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Faculty of Health Sciences
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Occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodation for employees with major depressive disorder

Submitted in the requirements of the fulfilment of the degree Masters of Occupational Therapy (MOccTher)

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Date: November 2021

DECLARATION

I, Mpho Silvia Ramano student number 27428053 hereby declare that:

1. This dissertation, "Occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodation for employees with major depressive disorder," is submitted in accordance with the requirements for the Master's degree in Occupational Therapy at University of Pretoria.
2. I understand what plagiarism is and am aware of the University's policy in this regard.
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ETHICS STATEMENT

The author, Mpho Silvia Ramano, whose name appears on the title page of this dissertation, has obtained, for the research described in this work, the applicable research ethics approval.

The author declares that she has observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the Policy guidelines for responsible research.

Ethics Number: 444/2020

DEDICATION

I dedicate this work to the Glory of God. I am grateful and appreciative of God's love and faithfulness through this journey. The blessing and anointing that enabled me and empowered me through the gift of the Holy Spirit, The Spirit of understanding, knowledge and wisdom.

Special dedication to my family. My loving husband for his unwavering support, encouragement and fully believing in me. Staying awake through the night to encourage me to work and not sleep. Being strict at times just to push me to the next level.

My precious children whose time and special moments were compromised. Their understanding that mommy could not spend as much time with them as they would want.

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ABSTRACT

Introduction

Major depressive disorder is forecast to become the leading burden of disease in 2030. Occupational therapists have a pivotal role to play in facilitating reasonable accommodations for employees with major depressive disorder. Even though reasonable accommodations have been mandatory for the past 22 years in South Africa, few occupational therapy studies have addressed the implementations and outcomes of reasonable accommodations in the workplace for employees with major depressive disorder.

Aims

The aim of the study was to explore and describe occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder.

Research design

The researcher employed an explorative descriptive contextual design from a social constructivist paradigm.

Methods

The study was done in Gauteng, focusing on occupational therapists working in mental health, performing return-to-work and/or vocational rehabilitation during data collection for this study. Purposive sampling and snowball sampling were used to recruit research participants. The researcher used one-on-one semi-structured interviews to collect data. Inductive thematic analysis according to Creswell, was used to analyse data.

Findings

Five themes were: (1) collaborative approach, (2) dynamic process of reasonable accommodation, (3) enablers of successful reasonable accommodations, (4) challenges of reasonable accommodations, and (5) proficiencies of occupational therapists.

Conclusion

The study found that occupational therapists play an integral part in the collaborative approach during facilitation of reasonable accommodation During collaboration, employee's limitations and abilities to perform a specific job are discussed and

confidentiality must be maintained. The occupational therapist presents recommended reasonable accommodation during the discussion.

Key terms: occupational therapist, knowledge, attitudes, practices, reasonable accommodation, major depressive disorder.

LIST OF ABBREVIATIONS / ACRONYMS

Abbreviation / acronym	Meaning
CRPD	Convention on the Rights of Persons with Disabilities
DEL	Department of Employment and Labour
EEA	Employment Equity Act
FCE	Functional Capacity Evaluation
HPCSA	Health Professional Council of South Africa
LRA	Labour Relations Act
MDD	Major Depressive Disorder
MHCA	Mental Healthcare Act
PEOP	Person-Environment-Occupation-Performance
PEPUDA	Promotion of Equality and Prevention of Unfair Discrimination Act
POPIA	Protection of Personal Information Act
TAG	Technical Assistance Guidelines on the Employment of People with Disabilities
UN	United Nations
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
WFOT	World Federation of Occupational Therapists

Table of Contents

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE: GENERAL ORIENTATION TO THE STUDY

1.1. INTRODUCTION AND BACKGROUND

Globally, major depressive disorder (MDD) is forecast to become the leading burden of disease by 2030.[1-3] Major depressive disorder affects an estimated 350 million people worldwide, [1,4-6] which represents 8-15% of the world's population.[2,7] In South Africa, one out of ten individuals experiences MDD.[2] The cost of MDD on employers is estimated at $51.5 billion in the United States of America and 92 billion euros in Europe as a result of absenteeism (missed days or reduced hours at work), presenteeism (reduced productivity at work) and early retirement.[4-5] A study by Stander et al.[5] reveals similar findings in South Africa whereby MDD has a considerable impact on work performance and absenteeism, resulting in a total loss of R3.6 billion in earnings per annum.

Ramano and Buys[8] and Joss[9] state that employees with MDD are mostly referred to occupational therapy for a Functional Capacity Evaluation (FCE) to assist in making a return-to-work decision.[9] Occupational therapists are qualified to use FCE to assess functional performance, which aids in suggesting the necessary reasonable accommodations needed by employees with MDD to execute essential/ key job functions.[8-10]

The position statement of the World Federation of Occupational Therapists (WFOT) on Vocational Rehabilitation affirms that people with disabilities have a right to engage in work related activities.[11] Grobler et al.[12] in South African Society of Psychiatrists guidelines 2017 states that there are benefits of working and there is a negative impact in not working.[12] Occupational therapists believe that active engagement in occupation, like work promotes, facilitates, supports and maintains health and wellbeing.[13-14] Returning employees with MDD to work is regarded as important because it reduces absenteeism and alleviates the economic burden on the employer and the country.[10,15]

Globally and locally, there are various laws that support the return-to-work of employees with disabilities including those with MDD.[16-20] Internationally, disability

and vocational rehabilitation related laws dates back to 1916 when soldiers with disabilities in the United States of America were granted rehabilitation services and vocational retraining.[17-18] According to Ebuenyi et al.[21] the American Disability Act (1990) was the first Act where the concept of reasonable accommodation was used within a legal framework for disability.[21] In 2006, the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) endorsed that people with mental disability have a right to work and may not be discriminated against.[21] The UN CRPD highlights that discrimination includes refusal of reasonable accommodations.[21]

Chapter III of the South African Mental Healthcare Act[22] (MHCA) No. 17 of 2002 (p8) adds that "a mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status". Moreover, South African legislation as guided by the Constitution of the Republic of South Africa Act No. 108 of 1996 protects people with disability in a workplace through reasonable accommodation under the Employment Equity Act No. 55 of 1998 (EEA).[20] Buys[16] states that the EEA is the first Act in SA to explicitly speak on disability in the workplace. It defines disability and provides the reasonable accommodations framework in order to retain an existing employee with disabilities and facilitate entry into open labour market for disabled people seeking employment.[16]

The Department of Employment and Labour (DEL) in South Africa published The Code of Good Practice: The Technical Assistance Guidelines on the Employment of People with Disabilities (TAG) in 2007 as an implementation document of EEA.[20] Chapter 6 of TAG[20] states that the employer should reasonably accommodate the needs of people with disabilities in order to lessen the impact of impairment on the person's capacity to perform their essential functions of the job.[20] It further states in subsection 6.8 that the accommodation can be temporary or permanent depending on the nature and extent of the disability.[20] Employment Equity Act section one of chapter one defines reasonable accommodation as modifications or adjustments in a workplace to enable people with disabilities to access or participate in employment.[20,23]

Recent studies have shown that 30% of the South African workforce experience MDD episodes, which result in significant decline in work performance.[5,8,24] Major depressive disorder might lead to absenteeism and presenteeism, which consequently results in low productivity, poor interpersonal relationships in the workplace and economic loss to the company.[8,15] Major depressive disorder might result in temporary or permanent incapacity.[8] The LRA 66 of 1995[19] Schedule 8 states that incapacity might be due to ill health or injury that prevents the employee from performing his/her inherent job functions and it can be temporary or permanent. However, Kessler et al.[21] and Kroger et al[22] emphasise that MDD has a significant effect on short-term work disability, which is associated with temporary incapacity. Employees with MDD struggle to complete tasks, show poor work speed, and thus fail to meet their targets.[5] In addition, their poor work quality due to excessive mistakes is attributed to cognitive functional impairment that includes poor ability to concentrate, forgetfulness and indecisiveness.[5]

According to Oluboka et al.,[25] of patients who received antidepressants during clinical trials of MDD, less than 50% of them reached remission.[25] Employees with MDD who return to work after sick leave may present with some residual symptoms and functional limitations which may require reasonable accommodation.[15] Several studies found that clinical improvement does not directly result in complete functional recovery and even during the remission period, cognitive deficits that affect individual's social and occupational function can still be traced.[15,26-27] This shows that employees with MDD might benefit from reasonable accommodations due to residual symptoms and functional limitations. However, McDowell and Fossey[28] found that employees with MDD were unlikely to receive reasonable accommodations compared to individuals with physical disabilities due to stigma, indefinable nature of accommodations, failure to disclose their mental condition or difficulty accommodating an episodic condition.

McDowell and Fossey[28] suggested that there is a need for further research in the workplaces to assist employees with mental health problems and to increase occupational therapists' knowledge of reasonable accommodations. According to Mcdowell and Fossey,[28] there is little agreement on the identification, grouping and explanation of reasonable accommodation for employees with mental illness.

Scheuer[29] argues that most studies show that it is more beneficial for the employers to retain their employees through reasonable accommodation rather than hiring new employees. Therefore, the researcher assumes that if reasonable accommodations for employees with mental illness specifically MDD, are clearly explained and implemented, more employees with MDD might be retained at work which will benefit both the employer and the employee.

Given the fact that MDD is projected to become the leading burden of disease in 2030[1-3], Ramano and Buys[8] argue that occupational therapists are the pivotal healthcare practitioners to assist employees with MDD to return to work and to facilitate the implementation of reasonable accommodations as contained in the South African Employment Equity Act (1998).[20] Occupational therapists have experience in reasonable accommodations, psychological adjustment to disability, workplace operations and related legislation.[30] Schreuer et al.[24] consider occupational therapists as experts in disability, occupation, job analysis and determining a person's function and participation in a workplace.[29] The researcher views occupational therapists as competent with regard to reasonable accommodations as they possess sound knowledge, are able to solve clinical problems swiftly and have well-developed clinical reasoning skills.[27] However, little is known about the occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder.

1.2. PROBLEM STATEMENT

The researcher is an occupational therapist who works in an acute mental health setting and has worked in this setting for approximately 15 years. She observed that reasonable accommodations for employees with MDD are not always implemented by employers. She has further observed that the employers' failure to implement reasonable accommodations has led to employees' unnecessary relapses into a depressive episode. Another observation by the researcher is that employees with MDD are scared to return to work because they fear that they will not cope with their job demands due to cognitive impairments associated with MDD. The common

cognitive impairments in remitted MDD are inattention, impaired executive functioning, and impaired verbal memory.[27]

While reasonable accommodation facilitates access to or retention of employment through the Employment Equity Act (EEA) for people with disabilities, its application appears to be broad and not tailored specifically to mental disability,[21] particularly MDD. According to Maja et al.[23] psychiatric disabilities are generally not understood and acknowledged fully as compared to physical disabilities. It is therefore important that occupational therapists use their clinical reasoning and clinical knowledge of MDD and incorporate legislation to create explicit reasonable accommodations provision for employees with MDD in order to minimise high levels of discrimination, exclusion in employment and increased unemployment rate of this group. According to some studies, reasonable accommodation for mental illness should assist in overcoming return-to-work challenges (low endurance, poor ability to concentrate, reduced planning and organisation abilities, difficult learning process) and facilitating interpersonal relationships at work (relating to management and colleagues, support group program).[4,8,31-32]

The employers' unwillingness to reasonably accommodate employees with MDD[8] has a negative impact on the employees, resulting in anxiety about return-to-work as they worry about losing their jobs. According to Bender and Farvolden[15], MDD is regarded as a threat to jobs and might result in unemployment. Impaired functioning of the employee in the workplace is a concern to employers, occupational therapists and employees with MDD.[27]

Even though reasonable accommodations have been mandatory in the past 20 years in South Africa, few studies have addressed implementation and outcomes of reasonable accommodations in the workplace for people with mental illness, including MDD.[4,28] Van Der Reyden[33] argues that the occupational therapists must have knowledge and uphold the provisions of the law, but the very understanding of the law is sometimes neglected by occupational therapists. She further asserts that experience indicates that most occupational therapists are not knowledgeable about legislation which affects their practices.[33]

Furthermore, there is paucity of research focusing on occupational therapist's knowledge, attitudes and practices in facilitating reasonable accommodations for employees with MDD.

1.3. RESEARCH QUESTION, AIMS AND OBJECTIVES

This section presents the research question, research aims and research objectives.

1.3.1. Research question

What is the occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder?

1.3.2. Research aim

The aim of the study was to explore and describe the occupational therapist's knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder.

1.3.3. Research objectives

From the mentioned aim of the study, the research objectives were:

i. To explore and describe occupational therapist's knowledge in facilitating reasonable accommodations for employees with major depressive disorder;
ii. To explore and describe the occupational therapist's attitudes in facilitating reasonable accommodations for employees with major depressive disorder, and
iii. To explore and describe the occupational therapist's practices in facilitating reasonable accommodations for employees with major depressive disorder

1.4. CLARIFICATION OF KEY CONCEPTS

Attitudes refers to a settled way of thinking or feelings about someone or something and willingness to engage.[34-35] In this study, attitudes is used to refer to the extent to which occupational therapists think or feel about reasonable accommodations specifically for employees with MDD.

Employee as stated in Section 213 of the LRA[19] 66 of 1995 is anyone, other than an independent contractor, who works for another person or who assists in conducting the business of an employer. In this study, employee refers to a person with MDD who assists in conducting the business of the employer.

Facilitating means to make easy, smooth the way, open the door for.[36] In this study, it refers to occupational therapists enabling the implementation of reasonable accommodation.

Knowledge refers to the information, understanding and skill that is gained through education or experience.[34-35] In this study, knowledge is used as the extent to which occupational therapists have information, understanding and skill about reasonable accommodations, specifically for employees with MDD.

Major depressive disorder is used to refer to "Five or more of the following symptoms (depressed mood, markedly diminished interest or pleasure in all or most activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, diminished ability to think, or concentrate, or indecisiveness and recurrent thoughts of death) being present during the same two-week period and represent a change in previous functioning.[37] The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. The episode is not attributable to the physiological effects of a substance or to another medical condition".[37-38]

Occupational therapist is a healthcare professional who studied a four-year degree in occupational therapy. Occupational therapists are responsible for therapeutic use of everyday life activities with individuals or groups for the purpose

of enhancing or enabling participation in roles, habits and routines at home, school, workplace, community and other settings.[13] In this study, occupational therapist refers to a healthcare professional who works in the field of mental health facilitating return-to-work and or vocational rehabilitation and enables participation of employees with MDD to fulfil their worker role in the workplace.

Practices refers to something that is done regularly as part of behaviour in one's settings and the ability to perform.[34-35] In this study, practices is used as the extent to which occupational therapists regularly behave in their settings in order to perform their daily duties while facilitating reasonable accommodations specifically for employees with MDD.

Reasonable accommodation as defined in Section 1 of EEA[20] (1998) is "any modification or adjustment to a job or to the working environment that will enable the person from designated group to have reasonable access to or participate or advance in employment". Reasonable accommodations in this study refers to assisting employee with MDD to have access to participate in employment with some modification or adjustment to a job or a working environment.

Vocational rehabilitation aims to re-establish the medical, psychological, social and occupational activities of the sick or injured worker with previous work history, their working capacity and prerequisites to return to the open labour market.[39]

1.5. SETTING

The study focused on occupational therapists working in private practice in Gauteng Province. The occupational therapists working in this setting treat patients with MDD amongst other diagnoses. The patients may be seen in hospital when they are admitted for two to three weeks and/or after discharge as they will be expected to return to work. In the hospital setting, the patients are usually referred to the occupational therapist by the treating psychiatrist. In outpatient care, the patient may be referred to the occupational therapist by the treating psychiatrist, employer or insurer. These patients are employed and have difficulties returning to work due to functional impairment caused by MDD. The intervention that occupational therapists

provide for these patients include vocational rehabilitation and return-to-work. The occupational therapists assess the patients and compare their abilities and functional impairments with their job requirements, and make appropriate recommendations. The recommendations may include reasonable accommodations needed while they are at work.

1.6. PHILOSOPHICAL ASSUMPTION

Philosophy is a notion that renders a framework within which the world is perceived.[40] Different types of research methods can be associated with different types of philosophical assumptions that guide the research.[41] The researcher considered the social constructivist approach as an appropriate philosophical assumption for the study.[41-43] Social constructivism is when "individuals seek to understand the world in which they live and work".[42] As a social constructivist, the researcher is of the idea that reasonable accommodations can be understood through deconstructing the elements that make them appear meaningful.[43] Social constructivists' ontological, epistemological, axiological, methodological and rhetorical assumptions are described next.

1.6.1. Ontological assumptions

Ontological assumptions are concerned with the nature of social reality or what is real as reality is subjective in nature.[43-45] Ontology "(onto from Greek 'being' and logia from Greek 'science, study, theory') can be defined as the study of reality or things that comprise reality. [43-44] Ontological positions describe what entities exist or can be said to exist and also what kind of relationships exist among basic categories of being".[46] The ontology of the social constructivist will provide multiple (constructivist) realities[47-48] on reasonable accommodations for employees with MDD. A social constructivist ontology allowed the researcher to interact with the Occupational therapists working in mental health and or vocational rehabilitation as their reality was constructed through an interactive process[48] during individual (one-on-one) interviews with the researcher. The researcher provided quotes to illustrate the participant's different perspectives.[41-42]

1.6.2. Epistemological assumptions

Epistemological assumptions refers to the views about the way in which knowledge is gained about social reality.[41,43-44,49] Social constructivist epistemology is based on the assumption that the human life-world is fundamentally constituted in language and that language constructs reality.[43,49] Accordingly, "The social constructivist researcher focuses on specific contexts in which people live and work in order to understand the historical and cultural setting of the participant".[42] Through the continuous interaction with the participants during individual interviews (one-on-one), the researcher elicited their knowledge, attitudes and practices about reasonable accommodations for employees with MDD. Thus, the researcher was able to understand their context with regards to their understanding of reasonable accommodations for employees with MDD.

1.6.3. Axiological assumptions

Axiological assumptions refer to the role of values in research that is value-bound.[44,47] This assisted the researcher in ensuring respect and accountability during data collection. The researcher ensured that she respected the participants during data collection and that each participants' view was not disregarded during the interview. The researcher ensured accountability by bracketing herself as the researcher has experience in the area being researched. A social constructivist axiology allowed individual participants to actively talk about their interpretation of their interactions with employees with MDD during the process of reasonable accommodations[47].

1.6.4. Methodological assumptions

Methodological assumptions are related to the process of research.[42,47] This is viewed as the way of generating the truth of reality.[42] The researcher considered qualitative method which is associated with social constructivist assumptions. The researcher used a semi-structured interview guide during one-on-one interviews

with the participants. Through one-on-one interviews, the researcher might elicited the participants' social reality, their knowledge, attitudes and practices. The researcher understood that the participants' social world was constituted in language, which was analysed as text to generate the research findings.[43]

1.7. THEORETICAL FRAMEWORK

Models assist the occupational therapist to understand and explain practice.[50] For this study, Person-Environment-Occupation-Performance (PEOP) model was used.[51] Person-Environment-Occupation-Performance was developed in 1985 by Baum and Christiansen[51] and revised in 2015. It aims at understanding people's occupational performance and the dynamics/processes that take place when people are actually ''doing'' occupations.[52] The model looks at the function and considers interaction among person, environment, occupation and performance. Baum and Christiansen[51] revised the Person-Environment-Occupation as a move away from a biomedical approach which was practitioner based to PEOP which is client-centred where the narrative of the client is developed. There are four components of PEOP viz person, environment, occupation and performance, as discussed below.

1.7.1. The person

The person involves intrinsic factors such as physiological, cognitive, neurobehavioral and psychological.[48] In this research, the ***person*** domain is the occupational therapist facilitating reasonable accommodation for employees with MDD.

1.7.2. The environment

Environment is where occupational performance occurs and it includes physical, cultural and social components. Physical components consist of buildings and tools, whereas cultural components include identity derived from family, profession, clubs and peer group, and social component is about interpersonal relationships, work

group, political and economic systems.[50] In this study, the ***environment*** refers to the practice of the occupational therapist facilitating reasonable accommodation for employees with MDD.

1.7.3. The occupation

Occupation is a goal-directed and meaningful activity that occurs over time.[50] The ***occupation*** refers to the tasks and processes that occupational therapists employ when facilitating reasonable accommodation for employees with MDD.

1.7.4. Performance

Performance is the ability of the occupational therapist (person) to carry out tasks (occupation) in the practice (environment). Performance focuses on the interaction of the person, occupation and environment.[48] The PEOP was used to guide the questions asked during the interview, and the researcher ensured that the interview guide covered questions regarding person, environment, occupation and performance.

1.8. DELINEATION

- The study explored and described the knowledge, attitudes and practices of occupational therapists working in acute mental health and/or vocational rehabilitation, facilitating return-to-work and reasonable accommodation, in private practice in Gauteng.
- The study described the occupational therapists' methods of facilitating reasonable accommodations when returning employees with MDD to work. Reasonable accommodation covers people with disability who want to enter open labour market and retention of those who are already employed, but for the purpose of this study, focus is on employees with MDD.
- The researcher acknowledges that there are other stakeholders involved in the process of reasonable accommodation when returning employees with

MDD to work like the treating psychiatrist, the psychologist, the human resources practitioners, employer and the patient, but these stakeholders were not part of the study.

- Occupational therapists facilitate reasonable accommodation for employees with other mental illness conditions but the study focused solely on MDD.
- Some patients with MDD reach remission after treatment, however for the purpose of this study, focus was on the patients who were not in remission and had functional impairments even after treatment.

1.9. SIGNIFICANCE OF THE RESEARCH

1.9.1. Occupational therapy profession

There were no published studies in the area of mental health and vocational rehabilitation with specific focus on MDD. When the results are published, the occupational therapists will get substantial knowledge on specific reasonable accommodation recommendations that are applicable to MDD. The study has generated knowledge on the process that the occupational therapists can follow when facilitating reasonable accommodation. This knowledge will assist occupational therapists working in mental health settings and/ or vocational rehabilitation to recommend appropriate reasonable accommodations for employees with major depressive disorder and that way, overcome challenges associated with implementation of reasonable accommodation.

1.9.2. Workplace

The knowledge that occupational therapists shared in this study can assist employers regarding implementation of reasonable accommodations for their employees. When reasonable accommodation is implemented for employees with MDD, the researcher assumes that such employees might be appropriately accommodated at work, which will allow them to be effective and productive in their jobs so that the short-term incapacity leave may not be necessary. Studies by Schreuer[29] et al., McDowell[28] and Bastein[6] confirm that it may be beneficial for the

employers to implement reasonable accommodations in order to retain employees than having to hire new workers given that implemented reasonable accommodations might have least or no cost and thereby reduce unemployment among people with mental illness.

1.9.3. Education and training

This study has highlighted the gap in the occupational therapy profession regarding reasonable accommodations, especially for employees with MDD, thereby providing information for curriculum review consideration and training for qualified occupational therapists. It aims to fill the theory-practice gap in the area of mental health.

1.10. OVERVIEW OF THE CHAPTERS

Chapter one provided the reader with general orientation of the study. **Chapter two** focuses on literature review which will cover major depressive disorder (MDD), the role of occupational therapist on MDD, return-to-work for MDD, occupational therapy facilitation of reasonable accommodation for employees with MDD, ethics and professionalism during reasonable accommodation. **Chapter three** covers methodology. This includes research design, participants in the study, data collection, data analysis and ethical considerations. **Chapter four** presents the findings of the study based on main themes. **Chapter five** discusses the findings while **Chapter six** reflects on the study, concludes and recommends future research.

1.11. CONCLUSION

This chapter covered the background on MDD, its symptoms, its effects on the economy and how it affects functioning in the workplace. The occupational therapists return MDD employees to work through the process of reasonable

accommodation as provided through the labour legislation. Occupational therapists' knowledge, attitudes and practices were important to explore as they were critical for reasonable accommodation process. This study has contributed towards the occupational therapy profession, workplace, training and education of occupational therapists.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

The literature review assisted in ascertaining if there is any research related to this study that has been done before and/or establish what is known and unknown about this topic. Following this thrust, the literature review focused on MDD, significance of working, laws, vocational rehabilitation, reasonable accommodation for employees with major depressive disorder and knowledge, attitudes and practices of occupational therapists in reasonable accommodations.

2.2. METHOD

The review of literature was performed through the University of Pretoria Library by making use of EBSCO host database. The platforms used include MEDLINE, PubMed, PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search was done from June 2021 to September 2021. The keywords that were used to search were “major depressive disorder” AND “occupational therapy”, “occupational therapy” AND “reasonable accommodation”, “ADA”, “EEA”, “MDD” AND “return-to-work”, “vocational rehabilitation”, “legislation” and “knowledge, attitudes and practices”.

2.3. MAJOR DEPRESSIVE DISORDER

According to Diagnostic And Statistical Manual of Mental Disorders Fifth Edition (DSM-5) the diagnostic criteria for MDD is five or more of the following symptoms over a period of two weeks with at least one of the symptoms being (1) depressed mood or (2) loss of interest.[37] Other symptoms are significant changes in weight, insomnia or hypersomnia, psychomotor agitation or retardation, loss of energy or fatigue, poor ability to concentrate or indecisiveness and recurrent suicidal ideation.[37] These symptoms result in clinically

notable impairment in social, occupational or other significant areas of functioning and the episode is not attributable to the physiological effects of a substance or to another medical condition.[25,37] Major Depressive Disorder is heterogenous and accompanied by symptoms such as persistent feeling of sadness, anhedonia, sleep disturbances and cognitive deficits.[27,53-54]

Major depressive disorder is a highly prevalent mental health condition that can be debilitating and is classified as a mood disorder.[2,55-63] Multiple studies reported MDD to have prevalence of 5% in the general population globally.[15,64-67] The lifetime prevalence in China is 2.3%, 6.7% in South Korea, 6.6% in Japan, 20.5% in Chile and 21% in France.[64-67] A national survey of United States adults found MDD prevalence to be 20.6% and remains United States' health concern.[68] Lifetime prevalence of Canada is 11.2%.[69] In South Africa, the lifetime prevalence of MDD is 9.8% and 4.9% for 12 months.[24,70-71] Only 25% of 9.8% of lifetime prevalence seek treatment. [70-71]

Major depressive disorder is considered a leading cause of disability globally.[6,72-73] The levels of disability, morbidity and mortality associated with MDD are remarkable.[54,58,63,74-75] Biological, psychosocial, environmental and risk factors presented in the workplace can contribute to the aetiology of MDD. [38,76] The aetiology of depression is related to biological abnormalities in monoamine neurotransmitters such as norepinephrine, dopamine, serotonin and histamine.[38] About 5-10% of people evaluated for depression have previously undetected thyroid abnormalities.[38] Family studies showed that if one parent has a mood disorder, a child will have 10-25% risk of mood disorder.[38] If both parents are affected then the risk doubles.[38] Depression can also result from negative distortion such as negative self-precept about the environment and the future.[38] The life events that can cause depression are loss and unemployment.[38] Persons with borderline, histrionic and obsessive-compulsive personality disorders are at risk of depression.[38]

2.3.1. Impairment due to MDD

Impairment from MDD could include cognitive dysfunction in executive functions, learning and memory, processing speed and concentration, and results in poor occupational functioning.[27,54-55,75,77-78] Major depressive disorder is a disabling condition that might negatively impacts patient's family, work, leisure time or social life.[62,79] The level of dysfunction is dependent on illness severity.[80] About 60% of patients with MDD have severe to very severe functional impairments that may continue even long after depressive symptoms have been resolved.[58,81] While the severity of symptoms may improve, most patients still report residual symptoms and persistent impaired functioning.[58] Major depressive disorder significantly impairs the client's ability to work productively and contribute positively in society.[27,56,62] Depressed mood, anhedonia, impaired concentration and guilt affect social functioning of patients with MDD.[67]

2.3.2. Remission in MDD

Remission is defined as a time within which the patient does not meet the symptomatic criteria for the disorder.[58,82] Full remission is a complete resolution of MDD symptoms but about two thirds of patients will not get full remission.[83] Increasing evidence shows that the cognitive and functional impairments persist even during remission of MDD.[27,55] Some individuals who have achieved partial remission of MDD symptoms still have persistent deficits in life quality, psychosocial and occupational functioning.[84-86] Delay in an effective treatment is likely to increase the duration to achieve remission and functional recovery.[25] A notable subpopulation of individuals with MDD after taking multiple pharmacological agents does not achieve functional remission due to persistent cognitive deficits. The functional impairments may have an impact on persisting cognitive symptoms of MDD.[54] Improvement of symptoms in MDD is therefore a poor predictor for improvement in functioning, resulting in possibility of job loss. [27,84-86]

2.3.3. Impact of MDD in the workplace

Recently Weziak-Bialowolska et al.[87] discovered that depression is more likely to be apparent in a workplace.[87] One of the most prevalent health problems in the workplace is MDD.[88] Stander et al.[5] reported that more than a quarter of the South African workforce have been clinically diagnosed with MDD and also established that MDD impacted their work performance.[5,89] Vocational functioning is when an employee is able to meet her/his job functions and the opposite is true for work impairment.[26] Work impairment may manifest through absenteeism and presenteeism. [26]

Absenteeism is characterised by time away from work.[67] Absenteeism can be aggravated by severity of illness, coinciding medical conditions and comorbidity.[67] In South Africa, 18 days account to missed days at work annually due to MDD.[72] It results in increased workload for colleagues, reduced production and loss of income from hiring substitutes temporarily.[5]

Presenteeism is loss of productivity while at work due to illness.[67] It is of main concern for employers as it might pose higher cost than absenteeism.[5] In the United States, employees with MDD lose about 27 work days yearly due to reduced work performance.[90-91] Furthermore, about 7-9% of full time employed adults reported having experienced MDD every year and more than 77% of them attested to reduction in productivity in the workplace as a result of MDD.[85] Stander et al.[72] in their study found that employees with MDD perform at 70% optimum.[5] The ongoing evidence shows that current antidepressant regimens do not fundamentally target psychosocial impairments and workplace disability caused by MDD.[54] Prolonged absence from work increases risk of social isolation and decreases a sense of meaningful activity for patients with MDD.[92] Grobler et al.[12] emphasise that absence from work may contribute to in disability which may potentially be permanent disability.[12]

Cognitive dysfunction such as difficulty in thinking, concentrating or decision making is the main characteristic of MDD which results in impairment in functioning and work limitations.[93-94] Cognitive dysfunction can be found during first episode of depression, recurrent depression and late-life depression.[94-96] Harrison et al.[94] point out that cognitive dysfunction in recurrent depression tends to worsen with each episode of depression.[94] Cognitive domains mostly associated with MDD are attention, information processing, memory and learning, executive functions and psychomotor processing.[75,97-98] Individuals with MDD display poor work behaviours like inability to complete simple tasks, meeting targets, poor work speed, high rate of errors with poor work quality as a result of cognitive impairment[5] and poor work behaviours can be exacerbated by high interpersonal and social alienation in the workplace.[99] Due to MDD symptoms of weeping and social withdrawal, interaction with colleagues is negatively affected.[5]

While MDD presents with disturbances in mood, energy, metabolism and motivation, studies have shown that cognitive dysfunction has impact on workplace impairment than MDD severity as patients with perceived severe cognitive dysfunction reported poor productivity in their work.[27,54,93,100] A large systematic meta-analysis study confirmed poor productivity as a result of impaired cognition when it found that tasks that required planning, memory, processing, and inhibition were performed poorly by employees with MDD.[73] Depression results in limitation in time management.[27]

An individual's ability to work may be affected by MDD resulting in poor work performance.[101] Employees with MDD have specific limitations (carrying out mental and interpersonal tasks) in their ability to be functional at work. [101,88,102] Impairment in ability to work and work productivity is more common in MDD than other mental and physical health disorders.[88] Employees may need to put extra effort in order to be productive during working hours, resulting in fatigue.[101] In order for an employee with MDD to achieve normal productivity, excessive physical and psychological effort is required of the employee.[26]

The challenges of poor performance, poor productivity and need for extra physical and psychological effort may result in lower earnings due to disability-related leave, reduction in perceived productivity and less working hours due to MDD.[99]

2.3.4. Economic burden of MDD

There is indisputable evidence that economic burden of MDD globally is enormous.[54,97] In the workplace, MDD has both direct and indirect economic loss.[15,56,72] The direct costs include absenteeism, disability costs, lost promotion or overtime, and moving from full-time to part-time.[6,15,56] Major depressive disorder contributes towards workplace absenteeism more than other chronic illness and physical disorders.[102-103] The direct cost of MDD in the USA is estimated at 47% of the total economic burden.[104] The indirect costs are presenteeism and high rate of staff turnover. [6,15,53,72,85] Presenteeism is regarded as five times more costly than absenteeism in the workplace.[85,102-103] The United State loses productivity to the value of $51.5 billion.[5,15] In 2016 alone, Canada lost $32.3 billion due to reduced work-place productivity and occupational dysfunction associated with MDD.[54] Major depressive disorder studies in South Africa show that one in four employees are diagnosed with MDD, consequently affecting the country's economic engine. [15 72] The loss of earning in South Africa is estimated at a total of R3.6 billion for depression and anxiety.[5] The cost of lost work productivity due to absenteeism and presenteeism across eight countries (Brazil, Mexico, Canada, China, Japan, Korea, South Africa and United States) is estimated at $246 billion.[97,105-106] It would therefore be beneficial for the employers to ensure that employees with MDD are treated effectively as their impairments affect the company's profitability.[5]

2.3.5. Treatment of MDD

Treatment of MDD is geared towards the reduction of depressive symptoms and treatment is considered effective when absence or near absence of MDD symptoms is achieved.[58,83]

Management of MDD must include both symptom relief and functional improvement during the recovery from MDD.[93] There are diverse evidence based interventions for MDD, including pharmacological and psychosocial treatments.[58,62,104]

2.3.5.1. Pharmacological interventions

Oluboka et al.[25] highlight that the treatment of MDD needs to be patient-centred considering patient's individual characteristics, preferences and treatment expectations.[25,67,107] Early treatment and optimization of dosage are fundamental to successful outcomes.[104,107-108] Oluboka et al.[25] add to this notion of early treatment by saying MDD must be treated with urgency as the delay prolongs patient's suffering.[25] Saddock and Saddock[38] reported that the use of very low antidepressant dosage for a brief period can result in poor results of antidepressant drug trial.[38] Antidepressant drugs must be maintained for six months or the length of the previous episode or whichever is longer.[38]

Canadian Network for Mood and Anxiety Treatments guidelines provides recommendations on the treatment of MDD.[67,83,107] Evidence-based guidelines advocate for use of antidepressant for the treatment of MDD and 33.3% of the patients respond to the first guideline Selective Serotonin Reuptake Inhibitors such as sertraline, fluoxetine, paroxetine and escitalopram while the majority respond to subsequent treatment.[56,62,79,85,101,109]

Selective norepinephrine reuptake inhibitors are also considered as first-line treatment option.[83,101,110] Tricyclic antidepressants are used as a second-line antidepressant due to safety and side effects. [83,101] Third-line treatment option are monoamine oxidase inhibitors and include isocarboxazid, phenelzine, selegiline and tranylcypromine.[83] Electroconvulsive therapy is an option in the treatment of MDD.[63,83]

2.3.5.2. Psychosocial treatments

The use of psychosocial interventions like psychotherapy (cognitive behavioural therapy) occupational therapy (cognitive remediation therapy, lifestyle change, work-based

interventions) and sleep therapy to augment pharmacological intervention can further facilitate return to premorbid functioning level and return-to-work.[56,62,79,101,104]

Cognitive behavioural therapy is a form of psychotherapy[83] which provides patient education on the understanding and inspection of their mood, thoughts and behaviour interaction which may cause or worsen depression.[83] It focuses on reducing distress by using replacement of dysfunctional thoughts and behaviours with adaptive ones.[83] Four or more psychotherapy sessions over a period of six months is said to be effective in reducing absenteeism.[15]

Lifestyle interventions is a multimodal approach that focuses on modifying behaviours, environment, diet, recreational substances and psychological habits in order to promote both physical and mental well-being.[111-113] Modification of behaviours includes physical activity which is a mood elevator and has other health benefits.[111-113] Dietary modifications discourage ultra-processed foods and encourage vegetables, fruits, nuts, seeds, lean proteins, seafood, and whole grains.[111-112] Recreational substances like alcohol, cigarettes and caffeine need to be avoided as they trigger anxiety and depression.[111-113] Psychological modification focuses on stress management and mindfulness techniques.[111-112] Sleep hygiene refers to environmental and behavioural recommendations that encourage healthy sleep.[114] Healthy sleep habits that patients are encouraged to follow in improving their sleep include avoiding caffeine, exercising regularly, removing noise from the environment where one sleeps, and maintenance of regular sleep schedule.[111-112,114]

A clinical case report by Sarsak[62] on applied occupational therapy for MDD found that occupational therapy is complementary to other MDD treatments (psychotherapy and pharmacology) and it is essential and effective in the management of depressive symptoms and build-up of cognitive abilities, social skills and independence in the performance of activities of daily living while ensuring safety and quality of life for depressed individuals.[62]

2.3.5.3. Occupational therapy in treatment of MDD

Occupational therapy has history in mental health with the primary goal to enable engagement in activities of daily living, including work.[62,115] The effectiveness of occupational therapy is in management of symptoms and improvement of cognitive abilities, social skills and functioning in activities of daily living (ADL).[62,115] A study by Kroger et al.[116] showed that occupational therapy intervention reduced days of incapacity to work in MDD and increased long-term MDD symptoms remission and prolonged return-to-work in good health.[116] The study further showed that inclusion of occupational therapy intervention was more cost effective than psychiatric treatment alone.[116] There are four principles that guide the contemporary occupational therapy: client-centred practice, occupation-centred practice, evidence-based practice and culturally relevant practice.[50] Client-centredness refers to a collaborative engagement of the client and the occupational therapist during therapeutic process.[50]

2.4. SIGNIFICANCE OF WORKING

Working is significant from a societal perspective and forms part of quality of life as it is a source of income, gives structure and provides opportunity for social interaction.[101,117] Work is central to one's identity and participation in work fosters health promotion and improves a person's self-esteem.[101,118] Work has been proven to be beneficial for both mental and physical health and wellbeing.[88] Therapeutic value, recovery and rehabilitation promotion, and reduction of adverse mental, physical and social effects are the benefits of work that result in improved quality of life and well-being.[88,119-120] Therefore, keeping people with MDD in the workplace when their condition improves should be encouraged. [88,119-120]

Work engagement is an important business success driver and engaged employees have high energy levels and enthusiasm about work.[24] Employees express themselves physically, emotionally and cognitively during work engagement, leaving them with fulfilled human spirit.[24,121] The sense of appreciation, recognition and success is experienced by

an engaged employee when they use their positive attitude and high activity level to influence occurrences that affect their work life.[24] Employees who are working tend to experience positive emotions (happiness, joy and enthusiasm), and greater physical and psychological health, job and personal resource creation and transference of work engagement.[24,122] Research shows that high levels of engagement result in increased organisational commitment, job satisfaction, decreased employee absenteeism and turnover rates, health and well-being improvement, increased performance and high job motivation.[122] Work is valuable to individuals with mental health conditions as it enables them to participate in something greater than themselves and yields self-value for their efforts.[123] Despite all the benefits of work, less people with disabilities are employed.[124]

Working brings about feelings of wellbeing, social integration and encourages participation in other areas like leisure pursuits and socialisation.[124-125] Decline in physical and mental health, increase in mortality rates, and medical consultation may result when the benefits of work are no longer enjoyed due to unemployment.[126] The benefits of work exceeds the 'risk' when risk is properly assessed and managed, and work demands are modified to match the employee's abilities.[126] Saunders and Nedelec[126] in their scoping review explored what is known in the literature about what work means to the work disabled after temporary or permanent unemployment as a result of illness or injury. They found that while work continue to be meaningful and significant to people with work disability, the majority of people with disabilities want to work. The common themes across various disabilities found in this review were "work being a natural part of life, source of identity, feelings of normality, self-esteem and worth, and financial support."[126]

Several studies have shown that people work for financial independence, societal contribution, to gain personal rewards, provide structure to one's life, to participate in different areas of life, to explore roles, for one's status in the community and most importantly, the identity of the person.[119-120,127-131] The ability to work enabled others to manage the symptoms of their illnesses better, and served as proof of regaining health and return to 'normal' life.[132-134]

2.5. RELEVANT LAWS

Disability is a natural part of the human experience and does not reduce person's right to belong and participate in the labour market.[135] However, people with disabilities have low employment participation as compared to abled people globally.[136] Majola and Dhunpath[137] argue that globally, there has been marginalisation of people with disabilities because they rely on social grants and are categorised as unemployable or not prepared to work.[137] In response, different countries globally, have developed legislations to protect people with disability in the workplace or entering employment.[16] The employment rates of people with disabilities are still lower compared to people with no disabilities in South Africa.[137-138] Govender et al.[139] argue that while reasonable accommodation policies have been around for some time, their implementation and monitoring remains a challenge.

Internationally, laws related to vocational rehabilitation and disabilities dates as far back as 1916.[18] The Americans with Disabilities Act of 1990 was enforced through Equal Employment Opportunity Commission.[18] Provision of reasonable accommodation by employers to employees with physical and/or mental disabilities is established through American Disability Act.[6] American Disability Act Amendment Act of 2008 highlights that reasonable accommodation must not cause undue hardship to the employer.[6]

The United Nations Convention on the Rights of Persons with Disabilities protects and promotes the full and equal rights of persons with disabilities[140] and has shown the transition from 'charity based' to 'rights based perspective'.[141-142] Disabilities opened for ratification in 2007. [21] About 177 countries are signatories to and have ratified CRPD.[21] Non-discrimination, equality of opportunities, and full and effective participation in the society are the principles guiding CRPD.[21]

South Africa became a signatory of CRPD and its Optional protocol in 30 March 2007.[143] It was ratified months later at the end of November 2007[143] when CRPD opened for ratification.[21] However, Hussey et al.[144] argue that South Africa became a signatory and ratified of both CRPD and Optional protocol in 2008.[144] What remains is that South Africa

is part of CRPD and the country had already enacted several laws that protect rights of persons with disabilities.

In 1994, South Africa enjoyed its first democratic elections, giving rise to a democratic parliament and the Constitution of South Africa.[16,145] The South African Constitution of 1996, in its chapter one of founding provisions, makes assertions for human dignity, non-discrimination and freedom.[145] Its chapter two Bill of Rights outlines clearly, human rights for all South Africans.[145] The constitution clearly endorses that disabled people must not be discriminated in the democratic South Africa.[145-146] The white paper on the Integrated National Disability Strategy was adopted in 1997, following an extensive discussion with various stakeholders.[146] The Integrated National Disability Strategy is the government's strategy to develop and promote integration of persons with disabilities into different levels of society while promoting and protecting their rights.[146]

Employment equity in South Africa resulted in the enactment of some progressive legislation in order to effect the Bill of Rights of people with disability in the workplace, including the Labour Relations Act (LRA) of 1995, the EEA 1998, and the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) of 2000.[19-20,147] As this study focuses on MDD which is a mental healthcare condition, it is important to include Mental Healthcare Act of 2002. [22] The Protection Of Personal Information Act (POPIA) of 2013[148] is of importance as well because reasonable accommodation may involve sharing of personal information.

2.5.1. Labour Relations Act

The Labour Relations Act No 66 of 1995, Schedule 8 of Code of good practice: Dismissal, states that incapacity may be temporary or permanent on the basis of ill health or injury. The extent of incapacity is investigated by the employer in the case where the employer is temporarily unable to work. If the duration of absence is unreasonably long, the employer should explore other possible alternatives short of dismissal. The factors that are relevant

when considering other alternatives are type of the job, length of absence and the degree of the illness or injury. Alternative employment, and job adaptations to accommodate employee's incapacity are considered when permanent incapacity is indicated.[19] Unlike the EEA, the LRA does not address reasonable accommodations per se but rather, job adaptation.[19] While the EEA focuses on designated groups including people with disability[20], the LRA focuses on all employees and addresses ill-health and not disability.[19]

2.5.2. Employment Equity Act

The South African government in an attempt to redress historical discrimination specifically in the workplace, introduced the EEA Number 55 of 1998.[147] In the area of equity and disability, Modise et al.[146] describe the EEA as one of the most advanced and progressive legislative measures.[146] Chapter 2 of the EEA addresses prohibition of unfair discrimination. The Employment Equity Act seeks to promote equal opportunity and implementation of fair treatment through elimination of unfair discrimination and implementation of affirmative action in order to redress disadvantages experienced by designated groups.[146,149] Affirmative action is outlined in chapter 3 of the EEA.[20] Affirmative action measures state that there should be equal employment opportunities for designated population groups.[20,146] Designated groups according to the EEA include black people, women and people with disabilities.[20] People with disabilities refers to those who have "a long-term or recurring physical or mental impairment which substantially limits their prospects of entry into, or advancement in employment" as outlined in the EEA.[20] Modise et al.[146] point out that people with disabilities are beneficiaries of affirmative action.[146] Reasonable accommodation is provided for under affirmative action measures.[20]

According to the EEA[20], reasonable accommodation means any modification or adjustment made to a job or the working environment in order to enable a person with disability to access or take part or advance in open labour market.[20] However, Modise et al.[135] reported that effective implementation of reasonable accommodation remains a challenge as some

employers are ignorant of it.[135] Govender et al.[139] add that there is lack of implementation and monitoring of reasonable accommodation policies in healthcare.

The Code of Good Practice: Key Aspects on the Employment of People with Disabilities was issued in terms of section 54(1)(a) of the EEA , No 55, 1998 and is based on the constitutional principle that a person may not be unfairly discriminated against on the basis of disability.[20] It states that employers must accommodate people with disability in order to reduce the impact of impairment on their capacity to fulfil their essential job functions.[20,146] Specific reasonable accommodations are outlined in the EEA.[20] According to the EEA[20] reasonable accommodation may be temporary or permanent and provision of reasonable accommodation must not cause “unjustifiable hardship” to the business of the employer.[20] In order to assist the understanding of the EEA for the parties involved, the Technical Assistance Guideline (TAG) was developed.[150] The TAG includes eliminating unfair discrimination through affirmative action measures in the workplace and gives guidelines on the implementation.[150] Denial of reasonable accommodation is viewed as discrimination on the basis of disability by UN CRPD.[21]

According to the EEA[20], the employee applying for reasonable accommodation has the obligation to disclose their disability unless it is self-evident to the employer.[20] When the reasonable accommodation imposes unjustifiable hardship on the business, the employer can decline the application for reasonable accommodation by the employee.[20] The Employment Equity Act defines unjustifiable hardship as considerably difficult or expensive act.[20]

Section 8.2 of Code of Good Practice: Key Aspects on the Employment of People with Disabilities addresses testing after illness or injury. The employer may require the employee who has been ill or injured to agree to functional determination of disability if the employee is not able to perform their job.[20] The medical or any related tests shall be used to determine the safety of the employee to perform their job or for identification of reasonable accommodation needed for the employee.[20] Disclosure of disability status is covered under Section 14.2 of Code of Good Practice: Key Aspects on the Employment of People with

Disabilities. People with disabilities have a right to keep their disability status confidential, however, the employer is not obliged to accommodate the employee if he/she is not aware of the disability.

2.5.3. Promotion of Equality and Prevention of Unfair Discrimination Act

The introduction of the Promotion of Equality and Prevention of Unfair Discrimination Act number 4 of 2000 assists the state to comply with its duty to pass legislation to effect prevention and prohibition of unfair discrimination and to promote the achievement of equality as outlined in section 9(4) of the Constitution.[146,151-127] Section 9 of the PEPUDA states that social transformation can be achieved when people with disabilities are reasonably accommodated as refusal to accommodate them may result in their exclusion from mainstream society. [135,152-154] The Promotion of Equality and Prevention of Unfair Discrimination Act provides reference for reasonable accommodation in South African legislation. [135,152-154] The employees who are not covered in section 1 of the EEA, can have recourse under the PEPUDA in the event that they experience discrimination.[146,151]

2.5.4. Mental Health Care Act

The Mental Healthcare Act 17 of 2002 states that people may not be discriminated on the basis of their mental health status.[22] Provision for persons who are mentally ill to receive care, treatment and rehabilitation is made in the MHCA. It recognises the Constitution of the Republic that prohibits unfair discrimination against people with mental or other disabilities.[155] Section 10 of chapter III states that the mental healthcare user may not be unfairly discriminated against on the basis of their mental status.[155]

2.5.5. Protection of Personal Information Act

The Protection of Personal Information Act Number 4 of 2013 ensures protection of the privacy rights in section 14 of the South African Constitution that ensures everyone's right to privacy.[148] It however balances the right to access to information.[148] Buys[156] highlights five areas that the act focuses on as: lawful information processing, the rights of the data subject, what is considered personal information, what recording of that information entails, and who can be seen as the responsible party.[156]

The Health Professions Council of South Africa (HPCSA) states that healthcare professionals must ensure that patients' information is not left where it can be accessed by unauthorised healthcare practitioners or the public. Patient's information must be treated with confidentiality and privacy.[157] The responsible party must ensure that consent is given to obtain information, protect information from being accessed or published by an unauthorised party, and avoid harm or distress to the subject.[156]

2.6. VOCATIONAL REHABILITATION

Vocational rehabilitation is defined by Escorpizo et al.[39] based on International Classification of Functioning as "multi-professional evidence-based approach that is provided in different settings, services, and activities to working age individuals with health-related impairments, limitations, or restrictions with work functioning, and whose primary aim is to optimize work participation".[158] There are several theories and models that Occupational therapists use in vocational rehabilitation which include but are not limited to Person-Environment-Occupation (Law et al.,1996), Model of Human Occupation (Kielhofner, 2009) and Person-Environment-Occupation-Performance (PEOP) (Baum, Christiansen & Bass, 2015).[50,159]

Vocational rehabilitation program aims to assist individuals to participate in work,[160] by attaining or maintaining employment.[99] During vocational rehabilitation, various

approaches are employed to assist an individual to overcome barriers to accessing, retaining and or returning to work.[161] Vocational rehabilitation employs an all-inclusive approach, viz: assessing the client holistically, doing job analysis, work visit, using work tasks and reasonable accommodation in order to enable the client to fulfil their essential job demands.[159]

Primarily, the goal of work-related occupational therapy intervention is to promote participation and engagement in work activities.[50] Occupational therapist can ensure this by modifying the environment to enable patients to participate in daily activities.[62] Occupational therapists have taken a variety of roles and majority are involved in vocational rehabilitation of individuals with mental illness.[162] The role of occupational therapists in vocational rehabilitation is further approved by WFOT.[11] During vocational rehabilitation, occupational therapists focus on human occupation of work, apply their pathology knowledge, activity analysis ability, and are concerned with occupational performance and purposeful activities since the profession of occupational therapy perceives occupation of work as an inherent part of treatment rehabilitation outcome.[163] The position statement of Occupational Therapy Association of South Africa on vocational rehabilitation views the role of occupational therapists in vocational rehabilitation as warranted due to their knowledge of pathology, impairment functional requirements of work.[164]

Vocational rehabilitation involves a multidisciplinary team including occupational therapists who facilitate employment in various work settings.[159] Vocational rehabilitation shows benefits on productive roles, coping at work and self-efficacy.[165] The International Labour Office's description of vocational rehabilitation outlines five steps: (i) vocational assessment, (ii) vocational guidance/ intervention, (iii) vocational preparation and training, (iv) selective placement and (v) follow-up.[159]

2.6.1. Vocational assessment

Vocational assessment begins the process of vocational rehabilitation and continues throughout the process of vocational rehabilitation as the client's progress is assessed and monitored after initial assessment in order to determine work readiness, suitability of placement and necessity for reasonable accommodations.[159] vocational rehabilitation assessment is commonly known as functional capacity evaluation.[159]

2.6.1.1. Functional capacity evaluation

In order to determine whether an employee is ready to return to work after suffering an illness such as MDD, occupational therapists conduct a functional capacity evaluation (FCE).[8,117] Functional capacity evaluation is an evaluation that determines the ability of an individual to perform his/her work or participate in an employment.[50,166] According to Schell and Gillen,[50] FCE can be carried out by other professionals. These two scholars argue that occupational therapists are best suited to carry out FCE due to their knowledge of evaluating individual's ability to execute activities, job analysis and measuring the environment through diverse methods.[50] Functional capacity evaluation is extensive evaluation that can last for several hours and is recommended to be performed over two days.[50] Schell and Gillen distinguish between generic FCE and job-specific FCE.[50] The generic FCE does not match client's abilities to a specific job's demands but rather, to general physical and cognitive demands and is relevant for clients who are unable to work. Job-specific FCE is targeted at a specific job and job description must be provided in order to outline job demands that the client needs to be matched with.[50]

Functional capacity evaluation process is dynamic.[8,167] Buys and van Biljon[167] write that FCE includes referral for and preparation of FCE, the initial interview, evaluation of performance components and activities of daily living, the vocational evaluation, the collateral and closure interview, the work visit, hypothesis testing – pulling all the steps of FCE together, and finally writing up the FCE.[167] A study by Ramano and Buys suggested that employees should be assessed in a workplace and/or home environment as part of FCE as this will give an indication of environmental factors both physical and social.[8]

Standardized and non-standardized tools are used during FCE and their choice can be guided by an interview with the employee.[8] Ramano and Buys[8] state that the employee's level of functioning, physical and mental capacity can be established through an FCE.[8] They further note that Occupational therapists through undertaking FCE, can assist employers in determining if the incapacity to work is temporary or permenant.[8] The FCE conducted by occupational therapists aids employers to fulfil the legislative provisions of EEA.[8,168]

2.6.2. Vocational guidance/ intervention

Swart and Buys[169] noted that factors like impact of mental illness, educational and vocational history of the patient, context, employment status of the patient and resources available influence the vocational intervention.[169] The improvement of physical, mental and social functioning of an ill person helps to restore work capacity which is necessary for return to work or availability for a job.[160]

2.6.2.1. Work hardening

Work hardening dates back to the 1970s when it was used to cut work-related injuries costs.[170] It is an intervention that is aimed at individuals with physical limitations and seek to return to work.[50] Work simulation, counselling, coaching, ergonomic assessment and cardiovascular conditioning forms part of work hardening.[50] While work hardening applies to various populations, it has been commonly applied to people with physical limitations and pain.[170] Cognitive work hardening seeks to bridge the gap for people with mental illness.[170]

2.6.2.2 Cognitive work hardening

Cognitive work hardening uses work as a treatment modality and uses the same occupational therapy principles of work hardening to restore work capabilities for individuals recovering from MDD.[50,170] Cognitive work hardening has multiple elements, is an

intervention that is occupation-based and addresses the gap between MDD symptom remission and work functioning.[170] Literature has presented strong evidence on cognitive dysfunction (memory, concentration, planning, multitasking) associated with MDD making cognitive work hardening the best choice for the employee with MDD and whose job has high cognitive requirements.[50,170] Strategies like stress management, assertiveness, following work schedule, simulated work tasks, organisational skills, pacing and mental endurance can be employed during cognitive work hardening for returning employees to work.[50]

2.6.2.3. Early Return-to-work

Generally, people who are employed have good health than those who are unemployed because being absent from work may lead to disability.[12,125] The longer the injured or ill person stays away from work, the more difficult it is to return them to work and the financial burden placed on the employer through productivity loss and insurance costs is also greater.[166] Early return-to-work for individuals with MDD on sick leave is in the best interests of both the employer and employee as it may reduce costs on individuals and the society.[166,171] When people are successfully employed, it improves their sense of worth, reduces symptoms associated with the illness, minimises admissions to hospital, improves social skills and brings about independence.[159] Given high absenteeism associated with MDD, reducing sick absence and facilitating return-to-work is vital.[92] Remission of MDD symptoms does not necessarily relate to return-to-work and therefore, treatment that focuses on symptom reduction solely is not enough.[92] Treatment focusing on both return-to-work (functional remission) and reduction of MDD symptoms (clinical remission) is important.[58,92,172]

The main objective that seems to be shared by the patients, companies and treating team is facilitation of return-to-work and reduction in number of sick leave days.[118] A successful return-to-work reduces disability costs for the employer and allows employees to return timely and stay at work.[173-174] A recent systematic review study of 2021 found evidence that return-to-work interventions were cost-effective.[80] Return-to-work programs have proved to reduce sick leave days, and employees who are ill or disabled are able to secure, retain or

advance in employment in their current workplace.[174-177] It also provides reintegration into open labour market for the employee which minimises disability pension's burden on the state. [174-177] Early return-to-work during recovery benefits people with mental illness as it has therapeutic value of improving self-esteem, psychiatric symptoms reduction, and minimises social disability.[168]

Hoo[166] asserts that the employer has the final decision on whether the employee can return to work. The employer is reliant on medical reports, fitness for duty and work assessment in order to rule out any medical counterindications for return-to-work.[166] Return-to-work interventions include interventions that are directed at work.[178-180] The multiple factors that predict return-to-work outcome are diagnosis, personality, socioeconomic and work-related.[181] Work motivation has been found to be a predictor for return-to-work for other illnesses and the study by Hees et al.[181] found work motivation to be a predictor for return-to-work for patients with MDD as well.[181] Early intervention facilitates successful return-to-work.[163]

Occupational therapists are key in providing vocational rehabilitation for an individual when experiencing illness, disease or injury to facilitate return-to-work readiness.[50] The focal point of return-to-work is on various levels of work participation including individual preparation, policies within workplace, and environmental adaptation.[50] Occupational therapists have a pivotal role in facilitating risk free, effective and prompt return-to-work.[62,117] Occupational therapists provide work rehabilitation and return employees to work after injury or disability.[12] Occupational therapists working together with the employee and employer is necessary when planning and implementing return-to-work program.[174] Despite the limited evidence on the effectiveness of occupational therapy intervention for individuals with MDD, a systematic review by Christie et al.[80] showed strong evidence of the effectiveness of occupational therapy return-to-work intervention for alleviating symptoms of MDD.[80] However, the study found that in terms of effectiveness of occupational therapy return-to-work interventions in the improvement of work readiness or general health and well-being there was no evidence.[80] In 2021 there was still no study on the effectiveness of occupational therapy's return-to-work interventions.

2.6.2.4. Case management

Schell and Gillen[50] define case management as "a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes." Case management is used to facilitate return-to-work more frequently for employees with mental illness.[159] The case manager is important in this process. The case manager assesses the needs of patient, develops the care plan, arranges suitable care in the workplace and keeps contact with the patient and involved stakeholders.[182] Case management and occupational therapy are compatible in both philosophy and practice as they both use client-centered and holistic approach.[183] An occupational therapist who is a case manager focuses beyond services provided in the hospital and assists the client achieve optimum participation during and after incapacity.[183]

2.6.3. Vocational placement

When placing people with disability, especially with mental illness, legislation needs to be applied to protect their rights in the work place and prevent discrimination.[169] Such legislation is EEA which makes provision for reasonable accommodation.[20] Personal and societal costs linked with low participation in work by people with disabilities has been reduced or eliminated by several countries through the enactment of employment equity legislation that requires employers to provide reasonable accommodation.[184]

Benefits of providing reasonable accommodation are: high job performance and satisfaction, improvement of colleagues' attitudes towards employees with disabilities, reduction in employees' perception of discrimination from employers and colleagues, and reports of improvement in job performance by employers.[185] Predictors of reasonable accommodation for patients with physical disabilities were found to be demographic factors, occupational factors, vocational training and severity of the disability.[99] A scoping review study by McDowell and Fossey[28] found that job tenure amongst employees with mental disabilities improved through reasonable accommodation.[28] Reasonable accommodation

ensures enjoyment of basic rights which include the right to employment[21] as the lack thereof results in high unemployment amongst people with disabilities.[186]

2.6.4. Follow-up and closure

This is the final stage of the vocational rehabilitation process where the occupational therapists review if the objectives of the programme were achieved or if ongoing support is needed.[169]

2.7. REASONABLE ACCOMMODATION FOR EMPLOYEES WITH MDD

Major depressive disorder symptoms result in functional impairment including poor work performance.[62,79] While treatment of MDD results in symptom remission, cognitive impairment tends to linger, resulting in poor social and occupational functioning.[27,54,84-86,93,100] Barriers to work performance and access lead to occupational imbalance, alienation, marginalization and deprivation.[187-188] Occupational therapists are well qualified for the assessment and determination of the environmental impact on occupational performance from which they recommend relevant modification or technology required by an individual with an illness or disability to perform their essential job functions.[18]

Maintaining productive workforce, fostering economic independence and self-determination among individuals with disabilities requires effective reasonable accommodation.[29] However, employers are reluctant to employ or retain people with disabilities due to the cost associated with reasonable accommodation.[185] Provision of reasonable accommodation is the employer's legal responsibility as stated in EEA.[20,31] Employees with mental illness are given less workplace accommodations than those with physical disabilities.[102] Fear of job loos, poor assertiveness skills amongst employees with MDD, issues of stigmatisation and not being aware that one can request reasonable accommodations, are some of the reasons that result in low rates of reasonable accommodations for employees with MDD.[102]

Reasonable accommodations for employees with MDD are more social and organisational unlike for those with physical disabilities which are structural.[31,102] The commonly provided reasonable accommodations for employees with MDD are modifying, reducing work schedule and allowing gradual return-to-work.[6,28,31] Providing reasonable accommodation for these employees allows them to continue working and also improves their mental health prognosis.[31]

2.8. KNOWLEDGE, ATTITUDES AND PRACTICES OF OCCUPATIONAL THERAPISTS REGARDING REASONABLE ACCOMMODATION

A pilot study on attitudes towards reasonable accommodations for occupational therapists with disabilities was conducted in 1996 and found that occupational therapists who had a positive attitude towards making reasonable accommodation were the ones who were trained in American Disability Act, and that many occupational therapists were oblivious of the American Disability Act provisions on reasonable accommodation.[189] This study recommended that occupational therapy students and occupational therapists should have education on the law.[189] In 2009, Schreuer et al.[29] contended that occupational therapists trained in ergonomics were able to mediate interactive process of workplace accommodations. Literature search did not reveal publications on occupational therapists' knowledge, attitudes and practices on reasonable accommodation in South Africa or elsewhere in the world.

2.9. CONCLUSION

This chapter gave a brief review of employees with MDD and the importance of occupational therapy in management of MDD. Relevant legislation is integral as it provides framework within which occupational therapists can return employees with MDD to work using reasonable accommodation. Internationally, literature refers to job accommodation or workplace accommodations than reasonable accommodations. There is dearth of research regarding facilitation of reasonable accommodation during return-to-work of employees with MDD by occupational therapists. Studies on reasonable accommodation

show occupational physician or rehabilitation practitioner as the stakeholders steering reasonable accommodation process. Little is known about this subject as well as the knowledge, attitudes and practices of occupational therapists during facilitation of reasonable accommodation for employees with MDD and. Chapter three covers the methodology for this study.

CHAPTER THREE: METHODOLOGY

3.1. INTRODUCTION

This chapter presents the methodology of this study. It looks at the research approach, research design research population, sampling and sampling technique. Furthermore, the development of the interview guide and method of data collection is discussed. Data analysis is outlined and measures to ensure trustworthiness are presented. Finally, ethical considerations that guided the study are discussed.

3.2. RESEARCH APPROACH AND DESIGN

Qualitative research approach and design were used as discussed below.

3.2.1. Qualitative research approach

"Qualitative research approach is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem".[42] The qualitative research approach allowed the researcher to explore and understand the meaning that occupational therapists had to share in facilitating reasonable accommodations for employees with MDD. Qualitative methodology was useful as the study did not require a yes or no answer but involved in-depth investigation of the characteristics of a phenomenon to give clear meaning and understanding thereof.[190-192] Qualitative research is used when little is known about a subject[190-191], and in this instance, little is known about occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodation for employees with major depressive disorder. Data that can shed light on this phenomenon cannot be elicited through yes or no responses, hence the researcher chose to incorporate a qualitative research approach. This approach enabled the researcher to collect data one-on-one, using flexible questioning which resulted in rich comprehensive data.[190]

3.2.2 Research design

An explorative descriptive contextual design[40,193] was employed. The researcher carried out an explorative design in order to gain insight into a situation or where there was lack of evidence and information was limited, namely on reasonable accommodations and the design assisted in answering “a what” question.[194-196] A descriptive design gives a picture of specific details of a situation and focuses on how and when questions.[48,197] A contextual design allowed the researcher to do research in the natural setting of the participants by bringing the researcher into the participant’s environment and not the participant into the researcher’s environment.[198] The initial plan for the study was to conduct interviews in the participants’ natural settings. However, it could not be done due to COVID19 lockdown regulations which saw the interviews moved to an online platform; Google Meet.

An explorative descriptive contextual design was used as the researcher wanted to gain insight on knowledge, attitudes and practices of participants when facilitating reasonable accommodations and get a picture of how the participants facilitated reasonable accommodations for employees with MDD in the specific context of own private practice in Gauteng.

3.3. PARTICIPANTS IN THE STUDY

3.3.1. Population

Grove[40] et al. define population as a group of people who share the same characteristics. The population of this study included occupational therapists in Gauteng, who were currently registered with HPCSA during data collection.

3.3.2. Sample

According to Grove[40] et al. the inclusion and exclusion criteria are established for the selection of participants who may or may not have characteristics needed for the target sample.

i. Inclusion criteria

The participants who met the inclusion criteria were:

- Occupational therapists who were registered with HPCSA as independent occupational therapists for a minimum of five years and were members of Occupational Therapy Association of South Africa.
- Occupational therapists who worked in mental health and/or vocational rehabilitation facilitating return-to-work and reasonable accommodation, in the private sector for a minimum of three years.

ii. Exclusion criteria

The participants who were excluded in this study were:

- Occupational therapists working in academia.
- Occupational therapists working in government settings /public health care sector. The researcher had observed that occupational therapists working in government mostly treated patients with more severe functional impairments related to schizophrenia spectrum disorders and bipolar disorders and the return-to-work was mostly left to the social workers.

3.4. RECRUITMENT OF PARTICIPANTS AND SAMPLE SIZE

3.4.1. Recruitment of participants

Occupational therapists that had worked in mental health and/or vocational rehabilitation for a minimum of three years and had been qualified as occupational therapists for a minimum of five years were contacted telephonically by the researcher. During the telephonic conversation, the researcher introduced herself and explained that she was doing her Master's degree in occupational therapy. The title of the study was explained to the eligible participants who were invited to participate in the study. After the participants agreed to participate in the study, the researcher sent them via email, the informed consent form **(Appendix A)** which also served as a letter of invitation, as well as demographic data form **(Appendix B)**. The demographic data form included the participant's age, qualifications, undergraduate university education, postgraduate university education, areas of interest, years of experience as an occupational therapist, years of experience in the field of mental health and/or vocational rehabilitation and area of work.

During the telephonic discussion, it was explained that the interview would take place online using an on-line platform – Google Meet. The date and time for the interview was agreed upon with the participant. The participant emailed the forms back to the researcher and the researcher sent the Google Meet link. The link had a one-day reminder and a recurrent thirty-minute reminder prior to the interview.

3.4.2. Description of semi-structured interview

An interview is a social interaction where researcher and the participant converse and exchange information on a particular topic.[48-49] There are three types of interviews, namely: structured interviews, unstructured interviews and semi-structured interviews.[191,193] A semi-structured interview was used in this study[48-49] as it allowed the researcher to get a detailed description of participant's accounts about reasonable accommodations. During exploration and probing, the researcher paid attention to the participants in order to identify new information that emerged in relation to the study.[42] The researcher interacted with the

participants focusing on the topic of reasonable accommodation as it applied to employees with MDD.

3.4.3. Sample size

In order to determine the sample size, the researcher must consider scientific and pragmatic factors like quality of the data (legible transcripts and clear audiotapes), the scope of the study, clear topic with easily obtained information, the quantity of the beneficial information given by the participants and study design used. [190-191] Brink et al.[191] argue that in qualitative studies where purposive sampling is used, sample size is sufficient when the meanings are clear and the data has been explored to capacity.[191] Sufficiency was met as the numbers showed a range of participants with most experienced and least experienced allowing those outside the population to connect with the experiences of those inside the population.[190] Saturation was reached as no new data was emerging and redundancy was achieved.[190-191,193]

3.4.4. Sampling method

Saldana and Omasta[49] define sampling as “the parameters and procedures used for selecting the specific participants for the study”.[49] The researcher used purposive and snowball sampling. [49]

3.4.4.1. Purposive sampling

The researcher used purposive sampling which is also known as judgemental sampling.[48,196] A homogeneous purposive sample was used as the participants were all occupational therapists working in mental health and or vocational rehabilitation. The researcher made a judgement on the sample based on the participant’s knowledge and experience about reasonable accommodation as set out in the objectives of this study.[48,196]

Occupational therapists in the field of mental health and/or vocational rehabilitation were knowledgeable on the topic of reasonable accommodation to assist the researcher to obtain rich data.

3.4.4.2. Snowball sampling

Snowball sampling is a type of convenience sampling in which the initial participants give referrals of other people who meet the inclusion criteria.[193] The researcher asked each participant that agreed to participate in the study, if they could suggest another occupational therapist who met the inclusion criteria. The researcher then contacted these occupational therapists and followed the same process. The participants were called telephonically by the researcher to recruit them for participation.

3.5. DATA COLLECTION AND ORGANISATION

The researcher used an interview guide[48-49] to collect data. The interview guide was formulated in a semi-structured manner.[48-49]

3.5.1. Development of interview guide

The researcher developed a complete, clear list or set of questions that covered all topics to be discussed with the participants as advised by Saldana and Omasta.[49] The questions developed were guided by the objectives of the study.[191] There were 12 specific main questions with probing questions.[191] The researcher set out questions that started from simple to complex, from broad to specific questions as this orientated the participant to the topic and helped to establish rapport.[48-49] Open-ended questions were used as they provided the researcher with richer and more diverse data.[191] The interview guide used in this study is included as **Annexure C**.

3.5.2. Piloting the interview guide

A pilot study is a small-scale study of the main study to test the interview guide to check if it will work out as planned.[199,61] The researcher used the pilot study to test the recruitment process, the interview guide and the interview process.[199-200] The potential pilot participant was purposively selected by the researcher. The participant worked extensively in vocational rehabilitation and was contacted telephonically to confirm that she met the criteria. The researcher introduced herself to the potential pilot participant and explained the purpose of the call. The participant was unable to talk further and requested the researcher to call at a specific scheduled time. The participant was called again at the agreed time and the researcher explained briefly what the study was about and invited the participant to take part in the interview. The participant accepted the invitation. The researcher requested the participant's email address to send her the demographic data and informed consent forms and set the appointment for the interview. The participant was asked to return the demographic data and informed consent forms before the interview took place. The Google Meet invitation was sent and the interview was conducted on the agreed appointment date.

During the interview, the flaws and limitations of the interview guide were identified, adjusted and revisions were made.[199-200] Question nine was rephrased as it was found to be ambiguous and confusing (**refer to Annexure C1 for the draft and annexure C for the final)**. A question about undergraduate training was added as it was found to be missing (**refer to Annexure C).**

3.5.3. Preparation for the interview

The researcher requested the participants to ensure the venue for interviews was quiet and comfortable. The interviews were scheduled for a time convenient to the participant.[201-202] The consent form and demographic data form were sent to the participants prior to the interview and were returned to the researcher before the interviews took place.[201-202] The

researcher requested the participants to ensure that their environment was quiet to allow for smooth running of the interview. The researcher familiarised herself with the questions and ensured that the Google Meet platform was working well.

3.5.4. Audio-recording of the individual interviews

Permission to audio record was obtained from individual participants and was included as part of the consent form (Annexure A).[48] The researcher recorded interviews on Google Meet recording and cell-phone to capture the participants' knowledge, attitudes and practices of reasonable accommodation. After each interview, the researcher made informal field notes by sitting in a quiet place and wrote down the description of what the researcher had heard, experienced and thought of during the interview with the participant.[190-191,193]

3.5.5. Interviewer

The researcher carried out the interview herself. This was beneficial because she was thoroughly familiar with the focus of the interview. [201-202] During the interview, the researcher spoke less and allowed the participants to talk more. [201-202] The researcher was able to steer the interviews until the end.

3.5.6. Duration of the interview

The semi-structured interview generally takes the duration of 30 minutes to an hour.[203] The interviews were scheduled for 60-90 minutes to allow enough time for in-depth engagement on the subject matter.

3.5.7. Interviewing the participants

The purpose and the duration of the interviews were again explained to the participants at the beginning of each interview. During the interviews the researcher was patient with participants' pauses and allowed them to express their thoughts and finish their utterances. The interview was steered in the direction of the information the researcher wanted to find out as the researcher followed the interview guide. The researcher ensured that she remembered the shared information to avoid asking a question in the interview guide that the participant had already covered. Instead, in instances where answers had already been provided for a particular question, the researcher paraphrased and clarified the information the participant had provided. At the end of the interview, the researcher summarised the discussion to each participant and asked the participant if there was any important information related to the topic that they wanted to add.

3.6. DATA ANALYSIS

The researcher inductively used thematic analysis to formulate themes.[42,190] The researcher used bottom-up approach[41] when analysing data generated from the individual interviews. The steps that were used during inductive data analysis were as per Creswell,[42] as discussed below.

STEP 1: Organise and prepare data for analysis

According to Creswell and Creswell[42] as cited by Botma et al[190], 'this involves transcribing interviews, optically scanning material, typing up field notes, cataloguing all of the visual material, and sorting and arranging the data into different types depending on the sources of information".[42,190] An experienced transcriber was carefully selected and contacted. A confidentiality form was sent to the transcriber to sign **(Annexure D).** The recordings were password protected and sent to the transcriber for transcription after the confidentiality forms were signed.[48] The recordings were transcribed verbatim and the transcriber sent the transcripts back to the researcher. The researcher ensured that the names of the participants were anonymised as participant number 1, participant number 2, for example.

STEP 2: Read and look at the data

The researcher listened to the recording to confirm the transcripts. Listening to recordings and reading the transcribed data familiarised the researcher with the information and at the same time afforded the researcher a chance to reflect on the overall meaning by among other things, making notes on the margins of transcripts.[42,190] The researcher read through the transcripts several times and made notes on the side regarding the meaning that was derived from the participants' statements.

STEP 3: Coding

The researcher followed eight steps of coding as outlined by Creswell as follows:[42,190]

- All the transcripts were read to get the sense of the whole by the researcher. The researcher wrote down on the margins the ideas that came to mind as she read through the transcripts.

- The transcripts that were interesting, shorter and concise in answering research questions were selected first. The researcher read through to understand the underlying meaning of the interview responses. The thoughts of the researcher were constantly written on the margins of the transcript.

- The researcher read through all other transcripts as described in step two. Then the topics that came to mind were listed and combined to form major and unique topics. Some topics were considered leftovers as they could not be clustered together to form a major or unique topic.

- A list of topics was taken back to the transcribers and this allowed some new codes and categories to emerge.

- In the end there was a long list of codes. The codes that had a common meaning or belonged together were grouped and the researcher used descriptive words to create categories. From topics, the researcher made a table in which she added the topics

together to make categories. Categories were combined together to make codes and quotes which supported particular codes were written down. The codes were developed only from the data collected from participants. This was done for each transcript after the interview.

- Final decision on the abbreviation for each category was made and the codes were put in a sequential flow.

- Data material that belonged together was gathered in one place for preliminary analysis.

- The researcher recoded that data before data was finalised.

STEP 4: Generating themes

This step used the coding process to generate a description of categories which were combined to form themes. The researcher used the coding as well to generate five themes. The anonymised transcripts were sent to two independent coders who generated their own themes. Each independent coder met with the researcher at different times to discuss the themes. The independent coder and researcher discussed the themes and consensus was reached. The agreed themes with the independent coders were further discussed with the supervisors and finalised. The researcher emailed the final themes to the participants as part of member checking. The participants commented on the themes which were subsequently finalised. These themes appear as major findings of this study and are used as subheadings in the discussion section of this study.[42,190]

STEP 5: Representation of description and themes

The researcher went into detail regarding themes and further generated subthemes which enhanced the understanding of the data. The findings of this study were represented in a narrative passage where detailed discussion of themes was included in chapter 4. The researcher made use of tables and figures to supplement the discussion.

STEP 6: Interpretation in qualitative research

The researcher wrote the essence of the data and showed how the analysis had answered the research question using themes.

3.7. DATA STORAGE

The data was saved electronically on a USB flash drive and stored at the University of Pretoria for a period of 15 years.

3.8. MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness was pioneered by Lincoln and Guba as an alternative to establish validity and reliability in qualitative research. [190] Validity focuses on the accuracy and consistency of scientific findings from the position of the researcher, participant and reader of the results. [42,190-191,193] Polit and Beck[204] define trustworthiness as the extent to which the qualitative researchers have confidence in their data. Lincoln and Guba initially developed four criteria viz: credibility, transferability, dependability, and confirmability and later added a fifth – authenticity. [193]

3.8.1. Credibility

Credibility refers to the belief or confidence of the audience in the truth of the data and their interpretation of findings by conducting the study in a way that enhances the believability of findings and persuading readers that a credible data analysis was done.[49,193,197,205-206] In order to establish confidence in the truth the following measures were implemented by the researcher:

3.8.1.1. Prolonged engagement

The researcher allocated 60 to 90 minutes which ensured prolonged engagement with each participant and also - continued with data collection until saturation was reached. Spending prolonged time with each participant established rapport and trust between the researcher and the participants and generally facilitated in-depth understanding of subject.

3.8.1.2. Member checking

The final themes were sent to the participants to check if the results were representative of the information they had provided. [42,190-191,193] The participants made corrections and additions to the themes which were subsequently confirmed. Member checking helped to determine the accuracy of the findings.[42,49,190-191,193]

3.8.1.3. Triangulation

Triangulation refers to when several references or data sources of information are used to make a conclusion regarding what constitutes a truth about a phenomenon.[42,49,190-191,193] Method triangulation is the use of various data collection methods. The researcher used method triangulation by using individual interviews, field notes and literature to come up with an in-depth understanding of the phenomenon.[42,49,190-191,193]

3.8.2. Dependability

Dependability refers to “stability (reliability) of data over time and over conditions”[204], and consistent use of procedures (semi-structured interviews) across participants.[197] The researcher ensured that detailed and precise methodology was used. If this study was carried out with the same participants in the same context, it would give the same results. [190-191,193]

3.8.3. Confirmability

Confirmability refers to objectivity, or neutrality of data and its interpretation, and can be ensured by two or more independent auditors agreeing about accuracy, relevance or meaning of data.[193,197] The researcher made use of two independent external auditors to develop themes. Each independent coder received anonymised transcripts, analysed data and came up with their own themes. The researcher met with the coders to compare the theme and reach consensus. The themes were also discussed with the research supervisors for finalisation.

3.8.3.1 Bracketing

Bracketing is when the researcher recognises and intentionally puts aside any preconceived ideas or beliefs they hold about the topic being researched.[190-191,193] In this study, confirmability was achieved through bracketing[48,191,193] of the researcher by taking a stance not to impose her knowledge, attitude, practice and experience on the participants as the researcher worked in the field that was being researched. Bracketing was achieved through discussions with the supervisors.

3.8.4. Transferability

Transferability refers to the degree to which the qualitative findings can be transferred or applied to other settings.[193,205-206] In this study, the researcher ensured that sufficient descriptive qualitative data on knowledge, attitudes and practices of occupational therapists in facilitating reasonable accommodations for employees with MDD was clearly reported so that the occupational therapists in other fields can contemplate if the transfer can be made to their setting. Clear description of demographics can also add to transferability.

3.8.5. Authenticity

Authenticity refers to “the degree in which researchers fairly and faithfully show a range of different realities”.[190] The researcher used open ended questions during the interview which allowed participants to share their narratives regarding their facilitation of reasonable accommodations.

3.9. ETHICAL CONSIDERATIONS

According to Babbie[196], ethics refers to right or wrong and generally relate to morality. Anyone involved in a research must be aware of the general agreement concerning what is proper or improper.[196] Ethical procedures that were followed in this study by the researcher are discussed below:

3.9.1. Obtaining permission to conduct the study

The University of Pretoria has different committees that the researcher had to submit the proposal to for scrutiny and approval. The committees’ responsibility is to ensure scientific validity of the research and to protect both the researcher and the participants.[191] Firstly, the researcher presented the proposal to the occupational Therapy Department of University of Pretoria and it was approved. Thereafter, the researcher submitted the proposal to the School of Healthcare Sciences of University of Pretoria and it was also approved. Finally, the researcher submitted the proposal for approval by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria. The Research Ethics committee approved it and gave the Research Ethics number (444/2020) **(Annexure E).**

3.9.2. Principle of respect for persons

The participants are autonomous, their practices need to be respected and their human rights not disregarded.[191]

3.9.2.1 The right to full disclosure

The participants received full disclosure about the nature of the study. During the recruitment, the researcher explained the nature of the research and that it would be conducted online.

3.9.2.2 The right to self determination

When the researcher recruited the participants, she informed them that participation was voluntary so they had the right to choose if they wanted to participate in the study or not.[48,190-191,193] The participants had the right to ask questions and not be forced to give information they did not wish to give. [48,190-191,193] The participants were also made aware that they could also withdraw during the study if they wanted to at any stage of the research.[48,190-191,193] All the participants participated voluntarily, answered all the questions asked and none of them withdrew their participation during data collection.

3.9.3. Informed consent

The researcher emailed an information and informed consent document to the participants. The informed consent document gave information about the nature of the study, including explanations about the study procedures, potential risks and benefits, and ethical approval. The participants were given the opportunity to ask questions before the informed consent process was concluded, prior to participation in the study. Refer to **annexure A** for the informed consent form.

3.9.4. Principle of beneficence and non-maleficence

The researcher has the responsibility to minimise danger and maximise benefit to the participants.[193] This principle, which includes two aspects, was observed in this study as follows:

3.9.4.1 The right to freedom from harm and discomfort

According to Babbie,[196] “the fundamental ethical rule of social research is that it must bring no harm to participants”.[196] The researcher constantly took cognisance of the responsibility to protect the participants from any emotional harm during interviews by asking well-considered probing questions. [48,190-191,193]

3.9.4.2. The right to protection from exploitation

Participants were not disadvantaged or exposed to situations that they were not prepared for, like asking them questions that were not related to the study. The information that the participants provided during the interview cannot be used against them in any way as they cannot be identified in the data in any way.

3.9.5. Principle of justice

Justice includes fair treatment and right to privacy.

3.9.5.1 The right to fair treatment

Fair selection and treatment of participants was ensured as the researcher was guided by the set inclusion criteria to select the participants. Agreements around setting up appointments and anonymising the transcripts was upheld.

3.9.5.2 The right to privacy

Confidentiality refers to agreement on handling of private information confidentially and protecting it.[48,190-191,193] The researcher clearly communicated to the participants that anonymity would be ensured and that no identifying data would be used in publications originating from this research. [48-49,190-191,193,196] To ensure confidentiality, the transcriptions of the interviews were anonymised and participants were identified using pseudonyms. The transcribers signed a confidentiality agreement before the recordings were made available to them (**Refer to Annexure C**).

3.10. CONCLUSION

This chapter was about methodology used in this study. A qualitative research approach was employed using explorative descriptive contextual design. Eligible participants were recruited by the researcher, guided by the inclusion and exclusion criteria outlined. Purposive and snowballing sampling methods were used to recruit the participants. The process of recruitment and interview guide developed by the researcher were piloted prior to their use in the main study and necessary changes were made. After the data was transcribed, the researcher analysed it. Trustworthiness and ethical considerations were adhered to. The findings of this study are presented next in Chapter 4.

CHAPTER FOUR: FINDINGS

4.1. INTRODUCTION

Chapter four reports on the qualitative data generated from semi-structured individual interviews with the participants. The social constructivist paradigm was used to create themes from the participants' inter-subjective experiences[41, 51] of facilitating reasonable accommodations for employees with MDD in their day-to-day practice as occupational therapists.

Thematic analysis[41, 51] following a bottom-up approach was used to deduce the underlying meanings elicited from participants in relation to their knowledge, attitude and day to day practices while facilitating reasonable accommodations for employees with MDD. This was achieved during semi-structured individual interviews as explained in chapter three.[46, 47] The demographic information of participants is reported first, followed by the themes, subthemes and their codes. All these aspects are substantiated by direct quotes from participants expressed during semi-structured individual interviews.

4.2. DEMOGRAPHIC INFORMATION

The demographic information of the participants is discussed in terms of sample size, gender, qualifications, years of experience as occupational therapists, years of experience in mental health, undergraduate and postgraduate university education, areas of interest and place of work.

4.2.1. Sample size

Although the researcher recruited 11 participants to take part in the study, only seven participants took part. The other four participants initially agreed to participate in the study but withdrew during the scheduled appointments. One of the four recruited participants signed the consent form, an appointment was scheduled for an interview but she withdrew because of network challenges. The other three participants did not return their informed consent forms on the agreed time, even after follow up. As snowballing was used the researcher continued to recruit more participants until data saturation was reached.

4.2.2. Sex

The researcher recruited both male and female occupational therapists but only female participants took part.

4.2.3. Qualifications of the participants

The qualifications of the participants who took part in the study are shown in Table 4-1 below. All the participants of this study had obtained different postgraduate qualifications in occupational therapy and other fields.

Table 4-1: Qualification of participants

Qualifications	BOccTher/ BscOccTher	DVR*	Diplomas in other professions	MOccTher	PhD
Number of participants	7	5	3	3	2

*DVR: Postgraduate Diploma in Vocational rehabilitation

4.2.4. University undergraduate and postgraduate qualification

The participants of this study obtained their undergraduate and postgraduate qualifications from the universities shown in Table 4-2 below.

Table 4-2: University of undergraduate and postgraduate qualification of participants

University	Undergraduate qualification	Postgraduate qualification
University of Witwatersrand	5	3
University of Cape Town	1	1
University of Pretoria	0	5
University of Free State	1	0
UNISA	0	2
Middlesex University (UK)	0	1
Boston School of OT (USA)	0	1

4.2.5. Participants' ages and years of experience

Table 4-3 shows the ages of the participants who took part in the study and their years of experience.

Table 4-3: Ages of participants and their years of experience

Participant	Age (in years)	Years of experience as Occupational therapists	Years of experience in mental health and vocational rehabilitation
1	34	11-15	6-10
2	57	31-35	31+
3	52	26-30	11-15
4	57	31-35	26-30
5	38	16-20	6-10
6	56	31-35	31+
7	39	16-20	11-15

The age group of the participants ranged from 34 to 58 years. The median age of the participants was 47.6 years. Their years of experience as occupational therapists ranged from 11 years to 35 years while their years of experience working in mental health and/or vocational rehabilitation ranged from 10 years to more than 31 years.

4.2.6 Participants' areas of interest

All the participants worked in the field of vocational rehabilitation and four of the seven were involved in vocational rehabilitation and mental health.

4.2.7. Participants' place of work

Table 4-4 shows the participants' place of work.

Table 4-4: Participants' place of work

Place of work	Johannesburg	Johannesburg and Pretoria	Westrand
Number of participants	6	2	1

From the table above, it should be pointed out that of the 6 participants who worked in Johannesburg, 2 also worked in Pretoria.

4.3. THEMES

The following terms are used to explain the findings of this study:
Theme: A recurring regularity that emerged from an analysis of qualitative data.[193]
Subtheme: it is a subcomponent of a theme. [207]
Codes: "are tags or labels for assigning units of analysis to the descriptive or inferential information compiled during a study. Codes are attached to "chunks" of varying size – words, phrases, sentences, or whole paragraphs, connected or unconnected to a specific setting."[208]

The study aimed to explore and describe the occupational therapist's knowledge, attitudes and practices in facilitating reasonable accommodations for employees with MDD. The use of social constructivist paradigm enabled the researcher to read for participants' underlying meanings from their individual interviews.[40-43] Five themes were generated from the participants' views about their knowledge, attitudes and practices of reasonable

accommodations for employees with MDD as shown in Table 4-5: Identified themes from individual interviews.

Table 4-5: Identified themes from individual interviews

Themes	Themes from individual interviews
1	Collaborative approach
2	Dynamic process of reasonable accommodation
3	Enablers of successful reasonable accommodation
4	Challenges of reasonable accommodation
5	Proficiencies of occupational therapists

The researcher punctuated the findings by the participants' intersubjective experiences of working with employees with MDD during facilitation of reasonable accommodations. For this study, the PEOP model was used.[51] The model looks at the function and considers interaction among person, environment, occupation and performance.

The PEOP is used in combination with social constructivism as this facilitated the researcher's understanding of the perceived world from the narratives and lenses of participants who were occupational therapists working in the field of vocational rehabilitation and mental health.[40] This helped the researcher to construct the participants' knowledges, attitudes and practices.

The PEOP which is client-centred,[50] assisted in eliciting rich data from participants during semi-structured interviews. The PEOP model was applied through answering questions about the occupational therapist as a person, the practice within which the occupational therapist practised, and the interaction that resulted in performing reasonable accommodations.

The themes and subthemes of the study were formulated as shown in Table 4-6.

Table 4-6: Themes and subthemes of the study

Themes	Subthemes
1. Collaborative approach	1.1. Stakeholders involved
	1.2. Communicating with stakeholders
	2.1. Referral

2. Dynamic process of reasonable accommodations	2.2. Assessment
	2.3 Worksite visit
	2.4. Formulation and implementation of reasonable accommodation
	2.5. Review
3. Enablers of successful reasonable accommodation	3.1. Application of legislation
	3.2. Understanding work environment
	3.3. Reasonable may need to be reasonable
4. Challenges of reasonable accommodation	4.1. Comorbidity
	4.2. Employees' narrative
	4.3. Inadequate undergraduate training
5. Proficiencies of occupational therapists	5.1. Staying on the cutting edge
	5.2. Skills
	5.3. Professional behaviour
	5.4. Case management

Theme 1: Collaborative approach

The participants of this study reported that a collaborative approach was the best way for a successful and sustainable reasonable accommodation. This emerged as an answer to the research objective of exploring and describing the occupational therapists' practices in facilitating reasonable accommodations for employees with MDD. Table 4.7 shows what the collaborative approach included.

Table 4-7: Theme 1- Collaborative approach

Theme 1	**Subtheme**
Collaborative approach	1.1. Stakeholders involved
	1.2. Communication with stakeholders

The participants voiced that there should be a collaborative approach that would facilitate agreement between the stakeholders, and that the occupational therapists should not insist on reasonable accommodation on their own. This was expressed by the participant who said:

"…collaborating with as many people [stakeholders] as possible." (Participant number 4)

"So, I think we [Occupational therapists] can't insist on a reasonable accommodation, it has to be a collaborative approach between everybody [stakeholders]." (Participant number 3)

Stakeholders' involvement and communicating with other stakeholders led to Theme 1: collaborative approach. Each subtheme will be discussed separately with its codes throughout chapter 4.

Subtheme 1.1: Stakeholders involved

The participants concurred that facilitating reasonable accommodations for employees with MDD required involvement of different stakeholders. Subtheme 1.1 stakeholders involved and its codes are shown in Table 4-8.

Table 4-8: Subtheme 1.1- Stakeholders involved

Subtheme 1.1	Codes
Stakeholders involved	1.1.1 Occupational therapists
	1.1.2. Employee
	1.1.3. Team leader or supervisor or manager
	1.1.4. Human resource practitioner
	1.1.5. Union representative
	1.1.6. Occupational health doctor
	1.1.7. Occupational health nurse
	1.1.8. Health and wellness practitioner
	1.1.9. Group insurer

All the stakeholders involved will be discussed below as codes.

Code 1.1.1: Occupational therapists

One of the participants commented that the occupational therapist's role is to facilitate reasonable accommodation by working with different stake holders:

"I think we [occupational therapist] are fundamentally necessary…the OT's role, is to enable accommodation, which means being able to work with different team members and stakeholders" (Participant number 4).

Another participant reported that because Occupational therapists could work with different stakeholders, they were well placed to analyse function of the person and address functional gaps in the workplace by recommending appropriate reasonable accommodation.

"We [occupational therapists] are well placed to analyse function of the person [employee with MDD] and the gaps there are, is where a reasonable accommodation is addressed." (Participant number 1)

Code 1.1.2: Employee

This code focused on the employees with MDD as an important member of the stakeholders, as such employees have to take responsibility for their own health and recovery process. This statement is echoed by the participant who commented:

"And responsibility. Yes, you [employee] are sick and yes, you [employee] have depression, but you [employee] have to take responsibility for your own health and your recovery process" (Participant number 1).

Another participant was of the opinion that the employee and their family should be involved in the decision-making process with other stakeholders regarding their reasonable accommodation. This is expressed by the participants' statement below:

"It's not a unilateral decision. So, I'm looking at the patient [employee], the employer, the therapists, the whole team has to be involved. The family, everybody." (Participant number 4)

Code 1.1.3: Team leader or supervisor or manager

One participant stated that the process of reasonable accommodation required the involvement of workplace management in reaching an agreement regarding what would be reasonable during an incapacity hearing. This was supported by one participant's statement below:

"But I always want a three tier or three prong team effort, consisting of the patient, myself, and if possible, the direct supervisor or reporting-to person at the workplace." (Participant number 2)

The other participant advised that in order to make appropriate recommendations for reasonable accommodation, information from the supervisor about the job requirements was vital:

"And usually, I find that when the employer or the supervisor of the particular person has this clear guideline, you actually get quite a rich amount of information [information regarding employee's performance]." (Participant number 5)

Code 1.1.4: Human resource manager

The participants indicated that the human resource manager should be involved as part of the stakeholders during an incapacity hearing to ensure a follow through:

"So, typically there would be a whole counselling process then maybe an incapacity hearing, Human resource (HR), Line Manager and employee usually have to together make some agreements about what is reasonable, what is realistic going forward." (Participant number 6)

"…at that meeting, obviously, then we need to have the manager, the line manager, because they are critical, and HR, if possible, so that we can definitely make sure that we get that follow through." (Participant number 3)

Code 1.1.5: Union representative

One participant advised that a trade unionist should be involved in the incapacity hearing to support the employee and to ensure that there was fairness.

"…then there may be a trade union involved." (Participant number 6)

Code 1.1.6: Occupational Health Doctor

One of the participants suggested that the company should continue to provide support to monitor the employees' progress with the help of an occupational health doctor.

"So the workplace may… if they offer such, an employee wellness program or have a Company Doctor, it may be appropriate that the employee has a specific support person who just monitors them, discreetly, confidentially." (Participant number 6)

Another participant reflected that most of the wellness services in companies are offered by occupational health doctors and occupational health nurses.

"Like mainly in terms of like, the wellness services where you find that it is mainly an Occupational Health doctor and an Occupational Health nurse that are there." (Participant number 5)

Code 1.1.7: Occupational health nurse

The participants reported that it was easier to facilitate reasonable accommodation when the company had an occupational health nurse. That made the process easier for the occupational therapist to hand over or to work together with the occupational health nurse. Two participants concurred:

"Now, some of the companies have good HR and nurses or medical teams on site. Then it's almost like, a hand over." (Participant number 4)

"But, sometimes you have an occupational health nurse, assisting with reasonable accommodation." (Participant number 2)

Code 1.1.8: Health and wellness practitioner

The participants echoed that for those employees who need further counselling in companies without an occupational health doctor or occupational health nurse, an external employee wellness program might provide additional support to the employees. This was supported by the two participants who said:

"And some companies subscribe to external employee wellness programs like ICAS [independent counselling and advisory services]. So it may be appropriate for the employee to be connected to someone at ICAS who will just play that monitoring role and companies that subscribe to places like ICAS, they actually literally have an allowance per employee." (Participant number 6)

"…most of the South African corporate companies usually use services like your ICAS and other services that you can actually tap into." (Participant number 5)

Code 1.1.9: Group insurer

The participants recommended that the insurer should be brought to the negotiation table early to discuss an employee with MDD. This is reflected in the comments that follow:

"…and if you've got an insurer, the insurer needs to be involved". (Participant number 3)

"And to bring the insurer into the picture, and for the insurer, it's often very good to be brought in early." (Participant number 6)

"...and the disability insurer may also want a place at the negotiating table." (Participant number 6)

Subtheme 1.2: Communication with stakeholders

As part of collaboration, the participants suggested that there should be communication among the stakeholders. Table 4-9 has tabulated the codes of theme 1.2 of communicating with stakeholders.

Table 4-9: Subtheme 1.2- Communicating with stakeholders

Subtheme 1.2	Codes
Communicating with stakeholders	1.2.1. Ensuring confidentiality
	1.2.2. Employee's strengths and limitations
	1.2.3. Presentation of recommendations
	1.2.4. Documentation of minutes

The participants agreed that when making decisions about reasonable accommodation, the occupational therapist must ensure that all the stakeholders are incorporated and the occupational therapist has their buy in:

"…it is a decision that incorporates all stakeholders." (Participant number 4)

"I think the most important thing is that we have buy in, from all the stakeholders." (Participant number 3)

Code 1.2.1: Ensuring confidentiality

The participants agreed that it was important to ensure confidentiality of the diagnosis during the meeting with relevant stakeholders. Some of the participants expressed this idea as captured below:

"It is important to maintain confidentiality. So, we [occupational therapists] don't go into details about someone's [employees] condition or stresses or things like that." (Participant number 1)

"One has to preserve confidentiality and the employer may not be aware of the diagnosis, or you [occupational therapist] may have an HR person who is bound to confidentiality and they [HR] are aware of the diagnosis but the Line Manager isn't." (Participant number 6)

"…but obviously just keeping all the information confidential." (Participant number 3)

Code 1.2.2: Employee's strengths and limitations

During the communication with stakeholders, it is important that the occupational therapist highlights the specific limitations that the employee has in relation to their job. The occupational therapist may need to highlight the gaps that limit the employee from executing their inherent job requirements. This was supported by some of the participants who said:

"…the first information that I would give them is, focusing on the limitations that the specific employee has." (Participants number 5)

"So, in terms of the recommendations that I make to the employer, first of all, is listing the limitations or the struggles that the employee has in relation to the work." (Participant number 5)

"Then, when they're in agreement, then we organize a meeting with the employer, and we discuss where - more or less - where there are gaps in performance of inherent job requirements." (Participant number 2)

Code 1.2.3: Presentation of recommendations

After highlighting all the limitations that hinder the employee from executing their inherent job requirements, it is important for the occupational therapist to recommend the possible reasonable accommodations that will enable the employee to productively execute their job functions. This was highlighted by the following utterances by the participants:

"We talk purely about, because of their health condition, they would require the following accommodations in the workplace." (Participant number 3)

"Identify and discuss what reasonable accommodations are needed to get that person back to work." (Participant 2)

Code 1.2.4: Documentation of meeting

During the communication with stakeholders, it is important that the minutes of that meeting are clearly documented and dated for record purposes:

"So, normally it would be then, a meeting. Those things would be documented." (Participant number 3)

Another participant advised that the agreements with the stakeholders may need to be written down and kept as record:

"And if they say yes, you need to make sure that it is to be written down." (Participant number 5)

Theme 2: Dynamic process of reasonable accommodations

The participants of this study referred to reasonable accommodation as being an event that follows a process. The dynamic process of reasonable accommodation was described by the participants as dynamic and flexible. This answered the research objective of exploring and describing the occupational therapist's practices in facilitating reasonable accommodations for employees with major depressive disorder. Table 4-10 shows the dynamic process of reasonable accommodation.

Table 4-10: Theme 2- Dynamic process of reasonable accommodation

Theme 2	Subtheme
Dynamic process of reasonable accommodations	2.1. Referral
	2.2. Assessment
	2.3 Worksite visit
	2.4. Formulation and implementation of reasonable accommodation
	2.5. Review

The participants of this study highlighted that the dynamic process of reasonable accommodation may need to be followed to ensure a successful reasonable accommodation.

"That it is a dynamic process [of reasonable accommodation] and things do change on the way." (Participant number 3)

"…you need to have an analytical mind and you also need to understand that the process is dynamic." (Participant number 5)

Subtheme 2.1: Referral

The first step of reasonable accommodation commences with a referral from the treating healthcare professional or an employer or insurer. Table 2-11 shows the subthemes of referral.

Table 4-11: Subtheme 1- Referral

Subtheme 2.1	Codes
Referral	2.1.1. Healthcare professional
	2.1.2. Employer or Insurer

The participants echoed that reasonable accommodation began with a referral that provided information on the pathology:

"I suppose it's, get the information from the referring person, I mean psychiatrist or employer. So that's the referral." (Participant number 1)

"So, I'll have a referral, which alerts me from the insurer or employer." (Participant number 4)

Code 2.1.1: Healthcare professional

Most of the employees who are diagnosed with MDD are treated by healthcare professionals. The healthcare professional will refer them to an occupational therapist to facilitate a return-to-work process. One of the participants voiced this:

"… they [employees with MDD] are referred by the psychiatrist." (Participants number 2)

Code 2.1.2: Employer or insurer

In some instances, the employer might struggle to manage the employees' incapacity, and then refer them to an occupational therapist for further management or assistance with reasonable accommodation. When the employer realises that the employee is struggling to cope with their job functions, they might suggest a possible referral to assist the employee. The insurer may also be a source of referral. This was elaborated by some participants who said:

"…it was a private referral from a big corporate [employer]." (Participant number 3)

"Both of them [employees] had been sent to me [occupational therapist] by the employer. It was the employer that identified the work-related problem, and they were trying to manage them [work-related problems]." (Participant number 4)

Subtheme 2.2: Assessment

Immediately after the occupational therapist has received the referral, he/she will commence with the assessment which is broken down into codes in Table 4-12.

Table 4-12: Subtheme 2.2-Assessment

Subtheme 2.2	Codes
Assessment	2.2.1. Interview
	2.2.2. Employees clinical presentation of MDD
	2.2.3. Functional Capacity Evaluation

The participants emphasised that assessment was the next step that may need to be followed by the occupational therapist after the referral. This observation is echoed by some of the participants:

"It [the process of reasonable accommodation] always starts with the assessment." (Participant number 4)

"…that's why we have to do that really good assessment in the beginning, because everybody's going to present differently, and it depends on the job." (Participant number 3)

One participant explained that the occupational therapist might need to interview the employee with MDD and ensure that the job description is reviewed.

"We also do our own assessments, just kind of, through interview and reviewing job descriptions." (Participant number 1)

Participant 2 added that the job requirements may need to be compared with the employee's work capacity, which is part of functional capacity evaluation:

"…the most important thing, is to first assess against the job requirements, the person's work capacity." (Participant number 2)

Code 2.2.1: Interview

The first part of an occupational therapy assessment is an interview with the employee with MDD. One of the participants commented that the occupational therapist will need to sit down and interview the employee with MDD.

"I would sit down and interview the patient." (Participant number 4)

Another participant emphasised that the interview should mainly happen during the first appointment with an employee with MDD:

"And in the first appointment it will be mainly, you know, an interview." (Participant number 5)

It is important for the occupational therapist to interview the employer to obtain collateral information regarding the employees' job performance. Participant 1 emphasized the importance of the interview with the employee.

"But it's important that you get that collateral information, and that is, interview with the employee." (Participant number 1)

Code 2.2.2: Employees' clinical presentation of MDD

Most of the participants stated that it was important to assess if the employees with MDD were still presenting with clinical symptoms of MDD such as cognitive impairments, mood problems and functional limitations. It was thus important to know the level of severity of MDD symptoms, as substantiated by some of the participants:

"I think what we see the most of, is the cognitive impact of depression…but also, they are emotional, distracted, so they're actually not present in the workplace…they're seeing a drop in performance…we see a lot of absenteeism, leaving work early. So, it's kind of a combination of absenteeism and presenteeism…we find that there is also relationship breakdown." (Participant number 1)

"Well, things like their general productivity, their pace of work, their ability to interact with other people, their ability to stay on task and see things through, because resilience is often affected. So things like perseverance, being able to problem solve, make decisions, depending on the nature of the work. And those are the sort of impacts that are particularly… especially in a job with a level of interpersonal demands, quite significant demands." (Participant number 6)

Code 2.2.3: Functional capacity evaluation

Most of the participants agreed that it is important to start with a full FCE in order to ascertain if the employee with MDD can return back to work or not. This idea is captured in participants' comments below:

"…look, all patients I would start off with a full sort of, FCE, if you can put it that way." (Participant number 2)

"They want to see if they can get the person back to work. So, I will do the full FCE in that case." (Participant number 7)

Subtheme 2.3: Worksite visit

The participants of this study recommended that it was important to have a good understanding of the employees' job and to have a discussion with the employer regarding the nature of the job and its requirements. Table 4-13 has tabulated the codes of the worksite visit.

Table 4-13: Subtheme 2.3- worksite visit

Subtheme 2.3	Codes
Worksite visit	2.3.1. Meeting with employer representatives
	2.3.2. Job analysis

The participants concurred on the need for a worksite visit:

"So, to have a good understanding of the job, and there I would normally do a work visit and certainly have communication with the employer." (Participant number 1)

"Then, the next one would be a work visit, where I actually go and have a look at what does it look like? How does it work? Talking to the employer making contact with the colleagues." (Participant number 4)

Code 2.3.1: Meeting with employer representatives

During the meeting with the employer, the occupational therapist will need to find out what the employee is required to do at work. As such, there is need for a clear job description, nature of the job and other expectations of the employee with MDD while doing their duties at work. This is supported by one participant who commented:

"Just, to meet the employer and to actually find out what the person is required to do." (Participant number 2)

Code 2.3.2: Job analysis

The participants reiterated that it was critical for the occupational therapist to do a basic job analysis in order to have a clear understanding of the employees' job demands. The job analysis does not only focus on establishing the employees' job demands, but also assists the occupational therapist to gain knowledge of the workplace culture and the manifestation of the job description. This was expressed by two participants who supported the use of job analysis:

"You do not necessarily need to do a detailed job analysis because that takes long and then your referral agent has to be willing to be paying for that and all of those things, but you can do your basic job analysis. Job analysis, these are the job demands, where is the employee in terms their limitations?" (Participant number 5)

"So the OT [occupational therapist] must also be able to do a job analysis, see a job description, get to grips with some of the workplace culture issues that impact on how the job description manifests." (Participant number 6)

Subtheme 2.4: Formulation of reasonable accommodation

After the completion of a comprehensive assessment, the participants reported that an occupational therapist would need to formulate reasonable accommodations. Table 4-14 has tabulated the codes of subtheme 2.4.

Table 4-14: Subtheme 2.4- Formulation of reasonable accommodation

Subtheme 2.4	Codes
Formulation of reasonable accommodations	2.4.1. Clear and specific reasonable accommodations
	2.4.2. Types of reasonable accommodation
	2.4.3. Implementation of reasonable accommodations

The participants agreed that the occupational therapist must look at everything and come up with relevant recommendations (reasonable accommodation). One participant supported this step:

"Then it's obviously looking at everything, formulating what you need to do, and then provide recommendations." (Participant number 1)

Code 2.4.1: Clear and specific reasonable accommodations

The participants reported that the facilitation of reasonable accommodations for major depressive disorder should be individualised as each employee is different and workplaces are not the same. Suggesting general reasonable accommodations was said not to be sustainable. The participants further explained that the reasonable accommodations that recommended for a particular employee with MDD needed to be clear and specific. This was voiced by some of the participants as follows:

"…we can't just have a blanket idea of accommodations for person with depression, it doesn't work." (Participant number 3)

"…what I have realized, is that it is important to be clear. So being specific in the recommendations, that is what I will do." (Participant number 5)

Code 2.4.2: Types of reasonable accommodation for MDD

Some of the participants reported that there were different types of reasonable accommodations that might be suggested for employees with MDD. Some of the examples of suggested reasonable accommodations were: acquiring new equipment/ adapting the environment, graded return-to-work, restructuring job functions, adjusting working time and leave, allowing time off for treatment, and providing specialized supervision, training and support.

Two participants agreed that reasonable accommodation for employees with MDD may be different:

“There are types of reasonable accommodations that can be implemented.” (participant number 5)

“So I can go on about the types of reasonable accommodations.” (Participant number 6)

Code 2.4.3: Implementation of reasonable accommodations

The participants were concerned that even though the formulated reasonable accommodations were clear and specific, implementation was a challenge. The occupational therapist might need to ensure that the recommended reasonable accommodations were implemented. This was shared by one participant who commented:

“Then, implementation. I've always found that, that's something that I sometimes have to drive.” (Participant number 5)

Another participant advised that it was important to give the duration of reasonable accommodations. For example, if an occupational therapist thought that the reasonable accommodation would be longer than a year, it was better to recommend permanent reasonable accommodations:

“For temporary accommodation, we look at three to six months. We do get some that go up to a year, but if we're heading up to a point of the year, then I'm really questioning that this should be permanent, you know.” (Participant number 1)

Subtheme 2.6: Review

The last subtheme 2.6 of the dynamic process of reasonable accommodation is review. Subtheme 2.6-Review is tabulated in Table 4-15.

Table 4-15: Subtheme 2.6- Review

Subtheme 2.6	Codes
Review	2.6.1. Circularity follow-up feedback
	2.6.2. Return to normal work
	2.6.3. Continuation of reasonable accommodation
	2.6.4. Relapse

The participants highlighted that during the process of reasonable accommodation, review was very important as it could take different forms. One participant articulated it this way:

"Then, review. Reviews are important… and reviews take different forms." (participant number 1)

The codes of subtheme 2.6 – review, will be elaborated below.

Code 2.6.1: Circularity follow-up feedback

The participants advised that it was critical for the occupational therapist to give feedback to the employer regarding the possible reasonable accommodations needed to enable the employee to execute job functions. The employer in turn, would need to give feedback to the occupational therapist regarding the success of the reasonable accommodations implemented. If the suggested reasonable accommodations were unsuccessful, the process may need to begin again. The occupational therapist may need to have constant follow ups with the employee and employer regarding the progress of the employee, as indicated by the utterances below:

"So, what I normally have, is regular sort of, once a week, where I do a telephonic follow-up with client…. We're going to try it for so long, we'll have meetings, we'll follow-up so long, so that they know that it's not an indefinite thing." (Participant number 2)

"I will typically get feedback from the employer, at least weekly via email, because they're too busy for telephonic calls." (Participant number 3)

The other participants emphasised the importance of follow-up feedback in ensuring the success of reasonable accommodations. The participant below concurred on the significance of follow up:

Follow up. For me, follow up is crucial. You can have the best assessment and the most amazing placement for the patient, but if you don't follow it up, there's going to happen something along the line, that's going to cause an issue. That's going to make this whole thing sink, yeah." (Participant number 4)

Code 2.6.2: Return to normal work

The participants advised that the main goal was to ensure that the employees with MDD returned to normal work. Returning the employees to their full duty was hailed as the successful part of the process of reasonable accommodation. This was substantiated by the participants who reported as follows:

"Then, in the last month, you try return to full duty." (Participant number 2)

"…so with them really making sure that they return-to-work is a success." (Participant number 5)

Code 2.6.3: Continuation of reasonable accommodations

If an employee fails to return to normal duties, the occupational therapist may need to assess if there is a need for continuation of reasonable accommodation. This is expressed by participants who commented:

"At the end of those three months, we weren't quite there, and they agreed to extend it further to continue the process [reasonable accommodation]." (Participant number 2)

"Going forward there is a potential for relapse, what are the structures we put in place to [reasonably] accommodate that?" (Participant number 3)

Code 2.6.4: Relapse

The participants advised that the occupational therapists should anticipate disappointments as some of the participants might relapse. The participants reported that there was a possibility of relapse among employees with MDD, whereby the process may have to start again from the beginning. This is voiced by two participants:

"The ones that are more complex, are often the ones that are going to continuously relapse and probably need some longer-term support structures in place." (Participant number 3)

"We were going forward and now we have to go back. And I think when it comes to people [employees] with MDD relapses can happen." (Participant number 5)

Theme 3: Enablers of successful reasonable accommodation

The participants emphasized that the enablers of successful reasonable accommodation were based on the application of legislation, understanding work environment and the need to be reasonable all the time. This answered two of the research objectives in which the researcher aimed to explore and describe the occupational therapist's knowledge and attitude in facilitating reasonable accommodations for employees with MDD. In Table 4-16, the findings related to Theme 3 and the subthemes are displayed:

Table 4-16: Theme 3- Enablers of successful reasonable accommodation

Theme 3	Subtheme
Enablers of successful reasonable accommodation	3.1. Application of legislation
	3.2. Understanding work environment
	3.3. Reasonable needs to be reasonable

The participants reported enablers of successful reasonable accommodation as captured the utterance below instantiates this:

"I think in my mind what ensures the success, is continued monitoring, which I understand in most of our roles we cannot provide that because you know, we kind of come in, establish and leave." (Participant number 7)

Below is the explanation of the subthemes of Theme 3, which is, enablers of successful reasonable accommodation.

Subtheme 3.1: Application of legislation

The participants advised that the occupational therapist needed to have good knowledge of different legislations.

Table 4-17 shows the codes related to subtheme 3.1 on application of legislation.

Table 4-17: Subtheme 3.1- Application of legislation

Subtheme 3.1	Code
Application of legislation	3.1.1. Employment Equity Act
	3.1.2. Promotion of Equality and Prevention of Unfair Discrimination Act
	3.1.3. Labour Relation Act
	3.1.4. Mental Health care Act
	3.1.5. Basic Conditions of Employment Act
	3.1.6. Protection of Personal Information Act

The participants stressed that the occupational therapy recommendations of reasonable accommodations should be within a legal framework. This sentiment comes through in the quotes below:

"…when you make this recommendation as an OT, this is how it goes from there. This is how we then apply the legislation." (Participant number 1)

"…they [Occupational therapists] need to understand the legislation underpinning it." (Participant number 6)

The participants added that the occupational therapists needed to know the legal implications of their recommendations:

"..legal and otherwise, and that is because normally, when we actually accommodate people, it will be in terms of the law, in the open labour market." (Participant number 2)

"…we need to have a good working knowledge of the laws, because you can't go and work and make recommendations to employers, if you don't understand the legal implications of what you're recommending." (Participant number 2).

Code 3.1.1: Employment Equity Act

The participants saw the EEA as the primary act that occupational therapists needed to know as it covers the provision for reasonable accommodations for people with disabilities. This is supported by the participants who said:

"First of all, the primary one is going to be your Employee Equity Act." (Participant number 1)

"I mean, it is one of the provisions of the Employment Equity Act, to do reasonable accommodation of people with disabilities, in order to allow that person to fulfil the inherent job requirements." (Participant number 2)

One participant was concerned that the EEA had been around for a very long time with very little effect in terms of disability:

"…well the one very specific piece of legislation is the Employment Equity Act which has been in place for a very long time with very little effect in terms of disability." (Participant number 6)

Code 3.1.2: Promotion of Equality and Prevention of Unfair Discrimination Act

The participants reported that the PEPUDA was important as it was used by the occupational therapists even though it did not apply to the labour market. This was supported by one participant who said:

"…there's some potential for 'PEPUDA', the Promotion of Equality and Prevention of Unfair Discrimination Act, which is not specifically connected to the Labour market but there's potential for that also to come into the situation." (Participant number 6)

Code 3.1.3: Labour Relations Act

The Labour Relations Act was considered key for the occupational therapist as it deals with disability:

"Then... because that talks to reasonable accommodation, talks to disability. Then, your Labour Act." (Participant number 1)

"…the Labour Relations Act, as it applies to dismissal." (Participant number 2)

Other participants hailed the benefits of the LRA in terms of protection against dismissal. This was supported by participants who said:

"I'm just thinking about Schedule eight, Labour Relations Act. In terms of doing everything to accommodate the person before dismissal, I think there must be emphasis on training [and] retention" (Participant number 3)

"…the Labour Relations Act also provides some guidance in terms of dismissal being a last resort…" (Participant number 6)

Code 3.1.4: Mental Health Care Act

One of the participants suggested that Mental Health Care Act was not particularly used in day-to-day speak during reasonable accommodations of employees with MDD.

"The Mental Health Act, I have not necessarily quoted it a lot." (Participant number 5)

Code 3.1.5: Basic Conditions of Employment Act

One participant reported that it was important for occupational therapists to understand the Basic Conditions of Employment as it provided guidance in terms of basic work conditions and procedural issues:

"…the Basic Conditions of Employment Act provides guidance. Just in terms of basic work conditions and procedural issues like, you know, if somebody seems to have incapacity, there are steps that must be followed to manage that incapacity." (Participant number 6)

Code 3.1.6: Protection of Personal Information Act

The participants expressed the need for occupational therapists to have knowledge of POPIA. This was expressed by one of the participants who said:

"You have to know your POPI Act very well, because you only give information – I always look at, who am I talking to" (Participant number 4)

Subtheme 3.2: Understanding work environment

The participants recommended that occupational therapists should understand the work environment of employees with MDD.

Table 4-18 illustrates the codes of subtheme 3.2 which is understanding the work environment.

Table 4-18: Subtheme 3.2- Understanding work environment

Subtheme 3.2	Code
Understanding work environment	3.2.1. Business knowledge
	3.2.2. Understanding of the job
	3.3.3. Understanding labour market culture

When facilitating reasonable accommodation, it is important to understand the work environment where the employee with MDD works. This was supported by the participants who reported as follows:

"They [Occupational therapists] can understand the workplace and that they can work in the workplace. Because that to me, is the biggest thing. That understanding, that stepping into that work environment." (Participant number 2)

"I think we [Occupational therapists] need to have a very clear understanding of the client's level of function, their capabilities and the job. And the work environment, the work context." (Participant number 3)

Code 3.2.1: Business knowledge

The participants highlighted that it was important for the occupational therapists to understand the business in which the employees with MDD worked. They emphasised that the occupational therapists need to know the business and the role of the employee within the business. This is supported by the participants who said:

"…but as an OT, you've also got to understand it's a business at the end of the day. And unless you have an acute knowledge of what that business is, what that person's role is, what their role is in the system of their business…." (Participant number 1)

"So, it's got to work for business as well. I think that's what as Occupational therapists, we have to look at the patient and the business." (participant number 3)

Code 3.2.2: Understanding of the job

The participants reported that the occupational therapist should understand the job of the employees with MDD. As reflected by one of the participants who said:

"…we need to have a clear understanding of that individual's profile, functional profile and their job" (Participant number 3)

Code 3.2.3: Understanding labour market culture

The participants of this study advised that the occupational therapists needed to have a clear understanding of the labour market culture. They referred to distinct cultures within each labour market, as supported by one of the participants who said,

"…they [Occupational therapists] need knowledge. Inherent knowledge of the actual labour markets. Not just the task itself, but the culture within each labour market." (Participant number 4)

Subtheme 3.3: Reasonable may need to be reasonable

The participants made a strong argument that occupational therapists should ensure that the recommended reasonable accommodation will be reasonable to the employer. In other words, they needed to look at what was considered reasonable during formulation of the reasonable accommodation plan.

Table 4-19 shows the codes of reasonable may need to be reasonable.

Table4-19: Subtheme 3.3- Reasonable may need to be reasonable

Subtheme 3.3	Code
Reasonable may need to be reasonable	3.3.1. Feasibility
	3.3.2. Sustainability
	3.3.3. Reasonable on both sides

The occupational therapist may need to draw a balance between the employees with MDD and the business. This was reinforced by the participants who expressed their views thus:

"…but the big thing is, in the corporate side, is the reasonable side and that is always a very difficult thing. So, accommodation is the easy part. The reasonable part is the difficult bit." (Participant number 1)

"I think that's what Occupational therapists, we have to look at the patient and the business. We actually have to manage all of the variables, to make sure that it works for everybody." (Participant number 3)

Code 3.3.1: Feasibility

One of the participants reported that reasonable accommodation may need to be feasible within the functional capacity of an employee with MDD and the employer's interests as captured in the statement below:

"it means that it has to be something that is feasible for the employer first of all and then secondly it has to be something that is also feasible within the person's functional capacity and also something that is feasible within the job position of that particular person" (Participant number 5)

Code 3.3.2: Sustainability

The participants were of the opinion that occupational therapists may need to recommend implementable and sustainable reasonable accommodations:

"We [Occupational therapists] know the words. We know practically, yes, we got to look at sustainability." (Participant number 1)

"It's got to be something that is negotiated and is reasonable and sustainable to the employer as well." (Participant 3)

One participant was concerned about occupational therapists who made recommendations that were neither implementable nor sustainable:

"I think a lot of Occupational therapists make recommendations that are not sustainable. You can't just, you know, recommend something that won't be sustainable. There is no point, because then it won't be implemented." (Participant number 3)

Code 3.3.3: Reasonable on both sides

The participants reported that what occupational therapists considered as reasonable accommodations towards employees with MDD should be reasonable to the employer as well. Thus, occupational therapists saw the need to strike a balance between the employee with MDD and employer. This concern was expressed by the participants who said:

"As healthcare professionals, what we might think is reasonable, at the end of the day, when you are sitting with a business, and they have certain demands and pressures, what we think might be simple is not simple from their side." Participant number 1)

"Obviously, we're looking after our patients, but it must be reasonable." (Participant number 3)

Theme 4: Challenges of reasonable accommodations

The participants expressed their challenges while facilitating reasonable accommodations. This answered the two research objectives in which the researcher aimed to explore and describe the occupational therapist's knowledge and attitudes in facilitating reasonable accommodations for employees with major depressive disorder. Table 4-20 shows the subthemes of challenges in formulating reasonable accommodations.

Table 4-20: Theme 4 – Challenges of reasonable accommodations

Theme 4	Subtheme
Challenges in formulating reasonable accommodations	4.1. Comorbidity
	4.2. Employees' narrative
	4.3. Inadequate undergraduate training

One of the participants highlighted that there were challenges experienced in the workplace regarding reasonable accommodations:

"…some of the things that some of us [Occupational therapists] are struggling now with [include] some of the clients that we [Occupational therapists] are trying to accommodate at work. We [Occupational therapists] should not be dealing with those challenges" (Participant number 5).

Subtheme 4.1: Comorbidities

The participants advised that the stakeholders should be aware of comorbidities that could compromise facilitation of reasonable accommodations for employees with MDD.

Table 4-21 shows the codes related to subtheme 4.1 of comorbidity.

Table 4-21: Subtheme 4.1 – Comorbidities

Subtheme 4.1	Codes
Comorbidity	4.1.1. Personality disorders
	4.1.2. Substance abuse

Comorbidity conditions can have an impact on the process of reasonable accommodation. This was supported by one of the participants who commented,

"So, looking at the impact of the other comorbid conditions is also important." (participant number 1)

Code 4.1.1: Personality disorders

The participants advised that occupational therapists should be aware of people with comorbidities such as those with personality disorders as they lacked resilience and were difficult to reasonably accommodate. This is captured in the statement below:

"There's often the co-morbid and often a co-morbid Axis II [Personality disorders]. And that's the one that also is difficult. So, the resilience is not there." (Participant number 1)

Code 4.1.2: Substance abuse

The participants reported that the process of reasonable accommodation for employees with MDD could be affected by substance abuse as a co-morbidity. The participants reported that occupational therapists should be aware of employees with substance abuse as reported by the following participants:

"I find a lot of the mental health clients do have other co-morbidities, whether it's perhaps, you know, substance abuse or self-harming. Things like that. Co-morbidities like that, can also be a big problem" (Participant number 2)

"…addiction in the workplace, too. So, we get reports of people with substances and things like that." (Participant number 1)

"The fact that he wasn't there, but he also had an alcohol, substance abuse issue." (Participant number 4)

Subtheme 4.2: Employees' narrative

The participants shared the common employees' narratives that were seen as a challenge during the facilitation of reasonable accommodation. Table 4-22 shows codes of subtheme 4.2 of employees' narratives.

Table 4-22: Subtheme 4.2 – Employees' narratives

Subtheme 4.2	Codes
Employees' narratives	4.2.1. Uninterested employer
	4.2.2. Socioeconomic challenges

One participant reported that occupational therapists needed to understand the narrative of the employee with MDD:

"…you need to know where the patients come from and where they are going…"' (Participant number 4)

Code 4.2.1: Uninterested employer

The participants shared the challenges of an uninterested employer, one not interested to reasonably accommodate an employee with MDD. Additionally, the employers' negative attitude might be influenced by their lack of interest to assist during the employees' reasonable accommodation. This was supported by one of the participants who said:

"Uhm, employer's attitude. Sometimes you have employers who just simply are not interested." (Participant number 2)

Code 4.2.2: Socio-economic challenges

The participants informed the researcher that the socioeconomic status of employees with MDD should not be taken for granted as this aspect is likely to be a

big challenge to reasonable accommodation. Lack of money may lead to patients' lack of funds to attend follow ups, lack of transport money to go to work and indeed, lack of time for work itself. These socio-economic challenges were reported to negatively impact on the patients' ability to participate during reasonable accommodation as underscored by the comments below:

"…the occupational therapist should understand where the client is coming from … the clients leaving home and having to walk in the dark, because by seven o'clock they have got to be at work. (Participant number 4)

"Perhaps they don't have money to follow up perhaps they can't get their meds, there's a whole lot of things that would make the case more complex." (Participant number 3)

Subtheme 4.3: Inadequate undergraduate training

The participants reported that some of the occupational therapists experienced challenges during reasonable accommodations due to their inadequate undergraduate training. Table 4.23 below shows subthemes of inadequate undergraduate training.

Table 4-23: Subtheme 4.3 – Inadequate undergraduate training

Subtheme 4.3	Codes
Inadequate undergraduate training	4.3.1. Limited information
	4.3.2. Limited clinical exposure

Undergraduate training was said not to facilitate detailed engagement on reasonable accommodation. This was supported by a participant who said:

"I think, in undergrad we touch a bit on it, but not really much in detail." (Participant number 5)

Code 4.3.1: Limited information

The participants raised a concern that their undergraduate occupational therapy training did not offer enough knowledge or prepare them to handle cases that require facilitation of reasonable accommodations. This concern was raised by some of the participants who commented:

"So, from undergrad [undergraduate] perspective I did not really learn much about reasonable accommodations." (Participant number 5)

"Well, I think at undergraduate level, there's not too much wisdom imparted regarding reasonable accommodations." (Participant number 6)

Code 4.3.2: Limited clinical exposure

The other concern that was raised by the participants was their lack of clinical exposure during their undergraduate occupational therapy training. None of their clinical exposure focused on reasonable accommodations. This concern was expressed by the participants who said:

"I thought I knew about it [reasonable accommodation] when I started off as an OT [occupational therapist]. And then in hindsight, I knew very little. I don't feel you get the kind of training. Well, certainly when I was at varsity, you don't necessarily get the training that you require for that. I think, vocationally, in terms of the practicals we did, there wasn't much exposure to see what is the next step from your assessment." (Participant number 1)

"…it is just like you need experience [clinical exposure]. When you are straight out of University, I do not think it is fair for anyone to expect you to do anything on your own." (Participant number 7)

Theme 5: Proficiencies of occupational therapists

The participants advised that the required proficiencies of occupational therapists that can enable them to be successful during reasonable accommodation should include staying abreast developments on skills and professional behaviour within the field of occupational therapy. This answered the two research objectives in which the aimed to explore and describe the occupational therapist's knowledge and practices in facilitating reasonable accommodations for employees with major depressive disorder. The proficiencies of occupational therapists are shown on Table 4-24 as subthemes.

Table 4-24: Theme 5- Proficiencies of occupational therapists

Themes 5	Subtheme
Proficiencies of occupational therapists	5.1. Staying on the cutting edge
	5.2. Skills
	5.3. Professional behaviour
	5.4. Case management

Theme 5 is supported by one of the participants' comments below:

"All the knowledge. What you've learned practically as an OT, what you've seen on the ground, what you've seen work, what you've seen hasn't – all these things really matter. In terms of, medically and OT in terms of practice. So, what you're seeing clinically, and that's the word I'm looking for. And then, the knowledge is also, how businesses work. And you need to be specific to your area" (Participant 1)

Subtheme 5.1: Staying on the cutting edge

The participants advised that it was important for the occupational therapist to stay on the cutting edge with regard to the subject of reasonable accommodations.

Table 4.25 shows the codes of staying on the cutting edge.

Table 4-25: Subtheme 5.1- Staying on the cutting edge

Subthemes 5.1	Codes
Staying on the cutting edge	5.1.1. Knowledge of occupational therapy
	5.1.2. Capacity building (mentoring, interest groups, continuing professional development courses, postgrad courses, webinars, forums)

The importance of acquiring necessary and up-to-date knowledge by occupational therapists is supported by one of the participants who said:

"So, we need to start gathering this knowledge, especially from our South African perspectives that we have recorded knowledge from each other that we can use and test." (Participant number 5)

The codes of the subtheme were as follows:

Code 5.1.1: Knowledge of occupational therapy

The participants highlighted that it was important for the occupational therapists to have a comprehensive knowledge of occupational therapy that covers the laws, application of occupational therapy models , understanding the world of work and the clients' working context. A comment by Participant 2 captures this sentiment:

"The PEO Model. Understanding the environment, the person and the occupations, and the link between all of those things, and how we address the gaps. …that's often how us Occupational therapists, and it's a wonderful thing, where we thinking and we're prioritizing our patient, but an OT does need to understand the world of work. You do need to understand productivity." (Participant number 2)

Participants underscored the understanding of the employees' pathology in relation to MDD, the level of functioning of employees with MDD, and the prognosis related to the condition.

"I think we need to have a very clear understanding of the client's level of function, their capabilities and the job. And the work environment, the work context. You need to know the condition, and how it can change, and the prognosis" (Participant number 3)

"They need good knowledge of the pathology…" (Participant number 4)

Code 5.1.2: Capacity building

The participants advised that occupational therapists needed to empower themselves through capacity building by upgrading their knowledge through mentoring, attending postgraduate diploma in vocational rehabilitation, advanced training, continued professional development courses, webinars, forums and interest groups. Other advice was for occupational therapists to use academic resources as part of capacity building such as Job Accommodation Network and journal articles. This was supported by participants who said:

"They can go on Tanya's course [postgraduate Diploma in Vocational Rehabilitation], they can learn it, they can work on it with other colleagues under mentoring situations or some sort of advanced training." (Participant number 4)

"…most people stepping into the Voc Rehab [vocational rehabilitation] field would do well to have some mentoring or supervision. And then resources like the JAN, Job Accommodation Network, journal articles can be of help." (Participant number 6)

Subtheme 5.2: Skills

The participants observed that it was important for the occupational therapists who work in the field of reasonable accommodation to ensure that they have adequate skills.

These skills are codes of subtheme 5.2 and are shown in Table 4-26.

Table 4-26: Subtheme 5.2- Skills

Subthemes 5.2	Codes
Skills	5.2.1. Clinical reasoning skills
	5.2.2. Assertiveness
	5.2.3. Listening skills
	5.2.4. Negotiation skill
	5.2.5. Interview skills
	5.2.6. Facilitation skills

The participants emphasised the specific skills that the occupational therapist needs when facilitating reasonable accommodation. In line with this point, one participant said:

"But if they can understand how you work with them, then that is likely to be beneficial to them. So it takes your people skills, your clinical skills." (Participant number 1)

Code 5.2.1: Clinical reasoning skills

The participants believed that occupational therapists need to have better clinical reasoning skills and understanding of the case to facilitate reasonable accommodation of employees with MDD, as supported by participants who said:

"Your clinical reasoning is important – your understanding of a case and your ability to formulate what needs to go" (Participant number 1)

"I want Occupational therapists with clinical experience in the pathology as they are able to apply their clinical reasoning skills." (Participant number 4)

Code 5.2.2: Assertiveness skills

The participants reported that occupational therapists needed to display some assertiveness skills to be able to put across the objective reasons for

accommodation of employees with MDD, as indicated in the utterance below by one of the participants:

"…being fairly assertive, being able to put across legislation, being objective." (Participant number 6)

Code 5.2.3: Listening skills

Participants believed that a better occupational therapist possessed listening skills as they should listen attentively in order to read between the lines of communication. This is supported by participants who said:

"Your listening skills are critical. To be able to really listen and hear, and that's not just what they say. There is also that nonverbal communication, what you're reading between the lines." (Participant number 1)

"…listening skills, a lot of listening skills are necessary. (Participant number 6)

Code 5.2.4: Negotiation skills

The participants of this study emphasised that occupational therapists needed to have negotiation skills to enable them to facilitate the process of reasonable accommodation for employees with MDD through effective negotiation with the employer or other stakeholders. This was supported by some of the participants who said:

"…they certainly need to have skills in consultation, because you're going out and speaking, negotiating with the employer" (Participant number 2)

"…very good negotiation and facilitation skills, in terms of dealing with the employer and all the different stakeholders." (Participant number 3)

Code 5.2.5: Interview skills

The participants expressed that the occupational therapists who work with employees with MDD during the process of reasonable accommodation may need to have good interviewing skills. This is supported by one participant who said:

"OTs must have good interviewing skills, very good interviewing skills." (Participant number 3)

Code 5.2.6: Facilitation skills

The participants reported that occupational therapists needed facilitation skills to enable them to deal with the employers and other stakeholders. This was supported by a participant who said:

"…facilitation skills, in terms of, dealing with the employer and all the different stakeholders. (Participant number 3)

Subtheme 5.3: Professional behaviour

The participants commented that occupational therapists should display professional behaviour. The codes of subtheme 3 are shown in Table 4-27 below.

Table 4-27: Subtheme 5.3- Professional behaviour

Subthemes 5.3	Codes
Professional behaviour	5.3.1. Ethical behaviour
	5.3.2. Compassionate client-centeredness

The participants urged that occupational therapists must ensure that they demonstrate professionalism by showing up as expected and using cooperate language. Two participants put it this way:

"The way they expect professionals to show up. You cannot be dialing in …. If you call a meeting for five, or whatever … if you call a meeting for nine o'clock, you know, you need to be dialing in at two minutes to nine." (Participant number 7)

"…the corporate language that you are now speaking and you just need to understand these are the parameters, this is what I need to do, this is what I can say, this is what I cannot say" (Participant number 6).

Code 5.3.1: Ethical behaviour

The participants emphasized that occupational therapists need to maintain ethical behaviour by ensuring confidentiality of certain information and adhering to their ethical duties. This was underscored by one participant who commented:

"To be able to speak to the employer, they [Occupational therapists] need to understand their ethical duties, that they're not giving information, not crossing boundaries, in terms of, confidential information on their client." (Participant number 2)

Code 5.3.2: Compassionate client-centeredness

Participants encouraged that occupational therapists be compassionate and client-centred when facilitating reasonable accommodation, as indicated by the comment by one of them:

"All the interpersonal skills from sort of empathy and client-centeredness are a necessity." (Participant number 6).

Subtheme 5.4: Case management

The participants of this study emphasised on the importance of case management of employees with MDD. Table 4-28 shows the codes of subtheme 5.4 of case management.

Table 4-28: Subtheme 5.4- Case management

Subthemes 5.4	Codes
Case management	5.4.1. Manage expectations of employee and employer
	5.4.2. Proactive consultancy role

The importance of case management was underscored by a participant who said:

"…when you've got a clinician and the person [employee with MDD] and their insurance company, or you know, you [occupational therapist] have to be a case manager…" (Participant number 1).

Code 5.4.1: Manage expectations of employee and employer

The participants recommended that the employees with MDD needed to be properly managed. The participants reported that all the stakeholders should ensure that the expectations were clearly managed. Utterances from two participants prove this point:

"It also helps to ensure that the employee is doing what they can, and helps manage expectations." (Participant number 1)

"But the thing is, it has to be properly managed [manage expectations], otherwise, it can backfire." (Participant number 2)

Code 5.4.2: Proactive consultancy role

The participants emphasized that occupational therapists need to be proactive during consultation with the employees with MDD and other stakeholders, as captured in the comment below:

"So, what I normally have, is regular sort of, once a week, where I do a telephonic follow-up with client." (Participant number 2)

4.4. CONCLUSION

In conclusion, the participants expressed that occupational therapists, along with other stakeholders, had a major role to play in facilitating reasonable accommodation of employees with MDD. Chapter four presented the qualitative findings of the study in respect of occupational therapists' roles during reasonable accommodation of employees with

MDD using themes, subthemes and codes. The discussion of findings and relevant literature are both discussed in Chapter five.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

5.1. INTRODUCTION

The findings presented in chapter four are discussed and compared to applicable literature. The themes in chapter four are deployed as headings and chapter four subthemes as sub-headings in this chapter.

5.2. COLLABORATIVE APPROACH

Bastien and Corbiere[6] advise that in order to successfully implement work accommodation, all stakeholders involved must establish a common vision of sustainable return-to-work. This is consistent with the results of this study where the participants reported that during facilitation of reasonable accommodation, there must be an involvement of stakeholders. The occupational therapist must not work alone but rather, in a collaborative approach with other stakeholders. In order to achieve a sustainable return-to-work, there has to be involvement of and collaboration with key stakeholders as advised by best practice guidelines and this may include EEA Code of Good Practice and the TAG.[6,209-210] Advancement of reasonable accommodation in the workplace, return-to-work, improved work performance and reduction in disability are the benefits of collaboration that were found in a study by Lappalainen et al.[4] on work disability negotiation. However, there is a concern that collaboration may breach confidentiality, and supervisor's role to include colleagues in work arrangement may even compromise employee's privacy.[211] Therefore, a collaborative approach that involves the stakeholders is an important approach to advance reasonable accommodation but the stakeholders should be cautious about the employee's privacy. The employee's medical information cannot be shared with other stakeholders unless informed consent is given as stipulated by HPCSA booklet 4.[212] Furthermore, everyone's right to privacy that is provided for in section 14 of the South African Constitution is implemented through POPIA.[148]

5.2.1. Stakeholders involved

The participants of this study expressed that the stakeholders that form part of the collaborative approach are employee, occupational therapists, supervisor, manager, human resource practitioner, union representative, occupational health doctor, occupational health nurse, health and wellness practitioner and the group insurer. Similar findings were also made by Bastien and Corbeire[6] where they identified stakeholders to include the employee, supervisor, colleagues, unions, physician and insurer. Bastien and Corbiere[6] noted that senior management needed to allow supervisors freedom to make decisions on required reasonable accommodation to ensure successful implementation of work accommodation. The Bastien and Corbeire[6] study did not include occupational therapists but had colleagues as part of the stakeholders. This current study however, did not have colleagues as stakeholders. While the participants in this current study did not include colleagues as part of stakeholders, Edgelow[123] agrees with Bastien and Corbeire[6] in their arguments that co-workers are important stakeholders in the process of return-to-work as the reasonable accommodation may affect their duties. The study by Bade and Eckert[30] on the occupational therapists' critical role in work rehabilitation and ergonomics found that services provided by occupational therapists in work rehabilitation included job accommodations within which they negotiated and implemented for employees with disabilities,[30] supporting the findings of this present study that occupational therapists are part of the stakeholders in reasonable accommodations. One of the participants emphasised the importance of occupational therapists' role in reasonable accommodation by saying, "I think we [occupational therapists] are fundamentally necessary…. Occupational therapists' role, is to enable accommodation, which means being able to work with different team members and stakeholders." This discussion indicates that all stakeholders are important in the facilitation of reasonable accommodation and suggests that occupational therapists and colleagues should not be excluded in the communication.

5.2.2. Communicating with stakeholders

Collaboration between various stakeholders during vocational rehabilitation should be directed towards a common goal with clear communication strategies when facilitating return-to-work.[160] Gold et al.[185] found that people with disabilities are unwilling to disclose their disabilities to employers fearing humiliation and stigma,[185] and Bastien and Corbiere[6] add that non-disclosure of the illness renders the implementation of reasonable accommodation complex.[6] These studies underscore the importance of confidentiality during meetings with stakeholders as reported by participants in this study. The participants noted that there was no need to disclose the diagnosis to the employer but only discuss the functional strengths and limitations of the employee as these relate to their job.

Contrary to this finding, various studies argue that in order for the employer to implement the reasonable accommodations recommended, the disability or illness has to be disclosed.[20,28,135,141] The EEA supports this notion as a requirement for application of reasonable accommodation.[20] However, informed consent must be provided by the employee as outlined in the HPCSA booklet 4 of guidelines for good practice in mental health care.[212] Chow and Cichoki[99] stresses disability disclosure as the strongest predictor of reasonable accommodation. Schreuer et al.[29] advise that alternative dispute resolution during interaction about reasonable accommodation can assist maintain confidentiality. Alternative dispute resolution is a method that involves a neutral third party where disputes are resolved through nonjudicial mechanism. There are several disadvantages of disclosing disability as discussed in a recent scoping review of 2017 by Prince.[213] They include remembering negative responses from colleagues and others, being excluded from a job that is fulfilling and becoming an object of curiosity at work. Moreover, any mistakes at work are blamed on the disability, resulting in being treated differently by colleagues, negative impact on one's self-image and being seen as needy, incompetent, or unable to perform accordingly compared to peers. Disability disclosure is associated with fear of demotion or reduction in hours or failure to be noticed for a job and shame that comes with disclosing private and sensitive information.[213]

On the other hand, disability disclosure has advantages like ensuring implementation of reasonable accommodations and effective work activities participation as well as provision of legal protection against discrimination as stated in the legislation. Relief of stress, clarification of expectations on the person and their ability, and provision of tailored support to ensure success of the employee are other benefits of disability disclosure. In addition, disclosing the disability opens communication channels when the employee is struggling, improves self-esteem of the employee, involvement of other stakeholders for the development of accommodations and increases the level of comfort for the employee.[213]

McDowell and Fossey[28] concluded that the stakeholders need information on the selection and implementation of reasonable accommodations that are individual and workplace customized. This information can be provided by the occupational therapists. This current study indicated that during the meeting with stakeholders the occupational therapists should communicate the limitations and strengths of the employee in relation to their job as identified during the FCE. Occupational therapists focus on the gaps that limit the employee from executing their inherent job requirements and thereby recommend reasonable accommodation that can remove barriers to successful return-to-work. This is in agreement with the results of study on workplace accommodations by Schreuer et al.[29] in which they reported that this process must include identification of precise limitations as a result of the disability and possible reasonable accommodations to overcome the limitations. During presentation of recommendations, participants in this study stated that the occupational therapist must identify and discuss relevant reasonable accommodation that will enable the employee to return-to-work. Furthermore, the participants expressed that the minutes of the meeting have to be documented and dated, and agreements should be written down and kept for record purposes. One participant added by saying that such documentation made continuation easy. In the event that a human resource practitioner left the company, a newly appointed practitioner would know what had been agreed upon.

5.3. DYNAMIC PROCESS OF REASONABLE ACCOMMODATION

The participants expressed that reasonable accommodation followed a process and that the process was dynamic as things could change. The steps reported by the participants of this study were referral, assessment, worksite visit, formulation of reasonable accommodation, circulatory feedback and review.

5.3.1. Referral

The findings of this study showed that the first step of reasonable accommodation process was referral. The referral can be from the psychiatrist or employer. The participants added that the referral provided information on the pathology of the employee. Swart and Buys[169] advise that the boundaries for service delivery and payment should clearly be indicated in the referral. They continue to advise that any ambiguity or vagueness must be clarified before the therapist can make contact with the employee.[169] They further insist that referral letter must include comprehensive information on medical reports, job descriptions and work performance of the employee.[16] However, Creek[161] argues that depending on the setting, the occupational therapist may or may not receive essential information about the patient prior to contact. Detailed and clear information on the referral letter can assist the occupational therapist to prepare for an interview and assessment of the specific employee.

5.3.2. Assessment

The findings of this study point out that assessment should be the next step following referral. One participant asserted that there should be a good assessment as patients present differently and have different jobs. Creek[161] agrees with this participant that assessment must be thorough and valid. The participants agreed that assessment should encompass conducting an interview, assessing the clinical presentation of MDD and performing FCE.

An Interview is a conversation between an occupational therapist and the patient.[161] It is used to gather information about occupational functioning, and for establishing rapport with the patient.[169,214] The findings of this study indicated that an interview with an employee was the first contact with the employee and included the employee's job description. Similar advice was highlighted by Buys and van Biljon[167] that an interview is the first contact with the employee where the reason for referral is established. Swart and Buys[169] add that the occupational therapist must use an interview guide that has been developed prior to contact with the employee and that it must include client's educational background, work history, psychiatric history, other medical history, current treatment and current functional status. This can guide on which assessment tools may be relevant for the specific employee.

The occupational therapist should observe and identify the symptoms of MDD such as cognitive impairments, emotional problems and functional limitations during an interview. Information from the referral letter, interview and observations of MDD symptoms guide the occupational therapist on which assessment tools can be used to carry out an FCE. The results showed that FCE assisted to determine return-to-work decision and the occupational therapist could recommended possible and reasonable accommodation. These results are congruent with Ramano et al.[8] in their study of occupational therapists' views and perceptions of FCE for employees with MDD where their participants reported that FCE assisted to formulate the decision to return-to-work.

5.3.3. Worksite visit

Worksite visit was reported as significant during the process of reasonable accommodation by the participants, highlighting that the occupational therapist must have a meeting with the employer and do a job analysis. The findings of this study are that job analysis can provide the occupational therapist with employee's job demands, knowledge of the workplace culture, and how job description manifests. Bade and Eckert[30] support this findings by reporting that occupational therapists can perform a once-off work site assessment to match job demands to employee's capabilities. According to Swart and

Buys,[169] worksite visit provides an understanding of work-related factors (environmental factors, interpersonal factors, work stressors and pace of work), possible reasonable accommodation and positions for realignment, getting job description and agreement on performance management.

5.3.4. Formulation of reasonable accommodation

Legislation in various countries including South Africa[135] requires employers to provide reasonable accommodation to enable people with disability to fulfil their essential job functions[28] and results in vocational recovery and improved quality of life for people with mental illness.[141] Ramano, Buys and de Beer[117] assert that the results of FCE may assist in formulation of modifications to the employee's workstation or workplace. Reasonable accommodations for people with disabilities can be negotiated and implemented by occupational therapists.[30] The occupational therapists should ensure that the recommended reasonable accommodations are clear and specific as mentioned by the participants of this study.

5.3.4.1. Clear and specific

Tailoring clear and specific reasonable accommodation for the individual employee and their specific job was emphasised by the participants of this study as necessary because blanket accommodations cannot work. This is in agreement with Gold's[185] study which found that in order for the employee to make their case, the formulated accommodation needed to be tightly matched to their specific job functions. Gold[185] aligns with the study by Rangarajan et al.[141] that looked at workplace reasonable accommodation for professionals with severe mental illness, where they warn that reasonable accommodation is not 'one size fits all' but should be tailored to an individual. Stergiou-Kita [215] also established that vague accommodations are ineffective and tend to be seen as a 'want' rather than a 'reasonable and justifiable need'. These agrees with the findings of this study that reasonable accommodations should be clear and specific for the employee with MDD.

5.3.4.2. Types of reasonable accommodation formulated for employees with MDD

The combination of medication and psychological therapy help reduce depressive symptoms.[216-217] Changes in person's tasks or working hours, employing gradual return-to-work or giving support with certain work situations can be beneficial to facilitate changes in the workplace.[101] Providing work environment that is quieter, breaking up and writing tasks to be completed down, and increasing the responsibilities gradually can be beneficial to employees with cognitive deficits.[6] The possible reasonable accommodations for employees with MDD are shown in Table 5.1 as suggested by the participants of this study.

Table 5.1: Types of reasonable accommodations for employees with MDD

Types of reasonable accommodation	Examples
1. Graded return-to-work	• Half-a-day to full day • Few days a week
2. Restructuring job functions	• Reduced targets • Reduced functions/tasks • Removing non-essential tasks
3. Adjusting working hours	• Flexi hours • Adjusting time to report on duty in the morning • Change shift hours to office hours
4. Allowing time off for treatment	• Appointments with treating team • Collection of medication
5. Providing specialised equipment	• Noise cancellation headsets
6. Training and support in the workplace	• Support from the supervisor

The findings are congruent with the study by Bastien and Corbiere[6] about work accommodation, employers and human resource directors in the context of return-to-work after depression. They are also consistent with Bolo et al.'s study[31] on workplace accommodations for people with mental illness and also align with a scoping review on workplace accommodations for people with mental illness by McDowell and Fossey[28] In addition, the findings are identical to the outline of reasonable accommodations by EEA.[20] For instance, Bastien and Corbiere,[6] Bolo et al.[31] and McDowell and Fossey[28] agree on reasonable accommodations that can be provided such as work schedule/ flexi scheduling/ reduced hours, modified training and supervision, task modification, job change/modified job duties/description, environment change/ physical accommodation, and reduced work

hours.[6,28,31] However, results of the study by McDowell and Fossey[28] found that from the employee's perspective, change to work schedule was a difficult accommodation to negotiate.

Bastien and Corbiere[6] explained that implementing reasonable accommodation that is focused on work tasks like restructuring job functions by removing the non-essential duties, minimises the risk of depression which in turn prevents relapses following return-to-work of employees with MDD. Provision of reasonable accommodation increases job tenure of the employee with MDD.[28,218]

5.3.5. Review

The dynamic process of reasonable accommodation is completed through review which was hailed by the participants as significant. It consists of circulatory follow-up feedback, return to normal work, continuation of reasonable accommodation and relapse. Review of intervention and services safeguards standards and ensures that the service was relevant for its purpose.[161] A continuous process where review and re-evaluation occur may lead to change in the intervention plan.[219] The steps of review are: re-evaluating the plan and its implementation relative to achieving outcomes, adjusting the plan where needed, determining the need for continuation or discharge or referral to other practitioners.[219] The findings of this study mentioned the steps of review as: circulatory follow-up feedback, return to normal job, continuation of reasonable accommodation and relapse as discussed below.

5.3.5.1 Circulatory follow-up feedback

Participants of this study agreed that there should be feedback to the employer from the occupational therapist about reasonable accommodation to be implemented. The employer must also give feedback to the occupational therapist regarding performance of the employee and the success or challenges of reasonable accommodation. In the event where

there are challenges with the reasonable accommodation, the process restarts. The occupational therapist needs to have constant follow up with the employer and employee. The follow-up can be done telephonically, physically in person or through an email. Initially, participants said follow-up can be done weekly, and then reduced to monthly as the employee improved. Buys[16] advises that follow-up needs to be done with both the employee and employer because it 'closes the case'. Schell and Gillen add that establishing 'just right' time for re-evaluation remains a challenge as too early re-evaluation may give false conclusion of unsuccessful intervention and conversely, too late re-evaluation may result in outcomes that may have long been chieved.[50] The significance of circulatory follow-up feedback is to maintain progress and ensure success of reasonable accommodation.

5.3.5.2 Return to normal job

The ultimate goal of reasonable accommodation is to return employees to their normal work functions and once that happens, it is celebrated as a success as mentioned by participants of this study. Reasonable accommodation can include shaving off non-essential duties and/or working for few/ flexi hours[6,28,31] so when the employee shows improvement, they can return to their full duties and full day.

5.3.5.3 Continuation of reasonable accommodation

In the case where the employee has not improved, then reasonable accommodation continues. The occupational therapist needs to re-evaluate where to make changes accordingly. Intervention is resumed when it has been decided that the service must continue after re-evaluation and changes may need to be made to the intervention plan depending on the patient's response and progress.[161]

5.3.5.4 Relapse

Occupational therapists are advised to be aware that some employees may relapse and the process might have to start from the beginning again. Schlicker et al.[220] add that even after treatment has been completed, there is still a possibility of relapse and recurrence. Experiencing difficulties at work can trigger depression relapse.[118] Relapse is when the symptoms return during remission, suggesting that treatment has to be intensified.[221] A systematic review and meta-analysis study by Zhang and colleagues[222] on modifications for relapse prevention in MDD found that the risk of relapse after first experience of MDD episode was 50%, after second episode was 80% and after third is likely to be up to 90%. The relapse might substantially result in high cost for the individual, family, and society[34].

5.4. ENABLERS OF SUCCESSFUL REASONABLE ACCOMMODATIONS

The application of legislation, understanding of the work environment and reasonable need to be reasonable were reported by the participants as enablers of successful reasonable accommodations and are demonstrated in Figure 5.1.

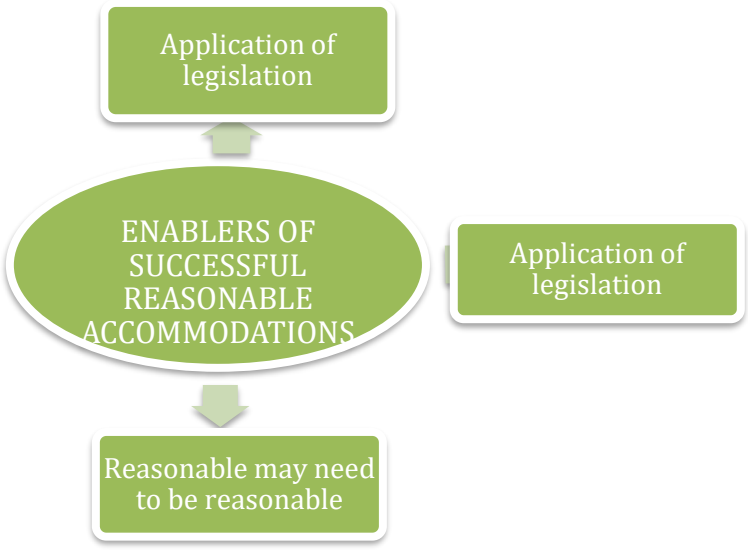

Figure 5.1: Enablers of successful reasonable accommodations

5.4.1. Application of legislation

The participants of this study advised that occupational therapists need to have knowledge of relevant legislation, which is consistent with a study by Telwatte et al.[184] where the participants noted that knowledge of occupational therapy legislation on disability was significant. McDowell and Fossey[28] and Holness[154] add that information on disability discrimination legislation needs to be accessible to employees, employers and treating team in order to be able to select and implement employee and workplace tailored reasonable accommodations. Participants in this present study emphasized that occupational therapists need to remain within the framework of the law when recommending reasonable accommodations. The relevant acts proposed by the participants to assist with the facilitation of reasonable accommodation include the EEA,[20] PEPUDA,[151] LRA,[19] Mental Healthcare Act,[22] Basic Conditions of Employment Act,[223] and POPIA.[148]

Participants consistently cited EEA as a fundamental act that occupational therapists need to consider when facilitating reasonable accommodation, as supported by Modise et al.[135] that EEA and PEPUDA assist people with disability with overcoming challenges in the workplace through the provision of reasonable accommodation and promotes rights of people with disabilities and prohibits discrimination of any sort.[135] There was concern by participants that although EEA had been in existence for a long time, it had had minimal effect for people with disabilities in the workplace. A recent 2021 study by Govender et al[139] concurs with this finding as they reported that the rate of implementation of reasonable accommodation was generally low. The findings of this study as elaborated by one participant indicate that PEPUDA is not specifically related to labour market but is relevant to reasonable accommodation. This might be because it does not specifically relate to workplace discrimination but discrimination in general. However, failure to reasonably accommodate a person with disability is considered unfair discrimination by PEPUDA.[135,151]

The Labour Relations Act was reported by participants in this present study as relevant because it addresses disability and dismissal due to incapacity amongst other things. The

employer can consider to reasonably accommodate the employee in order to retain them rather than considering dismissal. Modise et al.[135] agree with this sentiment by asserting that there should be consideration of alternative measures by the employer prior to dismissing employees.[135] van der Reyden and Crouch[224] advise that occupational therapists working in vocational rehabilitation providing services to people with mental disabilities need to be cognisant of labour legislation and disability management in the workplace which in South Africa are found in EEA and LRA.[224] They further argued that occupational therapists are obliged by Mental Healthcare Act to provide care, treatment and rehabilitation for people with mental illness in both hospital and rehabilitation centres.[224] Only one participant mentioned Basic Conditions of Employment Act, citing that it provides guidance for basic work conditions and procedural issues as it provides steps to be followed in managing incapacity for an employee. The Basic Conditions of Employment Act clarifies that the employee bears the burden to prove incapacity by providing medical certificate if absent from work for more than two days due to illness.[223]

5.4.2. Understanding work environment

Knowledge of the business and the role of the employee with MDD within the business by the occupational therapist, is imperative. The occupational therapist needs to understand the employee's actual job and the labour market culture. Agreeing with these findings is Swart and Buys[169] who advise that occupational therapists need to have a comprehensive understanding of corporate and industrial culture in order to carry out their specialised role in the workplace.[169]

5.4.3. Reasonable need to be reasonable

The success of reasonable accommodation included feasible accommodations, sustainable accommodations and ensuring that accommodations are reasonable on both sides.

5.4.3.1 Feasible

It is imperative that recommended reasonable accommodations are feasible for the employer, employee's functional capacity outcome and the position the employee holds at work. This is consistent with the scoping review on occupational therapists' return-to-work interventions for persons with trauma and stress related mental conditions by Edgelow et al.[123] where they found that occupational therapists need to collaborate with employers to determine feasible intervention as the smaller companies than bigger ones, find it difficult to find balance between accommodating the duties and maintaining budget thereof.[123]

5.4.3.2 Sustainable

Furthermore, the participants reported that to ensure implementation of reasonable accommodations, they should be sustainable and this is in line with Bolo et al.[31] who argue that while majority of accommodations include changes to current workplace and management practices, they should not be costly.[31] Telwatte et al.[184] reported that considering whether the cost is reasonable should be one of the other deliberations made when requesting accommodation.[184] The EEA[20] gives SA employers the duty to provide reasonable accommodations for employees with disabilities unless those accommodations cause unjustifiable hardship.[20,225] Unjustifiable hardship according to EEA[20] is defined as considerable cost or difficulty to the business.[20] "Nature and cost of reasonable accommodation in relation to the size, nature, structure of the employer's operation" are factors that could be considered as unjustifiable hardship.[6] Nonetheless, an optimistic scoping review by McDowell and Fossey[28] argued that direct costs of reasonable accommodation for people with mental illness are zero or very low.[28,141]

5.4.3.2. Reasonable on both sides

A study that explored employer's decision-making of workplace accommodations for employees with disabilities clarifies that reasonableness of reasonable accommodation contributes to the willingness to grant them.[184] This conclusion tallies with the results of this

study where the participants urged that reasonable accommodations need to be reasonable to both the employer and employee. This in line with the results of Bastien and Corbiere[6] who found that reasonable accommodation should be flexible and adaptable to the employee's needs and address the challenges of the organisation.

5.5. CHALLENGES OF REASONABLE ACCOMMODATIONS

Challenges of reasonable accommodations are shown in Figure 5.2.

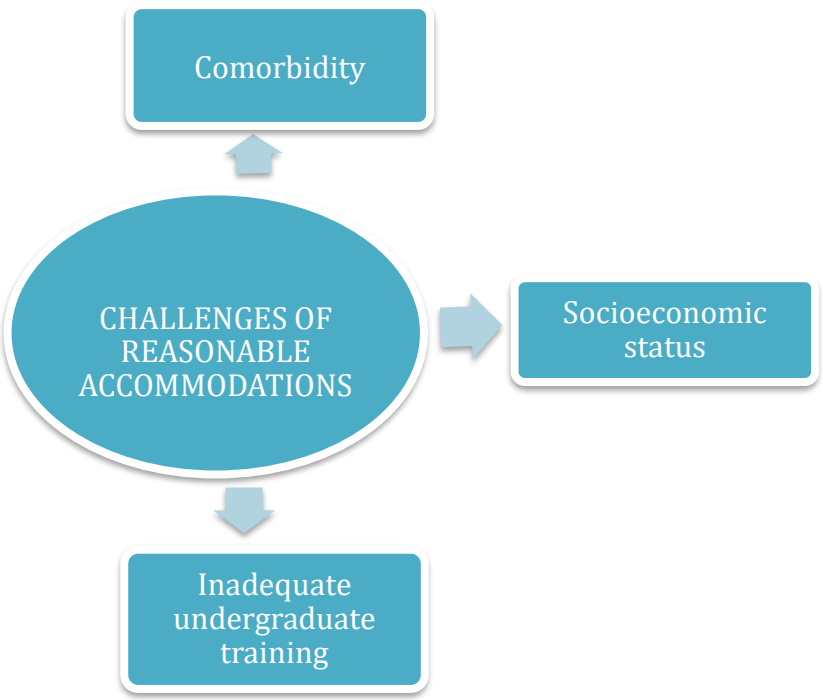

Figure 5.2: Challenges of reasonable accommodations

5.5.1. Comorbidity

Comorbid conditions in patients with MDD tend to be more than those without MDD.[226] Medical and psychiatric comorbidity contribute significantly to disease burden seen in MDD due to rise in the use of healthcare and functional disability.[85] An observational study on

recovery of patients with MDD indicated that 60-70% of MDD patients have at least one mental condition (anxiety disorder, dysthymia, personality disorder and substance abuse) which has a negative impact on depression course.[58] Stakeholders must be cognisant of the negative impact of comorbid conditions on the process of reasonable accommodation.

Participants in this study regarded substance abuse as a problematic comorbid condition during reasonable accommodation process. This is consistent with the results of the studies by Grobler[47] and Woo et al. [27]on cognitive deficits in remitted MDD patients. The results in both studies pointed out that psychiatric comorbidities such as substance abuse and anxiety needed to be given considerable attention in patients with MDD as they could independently impair cognition. Noted with concern by the researcher was that comorbid drug or alcohol use disorders resulted in poor prognosis.[61] The researcher pondered if this poor prognosis due to substance abuse may result in relapse and ultimately permanent incapacity as reasonable accommodation may no longer be a realistic option.

Furthermore, people with comorbidities such as personality disorders might lack resilience and make it difficult to reasonably accommodate them. This concurs with Kraus et al. [61] on prognosis and improved outcomes in MDD. Their results recognised that personality disorder was associated with poor outcomes regarding remission and continuing depressive symptoms.

5.5.2. Employees' narrative

Part of the challenges of reasonable accommodation was that employees are met by employers that are not interested to provide reasonable accommodations as expressed by the participants in this study. These findings are congruent with the study by Ramano, Buys and de Beer[117] where they looked at occupational therapists' experiences when formulating return-to-work decision for employees with MDD. They found that the employer might block reasonable accommodation recommendations or be reluctant to reasonably accommodate the employee making it difficult for the occupational therapist to facilitate return-to-work of

the employee.[117] Stander who looked at depression in the South African workplace, reported that the majority of managers did not know how to respond, let alone respond appropriately to employees with MDD.[5]

Socioeconomic status of the employee is important as they may not have enough funds to attend treatment follow ups and to transport themselves to work to start on time. Defaulting treatment may result in relapse which negatively affects the success of reasonable accommodation. An employee who lives far from work and uses public transport may need to wake up very early to be on time for work, in the process affect the effectiveness of medication. Glader, Jonsson and Norving[227] from their study on socioeconomic factors' effect on return-to-work after first stroke, found that there was less return-to-work rate of patients with low socioeconomic status one year after stroke. Findings by Ntsiea and van Aswegen[228] concurred with results in this study when they found that using public transport was a barrier for return-to-work in terms of physical accessibility and cost.[228]

5.5.3. Inadequate undergraduate training.

A concern raised in this present study was that undergraduate training was not sufficient to prepare occupational therapy students to facilitate reasonable accommodation effectively. The knowledge garnered was said to be limited and there was no real-world exposure to work and employees requiring reasonable accommodation. The participants were concerned that there was inadequate exposure regarding the next step after assessment during vocational the rehabilitation clinical block. A study by Ramano and Buys[8] which looked at occupational therapists' views and perceptions of FCE for employees with MDD, also found that occupational therapists lacked the clinical experience and rehabilitation experience to assist employees with MDD to return-to-work. This suggests that undergraduate training was inadequate for occupational therapists to facilitate reasonable accommodation of employees with MDD.

5.6. PROFICIENCIES OF OCCUPATIONAL THERAPISTS

To ensure success of reasonable accommodation, the participants of this study agreed that the proficiencies that occupational therapists needed to possess to facilitate reasonable accommodation included staying on the cutting edge, relevant skills and professional behaviour. Knowledge, skills and values were agreed upon as requirements for vocational rehabilitation service delivery.[16] Knowledge, experience and skills were identified by Ramano and Buys[8] as important competencies needed for occupational therapists to perform an FCE. Therefore, it is important for the occupational therapists to have knowledge so that they stay abreast of new knowledge and practices, have relevant skills and conduct themselves professionally, as elaborated below in Figure 5.3 which shows proficiencies of occupational therapists.

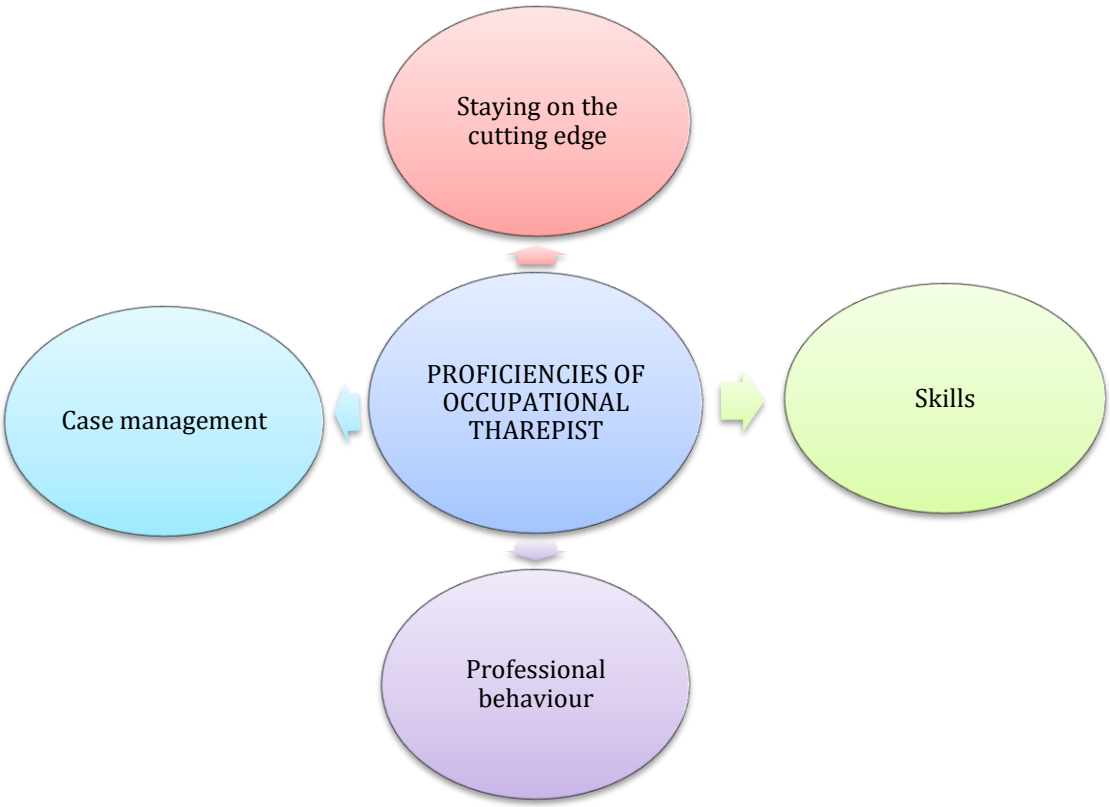

Figure 5.3: Proficiencies of occupational therapists

5.6.1. Staying on the cutting edge

Ramano and Buys[8] emphasised that one of the occupational therapists competencies is knowledge which encompasses knowledge of pathology, occupational theories, occupational therapy process, assessment, legislation, economic climate and knowledge of the world of work.[8] Buys[16] in her Delphi study of professional competencies in vocational rehabilitation highlighted the knowledge of employment setting, legislation related to disability, evaluation, different stakeholders and their roles, vocational rehabilitation process and evaluation. Similar findings were also made in this study that occupational therapy knowledge should cover legislation, application of occupational therapy models, understanding the world of work and the clients' working context.

Moreover, capacity building in terms of mentoring, interest groups, continuing professional development courses, postgraduate courses, webinars and forums are essential to offer and enhance occupational therapy knowledge. This is consistent with the systematic review study of DeCorby-Watson et al.[229] where participants in their study expressed that capacity-building interventions that include internet-based instruction, training and workshops, technical assistance, education using self-directed learning, communities of practice, and multi-strategy could improve knowledge, skill and self-efficacy. Therefore, the occupational therapists should continue to build and improve on their knowledge using different platforms.

5.6.2. Skills

Occupational therapists need to have solid knowledge, skills and experience in the field of work or vocational rehabilitation as well as mental health in order to prepare a return-to-work decision.[117]

Participants highlighted that the occupational therapists need to possess clinical reasoning skills, assertiveness skills, listening skills, negotiation skills, interview skills and facilitation

skills when facilitating reasonable accommodation in order to effectively negotiate with the employer and other stakeholders. Similar findings were made by Bade and Eckert[30], Ramano and Buys[8], and Buys[16]. Bade and Eckert[30] concluded that occupational therapists had a peculiar and critical value because of their comprehensive training in physical and psychosocial sciences and negotiation skills.[30] Ramano and Buys[8] underscored clinical reasoning, negotiation, advocacy, interview, assertiveness and communication skills as essential for occupational therapists. Buys[16] adds that the professional competencies that occupational therapists need to show in vocational rehabilitation are clinical reasoning and interpersonal skills[16] which concurs with the skills reported in this study.

5.6.3. Professional behaviour

A study by van Leiw[230] on balancing confidentiality and collaboration within multidisciplinary health care teams concluded that while collaborating between cross disciples is central to multidisciplinary treatment models, psychologists must be cautious about the information they share as guided by their profession's ethical standards concerning patient's confidentiality. Furthermore, they must remember their ethical obligations of balancing their contribution to the treating team and protection of patient's confidentiality.[230] This is consistent with the finding of this study that occupational therapists needed to maintain their ethical behaviour by ensuring confidentiality of certain information and to adhere to their ethical duties.

Participants of this study encouraged that the occupational therapist must employ empathy and client-centredness when facilitating reasonable accommodation as the process may affect people's careers and lives. Congruent to this findings is Parker et al.'s [231] conclusion that reduction of work disability and improvement of return-to-work outcomes are as a result of occupational therapist's role to provide a supportive and empathetic environment that is dependent on a client-centred approach which honours autonomy and permits the employee with disability to choose if, when, and how to change.

5.6.4. Case management

Buys[16] highlighted case management as one of the vocational rehabilitation services that needs to be understood and implemented by occupational therapists. During case management, occupational therapists need to manage expectations of the employee and employer so that the process does not collapse. Consultation with the employees with MDD and other stakeholders needs to be done proactively by the occupational therapist. It is imperative that this consultation is done regularly in order to facilitate recommended reasonable accommodations. Govender et al.[232] concur in theme three of their study where the participants specified that the occupational therapist as a case manager has to ensure that there are arranged meetings with the stakeholders, stakeholders follow legislative guidelines, guidance on goal setting is provided and role of the stakeholder is clarified. Moreover, the occupational therapist gives feedback on the recommendations through meetings.[232] Managing the expectations of the patient needs to be done early on in order to make corrections to misalignment of expectations concerning what the end goal is.[161]

5.7. SUMMARY

The researcher discussed the findings of the study. Literature was used to support the findings of this study. Literature related to reasonable accommodation and MDD was limited globally and absent in South Africa. Most of the literature accessed concurred with the findings of this study. Chapter six is the conclusion of the study.

CHAPTER SIX: REFLECTION AND CONCLUSION

6.1. INTRODUCTION

This chapter concludes the study as it provides the overview of the study, recommendations for the occupational therapy profession and further research. The researcher reflects on the journey travelled, lessons learned and the significance of the study.

6.2. AIM OF THE STUDY

The aim of the study was to explore and describe the occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with MDD. Semi-structured individual interviews provided data which answered aim and objectives of the study as presented in chapter four and discussed in chapter five.

6.2.1. Reflection on the themes

Themes generated answered the aim and objectives of the study. Data was analysed using bottom-up approach and steps of data analysis according to Creswell were employed where inductive analysis was used as outlined in chapter three. During data analysis, five themes were generated, namely (1) collaborative approach, (2) dynamic process of reasonable accommodation, (3) enablers of successful reasonable accommodations, (4) challenges of reasonable accommodations and (5), proficiencies of occupational therapists.

Collaborative approach identified occupational therapist as the primary stakeholder who must collaborate with the employee, employer, team leader/ supervisor/manager, human resource practitioner, union representative, occupational health doctor/occupational health nurse and health and wellness practitioner. During collaboration, confidentiality must be

maintained by the stakeholders involved and their discussion focused on employee's limitations and abilities to perform a specific job. The occupational therapist presents recommended reasonable accommodation during the discussion. The minutes of the discussion are documented.

In this study, the developed dynamic process of reasonable accommodation included the following steps:

Step 1: Referral;

Step 2: Assessment;

Step 3: Worksite visit;

Step 4: Formulation of reasonable accommodation, and

Step 5: Review.

These steps are not linear. They may be iterative depending on the employee's reaction to treatment and their integration in the workplace.

Application of legislation, understanding of work environment and reasonable needs were found to be the enablers of reasonable accommodation in this present study. However, comorbidity, employees' narrative and inadequate undergraduate training emerged as the challenges experienced by occupational therapists during the formulation of reasonable accommodation. Lastly, proficiencies of occupational therapists to successfully facilitate reasonable accommodation included staying abreast latest developments in occupational therapy knowledge and practice (staying on the cutting edge), possession of effective skills and conducting themselves professionally.

6.2.2. Attainment of research objectives of the study

The objectives that were formulated from the aim of the study were:

i. To explore and describe occupational therapists' knowledge in facilitating reasonable accommodations for employees with major depressive disorder,

ii. to explore and describe the occupational therapists' attitudes in facilitating reasonable accommodations for employees with major depressive disorder, and

iii. to explore and describe the occupational therapists' practices in facilitating reasonable accommodations for employees with major depressive disorder.

Objective 1: Occupational therapist's knowledge in facilitating reasonable accommodation for employees with MDD

It was achieved through themes three, four and five where it was found that occupational therapists needed to have knowledge of legislation (LRA, EEA, PEPUDA, Basic Conditions of Employment Act, Mental Healthcare Act, POPIA) as it applies to open labour market, disability, mental illness and sharing of personal information. Furthermore, occupational therapy knowledge, guiding theories as well as knowledge and understanding of the work environment were found to be significant. Undergraduate knowledge was viewed as inadequate and occupational therapists in this field of mental health and vocational rehabilitation should continue to develop themselves through various platforms. The following skills were found to be important for the occupational therapists in facilitating reasonable accommodation:

- Clinical reasoning skills;
- Assertiveness skills;
- Listening skills;
- Negotiation skills;
- Interview skills. and
- Facilitation skills.

Objective 2: Occupational therapist's attitude in facilitating reasonable accommodation for employees with MDD

Themes three and four answered objective 2. Attitudes towards what is reasonable during reasonable accommodation is vital. Theme three covered the enablers of reasonable accommodation, which are: application of legislation as related to each case, ensuring that occupational therapists understand the employee's work environment in terms of productivity for the business, understanding each job's requirements and the culture of a

particular company. Occupational therapists are likely to succeed with reasonable accommodations that they recommend. Application of legislation in each case, and understanding of work environment in terms of productivity, job requirements and company culture are the enablers of reasonable accommodations that occupational therapists need to consider as in emerged in theme three of this present study. Occupational therapists need to recommend reasonable accommodations that are feasible, sustainable and reasonable for both the employer and the employee. When reasonable accommodations have these features, they are easier for the employer to implement which may ensure success of returning to work an employee with MDD and success in implementation of reasonable accommodations.

Theme four which focuses on challenges of reasonable accommodations also answers objective 2 in that the occupational therapists need to be cognisant of comorbidities such as personality disorder and substance abuse as they may result in relapse during return-to-work. The participants believed that an employer uninterested in reasonable accommodation significantly influenced a negative outcome of recommended reasonable accommodations. The employee's economic status may also impede the reasonable accommodations put in place. Circumstances like living far from work may require the employee to wake up very early while the medication has not worn off, resulting in non-compliance of employee regarding regular taking of medication. Lack of funds for continuing treatment and therapy may also result in non-compliance. Therefore, occupational therapists need to take these factors into consideration and make provision for them when making recommendations for reasonable accommodation.

Objective 3: Occupational therapist's practices in facilitating reasonable accommodation for employees with MDD

Occupational therapists' practices were covered under themes one (collaborative approach), two (dynamic process of reasonable accommodations), and five (proficiencies of occupational therapists). Participants indicated that reasonable accommodation must be addressed collaboratively with different stakeholders while maintaining confidentiality and upholding principles of POPIA. A dynamic process was developed (refer to Figure 5.1)

which guides the practice of occupational therapists when facilitating reasonable accommodation. Professional behaviours that occupational therapists need to practice are ethical behaviour and compassionate client centeredness. The occupational therapists also need to practice as case managers where they manage employee and employer's expectations as well as consult proactively with the employee and employer.

6.3. CRITICAL APPRAISAL OF THE STUDY

The researcher critically reflects on what worked and what did not work in the whole study.

6.3.1. Research approach and design

While studies on knowledge, attitude and practices usually use quantitative research approach, qualitative research approach was an appropriate choice for this study as little is known about this topic and there is dearth of research and literature on reasonable accommodations in mental health in South Africa. The qualitative research approach also enabled the researcher to obtain detailed explanation of the participants' experiences and knowledge on reasonable accommodation for employees with MDD, which provided to be rich data that will contribute to the profession of occupational therapy.

An explorative descriptive contextual design was used. The researcher was able to explore the limited information on reasonable accommodations. The details of lack of research and limited information were described through the how and when question. The context was adjusted from the initial plan due to COVID19 lockdown regulations as the interviews were conducted virtually. The researcher was dependent on the information provided by the participants regarding their context as opposed to the researcher being in the participant's natural setting to make observations and to take field notes as initially planned.

6.3.2. Recruitment of participants

Purposive sampling helped the researcher to select participants that were knowledgeable about the topic of reasonable accommodation since they mostly worked in the field of mental health and or vocational rehabilitation. The participants provided useful information which was beneficial to the study as they were knowledgeable and experienced. Snowball sampling made the recruitment easier as the participants suggested their trusted colleagues in the same field of practice.

6.3.3. Data collection

Semi-structured individual interviews were used. The researcher had planned to conduct face-to-face interviews, however, due to the COVID19 pandemic, changes needed to be made and interviews were conducted virtually. This affected the element of observation that could have been made in their specific occupational therapy practice. The actual occupational therapy practice would have allowed the researcher to take field notes and make observations regarding the practices of occupational therapists. The fact that the interview was semi-structured, allowed flexibility of questioning and probing. The probing questions enabled the researcher to extract more and richer data from the participants as the follow-up questions were influenced by what the participants would say. The probing questions also enabled the researcher to know what direction of interviewing to take and what questions to ask subsequent participants.

The researcher's role as interviewer was a positive element as she worked in both the field of mental health and vocational rehabilitation. However, this experience brought a lot of challenge to the researcher, necessitating that she brackets herself by not imposing her knowledge, attitude, practice and experience on the participants as the researcher worked in the field being researched. The researcher also possessed interview skills as she had previously conducted regular interviews with patients and employers in her practice.

The duration of each interview was scheduled for 90 minutes, which was reasonable as it allowed the researcher to build rapport. It also helped the participants to relax. Rich data was extracted from the participants. Trustworthiness was achieved as there was prolonged engagement which allowed credibility. Consistent use of semi-structured interview ensured dependability and the open-ended questions during the interview guaranteed authenticity of the study.

6.3.4. Data analysis

Bottom-up approach was employed during thematic analysis of data. The researcher followed Creswell's steps of data analysis. Data analysis according to Creswell[42] has credibility if it is well researched and used. The steps that are developed by Creswell assisted in providing structure for data analysis and guided the use of data to create themes. Data analysis was relatively easy as the researcher had conducted the interviews herself. However, going through each transcript required sufficient time and place without distractions, which was not always easy given that the researcher also ran a private practice and had young children to look after. While there were challenges, data analysis provided vast knowledge for the researcher, empowering her to practice better and with confidence in the field of mental health and vocational rehabilitation which she worked in.

6.4. CONTRIBUTION OF THE STUDY

The anticipated contribution of the results of this study is discussed under subheadings of occupational therapy profession, workplace, and education and training below.

6.4.1. Occupational therapy profession

- Occupational therapists will be aware that when facilitating reasonable accommodation, they must not do it alone. They need to involve other stakeholders

such as employees, team leaders or supervisors or managers, human resource practitioners, union representatives, occupational health doctors, occupational health nurses, health and wellness practitioners, and group insurers. Reasonable accommodation needs to be facilitated collaboratively with other stakeholders.

- The dynamic process of reasonable accommodation that was developed in this study provides a guideline for occupational therapists to follow when facilitating reasonable accommodations. The dynamic process of reasonable accommodation is outlined in Figure 6.1 below.

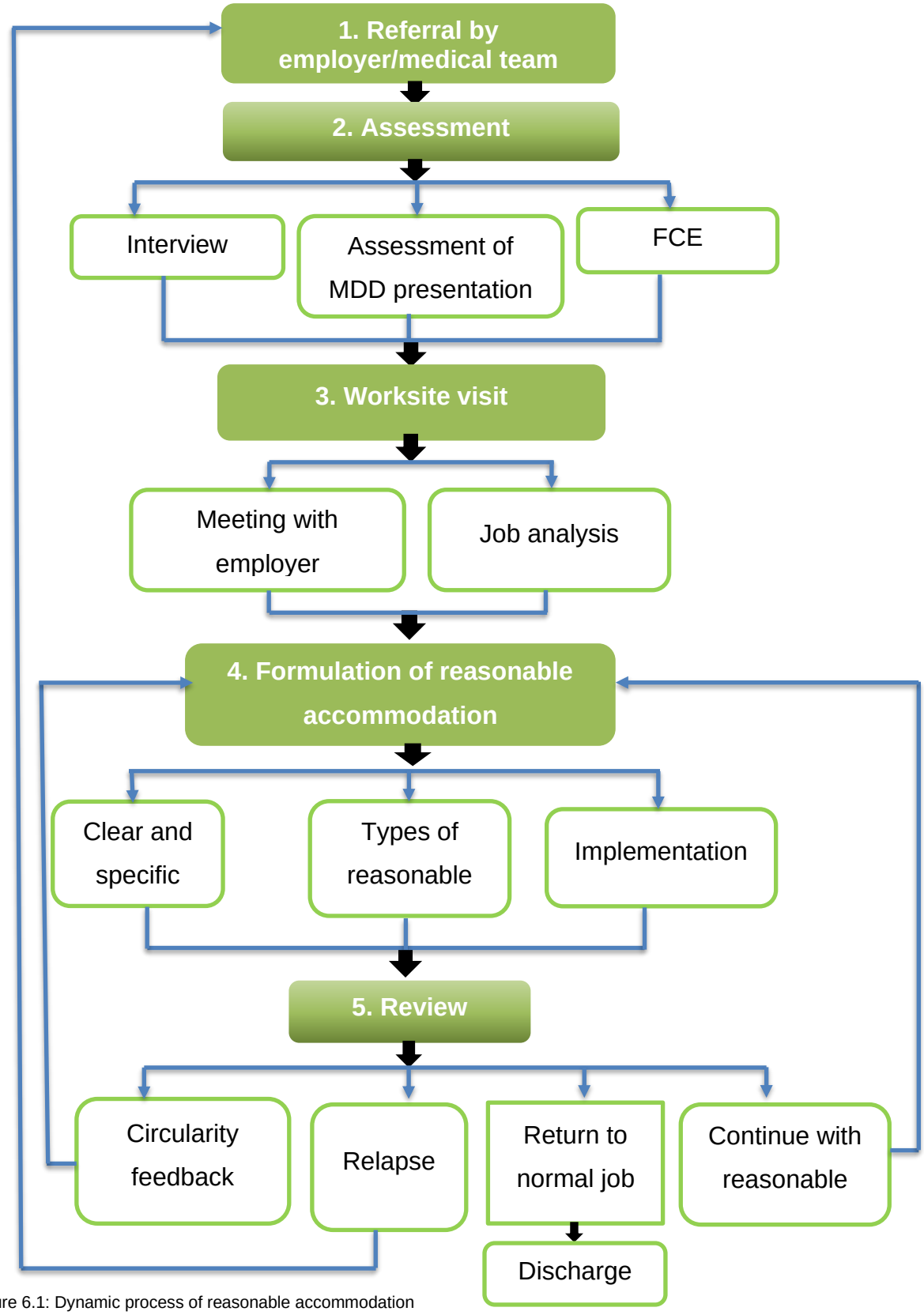

Figure 6.1: Dynamic process of reasonable accommodation

- Specific reasonable accommodations applicable to employees with MDD that were reported might serve as a resource for occupational therapists when formulating reasonable accommodation for their patients who are employed and are diagnosed with MDD. The possible specific reasonable accommodations for employees with MDD are: acquiring new equipment (e.g. noise cancellations headphones) or adjusting environment, graded return-to-work (few days a week, half a day for example), restructuring job functions (only key job functions, reduced workload capacity), adjusting working time and leave (flexi hours, office hours instead of shift hours), allowing time off for treatment and providing specialised supervision, training and support.

- Occupational therapists are warned of possible challenges of reasonable accommodation such as comorbidity, employees' narrative on socioeconomic status and uninterested employer, and inadequate undergraduate training. Awareness of these challenges might enable the occupational therapists to be mindful of them and empower themselves through capacity building.

- Occupational therapists should emphasise and pay more attention to the occupational therapists' application of legislation, understanding the work environment of employees with MDD and ensuring that the reasonable accommodation is reasonable for the success of envisaged reasonable accommodation.

- Proficiencies that are essential for occupational therapists are: staying abreast latest knowledge and practice (on the cutting edge), developing professional skills and professional behaviour. Different platforms such as mentoring, interest groups, continuing professional development courses, postgraduate courses, webinars and forums are encouraged for occupational therapists to capacitate themselves in order to gain necessary knowledge and skills in the field of mental health and vocational rehabilitation.

- Literature was used to support the findings as discussed in chapter five. Internationally, occupational therapists are just part of the team of reasonable accommodations and in some instances, they do not even form part of it. This study has highlighted the significance of the role of occupational therapists in the process of reasonable accommodation and identified them as the main drivers of reasonable accommodation in South Africa. As such, this study adds knowledge in the practice of occupational therapy.

6.4.2. Workplace

- Occupational therapists should ensure that they recommend reasonable accommodations that are clear and specific, feasible, sustainable and reasonable for the employer and employee. These kinds of reasonable accommodations will provide knowledge for employers on the reasonable accommodations applicable to employees with MDD. Literature has shown that some of the employers do not know where to start when it comes to reasonable accommodations. Therefore, the collaborative approach that is steered by the occupational therapists and other stakeholders including the employer, should serve as a platform to educate the employer on reasonable accommodations.

- As occupational therapists will be recommending reasonable accommodations that are reasonable, clear and specific as well as employee tailored, the researcher assumes that the chances of the employer implementing those recommendations might increase.

- Implementation of reasonable accommodation will improve employee's performance as it removes the barriers that affect employee's performance negatively. It will also decrease costs to the employer of terminating employment of the current employee and undertaking the process of appointing a new employee. The cost to the employer caused by absenteeism and presenteeism can be reduced

through implementation of reasonable accommodations. South Africa provides social grants for people with disabilities, so implementing reasonable accommodations for employees with MDD will reduce the economic burden on the country as they might continue in employment, receiving a salary. Furthermore, it might address the EEA strategy of encouraging employment for people with disabilities.

- The employers might be able to meet their obligation of having a certain percentage of employees with disabilities within their company as required by law (EEA) through the implementation of reasonable accommodation instead of terminating employment of persons with MDD.

- MDD is regarded as short-term mental disability. Returning employees with MDD to work through implementation of reasonable accommodations might contribute towards the reduction of unemployment rate amongst people with disabilities.

6.4.3. Education and training

- Consideration of curriculum review in undergraduate training is vital as more exposure to workplace environment during clinical block of vocational rehabilitation was advised. Universities can form relationships and partnerships with vocational rehabilitation centres in their areas to place their students during the clinical block which focuses on work practice. The universities can also work with tertiary hospitals to have a fully functioning vocational rehabilitation unit where they can also place students for their clinical block.

- Emphasis and details on various laws relating to workplace, people with disabilities, mental health and protection of information should become part of the undergraduate and postgraduate training.

6.5. Evaluation of the study

The strengths and limitations of the study are discussed below.

6.5.1. Strengths of the study

- To the best of the researcher's knowledge, this study is the first of its kind in South Africa that looks at reasonable accommodation in the profession of occupational therapy and might add a significant contribution to the occupational therapy profession.

- The participants involved were experienced occupational therapists in the field of mental health and or vocational rehabilitation, which provided data that can add value to the occupational therapy profession.

- The researcher was the interviewer which enabled her to steer the interview in the necessary direction that yielded rich data to answer the research objectives. She also possessed interviewing skills through the experience of working in the field of mental health and acquisition of a postgraduate diploma in vocational rehabilitation. She had additional experience in the field of vocational rehabilitation that was the subject of enquiry. The researcher was familiar with concepts explored during the interview, making it easier to identify what had been answered and what had not. Data analysis was also relatively easy because the researcher was involved throughout the whole process.

- Data saturation was reached with seven participants, which indicates that the interview guide was well developed.

- The interview guide and process of the interview were piloted. Piloting the interview guide assisted the researcher to rephrase a question that was ambiguous and remove tone that was not necessary from the interview guide. Interviewing during

the pilot study reduced the anxiety of the researcher and built her confidence in conducting successful research interviews.

- Themes were generated by the researcher during data analysis, and two independent coders also analysed data and came up with their themes. The researcher met with the independent coders individually and consensus was met. Themes were then sent back to participants for member checking. Finally, discussion with the supervisors on final themes was done. This way, credibility and conformability under measures of trustworthiness were achieved.

- All objectives of the study were answered as discussed in subsection 6.2.2.

6.5.2. Limitations of the study

- Interviews were conducted virtually. This placed a data cost for online connectivity on the participants, which could have been eliminated if the interviews had been face-to-face. Furthermore, lack of physical contact created a barrier which affected flow of interaction during the interview. The researcher was unable to take field notes and make observations of the participants' practice.

- The study focused on participants practising in Gauteng. The study does not allow for generalisation of findings due to its qualitative nature.

- Only knowledge, attitudes and practices of occupational therapists were researched. The other stakeholders involved in the process of reasonable accommodation were not included in the study and their views are missing. The other stakeholders were excluded from the study to shorten it for the purpose of a master's degree as advised by the study supervisors.

- The study focused on facilitating reasonable accommodation for employees with MDD only. It will be interesting to consider facilitation of reasonable accommodation for employees with other diagnoses in DSM-5 such as bipolar mood disorder and generalised anxiety disorder to see what would be the results. Other mental healthcare disorders to consider in DSM-V include post-traumatic stress disorder, schizophrenia and psychosis.

6.6. RESEARCHER'S PERSONAL REFLECTIONS

The researcher's personal reflections are discussed below.

6.6.1. Challenges of the research journey

- COVID19 pandemic that brought about lockdown restrictions just two months after the researcher had registered for the second year of her Master's degree caused a huge challenge in employing new methods of data collection that one had not anticipated, changing the original plan to online interviews. The anxieties that Covid 19 engendered created difficulties in getting willing participants who were also battling with making adjustments in how they conducted their practice and life.

- Although there were internet network challenges during one of the interviews, the participant was very patient and continued to participate in the study.

- Adult learning is a huge hurdle on its own. The researcher had to balance family, her practice, spirituality and the study. This required time management of the highest calibre. The researcher found it difficult to apply work-life balance techniques that she taught her patients.

- The use of technology was challenging. The researcher had to learn to record the interviews online and send the recordings to the transcriber on google drive. She learnt how to do some of these things step by step, with the transcriber telephonically assisting.

6.6.2. Benefits of embarking on the study

- The researcher was exposed use of technology more than one would under normal circumstances. There were several challenges that came with the use of technology and every hurdle cleared came with a sense of victory and learning. The hurdles included scheduling and responding to online invitations, conducting the interviews online, navigating endnote and technical use of Microsoft Word programme.

- Choosing qualitative approach for this research enabled the researcher to read intensively on qualitative approach which increased her knowledge in qualitative research methodology.

- Pilot study is commonly used in quantitative studies. In this present study however, the researcher used it in the quantitative component. It was relatively challenging as it required extensive reading and appropriate integration with the qualitative part. The researcher learned that pilot study can be used in both the qualitative and quantitative studies.

- The researcher gained tremendous knowledge on the importance of collaboration with other stakeholders during reasonable accommodation to ensure its success. Secondly, the dynamic process of reasonable accommodation in Figure 5.1 of this study might be followed for reasonable accommodation. Furthermore, taking of minutes during the meeting with stakeholders which serves as a contract, was edifying to the researcher because of its benefits.

- The researcher appreciated that as an occupational therapist, she had to make sure that any reasonable accommodations recommended might be implemented if reasonable accommodations were clear and specific, sustainable, feasible and reasonable for both the employer and employee.

- The occupational therapy department of University of Pretoria collaborated with department of Psychiatry in the supervision of this study. This provided supportive, unique and relevant guidance to the researcher.

- The researcher learned that return-to-work is not only a medical phenomenon but also economical as return-to -work contributes towards the economics of companies as well as of the country.

- While the legislation makes provision for reasonable accommodations, the researcher learned that occupational therapists carry a lot of responsibility in the success of recommended reasonable accommodations through the manner in which they are formulated.

6.7. RECOMMENDATIONS

The outcomes of the study brought about the recommendations that will be discussed below.

6.7.1. Recommendations for future studies

During data analysis, literature review and writing up of the chapters, the following studies might be needed in the near future:

- A similar qualitative study which focuses on the voices of other stakeholders (employee, human resource, employer, occupational health doctor) might be beneficial.

- A similar qualitative (explorative descriptive and contextual design) study for employees with bipolar mood disorder and generalised anxiety disorder might be needed. The estimated global prevalence of bipolar mood disorder ranges between 0.6% and 1.6%[233-234], and 5.3% to 10.4%[235] for anxiety disorder making these diagnoses significant.

- A quantitative study may be needed to determine the effectiveness of the newly developed dynamic process of reasonable accommodation (refer to Figure 5.1.

- A mixed method study comparing the work module for undergraduate training and postgraduate training with regard to knowledge and skill in facilitating reasonable accommodations will be of benefit.

- A survey study with occupational therapists to establish their understanding and knowledge of reasonable accommodations is also a possibility.

- A quantitative study to ascertain whether reasonable accommodations recommended by occupational therapists for employees with disabilities and their benefits are implemented by the employer or workplace can be carried out.

- A mixed method study to investigate which of the reasonable accommodations recommended by occupational therapists are found to be reasonable or not reasonable by employers, will be beneficial.

6.8. FINAL CONCLUSION

Rich data was collected which answered the aim and objectives of the study and was presented in different chapters. This last chapter critiqued the study, highlighted its contribution to the profession of occupational therapy, workplace and education and training. It also gave the researcher's personal reflections. Recommendations on future research were made.

The study found that an integral part of collaborative approach during facilitation of reasonable accommodation includes occupational therapists as they are best suited to lead the process. Stakeholders such as employee, manager, human resource practitioner, union representative, occupational health doctor, health and wellness practitioner and group insurer are part of the collaborative approach. Reasonable accommodation is an important legal provision that might enable employees with MDD to return to work. Occupational therapists need to be cognisant of the factors that enable successful reasonable accommodations. There are challenges of reasonable accommodation that can nonetheless be overcome if an occupational therapist is aware of them. In order to facilitate reasonable accommodation effectively, occupational therapists must stay abreast latest knowledge and practice (on the cutting edge), possess relevant skills, display professional behaviour and manage cases.

While there are limitations of the study including non-generalisation of the results, these results are considered to be significant in adding knowledge regarding facilitation of reasonable accommodation in the profession of occupational therapy, especially for those practising in mental health, vocational rehabilitation and treating employees with MDD. Furthermore, the findings of this study might serve as a guide to assist occupational therapists who facilitate reasonable accommodation for employees with MDD.

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ANNEXURES

ANNEXURE A: Informed consent form

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT FOR AN INDIVIDUAL SEMI-STRUCTURED INTERVIEW RESEARCH STUDY

Study title: Occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder

Principal Investigator: Mpho Silvia Ramano

Supervisor: Mrs Tania Buys

Co-supervisor: Prof C Kortze

Institution: University of Pretoria

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime number/s: Researcher: 072 503 5630

Supervisor: 083 407 8463

Afterhours number: Researcher: 072 503 5630

Supervisor: 083 407 8463

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

				:
date	**Month**	**year**		**Time**

Dear Prospective Participant

Dear Mr. / Mrs. .....……..

1) INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for Master's degree in OT at the University of Pretoria. This document gives information about the study to help you decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about what we will be discussing during the interview.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe the occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodations for employees with major depressive disorder.

By doing so I wish to learn more about reasonable accommodation for employees with MDD
You will be interviewed by the researcher in a place that is private and easy for you to reach.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM THE PARTICIPANTS

If you agree to participate, you will be asked to participate in an individual interview which will take about 60-90minutes. The individual interview will be a one-on-one meeting between the two of us. I will ask you several questions about the research topic.
With your permission, the interview will be recorded on a recording device which will be password protected to ensure that no information is missed.

4) RISKS AND DISCOMFORTS INVOLVED?

We do not think that taking part in the study will cause any physical or emotional discomfort or risk. There is no possible risk and discomfort involved. The participant may not answer a question that makes them feel uncomfortable.

5) POSSIBLE BENEFITS OF THE STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand the knowledge, attitudes and practices when facilitating reasonable accommodations for employees with MDD.

The information you give may help the researcher improve her knowledge of reasonable accommodations necessary for employees with major depressive disorder.

6) COMPENSATION

You will not be paid to take part in the study.

7) VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way.

8) ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee.

9) INFORMATION ON WHO TO CONTACT

If you have any questions about this study, you should contact:

Mpho Ramano at 0725035630

Tania Buys at 083 407 8463

10) CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not be possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All of these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All hard copy information will be kept in a locked facility at department of OT at the University of Pretoria, for a minimum of 15 years and only the research team will have access to this information.

11) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.
- I provide permission for the audio-recording of the interview.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to stop taking part in the study and my withdrawal will not affect my treatment and care.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

Participant's name (Please print)	Date
Participant's signature	Date
Researcher's name (Please print)	Date
Researcher's signature	Date

ANNEXURE B: Demographic data

Mark **X** in the appropriate block

Age in years: _____

Qualifications:

BOccTher		DVR		MOccTher		PhD		Certificate in …….		Others: …….	

Areas of interest:

Vocational rehabilitation		Mental Health		Others:	

Years of experience as an occupational therapist:

5-10		11-15		16-20		21-25		26-30		31-35		36+	

Years of experience in mental health and/or vocational rehabilitation:

3-5		6-10		11-15		16-20		21-25		26-30		31+	

Area of work:

- ☐ Pretoria
- ☐ Johannesburg

Other: Specify_____

ANNEXURE C1: Interview Guide draft

Knowledge

1. What are the possible symptoms of MDD that might require one to recommend reasonable accommodation?

Probing: How would these symptoms affect the employee's functioning at work?

2. What does reasonable accommodation mean to you?

Probing: When do you facilitate reasonable accommodation for employees with MDD, what information do you give to the employer?

3. From your experience, how do you ensure that your facilitation of reasonable accommodations becomes a success?

4. Where did you learn about reasonable accommodations?

Probing: What knowledge needs to be applied in facilitating reasonable accommodation for employees with MDD?

What would you say about your undergraduate training regarding reasonable accommodation?

5. When you recommend reasonable accommodation which legislation guides you?

Probing: How does it guide you?

Attitudes

6. What is your feeling about the OT's role with regards to reasonable accommodation?

7. What encourages you during the process of reasonable accommodations for employees with MDD?

Probing: Is there anything that discourages you during the process of reasonable accommodations for employees with MDD?

Practice

8. Which process do you follow when facilitating reasonable accommodations for employees with MDD?

9. In that process you followed, what do you think made your recommendations of reasonable accommodations successful?

Probing: what pointers do you use to determine the success of reasonable accommodations?

10. Which skills are needed to ensure success when facilitating reasonable accommodations for employees with MDD?

Closing questions

10. What do you think is missing in the OT profession with regards to facilitating reasonable accommodations for employees with MDD?

11. What do you think is needed to improve the knowledge of Occupational therapists during facilitation of reasonable accommodations for employees with MDD?

12. What more information is needed in improving the profession of occupational therapy with regards to reasonable accommodations for employees with MDD?

Note: The researcher will make use of motivational probes such as; can you explain more? Tell me more, how so, why is that, how come to prompt the participants where necessary .

The participants will be reassured of confidentiality.

ANNEXURE C: Interview Guide

The structure of interview guide by De Vos, Strydom, Fouche and Delport (2011) was followed to develop the interview questions. The phrasing and/or the probing questions will be guided by the flow of the interview.

Introduction

Firstly, the researcher will start by introducing herself to the participant. Secondly, the researcher will briefly explain the purpose of the research. Lastly the researcher will request the participant's permission to participate in the study.

Knowledge

1. What are the possible symptoms of MDD that might require one to recommend reasonable accommodation?

Probing: How would these symptoms affect the employee's functioning at work?

2. What does reasonable accommodation mean to you?

Probing: When do you facilitate reasonable accommodation for employees with MDD, what information do you give to the employer?

3. From your experience, how do you ensure that your facilitation of reasonable accommodations becomes a success?

4. Where did you learn about reasonable accommodations?

Probing: What knowledge needs to be applied in facilitating reasonable accommodation for employees with MDD?

5. When you recommend reasonable accommodation which legislation guides you?

Probing: How does it guide you?

Attitudes

6. What is your feeling about the OT's role with regards to reasonable accommodation?

7. What encourages you during the process of reasonable accommodations for employees with MDD?

Probing: Is there anything that discourages you during the process of reasonable accommodations for employees with MDD?

Practice

8. Which process do you follow when facilitating reasonable accommodations for employees with MDD?

9. When do you think you were successful during the process of facilitating reasonable accommodations for employees with MDD?

Probing: Which skills are needed to ensure success when facilitating reasonable accommodations for employees with MDD?

Closing questions

10. What do you think is missing in the OT profession with regards to facilitating reasonable accommodations for employees with MDD?

11. What do you think is needed to improve the knowledge of Occupational therapists during facilitation of reasonable accommodations for employees with MDD?

12. What more information is needed in improving the profession of occupational therapy with regards to reasonable accommodations for employees with MDD?

Note: The researcher will make use of motivational probes such as; can you explain more? Tell me more, how so, why is that, how come to prompt the participants where necessary.

The participants will be reassured of confidentiality.

ANNEXURE D: Confidentiality Agreement for Transcription Services

I_____,
transcriber, agree to maintain full confidentiality and non-disclosure with regards to all of the audio recordings, transcriptions and research documentation received from Mpho Ramano related to her masters research at the University of the Pretoria titled " *0ccupational therapists knowledge, attitudes and practices when facilitating reasonable accommodations for employees with major depressive disorder*". By signing this document, I agree to:

1. To keep all research information shared with me confidential, by not discussing or sharing the research information in any format with anyone other than the researcher, Mpho Ramano.
2. To maintain strictest confidence, the identification of any research participant as well as the university with whom the participant is affiliated which may become known during the transcriptions process.
3. To not disclose the content of the interviews which will be revealed during the transcription process to anyone.
4. To not make copies of the audio recordings, transcriptions and research documents other than those provided by and to, the researcher, Mpho Ramano.
5. To store all audio recordings in a safe and secure location during the entire transcription process.
6. To keep the transcriptions and audio recordings in a pass word protected file and computer.
7. To return all audio recordings and research related documentation to the researcher, Mpho Ramano as soon as the transcriptions are completed.
8. To delete all electronic files containing research data from my computer, lap top, tablet, hard drive and any other back up devices on completion of the transcriptions and after consulting with the researcher, Mpho Ramano.

Transcriber's full name: _____
Signature: _____
Date: _____

Researcher's full name: Mpho Silvia Ramano
Signature:
Date:

ANNEXURE E: Ethics certificate

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

30 July 2020

Approval Certificate

New Application

Ethics Reference No.: 444/2020

Title: Occupational therapists' knowledge, attitudes and practices in facilitating reasonable accommodation for employees with major depressive disorder

Dear Mrs MS Ramano

The **New Application** as supported by documents received between 2020-06-26 and 2020-07-29 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2020-07-29 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2021-07-30.
- Please remember to use your protocol number (444/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Dr R Sommers

MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of
Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African
Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Announcement and instruction to all researchers from the Faculty of Health Sciences Research Ethics Committee

This is an update following previous instructions from the Research Ethics Committee, accounting for recent announcements by government in relation to COVID-19 on 24 May 2020.

All researchers must minimise the risk of transmission at research sites and in studies involving human participants approved by the Research Ethics Committee. To this end,

1) all non-therapeutic or non-interventional research data gathering involving contact with human participants remain suspended, with the exception of studies involving telephonic or other online/remote methods of data collection;
2) research that is entirely situated in a laboratory is permitted provided that COVID-19 precautionary measures are in place;
3) research that is merely utilising existing records or data is permitted provided that COVID-19 precautionary measures are in place
4) emergency research related to COVID-19 is permitted after ethics approval;
5) everyone should endeavour protecting research participants, personnel and students in reducing the risk of transmission of COVID-19.

For therapeutic and clinical research trials:

1) each research study or study site must maintain a plan to minimise exposure to COVID-19 risk for all parties involved in the study, including but not limited to research participants, researchers and student researchers;
2) Whenever feasible, in-person visits should be substituted with telephonic visits;
3) Principal investigators and study sites should maintain measures to ensure that there is no interruption of required medication/essential treatment and monitoring of adverse events;
4) Researchers and study sites should develop a 'COVID-19' template register in case retrospective contact tracing becomes necessary;
5) New enrolments into clinical trials remain suspended. Potential exceptions to this announcement should be discussed with the chair or a deputy chair of the REC;
6) Serious adverse events at an UP-site should be reported on the PeopleSoft system within 72 hours as usual.