


Co-creation of a national burnout secondary prevention programme in Belgium: a pilot project

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ABSTRACT

Introduction Employee well-being is threatened by major technological and organisational changes in the work environment which lead to more burnout. This is why the Belgian Federal Agency for Occupational Risks (Fedris) commissioned two scientific experts to map and summarise existing research conducted on the prevalence and prevention of burnout to develop a national secondary prevention Burnout Treatment Programme (BOTP). This paper presents the development, content and evaluation of a pilot secondary prevention BOTP for the hospital and banking sectors.

Methods Based on a literature search, the BOTP was developed using a co-creation method, characterised by an iterative process. During the intervention development, proposals were presented and discussed with several field experts as well as social partners from both pilot sectors.

Results The designed BOTP is a multidisciplinary programme combining an individual and organisational approach. It comprises a maximum of 20 intervention sessions carried out with different health and prevention professionals, the burnout treatment provider and the individual sessions provider, over 9 months. The secondary prevention programme is flexible, allowing it to be adapted to each participant's needs and expectations. Also, a three-time measurement programme evaluation was designed (pre-test, post-test 1 after the BOTP and post-test 2 3–6 months after the BOTP).

Discussion Through an iterative, multistakeholder and co-creation process, this pilot project created interventions that hold promise in preventing burnout within the banking and health sector. It was implemented by Fedris in January 2019 and at the end of the study, in December 2022, approximately 1400 employees enrolled, thus encouraging further implementation and research in other sectors. The implementation process and outcomes of the planned evaluation will be reported in a separate paper.

INTRODUCTION

In the context of major changes and international competitiveness in work environments, working conditions affect workers' well-being and increase the probability of burnout.¹

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Burnout is an increasingly prevalent occupational mental health condition, associated with prolonged sickness absence and reduced work participation.
- ⇒ Combined interventions addressing both individual and organisational factors appear to be more effective in reducing burnout symptoms.
- ⇒ Evidence on secondary and tertiary burnout interventions remains limited.

WHAT THIS STUDY ADDS

- ⇒ This study describes the co-creation of a national secondary burnout treatment programme integrating individual and occupational-focused components.
- ⇒ It demonstrates the feasibility of an iterative, stakeholder-driven development process translating scientific evidence into practice.
- ⇒ The resulting programme offers a flexible, personalised treatment with structured outcome evaluation.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ The findings support the implementation of co-developed, multidisciplinary burnout interventions.
- ⇒ The programme provides a replicable framework for early burnout intervention targeting both mental health recovery and return to work.
- ⇒ At policy level, this approach may stimulate investment in secondary prevention strategies to reduce long-term work disability related to mental health.

Currently, there is still no consensus on the definition of burnout. It can be conceptualised either as a state or as a process. When considered as a state, burnout is defined through core symptoms (eg, exhaustion, mental distance, emotional impairment and cognitive impairment) and secondary symptoms (eg, psychological distress and psychosomatic complaints).² When conceptualised as a process, burnout is described as evolving through different stages (eg, stage 0/the creation of an ideal towards work with a high work commitment, stage 1/the loss of

the ideal at work, stage 2/a protective withdrawal from work that becomes threatening and stage 3/confirmed burnout).³

According to the WHO, burnout is a work-related syndrome resulting from chronic work stress that has not been successfully managed.⁴ The International Classification of Disease-11 considers burnout as an occupational phenomenon. However, burnout is not recognised as an occupational disease in Belgium but is rather regarded as a work-related disease.⁵

Burnout, regardless of its conceptualisation, has many negative consequences for individuals (eg, insomnia, depressive symptoms),¹ organisations (eg, absenteeism, presenteeism)¹ and society (eg, healthcare expenditure).⁶ In Belgium, specifically, absences from work due to work-related syndromes and mental disorders have continued to increase in recent years. In 2022, the National Institute for Health and Disability Insurance⁷ reported 502 371 people on long-term disability (>1 year) among employees, unemployed and self-employed people.

Mental illnesses and work-related syndromes explained 36.86% of these long-term disabilities. Among these, 47% suffered from depression and 21% from burnout. Overall, more than €1.8 billion was invested in compensation insurance for long-term work incapacity due to depression or burnout in 2021.

This underlines the necessity to increase knowledge in the field of work-related syndromes and to develop effective burnout prevention and treatment programmes. In Belgium, work-related burnout prevention is regulated by the law on well-being at work.⁸ This law requires risk analysis and primary prevention measures to eliminate/reduce risk for BO prevention in the workplace. However, despite this legal obligation for employers, burnout prevalence is still high⁹ and needs to be addressed once diagnosed. In 2015, the Minister of Social Affairs and Public Health demanded the implementation of actions within the framework of secondary prevention. To meet this request, the Scientific Council of Fedris (Federal Agency for Occupational Risks), a public social security institution, commissioned two experts (Hansez and Braeckman) to conduct a scientific literature review. This review had two principal objectives. The first was to identify occupational sectors at high risk of burnout. The second was to analyse the content and effectiveness of existing preventive measures for the development of a pilot Burnout Treatment Programme (BOTP).

The current paper aims to describe (1) the co-development process of the BOTP, (2) the content of the BOTP and (3) the setup of the evaluation of the BOTP.

MATERIALS AND METHODS

Co-development process

The literature review underpinned the co-creation process that consisted of six steps: (1) an initial pilot-project launch, (2) the codesign of the BOTP, (3) the validation of the final BOTP project proposal, (4) the

conception of the instruments, followed by (5) the recruitment, selection and training of the professionals involved in the BOTP and lastly (6) the BOTP Kick-off.

Literature review

The main findings from the scientific literature search are summarised in a report.⁹ Certain professional groups are at higher risk of burnout, even though this is a phenomenon that can affect all workers. In particular, healthcare workers, teachers, policemen and administrative staff, especially in the banking sector, are found to be more susceptible to burnout.^{10–18}

Former studies have described several types of interventions to address burnout, including individual interventions, organisational interventions and combined interventions that integrate both approaches.¹⁹ Individual-centred interventions aim to modify the relationship between the individual and their job, to optimise their personal resources, or to help modify some characteristics of their personality.¹¹ Organisation-centred interventions relate to work arrangements (eg, work schedule adaptation, team building).¹¹ Combined interventions integrate these two approaches and seem to be more effective.^{19 20} Nevertheless, authors still note the lack of studies and information regarding combined interventions.²¹

Concerning the professionals consulted in burnout cases, general practitioners play a central role.¹⁰ Prevention advisors such as occupational physicians and psychologists, as well as workers' supervisors and colleagues, can also be important key actors in the retention and return to work (RTW) of burnout cases.^{10 22 23} Due to the numerous individuals who can be involved, lack of coordination might occur.²⁴ This can lead to confusion about how and when to RTW, as the worker may receive conflicting information. Given these observations, it seems relevant to integrate a coordinator in future interventions.

Therefore, based on the literature search and within the permitted legal framework and mission of Fedris, Braeckman and Hansez⁹ suggested creating a BOTP with both individual-centred and organisation-centred interventions. They also recommended following a multidisciplinary approach with different health professionals, under the supervision of a coordinator, and to address this combined BOTP to the banking and healthcare sectors.

Co-creation process

To develop the BOTP, a methodology centred on co-creation was adopted. In 2016, Anderson *et al* defined co-creation as 'a process whereby researchers and stakeholders jointly contribute to the ideation, planning, implementation and evaluation of new services and systems as a possible means to optimise the impact of research findings'.²⁵ Although it is still a nebulous concept, the growth rate of health research papers using co-creation reached about 25% each year from 1994 to 2019.²⁵

On the one hand, the principle of co-creation offers numerous advantages, such as increased collaboration between experts and service providers,²⁶ more effective interventions, increased end-user satisfaction and cost savings.²⁷ On the other hand, disadvantages can include the amount of time and resources necessary for collaboration, as well as the need for different and experienced stakeholders willing to engage in a participative dialogue.²⁸

During this project, the co-creation approach with the various stakeholders was adopted whenever it was possible throughout all six steps (see details below).

First project launch

First, after the publication and presentation of the literature report⁹ to the Scientific Council of Fedris, a favourable advice regarding the co-creation and implementation of a pilot project focusing on the secondary prevention of burnout was given. In response to this decision, Fedris launched the project and asked its administration and the two scientific experts (namely the Burnout Team, described in figure 1) to take the necessary steps to co-design a BOTP proposal in the banking and hospital sectors, identified as priority sectors based on the literature findings and within the scope of action of Fedris.

Figure 2 summarises the different stages of the co-creation process.²⁹

Co-design of the BOTP

Once approval was obtained, different stakeholders and groups were involved in the co-design of the BOTP (see figure 1³⁰); for example, the Fedris Burnout team, the Working group comprising several kinds of field experts and a Steering Committee, involving the social partners. The Steering Committee was composed to ensure balanced representation of key stakeholders, including policymakers, employers and trade unions. Members were selected to reflect both employer and worker perspectives as well as the healthcare and banking sectors.

Several meetings involving the three groups were alternatively held in 2016 and 2017. The outputs of the meetings included (1) identifying the targeted population within the two sectors for a pilot study; (2) identifying instruments for early detection of burnout, like self-reported questionnaires and diagnosis instruments based on clinical judgement to support the health professional's diagnosis; (3) developing a treatment programme suitable for people at risk of burnout or in the early stages of burnout; (4) writing down the

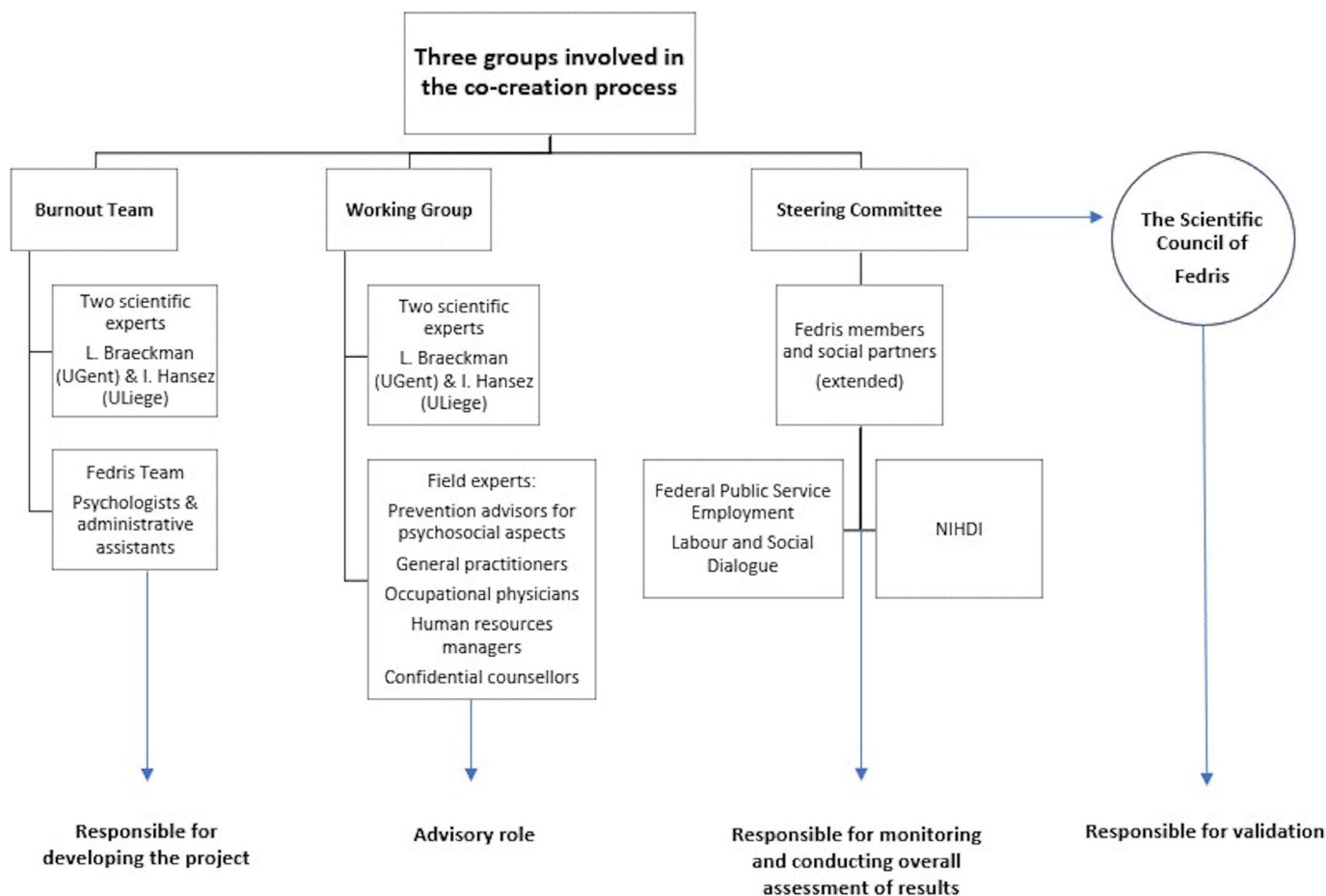


Figure 1 Groups involved in the co-creation process of the BOTP. Fedris, Federal Agency for Occupational Risks; NIHDI, National Institute for Health and Disability Insurance.

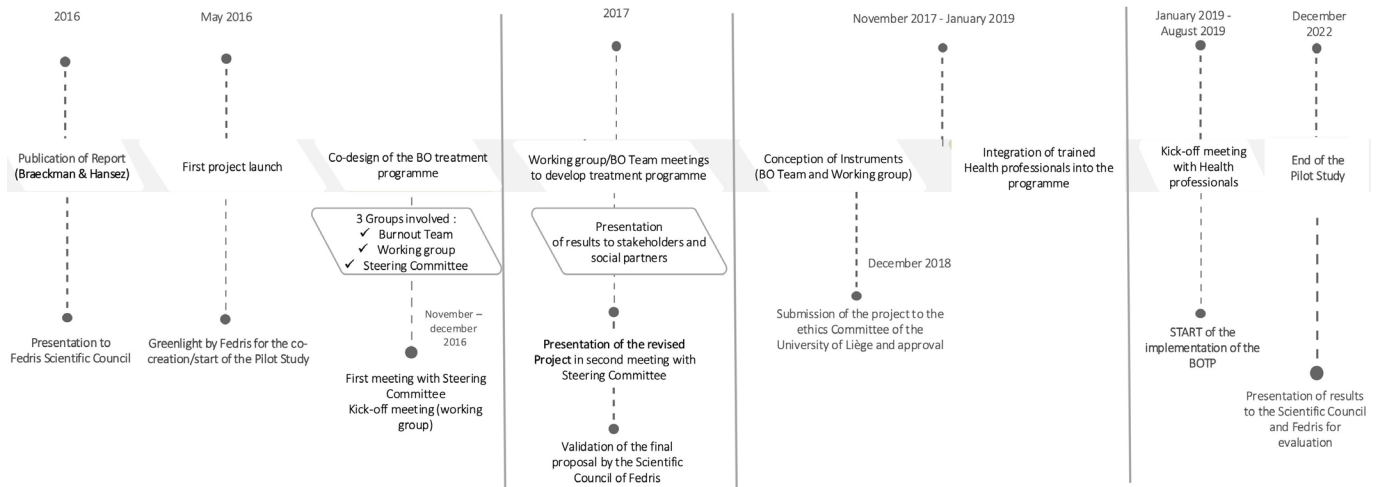


Figure 2 Timeline of the co-creation process. BO, burnout; BOTP, Burnout Treatment Programme; Fedris, Federal Agency for Occupational Risks.

profiles and roles of health professionals involved in this programme; (5) defining the content to include various forms and/or reports used in the BOTP and (6) identifying the collaboration/interaction to be established (eg, a data transmission report) between stakeholders at work, health professionals involved and the health insurance system in order to guarantee both effective care of the worker and respect for their rights and will.

The results of the work carried out were then presented at two workshops to a wider panel of stakeholders from the field, as well as social partners from the hospital and banking sectors. These workshops aimed to compare the Working Group’s proposals with the reality of the field and gather good practices that had not previously been identified. Following these workshops, the project was emended and presented at a second meeting of the Steering Committee.

Validation of the final project proposal

On 23 May 2017, Fedris’ Scientific Council validated the optimised proposal of the BOTP (for further details on the content of the BOTP, see [figure 3](#)).³¹

Conception of the Instruments

From November 2017 to January 2019, the Burnout Team and the Working Group co-developed various instruments to be used throughout the treatment programme, including diverse forms such as a screening request form, a diagnosis report form, a request for treatment form and a final report form.

Additionally, training materials for the future health professionals involved were co-designed and a starter kit containing psychoeducational information was drawn up. Then, a call for health professionals was issued and a recruitment procedure for those professionals was implemented.

Finally, the pilot proposal and project documents were submitted to the Ethics Committee of

the University of Liège, with approval obtained on December 13th, 2018, under reference number 1819-23. This ethical approval covered the overall project development process; no participants were involved in the present study phase.

Recruitment, selection and training of the health professionals involved in the BOTP

To ensure treatment, several different health professionals were included:

- ▶ Burnout treatment providers (BTPs): These self-employed professionals consisted of physicians, occupational psychologists or clinical psychologists. They were responsible for guiding the workers throughout treatment. They also conducted several sessions such as diagnosis sessions, ‘starter kit’ sessions, ‘work-related’ sessions, follow-up sessions and career change counselling (more details below). Furthermore, they prepared the multidisciplinary meeting with workers but did not attend that meeting. They were the coordinators between all key actors involved.
- ▶ Individual session providers (ISPs): These professionals included clinical psychologists or physiotherapists. Clinical psychologists could deliver ‘starter kits’ and individual sessions from a cognitive-emotional and/or psycho-corporal approach. Physiotherapists accepted as ISP carried out ‘starter kit’ sessions and individual sessions using a psycho-corporal approach such as relaxation and stress-management exercises.

To recruit BTPs and ISPs, two calls for applications were published: one for BTPs and one for ISPs. The Burnout Team’s psychologists and the scientific experts reviewed the applications and discussed them according to predefined criteria to ensure quality and a standardised way of working.

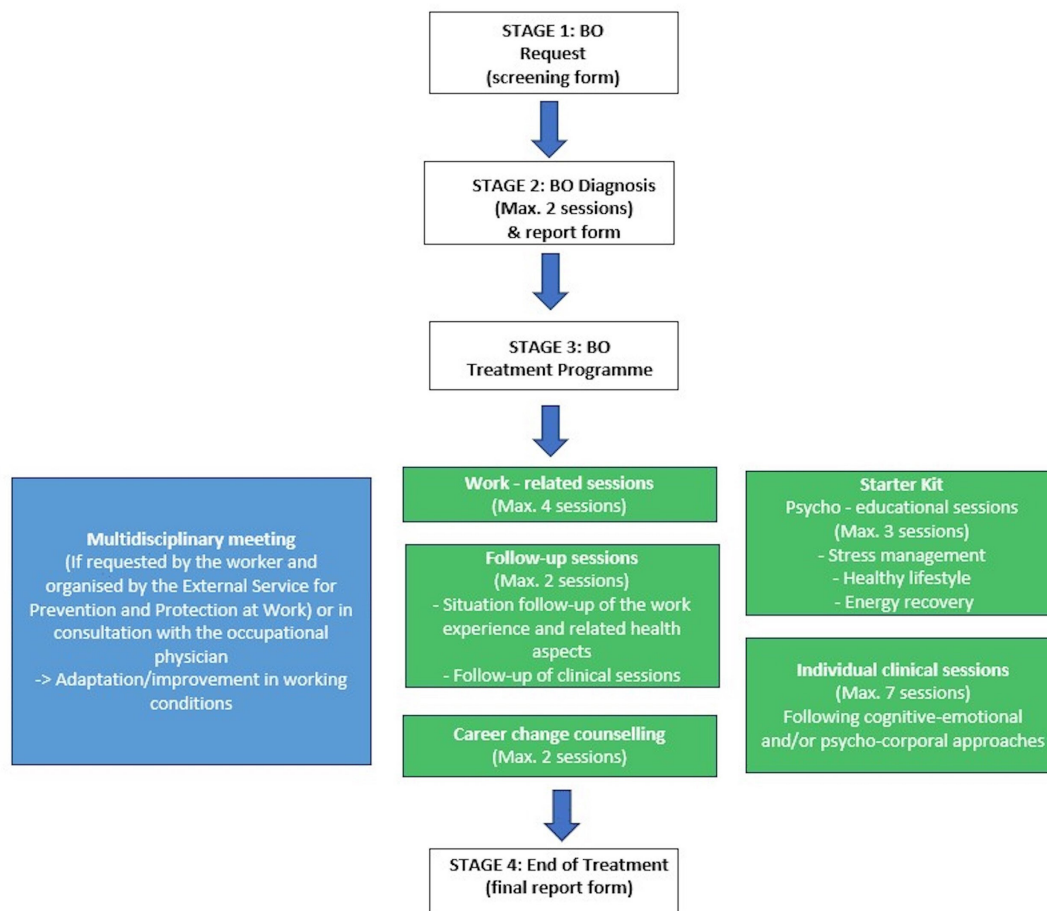


Figure 3 Overview of the FEDRIS' Burnout Treatment Programme. Note: Blue box (sessions organised by the External Service for Prevention and Protection at Work or the occupational physician). Green boxes (sessions carried out with the participants). BO, burnout; FEDRIS, Federal Agency for Occupational Risks.

Selected professionals received a manual and completed mandatory training by Fedris, with a catch-up session available if needed. In total, there were 191 health professionals, including 43 BTPs, 93 ISPs and 55 persons acting both as BTPs and ISPs.

BOTP Kick-Off

On 17 January 2019, the Burnout Team organised the kick-off meeting with the health professionals marking the start of the pilot BOTP.

RESULTS

Fedris' BOTP

To be as comprehensive as possible, the presentation of the treatment programme follows the Template for Intervention Description and Replication checklist and guide.³² This checklist aims to ensure that interventions are sufficiently detailed to allow for replication and is available as supplementary material.

Fedris' BOTP is accessible for workers, in the healthcare or bank sector, suffering from burnout at an early stage (secondary prevention programme). The programme aims to maintain the employee at work or to help them quickly RTW after an absence of a maximum of 2 months.

Sessions took place in the offices of the BTPs and ISPs and were preferably carried out individually. Nevertheless, some sessions could be conducted in groups, such as sessions including relaxation and breathing exercises.

The BOTP guaranteed participants' anonymity in two ways. First, the health professionals involved were bound by professional secrecy and any exchange of information between these professionals was, therefore, also covered by professional secrecy. Subsequently, the employer was only informed of the worker's participation in the BOTP if, and only if, the worker agreed to lift his anonymity to organise a multidisciplinary meeting with key actors from the workplace.

The BOTP consisted of four stages, which spanned up to 9 months: Request, Diagnosis, Treatment Programme and End of Treatment (figure 3). The costs of all the individual and organisational interventions and participants' travel expenses were covered by Fedris.

Stage 1: burnout request

To be included in the BOTP, a screening request form had to be completed either by a general practitioner, occupational physician or prevention advisor for psychosocial aspects and sent to Fedris. If administrative approval was

denied (a worker not belonging to the relevant sectors and/or longer than 2 months sickness absence), the programme ended.

Stage 2: burnout diagnosis

If administrative approval was granted, the participant met with a BTP of their choice, selected from a predefined list set up by Fedris. A maximum of two diagnosis sessions were conducted by the BTP to confirm or not the presence of an early-stage burnout.

At the end of these sessions, the BTP sent a diagnosis report to the psychologists of the burnout team as well as a treatment request. In the case that Fedris' psychologists did not confirm the diagnosis, an additional session was offered to the participant to discuss the reasons behind this negative decision with their BTP, as well as the most appropriate type of support.

On the other hand, if Fedris' psychologists confirmed the presence of an early stage of occupational burnout, treatment could start as soon as the participant received Fedris' formal approval.

Stage 3: BOTP

During treatment, the participant, in consultation with their BTP, was able to attend several types of sessions. The treatment was tailored to each participant's needs and characteristics to make it as suitable as possible, hence not every treatment programme was the same.

'Work-related' sessions (« Clinique du travail »)

Participants could attend up to four 'work-related' sessions conducted by the BTP. In general, these sessions aimed to help the participant express his emotions and work experiences, conduct an analysis of the causes leading to burnout, identify available resources and offer career guidance.

'Starter kit' sessions

Three 'starter kit' sessions were recommended. These psychoeducational sessions were provided by either the qualified ISP or the BTP. The aim of these sessions was to provide basic knowledge on well-being related topics to help the worker oversee their personal situation (eg, stress and time management, coping strategies, energy and energy recovery, healthy lifestyle).

Individual sessions

If the worker wished to do so, they could also participate in up to seven individual support and counselling sessions with an ISP. These sessions were based on a psycho-corporal and/or cognitive-emotional approach.

Multidisciplinary meeting

If the worker requested and agreed to lift his anonymity, a multidisciplinary meeting could be organised to discuss possible adaptations and changes at work. Various stakeholders could participate in this meeting (eg, the occupational physician, the prevention advisor for psychosocial aspects, employer representatives and worker

representatives). Though this meeting was prepared with the BTP, only the participant attended the meeting.

Follow-up sessions

Two follow-up sessions, conducted by the BTP, were also possible. These sessions aimed to discuss the participant's progress, his experience at work and/or debrief the multidisciplinary meeting. Moreover, this was also an opportunity to close the programme and, if further action was needed, refer the worker to appropriate care.

Career change counselling sessions

If deemed necessary, two career change counselling sessions were organised with the BTP to explore career transition or other job prospects with the participant.

Stage 4: End of treatment

At the end of the treatment programme, the BTP sent a final report to Fedris. All reports written by the BTPs were based on templates created and provided by Fedris in collaboration with the scientific and field experts.

All materials developed and used within the BOTP are available from the corresponding authors on request.

Evaluation setup

Based on literature and evidence, an intervention can be assessed through (1) evaluation process, concerned with answering how and why an intervention was or was not successful³³ and (2) outcome evaluation, concerned with the effects an intervention has had including the results that are measurable and meaningful for the organisation, its members, researchers and other stakeholders³⁴ and the areas the intervention is targeting and trying to improve.

The evaluation measures in this pilot study were collected from different sources through quantitative and qualitative methods (figure 4)³⁵ and are presented considering the two mentioned types of assessment.

Each participant was invited to take part in an online longitudinal survey at three measurement times: before the BOTP (pretest), directly after the BOTP (post-test 1) and 3–6 months after the end of the BOTP (post-test 2). The pilot study database also contained qualitative data from the request form, the diagnosis report and the BOTP final report, all of which were completed by the BTPs.

Evaluation process

Regarding the evaluation process, post-test 1 questioned participants' perceived satisfaction with the BOTP in relation to several items such as number and content of the sessions, flexibility in the choice of the sessions, the diversity of health professionals involved and the relevance of a multidisciplinary approach. Additionally, the proximity and ease of access to the BOTP location, as well as the accessibility, flexibility and punctuality of each health professional involved in the BOTP were evaluated.

Feedback from the stakeholders' network (eg, health professionals, prevention actors and social partners

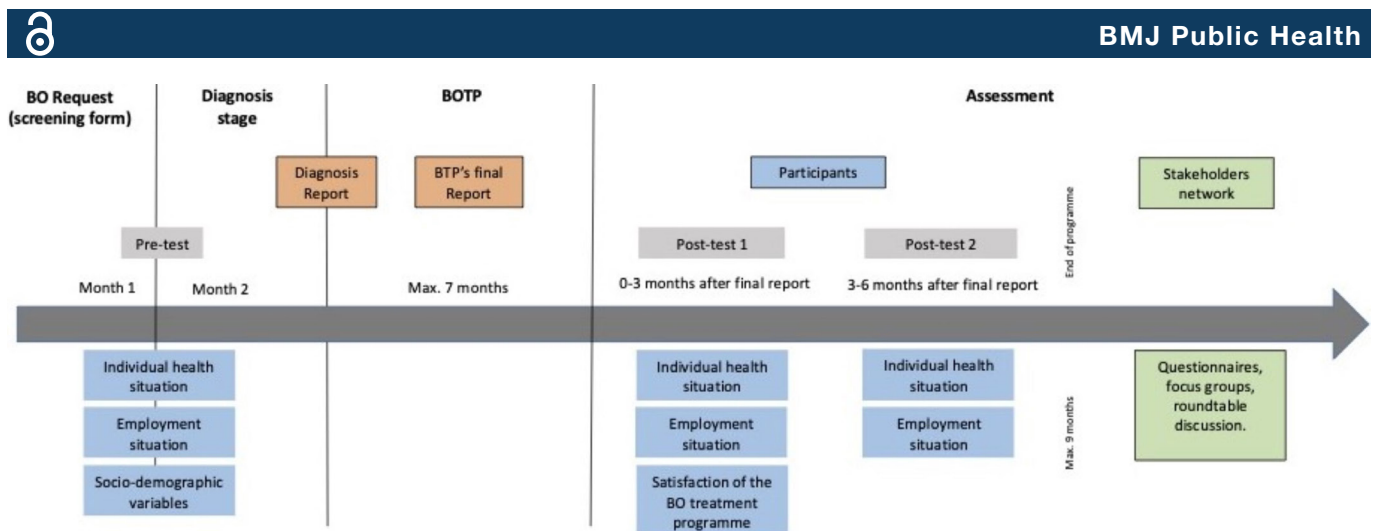


Figure 4 Set up of the evaluation process. Orange boxes (data collected from the BTP). Blue boxes (self-reported data from the participant). Green boxes (stakeholders network evaluation). BO, burnout; BOTP, Burnout Treatment Programme; BTP, burnout treatment provider.

including union representatives and HR employer representatives) was gathered through online questionnaires, focus groups and roundtable discussions. Several aspects were assessed, including the appropriateness of the information and communication channels, administrative aspects and clinical exchanges with Fedris psychologists, and the satisfaction with the combined approach and structure of the programme. Furthermore, difficulties encountered during the project and suggestions for adaptation and improvement were also questioned and discussed.

Outcome evaluation

From the participants, self-reported personal, clinical and professional data were online collected at each measurement, for example, mental and physical health, work-related syndromes through standardised questionnaires (Oldenburg Burnout Inventory³⁶; Depression, Anxiety and Stress Scale³⁷; Burnout Assessment Tool),² employment situation, periods of absenteeism and use of healthcare (medical consultations and exams, medication).

The effectiveness of the BOTP was assessed in terms of changes at post-test 1 and 2 in burnout symptoms and participants' perceived individual health on one hand, and in terms of employment situation, adjustments at the workplace, absenteeism and healthcare expenditure on the other hand.

Objective outcome data regarding the delivered programme were also gathered from the request and diagnosis forms and the final reports. The number and type of sessions provided were analysed in relation to the BTP's conclusion about the burnout diagnosis and the appropriateness of the treatment programme considering the participant's situation.

DISCUSSION

To address the high prevalence of burnout, a secondary prevention programme was co-created and tested in a pilot study. The main characteristics of the BOTP are the

combined intervention, the multidisciplinary and the tailor-based approach.

BOTP as a combined intervention

The existing literature indicates that combined interventions are more effective than those focusing solely on the individual or the organisation,^{38–40} which aligns with the guidelines followed in the present BOTP. However, the scarcity of high-quality studies on these combined approaches presents a significant challenge in this field.⁴⁰ One of the primary obstacles in evaluating combined interventions lies in obtaining reliable conclusions about their content and effectiveness. Essential details and characteristics are often lacking or can vary widely between interventions,^{19 21 32} making it difficult to draw consistent conclusions.

While the BOTP aimed to adopt a combined approach, addressing both individual and organisational levels, the intervention programme still predominantly focused on individual sessions, namely a maximum of 20 individual sessions vs one multidisciplinary workplace meeting. The main reason to focus on individual sessions is probably related to practical implications since these sessions are easier to organise.

BOTP as a multidisciplinary approach

Regarding the stakeholders in the programme, a wide and diverse range of actors were involved, including accredited health professionals, such as occupational physicians and psychologists but also representatives from the work organisation (eg, supervisors, HR managers), who could be invited to take part in the multidisciplinary meeting. This is in line with the suggestion that the work system should also be involved in the prevention of burnout.⁴¹

Karlson *et al.*²⁰ highlighted the lack of contact between the sick worker and his supervisor as a specific contributing factor to long sick leave. On the contrary, a good dialogue may help to diminish the worker's negative

feelings and cognitions associated with the workplace and the events before his sick leave, thus facilitating RTW.

In addition, Corbière *et al*⁴² proposed the inclusion of a work reintegration coordinator to create and maintain a working alliance between the various stakeholders involved in the RTW process. By including different types of sessions and stakeholders from both healthcare and the workplace, the present BOTP programme was created as a multidisciplinary one making it possible to centralise several activities and foster the contacts between the participant and all relevant actors.

BOTP as a tailored-based approach

Developing and implementing a targeted intervention that takes into consideration participants' specific situation is put forward by Shanafelt and Noseworthy⁴³ as a strategy to reduce burnout. Participants in the BOTP could choose to attend different types of sessions allowing for the treatment to be tailored to their needs and characteristics.

By using a flexible approach, participants may feel that they have more autonomy and control over practice,⁴⁴ allowing them to become an active participant in their progress (treatment). In line with the idea of playing an active role, Baathe *et al*⁴⁵ suggested that involving participants in identifying ideas and listening to them to understand their struggles may be a central dimension to prevent long absences due to burnout.

Strengths

First, the construction of the pilot BOTP was based on a literature review⁹ to summarise the available scientific evidence at that time on which to rely. Then, experts from various disciplines as well as representatives from the BOTP's target sectors were involved in the development of the BOTP. Including stakeholder and field experts engagement allowed for a better comprehension of the ground reality, ensured everything was coherent and enabled the development of tailored solutions.

Another important aspect of this study is its flexibility in the implementation of the programme. In addition, depending on the difficulties or shortcomings identified, the Burnout Team worked to propose appropriate solutions and new instruments to overcome the obstacles encountered. For instance, to facilitate communication between the BTP and the prevention actors (prevention advisor for psychosocial aspects and occupational physician) in the follow-up of the same participant, a data transmission report was created after the BOTP Kick-off. Furthermore, an additional session to discuss the reasons behind the negative decision following the diagnosis session and a referral to the most appropriate support was added. Participants, as well as health professionals, were recruited as the programme was being set up.

Another strength is the longitudinal design and data collection at three different times: pre-test, post-test 1 and post-test 2. In addition, reports written by the health professionals are also used in the data collection

which counterbalances any bias caused by self-reported data. Second, an evaluation system with the stakeholder's network associated with the implementation of the programme is carried out as described earlier in the setup of the evaluation process.

Moreover, as the treatment is confidential, participants could take part in the programme without worrying about their workplace being informed about the diagnosis of burnout.

Lastly, this study called for qualified professionals to be involved in the BOTP, hence experts with a relevant training in the mental health field that had a solid experience and frequent contacts with workers suffering from burnout. As a result, the diagnosis of burnout was clinically correct and the participant was treated in the best way.

Limitations of our study

It is important to note that the pilot BOTP is aimed exclusively at workers in the banking and healthcare sectors and is intended for secondary prevention (ie, workers in early stages of burnout). Therefore, the findings will not be able to be extrapolated to other sectors and to workers with longer duration of burnout.

Regarding the interactions between the stakeholders, even though these were of high quality, the amount of time required (spanning from 2016 to 2019) to co-develop and implement the programme remains a major constraint, as cited in the literature review.⁹

In addition, the design of our study, the complexity of the BOTP made it difficult, if not impossible in our case, to include a control group.

As noted by Street and Luoma,⁴⁶ participants in psychosocial intervention studies risk disease progression if untreated, face long-term harm from suboptimal care and may experience hopelessness and despair when unable to act on their desire to improve. This limits the ability to determine if the positive effects seen in post-tests stem from the BOTP or natural burnout symptom reduction over time.

Another limitation is that due to the multiple measurement moments, there is a risk of participants dropping out over time. Gustavson *et al*⁴⁷ report drop-out rates of 30%–70%, stating that the longer the follow-up period is, the higher the risk.

Moreover, the coordination of an intervention at work requires the lifting of workers' anonymity. This may discourage or even limit participation in the multidisciplinary meeting or even informal contacts with preventive actors, as some workers may refuse to lift their anonymity.

An additional limitation is related to the way health professionals reported their data (including diagnosis and intervention reports). Bias may be a possibility given that reports depended ultimately on the personal style of each professional who reported data at different levels, for instance, the level of detail indicated.

A final aspect that can be looked at as both a strength and a limitation is that this programme was completely

free of charge for participants. This is specific to Belgium's social security system which intervenes in funding. Therefore, it is reasonable to say that the programme cannot be generalised to other countries, namely those where employers or employees need to finance costs themselves.

Perspectives

The pilot study was implemented on 17 January 2019 and the data collection ended on 31 December 2022. The BOTP brought together nearly 200 trained professionals around the topic of burnout, and over 1400 employees participated. We will report elsewhere on the implementation and planned evaluation of this BOTP.

CONCLUSIONS

The added value of the development process relies on the collaboration between different stakeholders across diverse disciplines, from the administrative to the academic world, from field experts to social partners. This collaboration allowed for the conception and implementation of a national pilot programme that implies the creation of a support system tailored to the participant's needs at early stages of burnout, and based on a combined, personalised, coordinated approach, from the screening to the assessment phase.

Contributors DM and SV contributed to project conceptualisation and implementation. CD, KK, FL and ILR contributed to project conceptualisation, implementation, analysis and reviewing the manuscript. RS and KV contributed to manuscript drafting, figure conception and reviewing and editing the study. CL contributed to manuscript drafting, figure conception, reviewing and editing the study, as well as manuscript revisions. LB contributed to project conceptualisation, development and analysis, and to reviewing and editing the study. IH contributed to project conceptualisation, development and analysis, manuscript revisions, and reviewing and editing the study, and serves as the guarantor. All authors reviewed and approved the final version of the manuscript.

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Competing interests Six of the 11 authors are employed by FEDRIS (the Federal Agency for Occupational Risks), which funded the current research. Additionally, two of the authors were paid by FEDRIS to conduct the literature review, co-develop the study and evaluate the pilot project.

Patient and public involvement Patients were not involved in the design, or conduct, or reporting, or dissemination plans of our research. Stakeholders however were involved, including field experts such as: Prevention advisors for psychosocial aspects, General practitioners, Occupational physicians, Human resources managers, Confidential counsellors, Fedris members and social partners such as: Federal Public Service Employment agents and Labour and Social Dialogue members and the NIHDI- INAMI [National Institute for Health and Disability Insurance].

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the Ethics Committee of the University of Liège (under reference number 1819-23).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request. The materials developed and used within the Burnout Treatment Programme are available from the corresponding authors on request.

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