	.11
Perfectionistic striving	-.11	-.07	-.05	.26**	.38**	.14*	-.02	.04	.01	.08	-.09	.16
Perfectionistic concerns	.16*	.19*	.17*	-.08	-.06	.40**	.08	.04	-.10	.07	.04	-.02
Person-job fit	-.20**	-.19**	-.18**	.48**	.69**	-.11	-.17	.25**	.27**	.07	-.09	.08
Person-organization fit	-.27**	-.28**	-.32**	.29**	.40**	-.38**	-.09	.30**	.32**	.04	-.07	.04
Demands-abilities fit	-.16*	-.12	-.20**	.35**	.56**	.004	-.12	.19*	.14	-.006	-.07	.03
Needs-supply fit	-.25**	-.24**	-.24**	.42**	.66**	-.17**	-.19*	.35**	.31**	.13	-.14	.13
Task conflict	--	.86**	.58**	-.29**	-.25**	.35**	.12	-.21*	-.20*	-.09	-.05	-.08
Relational conflict		--	.60**	-.32**	-.25**	.37**	.13	-.27**	-.21*	.001	.01	-.11
Negative behaviors from others			--	-.32**	-.24**	.29**	.005	-.35**	-.23**	-.05	.05	-.07
Ability to adapt procedures				--	.45**	-.04	-.13	.22**	.20*	-.11	-.02	.10
Meaning in work					--	-.05	-.26**	.22**	.30**	.05	-.06	.16
Emotional load						--	.10	-.35**	-.35**	-.10	.28**	-.002
Burnout stigma Medex doctor							--	-.06	-.04	.006	.08	.09
Interpersonal justice								--	.72**	.12	-.15	.01
Informational justice									--	.13	-.12	.21**
Gender										--	-.12	.003
Ethnicity											--	-.10
Duration of burnout absence												--

Note. *N* = 226. * = *p* <.05; ** = *p* < .01. This correlation table relates the grand means of different variables (i.e. the average scale score per person across all timepoints), except for 'Burnout stigma Medex doctor', 'Interpersonal Justice', and 'Informational Justice' which were only measured at T1 and thus the T1 scale score is used to calculate correlations. TaskC = task conflict; RelC = relational conflict; NegBeh = negative behaviors from others; AAP = ability to adapt procedures; EmLoad = emotional load; BOstigma Medex = Burnout stigma Medex doctor; Interpers Justice = Interpersonal justice; Inform Justice = Informational Justice. Gender: 0 = man; 1 = woman (no other categories were applicable). Ethnicity: 0 = ethnic majority; 1 = ethnic minority. To correlate gender and ethnicity to the continuous variables, point biserial correlations are used. To correlate gender and ethnicity together, the phi-coefficient is used.

Annex N: FA-BOTP questionnaire

Determinant	Scale instruction (Dutch)	Item nr	Item (Dutch)
WRQ	Lees onderstaande stellingen en geef aan hoe je jezelf de afgelopen maand voelde op je werk. Beoordeel elk item op een schaal van 1 = 'helemaal oneens' tot 5 = 'helemaal mee eens'.	1	De kwaliteit van mijn werkhervatting was heel goed
		2	Ik had het gevoel dat ik het werk opnieuw goed heb opgenomen
		3	Het terug werken na mijn burn-out is vrij vlot verlopen
Job Autonomy	Hieronder volgen een aantal stellingen. Geef aan in hoeverre deze de afgelopen maand op jou van toepassing waren. Beoordeel elk item op een schaal van 1 = 'helemaal oneens' tot 5 = 'helemaal mee eens'.	1	Ik had zelf invloed op beslissingen rond werk
		2	Ik kon zelf mee bepalen hoeveel werk ik krijg
		3	Ik kon zelf mee bepalen wat ik moet doen op mijn werk
		4	Ik kon zelf mee bepalen hoe ik mijn werk doe
Workload		1	Mijn werklast stapelde zich op
		2	Ik had vaak geen tijd om al mijn werktaken uit te voeren
		3	Ik liep vaak achter met mijn werk
Supervisor Support	Beantwoord volgende vragen in functie van jouw werksituatie afgelopen maand. Beoordeel elke vraag op een schaal van 1 = 'helemaal niet' tot 5 = 'heel veel'.	1	Hoeveel deed uw leidinggevende zijn/haar best om uw werkleven makkelijker te maken?
		2	Hoe makkelijk was het om met uw leidinggevende te praten?
		3	Hoe goed kon u op uw leidinggevende terugvallen wanneer het zwaar was op werkvlak?
		4	In hoeverre was uw leidinggevende bereid bereid te luisteren naar uw problemen?
Resilience	Hieronder volgen een aantal stellingen. Geef aan in hoeverre deze de afgelopen maand op jou van toepassing waren. Beoordeel elk item op een schaal van 1 = 'helemaal oneens' tot 5 = 'helemaal mee eens'.	1	Ik had de neiging om na tegenslag telkens weer op te staan
		2	Ik kon mijn doelen bereiken ondanks obstakels
		3	Ik werd niet snel ontmoedigd door mislukkingen
Perf. Striving		1	Ik deed vaak meer dan er van me gevraagd word
		2	Ik stelde hoge eisen aan mijzelf in mijn werk
		3	Ik probeerde iets nuttig te doen als ik tijd over had
		4	Ik bereidde mij altijd goed voor in mijn werk
		5	Ik zette me extra in op mijn werk
		6	Ik focuste mij op resultaten in mijn werk
Perf. Concerns		1	Ik vond het moeilijk om te rusten
		2	Ik nam zelden of nooit pauzes

		3	Ik was kwaad op mezelf als ik een fout maakte
		4	Ik ergerde me aan collega's die hun best niet deden
		5	Ik merkte vaak pas achteraf dat ik veel te druk ben geweest
Person-org fit		1	De dingen waar ik waarde aan hecht in het leven stemden sterk overeen met de dingen waar mijn organisatie waarde aan hecht
		2	Mijn persoonlijke waarden kwamen overeen met de waarden en cultuur van mijn organisatie
		3	De waarden en cultuur van mijn organisatie sloten goed aan bij de dingen die ik belangrijk vind in het leven
Demands-abilities fit		1	De eisen van mijn job en mijn persoonlijke vaardigheden sloten goed op elkaar aan
		2	Mijn capaciteiten en opleiding sloten goed aan bij de eisen van mijn job
		3	Mijn persoonlijke vaardigheden en opleiding pasten bij de eisen die mijn job aan mij stelt
Task conflict	Beantwoord volgende vragen in functie van jouw werksituatie afgelopen maand. Beoordeel elke vraag op een schaal van 1 = 'helemaal niet vaak' tot 5 = 'heel vaak'.	1	Hoe vaak waren mensen van je team het oneens met betrekking tot het werk dat werd gedaan?
		2	Hoe vaak waren er conflicten over ideeën binnen uw team?
		3	Hoeveel conflicten waren er in uw team over het werk dat u deed?
		4	In welke mate waren er meningsverschillen in uw team?
Negative behaviors	Deze uitspraken beschrijven uw interacties met mensen op uw werk (collega's, leidinggevenden,…). Geef voor elke uitspraak aan hoe vaak u de volgende interacties heeft ervaren de afgelopen maand van 1 = 'helemaal niet vaak' tot 5 = 'heel vaak'.	1	Beledigende of kwetsende opmerkingen krijgen over je persoon, je opvattingen of je privéleven
		2	Genegeerd zijn of een vijandige reactie hebben gekregen als je benaderd werd
		3	Aanhoudende kritiek op je werk en inspanningen hebben gekregen
Ability to adapt procedures	Hieronder volgen een aantal stellingen. Geef aan in hoeverre deze de afgelopen maand op jou van toepassing waren. Beoordeel elk item op een schaal van 1 = 'helemaal oneens' tot 5 = 'helemaal mee eens'.	1	Ik kon gepersonaliseerd werk leveren
		2	Ik kon afwijken van werkprocedures wanneer ik dat nodig achtte
		3	Ik kon 'shortcuts' nemen (naar de essentie gaan) in procedures om mijn werk goed te doen
		4	Ik kon procedures aanpassen wanneer ik wist dat ze niet werkten
Meaning		1	Mijn werk was betekenisvol
		2	Ik vond de taken die ik deed belangrijk
Emotional load		1	Mijn werk bracht me in emotioneel zware situaties
		2	Ik moest omgaan met persoonlijke problemen van anderen als deel van mijn job
		3	Mijn werk was emotioneel veeleisend

French

Determinant	Scale instruction (French)	Item nr	Item (French)
QRTW (ruw)	Lisez les affirmations ci-dessous et indiquez comment vous vous êtes senti(-e) au travail au cours du mois écoulé. Notez chaque affirmation sur une échelle allant de 1 = "pas du tout d'accord" à 7 = "tout à fait d'accord".	1	La qualité de la reprise de mon travail était très bonne
		2	J'ai eu le sentiment d'avoir bien repris le travail
		3	La reprise de mon travail après mon burnout s'est bien déroulée
Job Autonomy	Vous trouverez ci-dessous un certain nombre d'affirmations. Veuillez indiquer dans quelle mesure elles se sont appliquées à vous au cours du mois écoulé. Notez chaque affirmation sur une échelle allant de 1 = "pas du tout d'accord" à 5 = "tout à fait d'accord".	1	J'ai eu de l'influence sur les décisions concernant mon travail
		2	J'ai pu influencer la quantité de travail qui m'était attribuée
		3	J'ai eu de l'influence sur ce que je devais faire au travail
		4	J'ai eu de l'influence sur la façon dont je devais faire mon travail
Workload		1	Ma charge de travail s'est accumulée
		2	Souvent, je n'ai pas eu le temps d'accomplir toutes mes tâches professionnelles
		3	J'ai souvent été en retard dans mon travail
Supervisor Support	Veuillez répondre aux questions suivantes en fonction de votre situation professionnelle le mois dernier. Notez chaque question sur une échelle allant de 1 = "pas du tout" à 5 = "beaucoup".	1	Dans quelle mesure votre supérieur(-e) faisait-il/elle de son mieux pour faciliter votre vie professionnelle ?
		2	Dans quelle mesure était-il facile de parler à votre supérieur(-e) ?
		3	Dans quelle mesure pourriez-vous vous reposer sur votre supérieur(-e) lorsque vous rencontriez des difficultés ?
		4	Dans quelle mesure votre supérieur(-e) était-il/elle disposé(-e) à écouter vos problèmes ?
Resilience	Vous trouverez ci-dessous un certain nombre d'affirmations. Veuillez indiquer dans quelle mesure elles se sont appliquées à vous au cours du mois écoulé. Notez chaque affirmation sur une échelle allant de 1 = "pas du tout d'accord" à 5 = "tout à fait d'accord".	1	J'avais tendance à me relever encore et encore après une difficulté
		2	Je pouvais atteindre mes objectifs malgré les obstacles
		3	Je n'étais pas facilement découragé(-e) par des échecs

Perf. Striving		1	Je faisais souvent plus que ce qui m'était demandé
		2	Je me fixais des normes élevées dans mon travail
		3	J'essayais de faire quelque chose d'utile quand j'avais du temps à perdre
		4	Je me préparais toujours bien dans mon travail
		5	Je faisais des efforts supplémentaires au travail
		6	J'étais orienté(-e) vers la performance dans mon travail
Perf. Concerns		1	J'avais du mal à me reposer
		2	Je prenais rarement, voire jamais, de pauses
		3	Je m'en voulais lorsque je faisais une erreur
		4	J'étais ennuyé(-e) par des collègues qui ne donnaient pas le meilleur d'eux-mêmes
		5	Souvent, je ne me suis rendu(-e) compte qu'après coup que j'avais été bien trop occupé(-e)
Person-org fit		1	Les choses auxquelles j'accorde de l'importance dans la vie correspondaient à celles auxquelles mon organisation accorde de l'importance
		2	Mes valeurs personnelles correspondaient aux valeurs et à la culture de mon organisation
		3	Les valeurs et la culture de mon organisation correspondaient bien aux choses que je valorise dans la vie
Demands-abilities fit		1	La compatibilité entre les exigences de mon travail et mes compétences personnelles a été très bonne
		2	Mes capacités et ma formation correspondaient bien aux exigences de mon travail
		3	Mes aptitudes personnelles et ma formation correspondaient bien aux exigences de mon travail
Task conflict	Répondez aux questions suivantes en fonction de votre situation professionnelle du mois dernier. Notez chaque question sur une échelle de 1 = "pas du tout fréquent" à 5 = "tout à fait fréquent".	1	Quelle était la fréquence des désaccords entre les membres de votre équipe sur des opinions liées au travail effectué ?
		2	Quelle était la fréquence des conflits d'idées dans votre équipe ?
		3	Combien de conflits concernant le travail effectué y avait-t-il dans votre équipe ?
		4	Dans quelle mesure y avait-t-il des désaccords dans votre équipe ?
Negative behaviors	Ces affirmations décrivent vos interactions avec les gens à votre travail (collègues, supérieurs, etc.). Pour chaque affirmation, veuillez évaluer la fréquence à laquelle vous avec vécu les interactions suivantes au cours du mois écoulé, de 1 = "pas du tout fréquent" à 5 = "tout à fait fréquent".	1	Faire l'objet de remarques insultantes ou offensantes sur votre personne, vos attitudes ou la vie privée
		2	Être ignoré(-e) ou faire l'objet d'une réaction hostile lorsqu'on s'approche de lui
		3	Critique persistante de vos eneurs ou fautes

Ability to adapt procedures	Vous trouverez ci-dessous un certain nombre d'affirmations. Veuillez indiquer dans quelle mesure elles se sont appliquées à vous au cours du mois écoulé. Notez chaque affirmation sur une échelle allant de 1 = "pas du tout d'accord" à 5 = "tout à fait d'accord".	1	J'ai pu fournir un travail personnalisé
		2	J'ai eu la possibilité de m'écarter des procédures de travail lorsque je j'ai jugé cela nécessaire
		3	J'ai eu la possibilité d'utiliser des raccourcis (aller à l'essentiel) dans les procédures pour bien faire mon travail
		4	Lorsque je savais que la procédure ne fonctionnerait pas, j'ai eu la possibilité de l'adapter
Meaning		1	Mon travail avait du sens
		2	Je trouvais que les tâches que j'avais fait étaient significatives
Emotional load		1	Mon travail m'a placé dans des situations émotionnellement exigeantes
		2	J'ai dû faire face aux problèmes personnels des autres dans le cadre de mon travail.
		3	Mon travail a été émotionnellement exigeant