



A qualitative evaluation of occupational therapy-led work rehabilitation for people with inflammatory arthritis: Perspectives of therapists and their line managers

Yeliz Prior¹, Evangeline A Amanna², Sarah J Bodell³ and Alison Hammond⁴

Abstract

Introduction: Occupational therapy-led work rehabilitation for employed people with inflammatory arthritis and work problems was piloted in five hospitals in the United Kingdom. This qualitative study explored the views of participating occupational therapists and their line managers about the work rehabilitation training received and conducting the intervention, with particular focus on the structured interview used, the Work Experience Survey – Rheumatic Conditions.

Method: Face-to-face semi-structured interviews were conducted with occupational therapists ($n=9$), followed by telephone interviews with their line managers ($n=2$). Interviews were audio-recorded, transcribed verbatim and thematically analysed by three researchers to maximize validity.

Results: The main themes emerging from the occupational therapists' interviews were: varying levels of prior knowledge and experience of work rehabilitation, initial concerns about the feasibility of a lengthy work assessment in practice and increased confidence in delivering work rehabilitation as the study progressed. The line managers' interviews generated themes around the positive impact of the work rehabilitation training the occupational therapists received, and changes in their practice.

Conclusion: The Work Experience Survey – Rheumatic Conditions was considered a good choice of work assessment which can be implemented in practice. Once therapists had provided the work intervention several times, their confidence and skills increased.

Keywords

Work rehabilitation, vocational rehabilitation, rheumatology, work assessments

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Introduction

Work rehabilitation, also referred to as 'Vocational Rehabilitation,' is defined by the United Kingdom (UK) Department of Work and Pensions (DWP) as 'a process to overcome the barriers an individual faces when accessing, remaining or returning to work following injury, illness or impairment' (DWP, 2004: 3). Musculoskeletal conditions are a major cause of sickness absence and work loss in the UK (Black, 2008), with up to 40% of employed people with rheumatoid arthritis (RA) stopping work within 5 years of diagnosis (Young et al., 2009). Therefore, provision of work rehabilitation before work cessation occurs is particularly important for individuals with RA as, more often than not, they are at employment age at the onset (Allaire et al., 2011; WHO, 2013).

Rheumatology occupational therapists are best placed to help employed people with RA who experience work problems, as they have an inherent understanding of occupation as a biopsychosocial construct, and have historically used therapeutic work activities in rehabilitation (Joss, 2002; Preston and Prior, 2013; Prior and Hammond, 2014). The National Institute for Health and Care Excellence (NICE, 2009) guidelines for adults with RA

also emphasize referral to occupational therapy for patients with RA who are experiencing activity limitations in any area of daily life (NICE, 2009).

This qualitative study was nested within a multi-centre pilot randomized control trial (RCT) which aimed to investigate the vocational, clinical and cost-effectiveness of occupational therapy-led work rehabilitation in people with inflammatory arthritis (IA), who are in work but have job concerns because of arthritis. The overall aim of this study was to explore the views of participating

¹Research Fellow, Centre for Health Sciences Research, University of Salford, Salford, UK

²Research Assistant, Centre for Health Sciences Research, University of Salford, Salford, UK

³Senior Lecturer, Centre for Health Sciences Research, University of Salford, Salford, UK

⁴Professor of Rheumatology Rehabilitation, Centre for Health Sciences Research, University of Salford, Salford, UK

Corresponding author:

Dr Yeliz Prior, Centre for Health Sciences Research, University of Salford, Allerton Building, Frederick Road Campus, Room L701, Salford M6 6PU, UK. Email: y.prior@salford.ac.uk

occupational therapists and their line managers concerning (1) the work rehabilitation training the occupational therapists received, using a structured interview, the Work Experience Survey – Rheumatic Conditions (WES-RC) (Allaire and Keysor, 2009), to identify and prioritize the work problems of people with IA and (2) providing the work rehabilitation to the trial participants.

At the start of the pilot trial, participating occupational therapists attended a 3-day training programme. Prior to this, they reported treating only a few employed people with IA experiencing work problems per month. The work interventions provided lasted on average 45 minutes, including brief verbal and written advice about ergonomic measures patients could apply at work (for example task rotation, work station re-design, pacing, joint protection) and signposting to other work services if necessary. Pre-training, the occupational therapists rated their knowledge of, and confidence in, delivering work rehabilitation as 'limited'. Post-training, this increased significantly to, on average, 'good' (O'Brien et al., 2013).

Literature review

Little is known of the effects of work rehabilitation provided by occupational therapists, or other healthcare professionals, for patients who are at risk of work disability due to IA in the UK. A recent systematic review of work rehabilitation trials in the UK (Preston and Prior, 2013; Prior and Hammond, 2014), identified only one study: a prospective randomized control trial (RCT) comparing occupational therapy and work rehabilitation versus usual care only (Macedo et al., 2009). The intervention was delivered by a rheumatology occupational therapist with work rehabilitation experience. The intervention group received six to eight sessions of occupational therapy, each lasting 30 minutes to 2 hours, over 6 months, as well as usual rheumatology care. Usual care included routine reviews by rheumatologists with early, aggressive medical management. Patients were also signposted/referred to other services as required. The control group received usual care only, with no occupational therapy. Its methodological quality was rated as medium to high (Preston and Prior, 2013; Prior and Hammond, 2014). At 6 months follow-up combined occupational therapy and work rehabilitation led to significant improvements in work instability, self-reported work satisfaction, performance and disability (Macedo et al., 2009). However, the authors identified several limitations: the occupational therapist both treated and assessed the participants, meaning there was no independent assessment; the trial was small, with only a short follow-up; and it had surrogate work outcomes. Consequently, larger studies with measures of work loss, absenteeism and presenteeism are needed. As there is only one small UK trial in IA, it is impossible to determine if these results are consistently achievable. Thus, there is a need for more interventional studies to evaluate work rehabilitation provided by occupational therapists for people with RA in the UK.

The findings of Macedo et al. (2009) were comparable to those from a RCT in the USA evaluating work rehabilitation in 242 employed people with a range of arthritis conditions (Allaire et al., 2003). Participants received on average two 1.5 hour sessions on job accommodations, vocational counselling and self-advocacy, delivered by rehabilitation counsellors. The control group received printed materials about disability employment issues. Between 12 and 42 months' follow-up, a greater proportion of those in the intervention group continued to work compared to the control group. This study concluded that timely, patient-centred work rehabilitation interventions assist in promoting work retention and reducing work disability (Allaire et al., 2003).

Evidence for the effectiveness of work rehabilitation in IA (and other arthritic conditions) is insufficient (Karjalainen et al., 2003; Hammond, 2008; Sokka et al., 2009; Vliet Vlieland et al., 2009) and further well-designed RCTs evaluating work rehabilitation and its cost-effectiveness are needed.

Method

The qualitative methodology chosen to elicit occupational therapists' views of the work rehabilitation intervention was thematic analysis, a flexible and useful research tool, which can potentially provide a rich, detailed, yet complex account of data (Braun and Clarke, 2006).

Participants

Nine experienced occupational therapists (\geq Band 6) were recruited from five rheumatology out-patient departments in the National Health Service (NHS). All were delivering the trial intervention, which was being tested, to employed people with IA (i.e. specifically early IA, RA and psoriatic arthritis (PA)) reporting concerns about working because of their arthritis. The work rehabilitation provided (described below) was spread over 2 to 4 months, dependent on participants' needs.

Procedures

The study was approved by the National Research Ethics Service (NRES) Committee, East Midlands, Nottingham. Confidentiality and anonymity have been addressed by not disclosing the name of the hospitals where participating occupational therapists practice and by using a means to identify participants without using names.

The occupational therapists were informed about the interviews during their work rehabilitation training programme (described below) and asked to consider participating. The first author, who was not involved in training delivery or mentoring, mailed a study invitation letter to the occupational therapists along with an information sheet, reply form and a Freepost envelope. Written consent was obtained. Semi-structured face-to-face interviews, lasting up to 30 minutes, were conducted with occupational therapists: after training and intervention delivery

with at least one participant, and again after the intervention had been delivered to all participants in the treatment group. These focused on their views on the applicability of the training and mentoring, and any recommended modifications to these; experiences of delivering the intervention, including conducting the structured interview assessment, the WES-RC; and any potential barriers and facilitators to delivering the intervention in a future trial or clinical practice setting.

At this latter interview, they were also asked for permission to contact their line manager. Line managers identified were then mailed the study information sheet and a consent form. Following written consent, arrangements were made for a mutually convenient time to conduct a short telephone interview, lasting up to 20 minutes. These interviews focused on their perceptions of the work rehabilitation training their staff member received, and any potential barriers and facilitators to delivering the intervention in a future trial or in clinical practice.

All interviews were audio-recorded and transcribed verbatim, with names replaced by codes to maintain anonymity.

Work rehabilitation training

As part of this pilot RCT, rheumatology occupational therapists initially received 2 days' training in work rehabilitation delivered by work rehabilitation experts. The therapists had identified that 2 days would be the most they could take out of work. The training included: assessment of patients' physical and psychosocial functioning related to work; use of the WES-RC (Allaire and Keysor, 2009); analysing jobs (for example, task analysis, working positions, postures, activity cycles); providing solutions for work-based problems (for example, ergonomic modifications, job redesign, specialist equipment); applying condition management skills (for example, fatigue management, joint protection, stress management, exercise, negotiation and communication skills); current work-related legislation (for example Equality Act 2010, statutory and third sector employment, support and advisory services in the UK); and how health is managed in the workplace. Following this, it was found that therapists needed further training. They agreed they could undertake a further structured self-study programme (equivalent to 1 day) and attend a follow-up training day 2 months later to consolidate knowledge and skills. The training programme included a variety of teaching methods: short talks, case studies, activity analysis, practical workshops, a telephone role play of delivering the WES-RC with feedback, and peer teaching with role play and feedback, on how to provide interventions in different case scenarios (O'Brien et al., 2013). Participating occupational therapists also received the Work Rehabilitation Resource Manual (developed for this study), with extensive information on work rehabilitation strategies, adaptive equipment, legislation and employment services. Occupational therapists also received on-going mentor support from the work rehabilitation experts during the intervention phase (via

telephone, visits, email). An email discussion group, along with quality monitoring to ensure adherence to the work rehabilitation treatment protocol, was also in place.

Work rehabilitation intervention

The work rehabilitation intervention developed for implementation in the UK was modified from the American intervention developed by Allaire et al. (2003) (Hammond et al., 2011a). This was designed to be a brief intervention, consisting of up to three 1.5 hour one-to-one meetings with a rheumatology occupational therapist, a 30-minute review by telephone, and to provide self-help booklets about managing problems at work (Arthritis Care, 2006; National Rheumatoid Arthritis Society, 2009). An optional 1.5 hour further contact could be provided for patients with more serious work problems. The WES-RC (Allaire and Keysor, 2009; Hammond et al., 2011b, 2001c) was used to identify patients' priority work problems and the barriers (physical, psychological, environmental (physical/social) and managerial) to overcoming them. Then the occupational therapist and the patient determined priority solutions and acted to resolve them through collaborative problem-solving and appropriate interventions. Occupational therapists worked towards empowering patients to set goals and supporting them to resolve difficulties themselves.

Data analysis

Qualitative data were thematically analysed (Braun and Clarke, 2006). The steps included: (1) reading and re-reading the transcripts to gain a general sense, and noting potential themes arising from the data; (2) generating initial codes; (3) searching for themes through an initial thematic map; (4) reviewing and refining themes; (5) defining and labelling themes through a developed thematic map; and (6) writing a report (Braun and Clarke, 2006). Validity of the emerging themes were supported by three researchers analysing the data independently and agreeing themes after analysing each transcript; through discussion of their data and analyses by the study management committee; and by asking one other member of the committee to independently review two occupational therapists' interview transcripts and the analyses. The final report was presented to the participants to confirm whether it reflected their experiences (Pope et al., 2000).

Results

Of the participating occupational therapists: six were Band 6, two Band 7 and one Band 8. They had 8.5 (SD: 4.10) years of rheumatology experience and had provided work rehabilitation and advice for 4 (IQR 1–9) years prior to the study. Occupational therapists treated 29 participants randomized to the intervention group, providing an average 3 (SD: 1.08) hours of work rehabilitation to each patient.

Initial interviews with occupational therapists

The analysis generated an overarching theme: the varying levels of prior knowledge and experience of work rehabilitation amongst rheumatology occupational therapists. There were a number of subthemes within this. Each sub-theme is illustrated with participant quotations and reported anonymously to preserve the identity of the participants.

The WES-RC as an effective tool to use in work rehabilitation. This subtheme relates to the occupational therapists' views on using the WES-RC as a structured assessment to identify and prioritize work problems of employed people with IA. Most occupational therapists considered the WES-RC as an effective tool to use in work rehabilitation, suggesting:

So I think the structure allowed me to be able to tweak out what potential problems were there, even though they seemed very little problems, but the actual little action made a really big difference to his work, so that was quite a surprise really I think (OT05).

explaining that:

It's because the questions we are asking promotes them to talk for longer or to open up more, I found both patients have had, have actually opened up and talked a lot more than a normal patient would do for their initial interview... (OT04).

Lack of previous experience in using structured assessments. Despite finding the WES-RC was an effective tool, their lack of experience conducting structured interviews meant it was initially difficult to efficiently use it. As an occupational therapist put it:

We had quite a bit of training, I know it had concentrated on that, again I don't know if it is just the fact that when you actually come to do it, live, it is like oh my goodness, did I not listen at this bit, I don't know if that is where I am kind of thinking if we were perhaps able to interview sort of clients who have got problems or if we could observe somebody who does it day in and day out and kind of see how they sort of apply it (OT01).

Another occupational therapist highlighted the difficulties experienced conducting a lengthy structured assessment in clinical practice when one is not familiar with the process:

I was feeling the need to do everything and tick all the boxes, whereas previously on the trial, one that I'd done with the mentor over the phone, I hadn't and I wouldn't normally do that, and it was just interesting

that it's just becoming familiar with using a lengthy standardized assessment I think (OT02).

A need for a more comprehensive approach to work rehabilitation training. All participants found the training and resources very valuable, but several stated the training programme assumed too much prior knowledge and expertise in work rehabilitation. More comprehensive training was recommended, including more: practical elements, activity analysis and practicing work rehabilitation delivery with feedback. An occupational therapist said:

I don't know whether there was an assumption that we already did a lot more than we actually do, in terms of VR [vocational rehabilitation], so, I think, that would have been helpful to have more a mixture of some of the practical stuff, where you find out for yourself, but also some more guided stuff with, actually, this is what we've done, case, you know, perhaps more case studies, more advice about what they'd actually do with the equipment and why they'd advise one piece against another (OT09).

They also commented on the fact that there was a gap between the training and treating their first patient, because recruitment started later than planned (as time to complete research site approvals took longer than anticipated). It was commented;

I thought it was very well organized and the literature they gave us was quite extensive and comprehensive and I liked the training pack immensely, it was quite interesting bedtime reading, kept me quiet for a long time. Now that I have actually starting seeing the patients, the only thing I would say is that it was a long time between actually attending the training and the first patient being interviewed by myself so there was a bit of a gap there which I found quite difficult really (OT01).

Closing interviews with occupational therapists

The analysis generated two main themes: (1) increased confidence in delivering the work rehabilitation intervention, and (2) concerns about the feasibility of a lengthy interview in practice. These themes are exemplified with participant quotations below.

Increased confidence in delivering work rehabilitation intervention. All participants considered the work rehabilitation intervention beneficial for patients and acknowledged an improvement in their service delivery had occurred, suggesting their skills in identifying and helping to solve patients' work-related problems were enhanced. Moreover, all therapists appeared more confident at the end of the study, having delivered the intervention to a number of patients, in comparison to how they felt in the initial interviews, after training and intervention delivery with at least one

patient. One therapist expressed how they felt overwhelmed at first:

Initially it was quite new and a bit challenging, because I'd never done anything so formal before and it was actually quite intensive... (OT08).

Another therapist expanded upon this, explaining how these new skills reinforced her role within the team:

As I got more clients to work with, it became easier to do. Some of the things it was all very new to me... I'd never, kind of, done adaptive work around keyboards and what have you, but the manual [Work Rehabilitation Resource Manual] was really helpful for that and, again, there was always a person at the end of a telephone, so, you know, I've worked away with some experience of those areas now. It has led to changes in practice, it's still on-going at work, we still get referrals for people with work issues, so it's definitely highlighted my role or reinforced my role within the team and it's quite nice (OT03).

The increased confidence in ability to do a work assessment also led to a more comprehensive assessment of patients' rehabilitation needs, and individualized intervention delivery. As one therapist put it:

I've altered the way that I probably discuss with patients the work having been on the course because I look at things differently and therefore I ask more delving questions and I would go into things more deeply than I have done before and looking at things like, particularly, equipment and talking about trolleys and computer equipment and things perhaps more deeply than I would have done before. So it's made me be aware much more of what I can do (OT04).

Concerns about the feasibility of a lengthy interview in practice. Despite finding the work rehabilitation intervention improved their service provision; occupational therapists were concerned about the applicability of the lengthy initial interview in practice. They strongly felt that the issues around increasing demands and limited capacity in the NHS might be a barrier to conduct the WES-RC as part of their usual service. An occupational therapist said:

It would have to be done in – we have an initial interview of an hour and it would have to be done within that time. It couldn't be longer than that because my management wouldn't let us have longer (OT04).

A participant expanded upon the aspects relating to service development issues in the NHS as:

The only barrier would be case load and time available and permission from managers to do it, because the

current climate in the NHS is, yes, they want service development, but only if it doesn't cost anything to do and so that would be the only challenge (OT02).

Another therapist explained:

In the NHS we don't get the opportunity always to do such a comprehensive job. As hard as we try I think and we are very limited, particularly when you work in, well, any area in outpatients, it's, like, this is what you do and that's your intervention and off you go. And anything that I think is seen as not directly reflective to help, like, social rather than medical, it needs to be something that comes from a different source of funding (OT01).

Telephone interviews with line managers

Telephone interviews were conducted with the two occupational therapy line managers, from different NHS Trusts, who consented to participate in this optional part of the study. Two main themes were identified through the analysis, these were: (1) the impact of the work rehabilitation training occupational therapists received, and (2) the positive change in occupational therapy practice.

Benefits of the work rehabilitation training occupational therapists received. This subtheme captures the examples of how the work rehabilitation training and mentoring occupational therapists received in this study impacted on their practice. As a line manager put it:

I think there are other things that they've learnt, you know, through the training and supervision they received in this study; things like more knowledge about access to work, better links with employers potentially in the future and the importance of things like keeping up to date with the legislation and so on. So, I think, as I say, overall I think it's probably improved their practice, so that's a good thing (OTLM01).

Both line managers thought that the training given was very comprehensive, and covered all aspects of work rehabilitation in occupational therapy. Reflecting on the occupational therapists' feelings following the intervention delivery, a line manager said:

...felt exceedingly supported and feels like she's had every opportunity and every... given training that she requires to actually take it forwards. She wasn't left wanting anything before starting the trial or throughout, and she's always been able to seek support and get support timely if she's needed anything (OTLM02).

Although the comprehensiveness of the work rehabilitation training was greatly appreciated, it was suggested that

for future practice the training could be spread over time to allow the therapists to evaluate the information given, and may be modified to include more practical elements, such as case studies, to allow therapists to understand the applicability of the information given in these sessions. As one occupational therapy line manager put it:

Yeah. I mean, the training they thought was very intensive and was . . . an awful lot of information had to be absorbed, and I think felt a little bit overloaded, is what the feedback was. And, potentially some more practical elements of the training might have been useful (OTLM01).

Improvements in the occupational therapy service provision. The line managers reported that a positive change in practice occurred as a result of using the WES-RC as a structured interview to identify and prioritize work problems of employed people with RA in occupational therapy. A line manager explained how:

Actually, it did improve their practice. It was a very detailed study and very detailed assessments, so I think by actually going through this process they actually learnt, perhaps, some extra aspects that they could include in their future assessments (OTLM01).

The occupational therapy line managers also believed that the occupational therapists changed the emphasis of their general assessment as a result of implementing the work rehabilitation programme within their practice, as this raised their awareness of the importance of work-related assessment within their service provision. A line manager stated:

I think it actually did change their practice, and I think they were perhaps a bit more aware of some aspects of their assessment that they could do in a bit more detail in the future. And, I think it perhaps changed the emphasis of their general assessment, in terms of work and where that fitted in with the more general assessment. So, I think the importance of work within their general assessment probably felt, you know . . . sort of, had a higher priority if you like after going through this study (OTLM01).

It was also highlighted by a line manager that these changes in the service provision were also appreciated across the multi-disciplinary team, as these professionals work very closely across cases. It was put forward:

. . . It's a very close-knit team across at the rheumatology department, and they work very, very closely with the consultants and the nurses, psychologists and the rest of the team. And, they discuss, on a monthly basis, what's going on in each area. So, obviously, the OT has fed this back across to all of the other . . . the rest of the team as well, who all find it beneficial because they do

cross over into each other's area. So, what affects one does affect another clinician as well across there, because it's very tight-knit (OTLM02).

Discussion

The aim of this study was to explore the occupational therapists' and their line managers' views of: the work rehabilitation training programme; using a structured interview (WES-RC) to identify and prioritize the work problems of people with IA; and providing the work rehabilitation. The semi-structured interviews were designed so that all participants were asked similar questions, restricting the discussion to the specific questions asked by the interviewer. This approach helped to produce a full range of relevant and salient themes and topics, generating the appropriate level of detail needed to address the research questions. However, this may have limited the discussions, as using unstructured interviews instead could have allowed for more in-depth probing to ascertain a wide-range of themes about the participants' views and experiences of training, using the WES-RC and providing work rehabilitation. However, this qualitative study was conducted as part of a pilot RCT, thus, it was important to focus the interviews on the feasibility of implementing this intervention in a future trial and in practice. The analytic approach was rigorous and the findings are grounded in participants' own words. The transparency of methods was ensured by describing the methods explicitly.

The participants were based in a range of NHS hospitals located in northern England, which included urban and rural settings. Although all were experienced rheumatology occupational therapists, their previous experience of delivering work rehabilitation varied greatly (O'Brien et al., 2013). Only two out of five line managers of the nine occupational therapists consented to take part in the qualitative interviews. A larger sample of occupational therapists and line managers working in a variety of rheumatology settings may have provided further insights into the training provided, using the WES-RC and providing work rehabilitation in clinical practice.

The occupational therapists received the equivalent of 4 days' training over 2 months (talks, discussions, practical workshops, role play and self-study). The evaluation of the training programme demonstrated that the therapists significantly improved knowledge and confidence in providing work rehabilitation (O'Brien et al., 2013). Initially, the therapists had indicated they could only be released for 2 days' training. During this, in response to the identified need for further training, an additional 2 days were added. During interviews, the occupational therapists recommended further practical work rehabilitation training was needed, spread over more time to help consolidate their learning. However, the barriers to implementing this in practice might be the pragmatic issues rheumatology occupational therapists face in the NHS such as managing heavy case-loads, and the

constraints placed on their schedules to make time to attend a more comprehensive training programme. The occupational therapists' confidence in delivering the work rehabilitation increased towards the end of the study as they treated more patients, and gained experience in using the structured assessment. This might suggest that what occupational therapists need is the experience of delivering work rehabilitation in practice, rather than more comprehensive training.

All participants agreed that the WES-RC is a good choice of work assessment which can be implemented in practice. They were able to better identify and prioritize patient issues, had improved their problem solving skills and derived positive outcomes owing to thorough assessments. However, they had concerns about the clinical applicability of this lengthy interview, as it took over an hour to deliver, over several sessions. Allaire and Keysor (2009) reported that, on average, during testing it took American occupational and physiotherapists on average 44 (range 25–60) minutes to complete the WES-RC with patients. In contrast, in our pilot study, it took the occupational therapists almost twice as long, on average 79 (range 40–110 minutes), to complete (Hammond et al., 2014). However, this may have been due to their lack of experience in using standardized assessments in practice as, towards the end of the study, they reported becoming quicker going through the assessment, prioritizing and goal setting. This is consistent with the findings of previous studies suggesting that occupational therapists are reluctant to use standardized assessments (Holmqvist et al., 2009), and tend to use clinical observations in place of these (Koh et al., 2009). This suggests our training programme needs increased practice and feedback to ensure that the WES-RC is completed in under an hour, including identifying priorities and beginning treatment planning, and that the occupational therapists are confident in its use with patients. Additionally, the occupational therapists were positive about delivering the work rehabilitation and its benefits to participants. The patients received on average 3 hours direct work rehabilitation (including conducting the WES-RC) spread over 3 months (Hammond et al., 2014). However, some therapists expressed concerns about the feasibility of delivering this comprehensive intervention in practice, because of pressures to provide minimal interventions in the NHS.

Conclusion

This study set out to explore the implementation of an occupational therapy-led work rehabilitation intervention for people with inflammatory arthritis, who are employed, but have job concerns. The findings reveal that the WES-RC is a good choice of work assessment which can be implemented in practice but that therapists had some concerns about being able to provide this work rehabilitation intervention in practice. Rheumatology occupational therapists need more wide-ranging training, including more practical elements, activity analysis and practice in work

rehabilitation delivery, to increase their confidence and efficiency.

Key findings

- The WES-RC is a good choice of work assessment which can be implemented in practice when delivering work rehabilitation to employed patients with inflammatory arthritis.
- Rheumatology occupational therapists need more training/experience in delivering work rehabilitation within the time constraints of practice in the NHS.

What the study has added

This study provides an account of rheumatology occupational therapists' experience of delivering a work rehabilitation intervention, including the WES-RC, to employed RA patients with work problems, and their line managers' views on the implementation of this intervention in clinical practice.

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Ethics

The NRES Committee East Midlands – Nottingham 1 approved the study (REC reference: 11/EM/0103).

Declaration of conflicting interests

None declared.

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