Supporting work participation of people with a chronic disease

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CHAPTER 8
General discussion
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The aim of the present research was to facilitate OHPs in their support of people with a chronic disease in participation in work, through the provision of evidence. The main objectives were to obtain an overview of which factors and interventions influence the work participation of people with a chronic disease, and to evaluate how the use of evidence by OHPs can be facilitated, in order to optimise their guidance and assessment of people with a chronic disease regarding work participation. This chapter presents the main findings, followed by methodological considerations. Thereafter, the interpretation of the findings, implications for future research and recommendations for practice are discussed.

Main findings

Which factors affect the work participation of people with a chronic disease, independent of their diagnosis?

We conducted a systematic review to identify factors that influence work participation (Chapter 2). The factors we identified were related to an individual’s health (e.g. comorbidity), to an individual’s environment (e.g. feeling welcome back at work) or to an individual him- or herself (e.g. own prediction of RTW). We further explored personal and environmental factors that influence work participation, by studying employees’ perceived value of work (Chapter 3). We found that respondents generally value work, mainly because work provides income, social contacts and the ability to contribute to society. Aspects that motivated or demotivated respondents to participate in work were related either to work or to the person him- or herself. Examples are positive or negative social contact with colleagues or clients, level of autonomy and work content.

Which effective interventions can enhance the work participation of people with a chronic disease, independent of their diagnosis?

As the influence of several factors can be changed through the use of interventions, we researched which interventions are effective in enhancing the work participation of people with a chronic disease (Chapter 4). The results showed that effective interventions were mainly focused on changes at work, and included changes in the work environment, workplace or work
equipment, work organisation, and communication between the stakeholders involved.

What role do people with a chronic disease have in improving their participation in work?

People with a chronic disease have the greatest interest in their participation in work. We therefore explored their perspectives on their role in participation (Chapter 5). Specifically, we asked what solutions they have to be able to participate in work and what support they need to find and use these solutions. Several solutions were reported, either focused on themselves (e.g. learning to accept and cope with the disease, gaining insight into what they are capable of, believing in themselves, getting information about the disease and types of available support) or focused on their job and workplace (e.g. disclosing the disease to the work environment, having a degree of autonomy at work, making adaptations to the workplace). They mostly needed support from OHPs, their employers and colleagues to find and use these solutions.

Can a training programme increase OHPs’ use of the guideline recommendations in the guidance and assessment of people with a chronic disease regarding their work participation?

The evidence obtained was included in a guideline, after which recommendations were formulated to provide OHPs with hands-on knowledge and skills to integrate the evidence in their daily work. A training programme was developed to facilitate the use of these recommendations (Chapter 6). We therefore explored OHPs’ training needs. Based on their training needs, learning objectives were formulated, such as ‘being able to empower the individual to take an active role’. Next, experts in the field of training were interviewed to explore relevant activities that would help the participants achieve the formulated learning objectives. Reported training activities were: homework, case study, roleplay, discussion of best practices, debate, and interviewing an employer or medical specialist. Finally, learning objectives and training activities were integrated in a six-hour training programme.

We then evaluated the feasibility of the training programme (Chapter 7) by exploring acceptability, implementation and limited efficacy. The results indicated that trainees found the training acceptable, by reporting the training programme as ‘relevant’, ‘useful’ and ‘increasing their capability’
regarding their guidance or assessment of people with a chronic disease. They also found the programme feasible to implement on larger scale, but anticipated some barriers and facilitators in this process, such as time, money and support of OHPs’ organisations. Finally, the results on limited efficacy showed that the training programme increased OHPs’ knowledge and skills both after reading the guideline and after participating in the training.

**Methodological considerations**

We used several research methods to gather evidence to facilitate OHPs, and to develop and evaluate the feasibility of a training programme. First, we conducted two systematic reviews to gather evidence on factors and interventions that influence the work participation of people with a chronic disease. This provided a broad overview of available international evidence. Second, we explored the perspectives of people with a chronic disease. People’s perspectives, needs and expectations can contribute to the evidence as we can learn from their experiences and insights [1,2]. Insight into people’s needs and expectations leads to research that better relates to people with a chronic disease [1-3], which may ultimately help OHPs to optimise their support of people regarding work participation.

Although we included various perspectives of people with a chronic disease and explored their solutions to participate in work, we might have missed some perspectives and solutions related to specific chronic diseases. For example, people with rheumatic diseases frequently experience morning stiffness [4]; these people might benefit from other solutions related to this limitation. In addition, several solutions provided by participants require a higher level of autonomy at work, such as the solution to have frequent breaks or to work from home [5]. This is in line with previous research, which showed that the level of autonomy an individual has at work influences the level of uptake of the reported solutions [6]. Therefore, the applicability of the solutions for people with lower levels of autonomy might be influenced. The tendency of solutions to focus on more autonomy at work may be explained by the fact that people with a lower education or social status, who generally have lower levels of autonomy at work, tend to be harder to reach as participants in studies [7]. Research has found that people with a
lower education or social status generally do not see the value or relevance of research [8], which can be reason why they do not participate in studies. As this is a common problem in research, more structural adaptations of the approach and research methods used should be made to include in research people representing the entire population. With respect to solutions per diagnosis and for people with lower levels of autonomy, OHPs should take into account that the solutions reported in this thesis serve as a framework, which may include useful solutions, that can be adapted and complemented with the individual’s working and personal situation, in discussion with the individual.

As OHPs were to be the end-users of the evidence presented in this thesis, we also explored the perspectives of OHPs in order to optimise and facilitate their use of the evidence in daily practice. This was done by involving OHPs in the development of the training programme, which enabled us to adjust the programme to the needs of OPs and IPs [9-11]. This is a strength, as involving OHPs increases their ownership with respect to the training programme [12], which generally positively influences their motivation to adhere to the programme [12-14]. Although we aimed to develop an effective training programme by involving OHPs in the development of learning objectives [15], and aligned the learning objectives and training objectives according to the constructive alignment theory [9], we were not able to fully align the knowledge and skills test with the training programme. The aim of the test was to measure the increase in OHPs’ knowledge of and skills related to the evidence. Although learning objectives and training activities were formulated to learn by personal experience in application, which according to Bloom et al. [16] facilitates the integration of the information, the knowledge and skills test focused primarily on memorising knowledge. Memorising is a lower order thinking skill, whereas applying knowledge is a higher order thinking skill [16]. Therefore, the knowledge and skills test could not indicate whether the knowledge is applied and fully integrated in OHPs’ daily practice. Although in our approach other methods were not feasible due to the setup and time schedule of the training programme, future research can evaluate this by exploring the integration of knowledge and skills using additional research methods, such as observation of OHPs’ guidance or assessment.
Interpretation of the findings

Value of work participation for individuals with a chronic disease

Our results, as well as previous research, show that people with a chronic disease often find working a challenge [17,18]. Individuals with a chronic disease can experience limitations due to their condition, such as the inability to move, fatigue or pain [19-22], that can hinder the performance of their work tasks [18,23,24]. We also know from previous research that receiving a diagnosis can have a large impact on an individual, which can temporarily or permanently influence the priority that work has for that individual [25,26]. The results presented in this thesis, however, show that many people with a chronic disease value work and want to participate in work. Participants’ value work as it provides financial independence and social contact with colleagues or clients and the opportunity to contribute to society. They also indicated that work contributes to their mental and physical health [5].

That work has value for people with a chronic disease, even though they may experience difficulties at work, is in line with other studies. Van der Klink et al. [27] argued that in recent decades the value of participation in work has shifted from generating income to the ability to achieve societal and personal goals and values. This means that being able to participate in work provides an individual with the opportunity to attain goals and values such as personal identity, self-esteem and social contacts [28], which is congruent with our results; that is, our participants reported such values as social contact, ability to contribute to society, and the use and development of one’s talents [29]. Generating income, and thereby financial independence, has thus become just one of the many values that can be attained through work. Following this perspective, most people can benefit from the opportunity to work and should therefore be supported to participate in work, since work provides the ability to attain goals and values.

Not only has the value of work changed in recent decades, but also the perception of ‘working with a chronic disease’ has shifted. Whereas the focus used to be on an individual's limitations and inabilities, the societal perspective now focuses on the individual and his or her capabilities. This concept underlying the capability approach [30-32] is that each individual has his or her own capabilities, based on personal resources or external characteristics. In this approach [30-32], the focus is no longer on the disease
alone, but on the ‘bigger picture’ of aspects that influence an individual’s capability, which aligns well with the findings presented in this thesis concerning aspects that are independent of diagnosis.

**Evidence facilitating support of people with a chronic disease**

Although work participation in the Netherlands is supported by OHPs, participants in our research indicated that they experience many difficulties in their performance of work [5,29]. Many of these difficulties are independent of diagnosis, such as lack of appreciation by the work environment, the content of work tasks and uncomfortable work environment [29]. In accordance with the model developed by Michie et al. [33], providing OHPs with additional information can increase their capability, which may facilitate their guidance and assessment of people with a chronic disease.

**Aspects independent of diagnosis**

First, evidence was gathered on which factors and interventions influence work participation independent of diagnosis. The results show that many factors that influence work participation irrespective of specific diagnosis are related to the person, or to their home or work environment. Interventions that are effective in changing work participation mainly focus on changes made in the work environment. That many factors other than the condition itself influence work participation, is explained by research that found that factors associated with the specific health condition are mainly present in the acute phase, whereas personal and work-related factors have a stronger influence in the chronic phase of a disease [34,35]. This may explain why these factors are found to influence the work participation of people with a chronic disease.

These results are in line with the capability approach [30-32], which stresses the influence of factors related to the person him- or herself and of factors related to his or her home and work environment on a person’s capability to participate in work. Also established models on work and health, such as the Job Demands Resources model [36] and the Person-Job-Fit model [37,38], focus on these personal and work-related aspects, as these models strive to match and balance the individual’s capabilities and work demands. This emphasises that in addition to the disease, aspects of the person or his or her work environment deserve close attention in supporting the work participation of an individual with a chronic disease. Consequently,
for OHPs to support an individual’s capability, all aspects (of which health is just one) are important and should be evaluated for the use of interventions and optimising support of people with a chronic disease regarding in work participation [30-32,39].

The added value of researching factors and interventions independent of diagnosis is the applicability of evidence for people with diagnoses in which limited evidence is available, and for people who are faced with co-morbidity. In addition, the results provide a manageable overview on which factors and interventions can affect participation in work. Based on this overview, OHPs can specify per individual which factors influence the individual’s work participation and which interventions are relevant to use in his or her personal and work situation. In addition, to obtain a complete image of an individual’s influencing factors and relevant interventions, the information independent of diagnosis can be complemented with information related to an individual’s specific diagnosis. In sum, the broad overview facilitates OHPs’ guidance and assessment in individualising the approach to the persons’ resources, preferences and external characteristics.

Role of individuals
As it is beneficial to take into account individuals’ perspectives, we explored which role individuals see for themselves by asking what types of solutions they use and what type of support they require to participate in work. The results show that people want to play an active role and that they use various solutions to retain or return to work. These solutions focus on individuals’ personal resources and work or personal life. Examples are: accepting and learning to cope with the chronic disease, disclosing the chronic disease to the work environment (under the condition of a safe social climate), setting boundaries and getting help from colleagues.

This focus on the role of the individual in work participation is in line with current perspectives that stress the role of self-management of the disease and its effect on work participation [40-44]. The ability to manage one’s own disease and life, including work participation, is reported by Huber et al. [45] as one of the six dimensions of the new definition of health, emphasising the importance of self-management. Other studies also focus on self-management by focusing on the empowerment of the individual [46,47] and ‘shared-decision making’ [48-52], emphasising the active role of
individuals with a chronic disease.

Researchers have found that in order for people to be capable of having an active role in work participation, they need information and skills to process the information, which is defined as ‘health literacy’ [53]. Literature on shared-decision making also stresses that it is important for the individual to have information in order to discuss with the professional the approach to take [48-52]. This is in line with our results, as our participants reported a need for information about their disease, the types of help available, possible adoptions and legislation with respect to working when faced with a chronic disease [5].

In addition, literature on empowerment also emphasises empowering an individual by increasing the individual's self-efficacy and developing his or her coping skills [46,47], which is confirmed by the solutions to remain in work or to RTW that our participants reported [5]. This may indicate that in order to support the role of individuals, OHPs could focus on, for example, providing information, supporting self-efficacy and assisting individuals to improve their coping skills. According to Bandura [54], OHPs can support an individual's self-efficacy beliefs by influencing four major sources, namely successful experiences of the individual, vicarious experience, verbal persuasion of others and the individual's physiological state.

Changes in occupational health professionals’ support
We included evidence on factors, interventions and the role of the individual with a chronic disease in a guideline to provide OHPs with the evidence in a clear and manageable way. Michie et al. [33] indicated a guideline as a policy modality, in which they defined a guideline as a ‘document that recommends or mandates practice’. Based on the evidence included in the guideline, we formulated recommendations so that OHPs have hands-on information about what they can do to optimise their guidance and assessment of people with a chronic disease. As these recommendations are not always integrated in OHPs’ daily practice according to both people with a chronic disease [5] and previous studies focusing on the adherence of OHPs to recommendations [55-57], changes have to be made to increase OHPs’ capability to use the evidence in daily practice.
Holistic approach

Even though research shows that OHPs are aware of the importance of personal and work-related factors, and indicate such factors to be important for sustained RTW [58], our results show that participants experience that these personal and work-related factors are not always addressed and evaluated by OHPs [5]. Participants in our study reported a need for OHPs to focus on ‘the person’ instead of ‘the disease’ [5], which confirms the need for a more holistic approach in OHPs’ guidance and assessment. Research shows that the use of interventions in a holistic approach, involving both the worker and his or her environment, could facilitate individuals’ RTW [59].

However, OHPs’ adaptation of a holistic approach may deserve extra attention. Research found that OHPs tend to underestimate the impact of psychosocial and organisational features of the workplace [60], which may limit the extent of evaluation of these aspects. In addition, OHPs generally have a more narrow view on health and work participation compared with individuals with a chronic disease [45,59,60]. In their exploration of the definition of health, Huber et al. [45] state that professionals see health in a more biomedical way, in contrast to individuals with a chronic disease who perceive spiritual/existential and social aspects of health as equally important as the condition itself. In addition, research concerning RTW described the OPs perceived ‘at-work functioning’ as successful RTW, whereas employees frequently consider the more soft aspects of work participation, such as job satisfaction, work-home balance and mental functioning, as successful RTW [61]. This discrepancy in view may limit the evaluation of personal and work-related factors that were found in this research as important influencing factors.

Including individuals in communication

This discrepancy can be overcome through good communication between the OHP and the individual, incorporating both views on work participation. Although this would benefit the guidance and assessment of people with a chronic disease, participants in this research reported that they do not always feel that their OHP listens to them. They reported that OHPs come up with solutions, without listening to their specific needs, and want OHPs to first listen and then adapt a specific approach tailored to their preferences [5].

It could therefore be more beneficial if OHPs were to adapt a more
inclusive approach, by listening to the individual’s perspectives, preferences and needs. Adopting a more inclusive approach can be facilitated through the use of the principles of shared-decision making, an approach in which health professionals and patients work together to choose the best course of action for each patient’s particular situation [62]. This approach includes understanding the patient’s situation, establishing which aspects require action [62,63], and discussing possible interventions [64] and how these fit with the patient’s situation, after which a decision on a plan of action is made [63,65].

However, as this approach was developed for curative care, not all principles of shared-decision making might be applicable to occupational care. For example, IPs are responsible for objectively assessing and evaluating the extent and prognosis of individuals’ work ability. Based on the work ability, the loss of income is determined, followed by the degree of disability. Therefore, they are not able to include the individual’s preferences in this decision. In addition, not all people are likely to be able to manage their disease [53] and therefore experience difficulty playing an active role in their work participation [5].

In that case, OHPs can strive to actively involve the individual in the conversation. By doing so, they ensure that individuals’ perspectives are included and that they feel heard, and the approach fits the individual’s specific situation and preferences. This need for a more personalised approach was also indicated by participants in our study [5]. By engaging individuals in the conversation, an OHP can provide his or her expertise on the disease and work participation, and individuals can contribute by providing input on their own specific context, preferences and needs. Research underlines this approach, stating that involving people can greatly improve people’s experience and people with a chronic disease leads to greater acceptance and compliance with the advice or interventions [2,12-14,66].
Work environment
What stands out in the solutions reported by people with a chronic disease in this research, is that the work environment (i.e. employer and colleagues) can play a major role in facilitating individuals with a chronic disease in these solutions and thereby their capability to participate in work. Organisations can, for example, provide working aids such as an adapted chair, get colleagues to provide help or provide a level of autonomy in work. Also the provision of support and empathy by the supervisor and colleagues was highly valued by participants with a chronic disease. This is congruent with earlier research that emphasises the role of the supervisor in work participation [67] and the use of work adaptations reducing sick leave among employees with a chronic disease [68].

Although research emphasises the importance of support and adaptations from the work environment [5,36], many participants in our study reported a lack of support or empathy from their work environment [29]. This implies that even though these solutions are relatively easy to implement and could strongly support an individual’s capability, a lack of adaptations or support is still experienced by some participants and can limit them in their work participation [29]. Minimum effort concerning support and adaptations at work can often contribute greatly to an individual’s perception of work [69]. In addition, as the expected return on investment for employers can be high, as investing in work adjustment can lead to a reduction or even prevention of sick leave [68], support provided by or focusing on the work environment should receive attention.

The discrepancy between the needed and the provided support may be explained by the fact that employers are not always aware of the chronic disease of the employee and its functional restrictions regarding work. Disclosure of a chronic disease can be an issue for people with a chronic disease due to the fear of stigmatisation [70,71]. Participants reported experiences of employers being hesitant to hire them, which increased their fear that disclosing their disease reduces their chances of being hired or keeping their jobs [5]. Receiving support and empathy contributes to a safe social work environment, and therefore facilitates an individual in feeling save to disclose the chronic disease [72]. Therefore, OHPs should advise employers about the value of support and the provision of empathy towards employees with a chronic disease.
Research also reported that organisations focus on ‘sickness absence’ and ‘RTW’ instead of on supporting employees with a chronic disease to retain their work [68], which may also explain why the value of known facilitators such as support, empathy, work adaptations, etc. is not fully recognised and applied in daily practice. A good dialogue between employee and employer can reveal what adjustments in work content, organisation or environment are needed to increase the individual’s capability.

In addition, literature on support of employers towards their employees with cancer shows that employers found it difficult to deal with their employees with the disease [73]. Employers reported a need for additional information about diagnosis and RTW policies [73,74] and skills in communication to support employees [73]. There are few interventions that facilitate employers in supporting employees with a chronic disease [74]. Therefore, it may be necessary to pay more attention to the implementation of knowledge to facilitate the employer and the organisation to support employees with a chronic disease regarding work participation. Also, OPs can facilitate employers and organisations by providing knowledge, insights and advice to employers on the importance of social support and adjustments in work tasks, conditions or environment.

**Facilitating OHPs' use of evidence**

We focused on facilitating OHPs' use of knowledge and skills, such as the more holistic approach, more attention to the work environment and the role of the individual, provided in the guideline. Grol et al. [11] explain that dissemination of new information is not enough and that for people to adopt new information, active strategies are needed. As Michie et al. [33] show, a training programme is such an active strategy to change OHPs' capability.

The training programme was developed with the involvement of OHPs to discover their training needs. Thereafter, learning objectives were formulated based on their needs, and subsequent training programme activities were formulated. By involving OHPs, we aimed to focus on learning objectives that had the highest relevance for OHPs’ work. Matching training needs is shown to increase trainees’ motivation to learn [9,10] and increase adherence to the training programme [13,14]. As indicated by literature, the approach used followed the principles of constructive alignment, which is shown to facilitate the integration of new information with OHPs’ current set
of knowledge and skills [75].

The results of the training programme showed that OHPs' knowledge and skills improved after following the training. The increase in knowledge and skills is an indication that OHPs increase their capability (‘Do OHPs know how to use the knowledge and skills?’) to use the knowledge and skills provided by the guideline. Capability is one of the dimensions for change reported by Michie et al. [33], which indicates that the training programme can facilitate OHPs’ change in using knowledge and skills provided by a guideline in daily practice. In addition, the training programme seemed to also influence OHPs’ attitude, as OHPs indicated that they found the training acceptable, with the training programme being useful and relevant, and improving their guidance and assessment of people with a chronic disease. This indicates that they are motivated to use the knowledge and skills in their daily practice, which is congruent with one of the three dimensions that could benefit change, namely ‘motivation’ [33]. Michie et al. [33] explain the motivation dimension as ‘Do OHPs believe the knowledge and skills benefit them in their guidance and do they want and plan to use the knowledge and skills?’ The results, which show an increase in knowledge and a change in attitude, are in line with other training programmes for IPs implemented by Zwerver et al. [13] and OPs conducted by Joosen et al. [14]. These training programmes contributed to the OHPs’ attitude, self-efficacy and intention to apply the guideline [13,14].

OHPs also indicated that the training programme could be implemented on a larger scale, in which they foresaw various barriers and facilitators. The barriers time, money and OHPs’ organisational support were reported; the facilitators were related to the added value of the knowledge and skills to OHPs’ support and OHPs’ learning to apply the evidence in practice. This indicates that extra attention might be needed with regard to the last dimension reported by Michie et al. [33], ‘opportunity’, which is explained as ‘Do OHPs have access to the knowledge and skills and are they supported to use the evidence?’

The barriers time and money are frequently indicated in other research [56,76], which can be explained by the fact that change takes energy (influencing time and money), since the information is not yet integrated in one’s daily routine [77]. It is not to say that after the knowledge and skills are integrated in OHPs’ daily practice, these barriers are still experienced.
However, for the first step in implementation, one should take into account the time it takes for OHPs to change and integrate the knowledge and skills provided by the guideline. Provision of time can, for instance, be facilitated by OHPs’ organisations, which could be included in the implementation approach. This is confirmed by Grol [11], who states that integrating new information can be a long journey, using various methods, as represented in Michie’s model [33]. Therefore, for future implementation it is recommended to make a process-based implementation plan [11] that takes into account all aspects of Michie’s model [33].
Recommendations for practice and research

Recommendations for practice

Occupational health professionals

- We recommend that OHPs be aware of which value being able to participate in work generally has for an individual and that work can contribute to an individual’s values and goals.

- We recommend that OHPs adopt a more holistic approach, which includes attention to the evaluation of the personal and work-related factors influencing an individual’s work participation.

- We recommend that OHPs focus on work-related interventions to increase individuals’ participation in work. It is recommended to focus the interventions on the specific factors that influence an individual’s work participation.

- We recommend that OHPs advise the supervisor or organisation to facilitate and support work adjustments, as a small investment in time, money or interest can have a large influence on an individual’s work participation. In addition, we recommend that OHPs explain to employers the value of social support and empathy, so that people feel safe to disclose their diseases.

- We recommend that OHPs facilitate individuals’ active involvement in work participation. Through actively involving individuals in the approach, individuals have the opportunity to share their perspectives and the approach can be tailored to the individuals’ preferences and needs. To facilitate active involvement, we recommend that OHPs provide individuals with a chronic disease with information about their disease, legislation regarding work participation and the types of support that are available. In addition, people can be empowered through the support of an individual’s self-efficacy and improving their coping skills. OHPs can support self-efficacy by facilitating successful experiences, vicarious experience, verbal persuasion and being aware of a positive physiological state.

- We recommend that OHPs follow the training programme to facilitate their use of the knowledge and skills in their guidance and assessment of people with a chronic disease.
Employers

- We recommend that employers be aware of their workers with a chronic disease and provide them first of all with understanding and support, after which needs and work adjustments can be facilitated. We also recommend that employers discuss needs and adjustments together with their workers with a chronic disease.

Individuals with chronic disease

- We recommended that individuals with a chronic disease actively ask for help and information from OHPs, employers, colleagues, friends, family and patient federations, as they can support individuals in the process of WR or RTW.
- We recommend that individuals with chronic diseases play an active role in work participation. Knowledge on their disease, legislation with regard to work participation, the types of support that are available, etc. can contribute to their ability to play an active role and to their sense of empowerment. In addition, self-efficacy can contribute to an individual's sense of feeling empowered. Self-efficacy can be supported through successful experiences, vicarious experience, verbal persuasion and a positive physiological state.

Policymakers

- We recommend that policymakers be aware of the value that participation in work has for individuals with chronic disease. In addition, policymakers are recommended to facilitate work participation by integrating provided knowledge, such as influencing factors, supporting interventions, role of the individual and the influence of the work environment, in current and future policies supporting work participation of people with a chronic disease.
- We recommend that policymakers develop and use training programmes, possibly with the inclusion of the target group, to facilitate the uptake of knowledge and skills provided by guidelines by OHPs.
Medical specialists

- We recommend that medical specialists be aware of the value that work has for people with a chronic disease and to address the theme ‘participation in work’ in consultation with their patients with a chronic disease.

Recommendations for research

- Based on the evidence obtained on factors and interventions irrespective of diagnosis, we recommend gaining insight into which specific approach works for whom, so that interventions can be better adapted to the individual with a chronic disease.
- To include people in research with a lower level of education or people with specific types of diagnosis, we recommend using other methods of research, such as observation and one-on-one interviews.
- For future implementation of the training programme on a larger scale, we recommend making a process-based implementation plan that takes into account all aspects of Michie’s model, including capability, motivation and opportunity.
- We recommend conducting further research to establish whether the acquired knowledge and skills promote OHPs’ guidance and assessment of people with a chronic disease, and whether this supports the work participation of people with a chronic disease.
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