



UNIVERSITY *of* LIMERICK

O L L S C O I L L U I M N I G H

MSc Occupational Therapy  
(Professional Qualification)

OT6054

Occupational Therapy Project 4

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Year 2

Word Count: 4,750

April 11<sup>th</sup> 2016

Qualitative evaluation of an occupational therapy led vocational rehabilitation service for people with arthritis; The Therapist's Perspective.

## **Abstract**

**Introduction:** The socio-economic implications for individuals being out of work, places a large amount of pressure on an already struggling Irish economy. Costs incurred as a result of musculoskeletal disorders affect not only the person but the employer, the health system, the social welfare system and therefore have a wider societal cost. While barriers exist that prevent people from remaining in or returning to work there are also structures in place that help support the breakdown of these barriers. The 'Working with Arthritis: Strategies and Solutions' program was an occupational therapy (OT) led vocational rehabilitation (VR) program aimed at supporting people with arthritis to access, remain in or return to work.

**Method:** Adopting a qualitative research design, a focus group and in-depth interviews were carried out with three occupational therapists (OTs) who facilitated the VR program. The study explored their perspective of the barriers and enablers people with arthritis experience when remaining in or returning to work, within the Irish context. Data collected was analysed using thematic analysis.

**Findings:** Five main themes emerged including; (1) the influence of health professionals on return to work, (2) navigating employment supports, (3) living in areas of greater disadvantage, (4) clients personal characteristics, and (5) how the 'Working with Arthritis' program supported clients workability.

**Conclusion:** The findings of this research indicate that VR is an area not routinely addressed by healthcare professionals. It is important that VR is supported by a multidisciplinary team (MDT) approach to ensure clients have the greatest opportunity for success when returning to work.

## **Introduction**

The 'Working with Arthritis: Strategies and Solutions' program was an occupational therapy (OT) led vocational rehabilitation (VR) program aimed at supporting people with arthritis to access, remain in or return to work, education or training and ran from 2013-2015 (Arthritis Ireland 2012). A description of the program is outlined in Appendix I. The program was

funded by the EU Social Fund and the Department of Social Protection and thereby participants were required to be of working age, have a musculoskeletal disorder, living in the Border, Midland and Western counties and in receipt of an illness or disability payment. Two senior OTs facilitated the program from a clinic base in Galway or in clients own home or community. A third OT project managed the program.

This study aimed to develop insight into the experience of OTs who delivered the ‘Working with Arthritis’ program examining their perspectives of the barriers and enablers for people making the transition from illness or disability payments to employment, education or training.

## **Literature Review**

There is strong evidence in support of the theory that work is good for individuals’ physical and mental health and well-being (Law 2002; Baker and Jacobs 2003; Waddell and Burton 2006; College of Occupational Therapists 2009; Hammell and Iwama 2012). As well as providing economic benefits work helps forge a persons’ sense of identity and for many affords them socio-economic status (World Health Organisation 2013; Waddell and Burton 2006). Additionally, returning to work and coming off benefits after a period of unemployment has been seen to enhance self- esteem and quality of life, improvements in level of income and better socio-economic status (Waddell and Burton 2006).

The most common cause of working days lost in Ireland is related to musculoskeletal disorders (MSDs) costing the country an estimated 750 million euro (Bevan *et al* 2009). Thus, MSDs have cost implications related not only to the person but to the economy and the wider society as a whole (Bevan *et al* 2009; Arthritis Ireland 2008; Veale *et al* 2008). The Bevan *et al* (2009) report seeks to increase employability of people with MSDs by improving their capacity to work, reduce the effect of MSDs on workplace absences and play a part in improving the Irish economy.

Other factors associated with an individuals’ MSD which can impact on their return to work, include physical pain, psychosocial ill health, job related factors such as length of commute, job-related demands, relationship with employers and work colleagues, accessing the physical environment, as well as a lack of knowledge of available services that support employment (Veale *et al* 2008; Codd *et al* 2010; Waddell *et al* 2008). Lack of effective

communication between relevant stakeholders, such as employers and employees, general practitioners and employers, has been recognised as a barrier for people when returning to work (Waddell *et al* 2008).

Many of these barriers, however, can be worked on or adapted (College of Occupational Therapists 2009; Hammond 2008). In Ireland, social and economic policy has tried to address these issues, for example, the Employment Equality Acts 1998 and 2004 set out to guard against discrimination of people with disabilities in the workplace and places requirements on employers to facilitate, within reason, the needs of individuals, both within the workplace and when returning to work (Government of Ireland 1998, Government of Ireland 2004). Additional legislation including the Safety, Health and Welfare at Work Act 2005 and the Unfair Dismissals Acts 1977-2007 also seek to protect individuals at work including those with disabilities (Government of Ireland 2005, Government of Ireland 2004). The National Action Plan for Social Inclusion contributes to supporting people with disabilities by promoting “equal opportunities for individuals in the open labour market supported by enhanced vocational training, employment programmes and further development of supports” (Government of Ireland 2007, p56).

According to Waddell *et al* (2008, p.5), VR is described as “whatever helps someone with a health problem to stay at, return to and remain in work”. VR has been seen as an important step in supporting people with disabilities who are out of work, to access employment (College of Occupational Therapists 2009; Lee and Kielhofner 2010; Heller and Harris 2012; Brennan *et al* 2012; Jellie *et al* 2014).

According to the College of Occupational Therapists (2009) OTs provide a number of services to individuals with the aim of supporting them maintain or regain employment, such as, career counselling and advice, worksite assessments, ergonomics, task analysis, vocational assessments, negotiation with employers, job analysis and job modification or adjustment (College of Occupational Therapists 2009). OTs are reported to be well situated to carry out VR because of their unique focus on occupation and how the environment impacts on an individuals’ performance (Thurgood and Frank 2007; Turner 2009; Baxter *et al* 2013). Back to work initiatives such as social welfare payments, supported employment services, further education and training provided by services such as SOLAS, the Department of Social Protection and the Education and Training Board alongside relevant legislation by all seek to provide individuals equal opportunities when accessing the labour market (Brennan *et al*

2012, Department of Social Protection 2010, Department of Social Protection 2013, SOLAS 2014). While these schemes seek to encourage disabled people to return to work, the reality for people with MSDs is that accessing these supports can be a tiring and lengthy process due to the level of information that is required on application and benefit forms. Although benefits are set up in a way that allow people to retain their payments when transitioning back to work, there continues to be a fear among people that they will lose this income (Clayton *et al* 2011).

While the literature indicates a role for OTs in VR and supports that are offered to clients (Ross 2008, College of Occupational Therapists 2009, Brennan *et al* 2012; Baxter *et al* 2012), it does not however, address OTs perceptions of the barriers and enablers people with arthritis' experience when trying to negotiate return to work within the Irish context. As professionals working within a larger system, these therapists may be aware of additional implications that constrain return to work for people with arthritis. This suggested the need to explore this avenue of inquiry in order to gain additional insight that can inform future programs and policy. As the 'Working with Arthritis: Strategies and Solutions' program has drawn to a close it is important to observe these findings from the point of view of the programs facilitators.

## **Methods**

A qualitative research design was chosen as this approach offers "deeper understanding of a social phenomena than would be obtained from purely quantitative data" (Silverman 2000, p.8). Qualitative research is routinely used to examine OT practice (Curtin and Fossey 2007). By conducting in-depth interviews and a focus group, this study investigated the OTs' perceptions of what restricts and facilitates the move from illness or disability payments to employment, education or training.

## **Data Collection**

Research participants were recruited using purposive sampling which involved the researcher intentionally selecting the participants because of their explicit knowledge of the topic under investigation and supports answering the research question (Higginbottom 2004). The participants were three female occupational therapists, two of whom carried out the 'Working

with Arthritis' program and one who project managed the program. The mean year since OT graduation was thirteen years. Although the sample size is small, this is not a comparative study and as only three therapists were involved in the program only their opinions can be sought in response to the aims of the research. Initially a focus group was facilitated with the three therapists followed by individual interviews using a semi-structured format directed by the aims of the research question. The focus group assisted the researcher in determining the design of the semi-structured interviews (Curtin and Fossey 2007). Semi-structured interviews allowed participants contribute more to the research question as they could expand on their answers unlike structured interviews (Polgar and Thomas 2003). Researchers have commended the use of in-depth interviews combined with focus groups as they allow participants to share their individual experience in interviews while expanding their answers in the focus group (Curtin and Fossey 2007). Interviews ranged from thirty five minutes to eighty minutes in length.

### **Data Analysis**

The data in this study was analysed using thematic analysis as described by Braun and Clarke (2006). This method involved inputting the transcribed data into NVivo (2012), a qualitative computer software package. The six phase guide to operate thematic analysis involved reading and re-reading transcribed data in order to become familiar with the information, identifying initial codes, assembling codes to produce potential themes, checking themes fit with the codes and data collected then generating a story from the themes by defining and naming each theme. The sixth and final phase entails compiling the analysed data in a report that synthesises with the research question and the literature (Braun and Clarke 2006).

### **Rigour and Trustworthiness**

The researcher carried out a thorough investigation, to include a well structured methodology to uphold the credibility of the study (Brod 2009). Additionally, strategies such as a detailed description of the selection of participants, data collection and analysis techniques, in-depth findings supported by participants direct quotations, helped facilitate transferability which refers to the degree to which the results of this research can be transferred to other contexts or settings (Curtain and Fossey 2007). At all times the researcher aimed to conduct this study in a means that respects the participants and the data gathered. Although the process involves

active engagement between the researcher and participants it was important to ensure that findings are the perspectives of the participants and not the researcher (Curtin and Fossey 2007). In doing so, the researcher kept a reflective journal to record any interactions or feelings that arose during the course of the research project to ensure reflexivity and enhance the depth of the study.

## **Ethical Considerations**

This research study received Ethics approval from the Education and Health Science Research Ethics Committee (2013\_06\_26\_EHS) at the University of Limerick. In order to make an informed decision and ensure voluntary participation research participants were provided with information relevant to the research project, they were made aware that they were free to withdraw from the study and consent forms were signed and kept by each party. All participants were afforded numbers to protect their privacy and maintain confidentiality at all times. Additionally any statements made by participants during the interviews that could potential compromise their identities were discussed with the participants and removed if required. All electronic gathered data and transcribed interviews were stored on a password protected computer belonging to the interviewer for the duration of the MSc Occupational Therapy Program and will be returned to the principal investigator in May 2016. No information that could potentially identify participants will be attached to the transcribed interviews.

## **Research Findings**

From the ninety eight codes generated five main themes emerged namely (1) the influence of health professionals on return to work, (2) navigating employment supports, (3) living in areas of greater disadvantage, (4) clients personal characteristics, (5) how the 'Working with Arthritis' program supported clients workability.

### **1. Influence of health professionals on return to work**

Participants reported their experience of the lack of emphasis being placed on return to work by health professionals and the affect this had on clients;

*“I don’t think it’s something that other professionals purposefully ignore.....they have a different focus sometimes...due to time, resources and maybe lack of confidence around work rehabilitation...don’t place as strong an emphasis on it...and maybe don’t have an awareness of the impact of being out of work for a person” (IP2).*

From collaboration with other health professionals, in general, participants’ perceived return to work as not being a top priority for health professionals including occupational therapists. This was reported to be due to time constraints, lack of resources, having limited knowledge of the different factors relating to the person including psychosocial factors or not having the confidence to initiate the process of vocational rehabilitation;

*“the feedback from healthcare professionals.....was that they didn’t have the time to be going into the whole VR process” (IP1).*

In addition, participants recounted the numerous times clients reported being advised by different sources including health professionals that they would be better off not working. This came in many forms including; being better off financially, not taking the risk of losing payments, or not being fit enough for work. While acknowledging the pressure sometimes placed on General Practitioners (GP’s) to provide the sick cert participants reflected on the impact this had on those who may have wanted to continue working;

*“in some instances they were encouraged to leave the workplace...but the stepping aside from work was actually more detrimental to them than from an emotional, psychosocial and purpose point of view, because they lost their occupation which was hugely valuable to them” (IP2).*

Participants felt clients would have succeeded in remaining in work with some minor supports and believed that; *“there was more damage done to them because they started to believe that they were not able to work” (IP2).*

Given the status of the GP participants felt that the impact *“is so much more because of the credibility....and the powerful position that they are in means that on the whole what they say, is valued by people” (IP3).*

Furthermore, the lack of proactive conversation between health professionals and people with arthritis surrounding return to work proved to have a negative impact on client’s self-belief

and motivation in their ability to return to work and reinforces the idea that they are unable to work;

*“it is damaging to have a silence around work. Whether your consultant rheumatologist or your physiotherapist isn't asking you anything about work you feel they're not interested in it or they don't expect you to go back to work” (IP3).*

However, participants felt that multidisciplinary team working is crucial in supporting people with arthritis in returning to work be it in addressing the physical or psychosocial factors;

*“the input of a physiotherapist and occupational therapist would be really useful and improve outcomes...consistent messages from all the players in the field about work is really important....around returning to work.” (IP3).*

## **2. Navigating employment supports**

Participants emphasised the complexities of navigating the various services and agencies available in Ireland part of whose role it is to support individuals return to work, for example, Department of Social Protection (DSP), SOLAS, and Employability;

*“employment support systems..are there but it is difficult to find out information about them” (IP2).*

Proceeding through the appropriate channels to reach the correct support service also proved an arduous task;

*“to get people to employability you first have to go through SOLAS. I think the first level of SOLAS is quite onerous and difficult to navigate” (IP2).*

Clients often reported to participants that contacting these services left them feeling less confident and as a result may not have proceeded with their query;

*“for people who have lost confidence in their ability to work...to make that phone call is a challenging step...if they get knocked back at the first point...they may not actually*

*make the next phone call....they get frustrated and their confidence gets lost even more.” (IP2).*

Recent changes in the service structures were thought to have made this process more difficult for clients;

*“there has been a huge transition in those services since the disbandment of FAS to become SOLAS.....and it’s difficult to navigate that system” (IP2).*

Additionally, participants felt there was a *“reluctance in some SOLAS services or some employability services of taking people on who they felt had little hope of progressing” (IP3)*, thought to be linked to having a negative effect on their outcomes.

Clients often reported not knowing what payments they were in receipt of indicating the complexity of the system;

*“all of that uncertainty about payments then follows through into uncertainty about entitlements, pathways, and options and there’s a level of literacy that’s needed to access the information”(IP3).*

In addition, participants had to continue working with clients, encouraging them on their return to work journey while factors out of their control were challenging the outcomes.

*“there is a huge backlog...in terms of having payments processed, even starting a payment or trying to move on to another payment, or being assessed for a payment. They may be waiting months for an answer or for a payment.” (IP2).*

Furthermore, because of the length of time taken to secure payments and entitlements there was often a fear of losing social welfare benefits or being worse off financially by returning to work.

*“It’s very hard for them then to take the risk of returning to work when they don’t know how they are going to manage...particularly in an economy that is depressed...often they are in a household that there is another person unemployed... that money is an absolute priority just to get food on the table” (IP1).*

### 3. Living in a disadvantaged area

Participants reported that the 13 counties they covered were among the most disadvantaged in the country in terms of services available to people with arthritis;

*“ certain more disadvantaged counties....would not have the same amount of rheumatology or allied health....provision...there was more of a desperation in terms of their cry for help.....when you try to refer them on....the lack of services....or the [length of]waiting lists” (IP2).*

Education and training opportunities in addition to accessibility to transport networks and particularly high unemployment rates were described as being a major barrier for people with Arthritis when pursuing opportunities for return to work;

*“ in terms of geographic location...the lack of infrastructure means that some people can't access [education and training] because of restricted transport and poor public transport...we saw a lot of people in rural situations who's choices were limited because of that” (IP2).*

These areas were reported to be among some of the most badly affected by the economic downturn and as such opportunities to source employment was greatly reduced;

*“They were 13 counties with some of the highest...black-spots in terms of unemployment....additional challenges that this population face” (IP3).*

In addition, any prospect of securing employment depended on access to transport and the necessary finances to fund such an essential requirement which was limited for some clients of the program;

*“We might have been able to secure employment or education opportunities for people but they reported that they were not able to access it....there may not have been public transport...[or]they did not have options to have private transport because of the financial implication of it.” (IP2).*

#### 4. Client characteristics

Participants reported that many factors influence people with arthritis' decision to remain in or return to work evidenced by the clients they saw for intervention. Client factors were seen as both barriers and enablers to returning to work, for example, some clients were highly motivated to get back to work; *“some people would enter the service with work on their mind ‘yes my goal is definitely I want to get back to some form of work’ ”* (IP1) while for others the experience of chronic symptoms or distance from the labour market meant; *“they might never have even considered work”* (IP1).

Participants reflected on the barrier imposed on clients who had already lost their job counter to those who remained in work but needed some level of support;

*“When somebody has lost their job that’s when it’s very difficult to get people back to work because... they have to actually find a job....get a job offer and all that is tricky and challenging.”* (IP3).

As oppose to the physical symptoms of arthritis psychosocial factors were reported to be among the greatest barriers related to clients not remaining in or returning to work;

*“A lot of our work was around the more psychosocial side of a person’s capacity and motivation and sense of self-efficacy in terms of their workability...a lot of people with chronic arthritis and fibromyalgia....lack confidence [in their]ability to return to work...a lot of the work was helping them understand...they have a very valuable work capacity”* (IP2).

Participants reported to have thought that some of these factors were a response to being out of work;

*“the impact of being out of work was huge...particularly from a psychosocial point of view. [There was a] high degree....of depression and mental health issues....in the clients we saw.”* (IP2).

The existing value clients placed on the worker role, past experiences in the workplace, their intrinsic desire to work and their current financial situation all impacted on their willingness to seek out opportunities to return to work;

*“people [often]struggle....to return to work because of their mood, their confidence, their self-esteem, their belief in their ability to work, relationships with their colleagues....their employers, how intrinsic the worker role is to them... their cultural beliefs about work, the family they grew up in.” (IP3).*

Furthermore, participants reported some clients; *“didn’t have the skills, [or] reported not to have the funds to be able to buy that technology” (IP2).*

Additionally, many individuals who got in touch with the program did so, only to seek support for their condition and not necessarily vocational rehabilitation. These individuals felt that returning to work was not even an option for them;

*“a big group of people.....were willing to get in touch and wanted help from the program even though they weren’t interested in returning to work, they just wanted help” (IP2).*

## **5. How the ‘Working with Arthritis’ program supported clients workability**

Participants reported the valuable contribution VR made to those who enrolled in the program;

*“ a lot of younger clients.....who had fallen out of work...the impact on them was just huge....the change in them when we got them back to education or work... was fantastic to see.” (IP2).*

Not alone did a proportion of clients return to work, further education or training but for those that did enrol in the program participants described the significant gains in terms of quality of life;

*“in terms of helping them understand their capacity of returning to work... their value as a worker....in the majority....there was an improvement in their health outcome....their general demeanour....quality of living and their mental health.” (IP2).*

In addition to being educated on the benefits of work for their health and well being clients

experienced a new confidence and belief in their ability to return to work and as such became more motivated to participate. Participants reported the importance of asking the ‘work’ question as an enabler of return to work;

*“when you ask people the work question, even if they hadn’t considered it before, it gets them thinking about it.....people that would have initially come not really sure what the service was about.....got really enthusiastic about work or education” (IP1).*

As well as identifying barriers, the interventions offered by the OTs created supported pathways for returning to work, for example, support with establishing goals, navigating employment services and negotiating with employers;

*“there was a lot of interagency work in...moving people along a pathway to work or education...there was another part which.....focussed on self management of symptoms.....sleep management, sleep hygiene, fatigue management, pain management, joint protection, healthy lifestyle.” (IP3).*

In general participants found employers to be supportive once they had been given relevant information, advice and support;

*“I found employers to be....appreciative of our input.....it was reassurance.....that there is somebody else that is also able to give advice” (IP1).*

Participants reported what was often important to employers was, that the cost does not outweigh the benefit, and from a risk point of view, the employer was protected when employing a person with a disability;

*“we were a professional that was able to reduce the risk.....and ultimately improve the clients productivity” (IP2).*

The ‘Working with Arthritis’ program equipped clients with a new found knowledge of opportunities available to them which offered them choice in their lives. All of these interventions act as enablers for individuals with arthritis and the program is testament to this much needed service.

## Discussion

This study explored occupational therapists' perspectives of the barriers and enablers of return to work for the clients they worked with during the 'Working with Arthritis' program. The findings reveal a number of factors that influence return to work for people with arthritis. Participants identified health professionals as both supporting and hindering return to work. They reported that health professionals, in general, are not addressing work as an outcome with clients. These findings echo those reported in other studies relating to people with disabling conditions (Codd *et al* 2010; Dekkers-Sánchez *et al* 2010; Tiedtke *et al* 2010). In a Irish qualitative study of work in early rheumatoid arthritis Codd *et al* (2010) claimed there was confusion among participants regarding where or how to access work interventions. Equally breast cancer survivors reported not receiving adequate information about returning to work from their GP with work being discussed very little and GPs tending to let patients decide for themselves when to return (Tiedtke *et al* 2010). A qualitative study carried out in the north of England exploring personal experiences of returning to work following a mild or moderate brain injury highlighted the lack of work-related advice given by health professionals and participants were unable to recall any discussions with GPs around return to work (Gilworth *et al* 2008). Lack of co-operation among health professionals and guidance on the vocational process was perceived a barrier for return to work in a qualitative study of perpetuating factors for long-term sick leave for chronic work disabled individuals (Dekkers-Sánchez *et al* 2010). Similar to the current study individuals returning to work after a stroke experienced health professionals perceiving the person as unfit or unable for work (Koch *et al* 2005) whereas with some adjustments people have made a successful labour market re-entry (Wolfenden and Grace 2009). In a qualitative meta-analysis carried out by Stergiou-Kita *et al* (2016) cancer survivors reported valuing health professionals advocating on their behalf and advice received regarding the best time to return to work. Although, they argued that the guidance offered from these services needs to be better co-ordinated (Stergiou-Kita *et al* 2016). Additional studies identify support from health professionals as key to work success (Koch *et al* 2005; Tamminga *et al* 2012). Research supports the findings from the current study where participants suggested health professionals need to be more considerate to client's work-related issues and liaise effectively with other members of the team as well as with employment or VR services (Varekamp *et al* 2005).

In the current study participants believed a multidisciplinary team (MDT) approach to VR as key to achieving positive sustainable outcomes for people with arthritis. In a two-year follow

up of an MDT approach to VR with early rheumatoid arthritis Nordmark *et al* (2006) found there was an increase of 14% in the number of patients working full-time and a decrease of 65% for patients with full-time sick-leave compensation. These results were achieved by an MDT consisting of a nurse co-ordinator, an occupational therapist, a physiotherapist and a social worker who liaised with both employers and social security officials (Nordmark *et al* 2006). Interestingly, Varekamp *et al* (2005) found that health professionals believed that their effective co-operation was an important factor in preventing work-disability for people with arthritis. The authors believed this was down to the professionals' comprehensive view of solutions and their ability to collaborate with others to achieve successful outcomes (Varekamp *et al* 2005).

As reported by participants in the current study, financial concerns can be a factor in deciding when to return to work and access to sick leave benefits plays an important role (Stergiou-Kita *et al* 2014). Additionally, the level of financial compensation received for sick leave can impact on an individual's willingness to return to work and Dekkers-Sánchez *et al* (2010) report higher illness related payments are linked to a greater number of work days lost. Similar to the current study, Barnes and Mercer (2005) argue that the lengthy process involved in being assessed for benefits adds to people's disinclination to seek employment. Furthermore, many experience being penalised by moving into paid employment (Barnes and Mercer 2005) and fear the loss of income from benefits if they are to return to work (Clayton *et al* 2011). However, Clayton *et al* (2011) advise on financial incentives available to soften the transition from welfare payments to employment. Partial Capacity Benefit, for example, is a DSP scheme which allows those with reduced capacity to return to work while continuing to receive a social welfare payment (DSP 2015). Participants reported this scheme was great in theory but the delays in receiving payments were a big issue. In a systematic review of return to work initiatives in the UK Clayton *et al* (2011) discovered some schemes, including a Condition Management Programme, had positive results in tackling deep-seated issues for people with chronic health conditions who were further from the labour market helping them move closer or re-enter the workforce. However, Personal Advisors also claimed to have inadequate knowledge of health conditions which could lead to ineffective outcomes (Clayton *et al* 2011). Additionally, this study emphasises Personal Advisors were more inclined to work with clients who were more work-ready suggesting that these evaluations are not a clear indication of work related outcomes for those who are further from the labour market and more to do with meeting targets (Clayton *et al* 2011). These findings

are similar to those in the current study where participants felt employment support services were more equip to working with those who were closer to the labour market and would have a more immediate effect on outcomes. In addition to financial support, high quality evidence suggests that early contact between the worker by their workplace, work accommodation offers, contact between the healthcare provider and workplace, ergonomic work site visits and the presence of a return to work co-ordinator significantly reduces work disability duration associated with musculoskeletal or other pain-related conditions (Franche *et al* 2005).

Similar to other studies participants in the current study observed that clients who were motivated to work and who were closer to the labour market were in a better position for gaining employment (Dekkers-Sánchez *et al* 2010). While having a chronic condition, being further from the labour market, having low motivation and self-efficacy, having a poor illness representation and a low expectation of return to work coupled with additional psychosocial issues were all risk factors for not returning to work (Gilworth *et al* 2008; Dekkers-Sánchez *et al* 2010). Furthermore, in 2013 the Border, Midland and Western (BMW) region, covered by the 'Working with Arthritis' program, experienced an unemployment rate of 14.9%, among the highest in the country, an increase of 9.5% from 2003 (BMW Regional Assembly 2013). Many of these areas relied on employment from the construction sector which significantly declined during the economic downturn. In addition, transport routes in these regional areas had not improved and availability of rural public transport is not consistent creating accessibility difficulties for those without private transport (BMW Regional Assembly 2013).

The role of the occupational therapist in providing vocational rehabilitation is reported in many studies as having an immense contribution along with their understanding of how the social and physical environment influences an individuals' performance and participation (Thurgood and Frank 2007; College of Occupational Therapists 2009; Turner 2009; Lee and Kielhofner 2010; Association of Occupational Therapists of Ireland 2012; Baxter *et al* 2013). Additionally, standardised assessment tools developed by OTs have benefits in identifying psychosocial and environmental effects on clients as well as helping direct intervention and measure the outcomes of therapy (Baxter *et al* 2012). As the OTs in the current study were restricted by the requirements of the funding bodies their capacity to facilitate the program within their full remit may have been compromised as has been reported in the literature (Migliore and Butterworth 2008; Ross 2008).

## **Recommendations for practice**

As part of their continuing professional development all health professionals, including OTs, who work with clients who are out of employment, due to arthritis or any debilitating condition, should engage in training that highlights the importance of work for people's health and well-being and acknowledges the potential harmful effects being out of work may have on these individuals (Franché *et al* 2005; Gilworth *et al* 2008; Dekkers-Sánchez *et al* 2010). In addition, health professionals should be exposed to the numerous variables that can impede clients return to work including personal and environmental factors. As suggested by the findings in the current study therapists should assist clients overcome these barriers using evidence-based research to facilitate successful return to work. Therapists should be aware of voluntary and statutory services that their clients can access. OTs who work in VR should be encouraged to complete more research on the factors that impact return to work, to increase the practice knowledge on this topic, especially in an Irish context. The overall findings of this research indicate that VR is a very worthwhile area for therapists and it should be a central part of OT assessment for clients' who are in the suitable age profile.

## **Limitations and Recommendations for future research**

Although this study contributes to the vast array of information available on the subject of barriers and enablers experienced by people with disabilities when negotiating return to work several limitations have been acknowledged.

The small sample size limits the transferability of the study. Given a longer timeframe a larger sample size exploring the perspective of OTs in other VR settings would provide an interesting comparison.

While many issues specific to the 'Working with Arthritis' program were spoken about during participants interviews the nature of the current research question does not allow for those to be explored in this context. However, further research running parallel to this study includes a quantitative study on the outcomes of the 'Working with Arthritis' program along with a qualitative study involving the programs participants. All three studies will give a comprehensive evaluation of the program.

## **Conclusion**

The findings of this study reveal several barriers for return to work for people with arthritis as perceived by the occupational therapists who facilitated the 'Working with Arthritis' program. These included lack of proactive discussion on the subject of work between health professionals and their clients, the complexity of the employment support structure and benefits system, clients own personal factors, condition-related factors as well as environmental factors. However, clients' motivation and desire to return to employment, training or education is a strong enabler of return to work. In addition, support from a professional, for example, an OT in VR, in collaboration with a multidisciplinary team can facilitate the clients navigate the obstacles that can be difficult to negotiate alone.

The participants in the this study have demonstrated how effective communication between all players creates a holistic approach to working with clients offering them the greatest opportunities to return to work in a climate that possesses so many barriers for people with disabilities. These findings place an onus on health professionals to become more proactive in their approach to clients who may be considering returning to work but are unsure of the pathways available to proceed further. As health professionals working within a larger system asking the work question and having the conversation is a step in the right direction to lifting some of those barriers.

## **Acknowledgements**

This research project was carried out as part fulfilment of an MSc in Occupational Therapy at the University of Limerick. Sincere gratitude is extended to the occupational therapists for giving their time to participate in this study. I would like to thank my research supervisor, Dr. Katie Robinson, for her expert guidance and unwavering patience and support.

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## Appendix I

The Working with Arthritis The ‘Working with Arthritis: Strategies and Solutions’ program was a free occupational therapy (OT) led vocational rehabilitation (VR) program aimed at supporting people with arthritis to access, remain in or return to work (Arthritis Ireland 2012). The program was funded by the EU Social Fund and the Department of Social Protection and thereby participants were required to be aged between 18 and 65 years, living in the Border, Midland or Western counties and in receipt of an illness or disability payment. Two senior occupational therapists (OTs) carried out the program and one OT project managed the program.

- The OTs offered one to one assessment and intervention sessions to clients at a base in Galway or in the person’s own home/community.
  
- The interventions aimed to improve a person’s skills in the following areas;
  - Job seeking and preparation
  - Career exploration
  - Stress and fatigue management
  - Looking after your joints
  - Environmental adaptation to help improve the work environment for clients physical/emotional needs
  - Employer liaison
  - Work-site visits