

Time utilisation trends of supported employment services by persons with mental disability in South Africa

Lana Van Niekerk^{a,*}, Zelda Coetzee^a, Madri Engelbrecht^a, Zerina Hajwani^b and Santie Terreblanche^a

^a*Division Occupational Therapy, Department of Interdisciplinary Health Sciences, Stellenbosch University, Tygerberg, South Africa*

^b*Division of Occupational Therapy, School of Health and Rehabilitation Sciences, University of Cape Town, Cape Town, South Africa*

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Abstract.

BACKGROUND: This paper reports on the second phase of a two-phased study that was undertaken to determine the feasibility of supported employment (SE) as a strategy with which to facilitate the employment of persons with disability in competitive work contexts. The study population comprised people with mental disabilities receiving SE in the Western Cape Province, South Africa.

OBJECTIVE: To describe the components of SE utilised by persons with mental disability (i.e. psychiatric or intellectual disability) in terms of type and time utilisation patterns over 12 months.

METHODS: Criterion sampling, a form of purposive sampling, was used to identify 29 study participants - 19 with intellectual disability and 10 with psychiatric disability. Data collection commenced for each participant when a work placement had been identified and preparation for such ensued. Data was collected prospectively for a period of 12 months. SE service components utilised by participants were captured using a data capture sheet that was developed for this purpose.

RESULTS: Time utilisation indicated a steep downwards trend for both cohorts. The decrease in utilisation of SE service components over a period of one year was more pronounced in the psychiatric disability (PD) cohort, who utilized almost half the total SE services in the first month.

CONCLUSIONS: SE services can be considered as a viable option for return to work in resource-constrained environments. Providers of SE services will need to modify approaches in order to meet contextual realities.

Keywords: Vocational rehabilitation, return-to-work, disability, employment equity, reasonable accommodation

1. Introduction

The benefits of work to people's health and well-being have been explored extensively in occupational therapy literature [1–3]. Unfortunately, people with psychiatric and intellectual disability face inimitable barriers to employment, including stigma, fluctuating

impairment patterns, difficulties with social skills and complex support needs. Macro influences, such as high unemployment, inequality and systemic poverty, further reduce opportunities for disabled persons to find work in lower- and middle income countries. South Africa's 24.9% general unemployment rate [4] places job seekers with disabilities in a strongly competitive labour market. The most recent Employment Equity Report confirms the dire statistic that only 0.8% of formally reported employees are persons with disabilities [5]. It is evident that an effective employment strategy is

*Address for correspondence: Lana Van Niekerk, Division of Occupational Therapy, PO Box 19063, Tygerberg 7505, South Africa. Tel.: +27 21 9389307; Mobile: +27 82 4159065; E-mail: lanavn@sun.ac.za.

critical to facilitate more persons with disabilities into competitive employment in South Africa.

Supported employment (SE) is a return-to-work strategy promoting the inclusion of persons with disabilities in competitive employment environments, i.e. those not necessarily earmarked for such individuals. SE proponents operate on the assumption that with the right support, people with the most severe disabilities can be integrated into competitive employment [6]. When compared with other strategies for achieving work participation for people with disabilities, SE has the most empirical support and there is strong evidence for the effectiveness of SE as a strategy to achieve employment outcomes for people with mental disabilities [7–9]. SE services typically comprise a number of essential steps effecting the desired integration of service consumers in the workplace, namely assessment, job finding, -analysis, -matching and -coaching [6]. Service users have to meet the requirements of the job and are paid accordingly, while job coaches provide on-going support that is determined by the worker's individual needs and by the particular SE programme.

Much evidence exists in international literature for the preferred use of SE to (re-)integrate people with disabilities in work [10–13]. However, in South Africa the development of SE has been restricted by several factors [14], the most important being funding for such services. Also, the current disability grant system potentially reduces economic empowerment, whereby a person with a disability living in poverty might prefer to receive a regular monthly disability grant, instead of seeking employment. Therefore, it is clear that a conducive legislative environment is required for SE to develop effectively. Significant changes in the South African legislative framework since the dawn of democracy in 1994, support the development of services focused on equal access to employment for persons with disabilities. For example, the Skills Development Act of 1998 [15] incentivises the improvement of employment prospects of people with disabilities, as a previously disadvantaged group^a, through work-based training. Along with women and black people, the Employment Equity Act (EEA) of 1998 [16] prohibits unfair discrimination in employment practices based on disability. The EEA further legislates for affirmative action by employers to eliminate employment barriers and promote reasonable accommodation for people with disabilities. Attached to the EEA is the

Code of Good Practice on the Employment of People with Disabilities of 2002 [17] that guides employers and employees on promoting equal opportunities and fair treatment for people with disabilities in the workplace. In 2007 South Africa was one of the first countries to sign the UN Convention on the Rights of Persons with Disability and Optional Protocol [18], committing the country to protect the right of people with disabilities to work on an equal basis with others.

A prominent model of work re-integration used in South Africa, is that of traditional vocational rehabilitation (VR). For this reason, the modest amount of government funding available for return-to-work services flow towards hospitals, rehabilitation or protected work contexts [14]. Because on-going support during work placement of persons with disability is not funded in a formal or sustainable manner, the feasibility of SE services in middle income countries will be affected by the cost of such services. Therefore, the ultimate reason for conducting the research presented here is to determine the feasibility of an SE service for use in South Africa, specifically as it relates to costs. The data reported here describe the time utilisation of the full range of SE service components over 12 months. These findings will provide the basis for estimation of cost of SE services in different contexts and offered by different service providers.

2. Methodology

A longitudinal descriptive study was used to determine the time utilisation for the range of SE service components consumed by people with mental disabilities. For the purpose of this study the following criteria were used to delineate SE: (1) Participation by person with a disability in competitive employment, (2) conditions of employment, including remuneration, were directed to the person with disability and were market related, and (3) on-going support (e.g., job coaching) was provided as a form of reasonable accommodation. Ethical approval for the study was obtained from the University of Cape Town Health Sciences Faculty Ethics Committee (REC REF: 281/2009).

2.1. Participants and programmes

Criterion sampling, a form of purposive sampling, was used to select participants who were of working age, expressed a need to work and matched one

^a Groups of South African people who were disadvantaged and discriminated against under the Apartheid dispensation.

of two impairment categories: Psychiatric Disability (PD) or Intellectual Disability (ID). Additionally, all participants were new service users of one of two SE programmes. The two SE programmes in this study fulfilled critical components of the SE Fidelity Scale [11], except that the employment specialists were occupational therapists, with case management included in their work role, and that a rapid search for competitive employment was not a realistic goal in the South African context. Programme A was for persons with psychiatric disabilities (PD) and Programme B was for persons with intellectual disability (ID).

Programme A was situated in a psychiatric hospital in Cape Town. This programme served individuals from forensic wards, general wards and the out-patient department. An occupational therapist and occupational therapy assistant offered job coaching and job support to workers in the programme. Contracts between employers and workers included agreed terms for reasonable accommodations, for example time off to attend to medical appointments or to collect social grants. Almost all individuals referred to this SE programme had a long history of unemployment, had limited education (mainly primary school levels) and were from low socio-economic circumstances. Programme A had been operational for 12 years and secured employment for an average of 25 workers per year. The majority were employed on fixed-term contracts for which job tenure varied according to the availability of contract work (e.g. bottle packing, packaging spices, lock assembly and cleaning). Permanent jobs obtained by individuals in Programme A included vegetable farming, paper making, food production and book packaging. The programme was funded by reintegration benefits for persons with disability in the form of government support.

Programme B was offered by a protective workshop group in Cape Town. An occupational therapist and two job coaches provided services for individuals who successfully completed a bridging programme that prepared them to enter the open labour market. The job coach assisted the persons with intellectual disability during job interviews and to negotiate for reasonable accommodation, such as attendance at a monthly support group, picture schedules and duty lists, more time to master new tasks and access to a job coach as needed during performance appraisals and disciplinary procedures. The participants of the bridging programme were selected from the work skills training programmes at two protective workshops in Cape Town. They resided in low socio-economic or previously disadvantaged

areas, had limited education (mainly special education and left school without an academic qualification) and had never worked in the open labour market. Programme B had been operational for 8 years and secured employment for 56 persons with intellectual disability. These individuals were employed in entry level jobs in the open labour market including cleaners, laundry assistants, assistant carers, basic assemblers, gardeners and assistant grounds men. Employment contracts varied between fixed term contracts and permanent employment. Programme B was financed by a Non-Governmental Health Service Provider.

Both programmes were overseen by occupational therapists who, by virtue of their professional knowledge and skill plus additional experience were able to offer specialist and quality support. However, it was not feasible for the occupational therapists to offer one-on-one job coaching to all participants in these contexts. Therefore, support staff received in-service training to provide the job coaching with close supervision from the occupational therapist.

2.2. Data collection

A data capture sheet comprising the components of SE was developed. Components included originated from literature and the experience of the authors who were SE providers. A pilot study was done with the ID cohort to refine the components and increase the validity of the data capture sheet. Changes made following the pilot study included a split between interventions that took place on the job site (i.e. on-site) and those that took place away from the job site (i.e. off-site), a differentiation between group and individual intervention, and one component, namely *administrative tasks directly related to SE*, was added. These changes improved sensitivity and specificity of the data capture sheet. SE components were grouped into categories and the final data capture sheet used in this study was created (see Table 1).

Data collection commenced when a particular job had been identified for the participant and preparation ensued. Data was collected for a period of 12 months. SE components utilised by participants were recorded prospectively by job coaches who were trained by two of the researchers. Time utilisation was recorded in 15-minute units on the data capture sheet. On-going discussion during monthly research meetings assisted with reliability and validity by ensuring consistent application of terminology. Data was verified throughout, and at the end of the data collection period, by two of the

Table 1
Data capture sheet

		On Site		Off Site	
		<i>Individual</i>	<i>Group</i>	<i>Individual</i>	<i>Group</i>
Administration	Administrative tasks directly to SE				
Non-job advocacy	Non-job advocacy with parents				
	Non-job advocacy with landlords				
	Non-job advocacy with case managers				
	Non-job advocacy with therapists				
	Non-job advocacy with educators				
	Non-job advocacy with bank personnel				
	Non-job advocacy with doctors				
	Communication with guardians				
	Workers' rights				
	Personal life skills	Training - money handling			
Training - grooming,					
Training - use of transportation					
Training - management of symptoms					
Health and Safety					
Time Management					
Training - communication					
Simulated work	Training - simulated work				
	Programme development: Trial placement				
Prepare work placement	Person-centred instructional plans				
	Job advocacy - at job site with employers				
	Job advocacy - co-workers (and customers)				
	Communication with involved agencies				
Transportation	Transportation				
Work assessment	Evaluation of employment potential				
	Evaluation of goodness of job fit				
Work visit	Work visit to observe real work				
	Work visit to discuss reasonable accommodation				
	Work visit to assist with performance appraisal				

researchers who supervised the job coaches, to ensure accuracy and consistency.

2.3. Data analysis

The average time utilisation of each component of SE was calculated (per month) for both cohorts. On- and off-site service utilisation was differentiated, as well as service utilisation in individual- vs. group formats, as it has direct implications for service cost. Service utilisation was descriptively compared between the two groups and trends were evaluated in the use of services for each group across the year. Average monthly and annual use for each type of service was calculated and the overall distribution of services within each group was captured.

3. Results

The sample ($n=29$) comprised 19 people with mild intellectual impairment, five with schizophrenia, three

with schizoaffective disorder, and two with Bipolar I disorder. Most participants continued to receive at least a portion of a disability grant (a social security grant for people with disabilities who are unable to work), as allowed by the sliding scale of the national social security agency. Participants were placed in low-end jobs, for example industrial cleaning and assembly jobs.

Time utilisation across the 12-month data collection period for each of the two programmes is presented in Table 2. The average monthly time utilisation of SE services for both cohorts (over 12 months) was 9.19 hours; with a rapid decrease from 37.22 hours in the first month to 2.29 hours in the last month of data collection. Approximately one third of SE service components were utilized in the first month. The total time utilisation for the PD cohort was 71.38 hours over one year whilst it was 130.83 hours for the ID cohort. More was time spent providing services in a group format for the PD cohort compared to higher use of individual services within the ID cohort.

Utilisation of SE services was high during the placement phase, but showed a rapid decline in both cohorts

Table 2
Supported employment services utilised

Month	Psychiatric Disability (n = 10)					Intellectual Disability (n = 19)					All Participants (n = 29)							
	Total average hours per month	%	Average hours individual format per month	Average hours group format per month	% of total average hours per month	Total average hours per month	%	Average hours individual format per month	Average hours group total per month	% of cohort total	Total average hours per month	%	Average hours individual intervention per month	Average hours group intervention per month	% of total all participants			
1	33.48	46.90	6.88	20.54	26.60	79.46	39.20	29.96	21.05	53.71	18.14	46.29	37.22	33.74	16.16	43.42	21.06	56.58
2	7.03	9.84	3.83	54.45	3.20	45.55	28.74	21.97	16.04	55.82	12.70	44.18	21.25	19.26	11.83	55.66	9.42	44.34
3	8.93	12.50	5.08	56.86	3.85	43.14	18.17	13.89	15.75	86.68	2.42	13.32	14.98	13.58	12.07	80.55	2.91	19.45
4	8.10	11.35	3.10	38.27	5.00	61.73	11.03	8.43	10.71	97.14	0.32	2.86	10.02	9.08	8.09	80.72	1.93	19.28
5	3.00	4.20	0.15	5.00	2.85	95.00	6.74	5.15	5.80	86.13	0.93	13.87	5.45	4.94	3.85	70.73	1.59	29.27
6	3.08	4.31	0.28	8.94	2.80	91.06	4.32	3.30	4.32	100.00	0.00	0.00	3.89	3.52	2.92	75.17	0.97	24.83
7	2.13	2.98	0.15	7.06	1.98	92.94	3.34	2.55	3.33	99.61	0.01	0.39	2.92	2.65	2.23	76.40	0.69	23.60
8	1.90	2.66	0.43	22.37	1.48	77.63	4.66	3.56	4.24	90.96	0.42	9.04	3.71	3.36	2.92	78.84	0.78	21.16
9	1.18	1.65	0.23	19.15	0.95	80.85	3.33	2.54	3.13	94.07	0.20	5.93	2.59	2.34	2.13	82.33	0.46	17.67
10	0.78	1.09	0.13	16.13	0.65	83.87	4.22	3.23	4.01	95.02	0.21	4.98	3.03	2.75	2.67	88.07	0.36	11.93
11	0.88	1.23	0.38	42.86	0.50	57.14	4.08	3.12	3.89	95.48	0.18	4.52	2.97	2.70	2.68	90.14	0.29	9.86
12	0.93	1.30	0.53	56.76	0.40	43.24	3.01	2.30	2.66	88.21	0.36	11.79	2.29	2.08	1.92	83.83	0.37	16.17
Total hours: 12 months	71.38	100	21.13	29.60	50.25	70.40	130.83	100	94.93	72.56	35.89	27.44	110.33	100	69.48	62.98	40.84	37.02
Average hours: 12 months	5.95	8.33	1.76	29.60	4.19	70.40	10.90	8.33	7.91	72.56	2.99	27.44	9.19	8.33	5.79	62.98	3.40	37.02

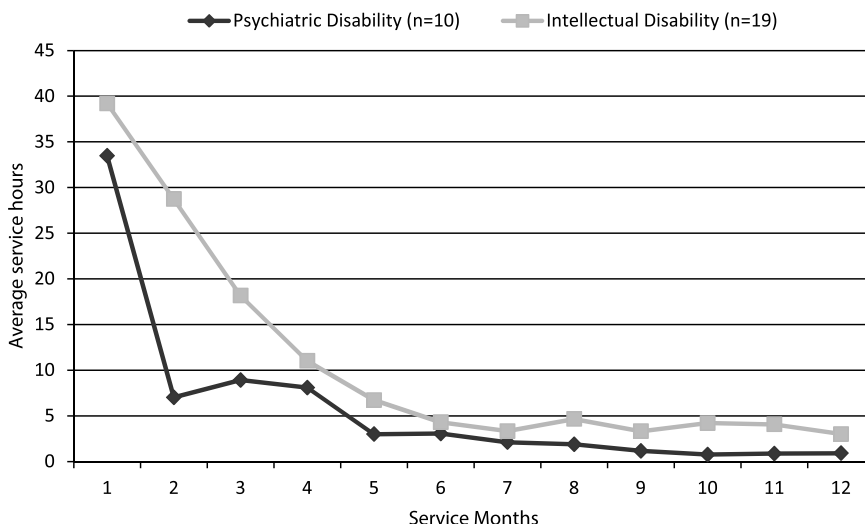


Fig. 1. Average SE service hours utilised per month in the two cohorts.

Average SE Hours utilised per person per service category for 12 months: Intellectual Disability

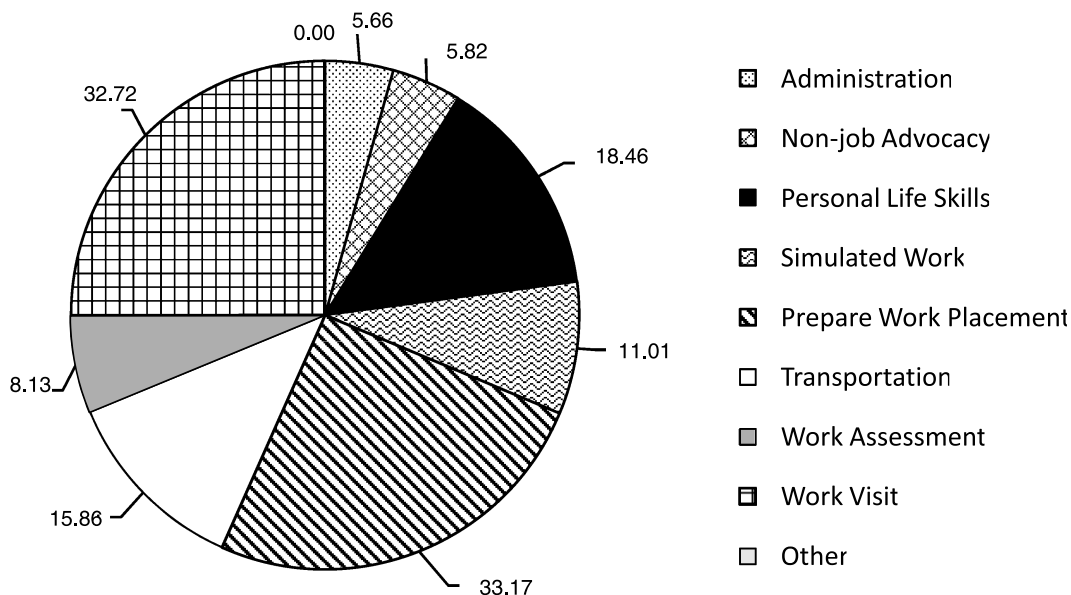


Fig. 2. ID cohort - Averaged SE hours per service category for the year.

within the first few months after initiation of the programme. Although the need for support declined rapidly, both cohorts continued to require support for the 12-month duration of data collection. The rapid decrease in service utilisation was more pronounced in the PD cohort, who utilized almost half (46,9%) of the total SE services in the first month, whereas the

ID cohort utilised an average of 39,2 hours (≈30%) of support during the first month. For the ID cohort the decrease in service utilisation was more gradual and remained higher than the PD cohort for the entire year. The level of service consumption became more constant, seemingly at levels required to maintain work participation in month six.

Average SE Hours utilised per person per service category for 12 months: Psychiatric Disability

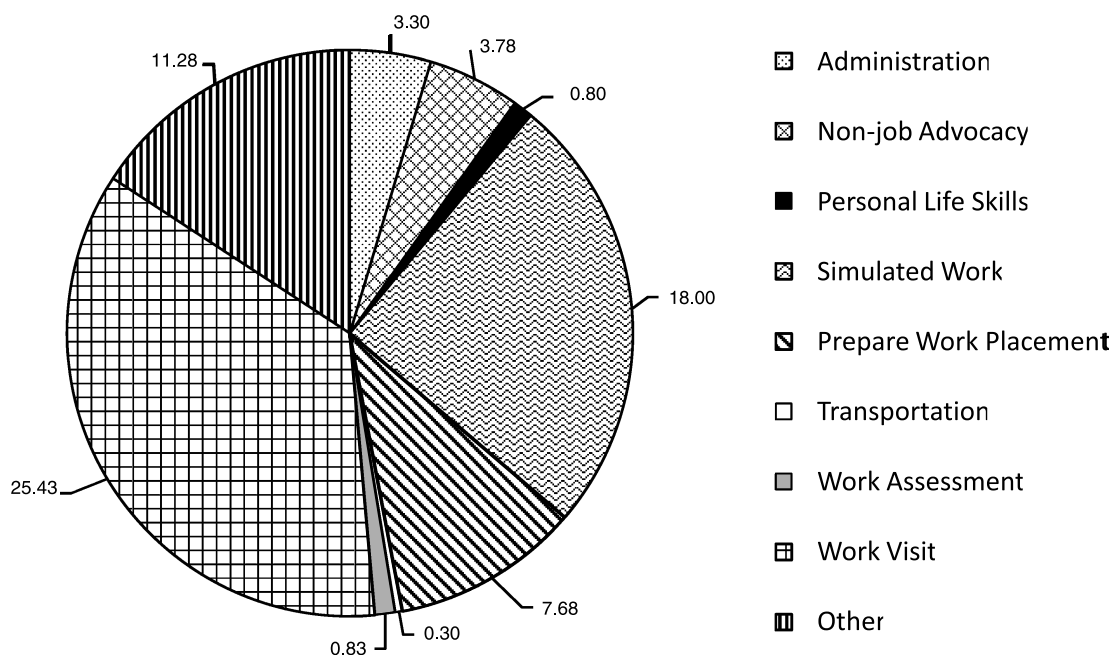


Fig. 3. PD cohort – Averaged SE hours per service category for the year.

The utilisation of SE components over one year for ID and PD cohorts are shown in Figures 2 and 3 respectively. The service components with highest utilisation for month one in the PD cohort were 'simulated work' (18 hours/53.8%) and 'work visits' (8 hours/24.8%). For the ID cohort, the highest utilisation in the first month was to 'prepare the work placement' (13,45 hours/34,3%), followed by 'personal life skills' (6,74 hours/≈17%), 'simulated work' (5,79 hours/14,8%) and 'work visit' (6,3 hours/16,1%). Distribution of all services across the entire year varied between the two groups (Fig. 1); however, the largest percentage of services for both groups across the year were 'work site visits.' This category included visits to the work site to observe workers in action, to discuss reasonable accommodation, and to assist with performance appraisal. The PD cohort showed a gradual decline in support utilised for 'work site visits', while the ID cohort's utilisation appeared to fluctuate from month to month. Although fluctuating from month to month, 'work site visits' was the most consistently utilised service while support in most other categories decreased as the year passed.

4. Discussion

The purpose of this study was to evaluate the utilisation of SE services for individuals with ID and PD as a foundation for establishing feasibility and cost calculations. Utilisation of SE services was much higher in the first month for both cohorts due to high demand for SE services related to preparation for, and placement in work. Although immediate reduction for the ID cohort was not anticipated, the marked reduction in overall service utilisation for the PD cohort from the second month onwards was expected. For the PD cohort the focus of service utilisation changed to components offering on-going support and management of psychiatric disability in the workplace in order to maintain and foster integration. The highest service utilisation in the first four months for both cohorts was for components directly linked to preparation and placement stages of SE, namely 'work visit', 'transportation' and 'prepare work placement'. Importantly, these service components were utilised by participants as well as employers. Utilisation for the component 'work visit' remained the highest throughout the year due to demands associated

with implementation of the job retention plan. 'Non-job advocacy' was constantly utilised by the ID cohort during the preparation and placement phase, confirming that advocacy, linked to the rights of persons with intellectual disability, comprised a large and important portion of SE services. The ID cohort seemed to utilise the full range of SE components consistently throughout the year, resulting in their overall higher utilisation of support across the full scope of service, than to the PD cohort.

SE services are usually offered in one-to-one format with individualised support; however, resource constraints have led to development of a blended model in which support is offered using individual and group formats. Individual support was offered when issues confronted by a particular worker were unique or when support was provided on-site. Conversely, group formats were used when workers had similar support needs. A large proportion of participants were placed in pairs or groups because of the nature of negotiated work placements, thus making the provision of SE services in group format more feasible. Over one year, 63% of support was offered at individual level, and 37% in group format. For the PD cohort, only 30% of support was done individually, compared to 73% for the ID cohort. Services were thus provided primarily in group format to the PD cohort. Affordability of the service was a major consideration for this modification to the SE model that promotes individualised support. Authors offering SE services held the view that such services, when offered in groups, have the added elements of peer learning and support.

The findings of this study support the inclusion of SE in minimum standards of training for occupational therapists, specifically to equip occupational therapists with skills for job coaching, as well as directing the development and oversight of SE programmes. In this study, the SE services were offered to participants by support staff (occupational therapy assistants) that were trained and supervised by occupational therapists. While this could create a debate regarding scope of practice for the delivery of SE services, it is not feasible for an occupational therapist to provide all services. Therefore, to ensure best practice and broaden access to these services, occupational therapists must engage in the task of offering guided supervision to other providers. The SE service components on the data collection sheet provide a comprehensive and detailed list of components that comprised SE. In contexts where SE is underdeveloped, such as in South Africa, such a list could support the development of SE services and the training of job

coaches who are not occupational therapists. The use of various providers will impact the final decision of feasibility, given various cost implications for hiring skilled professionals. The results of this study are expressed in time units so as to provide a basis for cost calculations that might be based on the amount of time spent by different providers.

Due to the limited availability of SE programmes in South Africa, the sample size was restricted and only two impairment categories were included. Sample size could have been increased by evaluating retrospective SE data; however, the prospective design allowed for more consistent and reliable documentation of service utilisation using the data collection forms validated for this purpose. The study did not include the SE service components necessary to establish relationships with employers to secure jobs (i.e. prior to the placement of the person with a disability in a job). Although these indirect services fell beyond the scope of this study, the potential cost of this phase of preparation should also be considered for readers interested in understanding the cost of setting up a SE programme. The amount and range of support provided to participants of SE in this study was not fully shaped by client needs (as prescribed by the SE model), but by the context and resource limitations. Therefore, utilisation trends in our study may not be generalizable to other countries or contexts in which a different scope of SE services is utilised in order to meet *individual* needs. Direct comparison with service utilisation within programmes that are better resourced (e.g. in high income countries) was not done, primarily because a comparable study that focuses on individual consumption and provides similar detail to this study could not be found. However, the study's reflection of SE services utilised in a resource constrained context provides insight into a SE model in middle income countries.

5. Conclusions

Because the bulk of costs associated with SE are in the remuneration of service providers, understanding the number of provider hours necessary will be an important consideration for employers in middle-income countries who are concerned with the feasibility of SE. In this study, utilization of SE services for individuals with mental disabilities was highest during the first month, requiring up to 38 hours per participant on average. Utilization of SE services decreased incrementally over a 12 month period for individuals with both

intellectual and psychiatric disabilities. The use of group support and placement of workers in pairs or groups seems to be a desirable option for SE services in South Africa. Placement of persons with disabilities in groups was seen to have distinct advantages in the early stages of employment. However, disadvantages include that persons with disability could be seen to be separate and 'different' by co-workers, which has the potential to interfere with integration in the workplace.

Evaluation of the compatibility of this adapted SE model with local legislation and human resources, as well as its overall effectiveness, fell outside the scope of the study reported here. Despite strong evidence for the effectiveness of SE services internationally, similar research is needed in middle-income countries where a more modest suite of SE services may be feasible. We therefore recommend that research is conducted to determine effectiveness over the longer term and including more impairment categories. Furthermore, for a health service to be feasible, it should reasonably fit into funding and or service models in private health care settings, public health institutions or both. Considering the utilisation of SE services within both programmes, it seems feasible to offer SE in resource-constrained environments; however, further studies are needed to determine actual costs of service provision given various contextual considerations (e.g., type of provider, travel reimbursement). When paired together, effectiveness studies and cost-evaluation studies could provide solid evidence on which employers, agencies, or providers could make informed decisions regarding the implementation of SE programmes.

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