

What works: Health and care interventions to support people from disadvantaged backgrounds in returning to work

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EVIDENCE BRIEF

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Summary

Employment, while being a marker of economic growth and productivity, is also a wider determinant of health. Disadvantaged groups have higher rates of work-limiting conditions which is compounded by poorer access to health and care interventions. Return to work (RTW) interventions seek to address long-term work or sickness absence, but whether they achieve equitable outcomes is unclear.

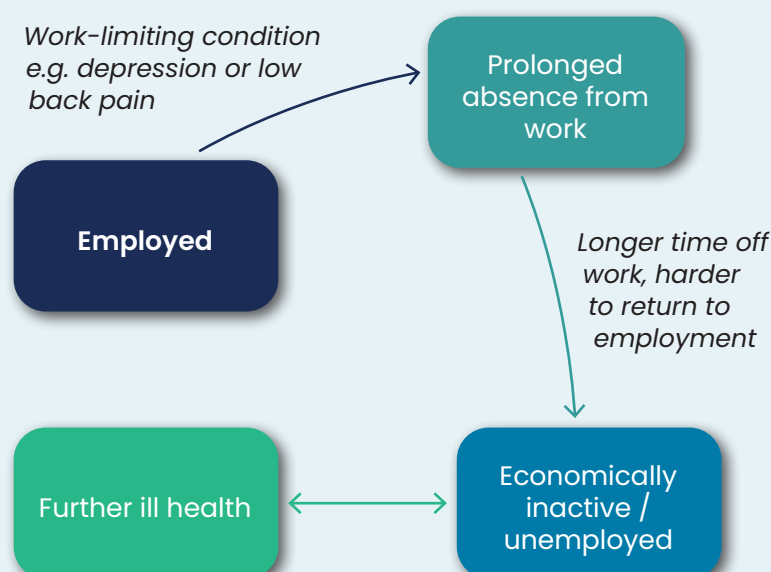
We reviewed evidence across 57 studies to determine health and care interventions that support people from disadvantaged backgrounds return to employment. RTW interventions varied in both design and target population and rarely sought to address the needs of disadvantaged groups. Generally, effective interventions were multicomponent, multidisciplinary, involved the workplace, and for some conditions, were individualised. Based on the evidence, to optimise RTW for disadvantaged groups, programmes should be:

1. Holistic and adapted using the biopsychosocial model, tailored approaches, and cultural sensitivity.
2. Multicomponent with collaboration between health services and the workplace, advocacy for reasonable adjustments, and work-focused psychological therapies.
3. Multidisciplinary with RTW coordinators and referral to non-health care services such as supported employment.

Current challenges

Decades of research has proven the correlation between employment and better health outcomes. UK studies have found higher rates of self-reported poor health and mental wellbeing in economically inactive and precariously employed people compared to those fully-employed (1,2). A comparative study across 34 European countries including the UK showed that unemployment is associated with poorer health for both men and women, regardless of national welfare provision (3).

Figure 1: Relationship between ill health and economic inactivity



Economic inactivity rates in the UK have been slowly declining in the last decade, with 21.7% of people aged 16 to 64 being economically inactive as of August to October 2024 (4). Results from the 2022 Annual Population Survey revealed that Pakistani and Bangladeshi ethnic groups combined had the highest rate of economic inactivity (33%) (5), possibly explained by higher prevalences of work-limiting conditions seen in these groups (6). Furthermore, data from the 2024 Labour Force Survey revealed that people with Multiple/Mixed ethnicity, as well as Pakistani and Bangladeshi ethnicities, had higher rates of unemployment compared to other ethnic groups (Figure 2) (6), despite unemployment rates being the lowest they have been since the COVID-19 pandemic (7).

Women and men from the most deprived areas also suffer from lower healthy life expectancy rates and higher rates of economic inactivity compared to their least deprived counterparts (8) (Figure 3). Women in the UK also have higher rates of sickness absence, and evidence shows that the longer an employee's sickness absence lasts, the less likely they are to return to work (9–11).

Definitions

Return to work: The process by which an individual is supported towards full recovery to recommence employment. It typically reflects a person re-entering the workforce after a period of work or sickness absence.

Working-age population: Those aged 16 to 64 years old.

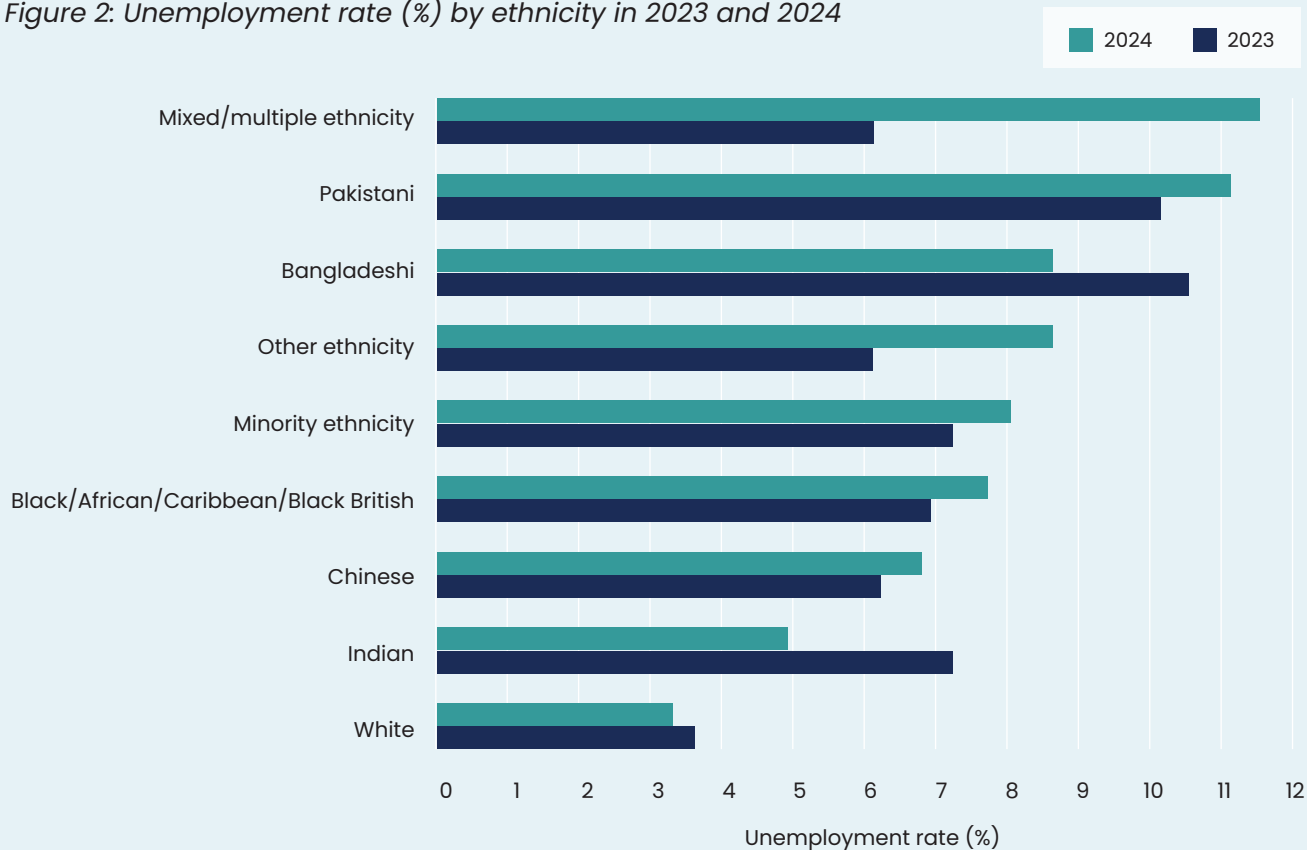
Unemployment: People without a job, who have been actively seeking work in the past four weeks and are available to start work in the next two weeks. Or people out of work who have found a job and are waiting to start it in the next two weeks.

Economically inactive: People not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two months.

Long-term health condition: A condition that lasts for 12 months or more.

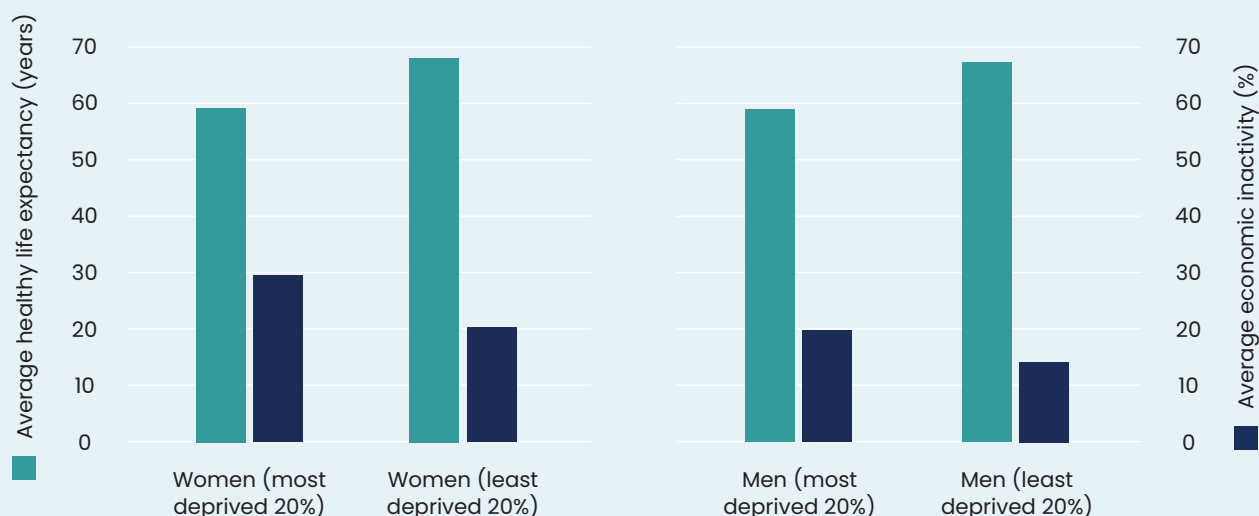
Source: Office for National Statistics

Figure 2: Unemployment rate (%) by ethnicity in 2023 and 2024



Source: Office of National Statistics – A09: Labour Market Status by Ethnic Group

Figure 3: Relationship between economic inactivity and average healthy life expectancy in women and men in England (2018 to 2020)



Source: Health Foundation Analysis using Office for National Statistics, Annual Population Survey, England, Oct 2022–Sep 2023, Ministry of Housing, Communities & Local Government, English Indices of Deprivation, England, 2019, Office for National Statistics, Health state life expectancies, UK, 2018–20

The NHS is the largest employer in the UK. Almost 1 in 20 NHS staff were off work due to sickness absence in August 2024, with the most common reason being mental health reasons, closely followed by back problems and other musculoskeletal problems (12). Mental health accounted for 28.5% of all sickness absence in that time period, increasing from 26.3% the month before (12).

Here, we review the evidence of RTW programmes to support groups disproportionately affected by being out of work. RTW is an outcome measure used to describe the process in which an individual is supported towards full recovery to recommence employment. It typically reflects a person re-entering the workforce after a period of work or sickness absence, though some researchers advocate RTW more broadly include productivity of the employee and the quality and satisfaction of the work (13,14).

Summary of evidence

We prioritised 57 of the most relevant and robust studies from 90 systematic reviews of RTW interventions identified through a search of MEDLINE. Recent evidence shows inequalities in the RTW process for minority ethnic groups (15,16). However, there is a lack of evidence on the underlying reasons for differences in RTW outcomes across characteristics such as age, sex, ethnicity, or levels of socioeconomic deprivation.

Overall, RTW interventions were mostly targeted to people of working-age and with four major conditions: 1) mental health, 2) musculoskeletal (MSK), 3) cancer and 4) brain injury (either acquired through stroke or traumatic). Most studies examined RTW for people with mental health conditions.

There were limited RTW reviews focusing on those with acute complications of long-term chronic conditions (such as post coronary event in the setting of cardiovascular disease, or flare-up of inflammatory bowel disease).

RTW interventions ranged from psychological interventions to physical activity, including workplace and recreational interventions. Interventions were also delivered by professionals from multiple disciplines, ranging from allied health specialists to job coaches hired external to health care settings.

The effectiveness of RTW interventions varied according to condition and context. For example, supported employment interventions appeared to be better suited to people with mental health conditions. Overall, RTW interventions were more

likely to be successful across all population groups if they were, in order of the most supporting evidence: 1) multicomponent, 2) workplace-related, 3) multidisciplinary, and 4) person-centred.

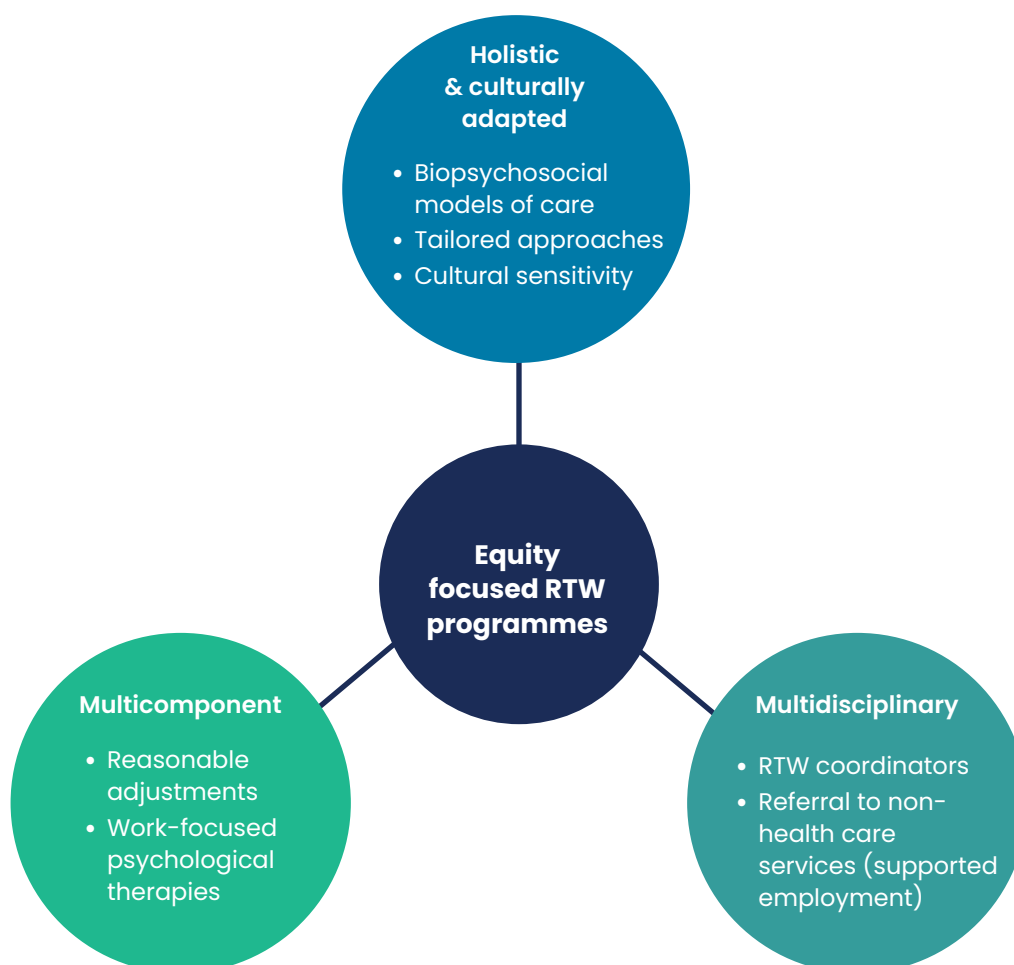
Health care organisations play an important role in supporting people to return to work and there is evidence that early involvement of workplace is essential for successful RTW. A review of 95 studies by the Swedish Agency for Health Technology Assessment (17) looked at health care RTW interventions in the case of long-term sick leave and found that, across both single and multicomponent interventions, those that involved some type of workplace contact or workplace coordination activity had a positive effect on RTW in the short term (12 months), particularly with sick leave associated with mental health or MSK conditions. While the certainty of the evidence was low, it is supported by findings from many reviews that demonstrate that workplace involvement, whether it be through liaising with employers or modifying the workplace, is better for RTW outcomes (18–24).

For the health care setting, we found that RTW programmes worked better for disadvantaged groups if they were:

1. Holistic and culturally adapted, focusing on:
 - Biopsychosocial model of care
 - Tailored approaches
 - Culturally sensitive RTW programmes
2. Multicomponent, focusing on:
 - Reasonable adjustments
 - Work-focused psychological therapies
3. Multidisciplinary, focusing on:
 - RTW coordinators
 - Referral to non-health care services, such as supported employment

In the following paragraphs we discuss these components in greater detail, and we conclude with a summary of cost-effectiveness for some of the interventions discussed.

Figure 4: Effective components of RTW programmes



1. Holistic and culturally adapted RTW programmes

Biopsychosocial model of care

Returning to the workplace is a complex process that requires intervention components to holistically address the clinical, occupational, and psychosocial factors keeping people off work. Ideally, this process should be informed by theoretical models that underpin the value of the interactions between the person and the workplace. Evidence has consistently found that psychosocial factors have an independent effect on RTW outcomes (25) and the biopsychosocial (BPS) model (see definitions box) is widely recognised across reviews to be the most appropriate and effective approach to RTW intervention design, particularly for people with musculoskeletal conditions (26–32). Designing RTW programmes from a BPS perspective is promising for disadvantaged individuals because it is more likely to account for the psychosocial factors these people uniquely experience in their effort to recover and return to work. While we did not find evidence to demonstrate the impact of RTW interventions using the BPS model on disadvantaged groups specifically, we know that acknowledging psychosocial pathways can reduce health inequalities (33).

Definition: Biopsychosocial Model (34)

Initially conceptualised and developed by George Engel in 1977, the biopsychosocial model has been refined over the years to be defined as a model of care that appreciates the complex, circular relationship between mind, body, and environment. The model views health and illness as shaped by psychosocial factors beyond their biomedical explanation (35), incorporating an understanding of how culture, economic status, health literacy, self-efficacy, and beliefs and norms impact health outcomes.

Tailored and person-centred approaches

While the RTW evidence base was mixed regarding the optimal method of delivery for RTW interventions (i.e. individual vs group), researchers emphasised the importance of ensuring at a minimum that interventions are person-centred (34–37). A qualitative review of 97 studies (38) found that patients' needs for work-focused health care covered four themes including a tailored approach. Tailored approaches to RTW included:

flexibility in work-focused health care, attention for the personal situation, inclusion of individual goals, and disease-specific information in relation to work (38).

Two reviews examining RTW in people with acquired brain injury found that tailored, person-centred approaches were often more successful (24,39). A review of 57 studies by Murray and colleagues (39) looking at the use of vocational rehabilitation (VR) found that VR that emphasised tailoring to the individual by considering the interaction between the client, stakeholders, work tasks, and environment was often more successful.

Culturally sensitive RTW programmes

An integrative review augmented with focus groups by Coutu and colleagues explored ethnocultural factors influencing sustainable RTW. The authors found that, first, belonging to a minority ethnic group was associated with cumulative risk factors, such as low educational levels and/or manual work; and second, for people who have recently immigrated, differences between the prevailing workplace culture of the host country and workers' reference points can negatively affect RTW due to miscommunication, trust issues and conflicting values (16). They suggested strategies including the use of a 'cultural humility' model to help promote different cultures without one dominating the other. Cultural humility helps health care workers to recognise structural factors that may compound RTW progress and has been described extensively in Canadian occupational health literature (40,41).

Jetha and colleagues' review (15) looking at racial and ethnic inequities in RTW also suggested anti-racist approaches to work disability management. Anti-racist models of care adopted across all organisational levels, either through staff cultural competency training or meaningful involvement of marginalised groups through leadership, can address structural challenges faced by minority ethnic groups in the RTW process (42).

These findings echo broader evidence suggesting that cultural adaptation is a key component of interventions that can effectively address the needs of disadvantaged groups as demonstrated in detail in our evidence brief: What works to improve access, uptake, and optimisation of behavioural interventions in health care settings to better meet the needs of disadvantaged groups (43). Given that ethnic minorities are more likely to be diagnosed with certain conditions such as prostate cancer (44) or to be diagnosed at a later stage (e.g., ethnic minority women with breast cancer) (45) delivering culturally tailored RTW programmes is necessary to ensure that these programmes will be effective for those who need them the most.

2. Multicomponent RTW interventions

RTW interventions with multiple components appear to better address biopsychosocial factors than single component interventions. For example, Cullen and colleagues (18) looked at the effectiveness of 36 workplace RTW interventions for both mental health and MSK conditions, and found that most effective interventions included the following components: a health-focused work component, service coordination and reasonable adjustments (46). They found that interventions encompassing at least two components were more effective, which is also supported by Nowrouzi and colleagues (47) and Mikkelsen and colleagues (48).

Multicomponent interventions were also effective among people with different conditions, including individuals post road traffic collisions (49) and those with chronic pain (50). Wegrzynek and colleagues (50), across 16 trials, found that multicomponent interventions had more positive effects compared to cognitive behavioural therapy (CBT) or physical treatments alone. In fact, they found that CBT alone sometimes delayed RTW for some chronic pain sufferers compared to treatment as usual. Similar findings of combining RTW methods were also found in Hult and colleagues' review (51) regarding health-improving interventions to increase employment in job seekers.

Multiple complementary reviews examining RTW interventions for people living with or recovering from cancer also found that multicomponent interventions were more likely to be effective (52–54). De Boer and colleagues (52) reviewed 15 RCTs looking at psycho-educational, vocational, physical or multicomponent interventions in participants mostly with breast or prostate cancer. They found that both physical and multicomponent interventions were more effective. Their review suggested that multicomponent interventions are likely to help between 69 and 219 per 1000 people with cancer return to work. Cocchiara and colleagues' umbrella review (53) focusing on RTW programmes for people with breast cancer also found more positive effects in interventions that combined physical activity, counselling and education, and addressed modifiable environmental factors.

Reasonable adjustments

Reasonable adjustments include modifications to the workplace that allow for a safer and more sustainable RTW (46). An example of a reasonable adjustment is having graded or paced RTW, a type of stepped approach to workplace integration or contact. Mikkelsen and colleagues (48), across 42

RCTs that studied RTW in sick-listed workers due to common mental disorders, stress-related disorders, and other mental health conditions, found moderate evidence for graded RTW compared to standard programmes and therapy alone. Timing and length of interventions did not change the size of effect, and the population group that benefited the most were employees on sickness absence due to stress. Similarly, a study by Cochrane and colleagues (55) suggested that a stepped care approach may be more effective than usual care in facilitating RTW in employees with MSK pain.

Health care professionals can advocate for reasonable adjustments, predominantly through written reports. While it is not a doctor's role to give advice on the law and define workload concepts within disability, a doctor can comment on the ease or otherwise with which the person they are treating carries out their day-to-day activities that can then inform paced approaches to return to work (56). Furthermore, recent legislation has expanded the scope of health professionals able to certify fit notes (57). Referring patients to specialist occupational health assessments performed independently may also be valuable (56,58).

Work-focused psychological therapies

Severe mental illness is higher in more socioeconomically disadvantaged areas (59). Furthermore, there are known inequalities to both mental health access and quality of mental health care for disadvantaged groups (60). Therefore, mental health interventions targeted at socioeconomically disadvantaged areas are more likely to support disadvantaged groups.

There is some evidence that adapting psychological therapies, such as CBT and counselling, to be more work-focused improved RTW outcomes compared to standard programmes. Several reviews (21,61–65) focusing on working-age people with mental health conditions found such adaptation beneficial. For example, Slater and colleagues (61) assessed the effectiveness of work-focused CBT (W-CBT) in facilitating RTW, and across 23 studies found that it was effective particularly with mild to moderate mental health conditions. W-CBT was defined as CBT that is delivered with 'an understanding of RTW as the goal', with components that are always framed 'by matters, subjects and contexts related to work' (61). Brämberg and colleagues (64) also found the same results across 11 European studies (including 8 RCTs) in workers on sick leave due to mental health problems. Their findings showed that W-CBT resulted in increased or faster return to work compared with standard care or no intervention.

Delivering work-focused psychological therapies to areas known to be linked with higher prevalences of mental health conditions may increase access and improve RTW outcomes by targeting service delivery to at-risk populations.

3. Multidisciplinary care

Interventions involving multiple disciplines, both within and outside health and care, were more successful in returning people to work. Evidence consistently shows that multidisciplinary health care teams improve outcomes (66). Multidisciplinary care is particularly effective and relevant for disadvantaged groups because of multiple compounding BPS issues (67), so the addition of team roles such as a care coordinator, social worker or community health worker can better address these issues (68,69).

Programmes in the reviewed evidence include a diverse range of professionals, from occupational therapists (OTs) to psychiatrists, as well as non-healthcare roles such as vocational counsellors and job coaches. While it is difficult to determine the isolated impact of a single discipline, RTW outcomes generally improved when employees were provided with coordinated, holistic multidisciplinary care (18,19,65,70). The health and care disciplines most involved in returning people to work which showed positive effects included physiotherapists, OTs, and psychologists (47–50,53,62,70–75). Rehabilitation specialists were also present for more complex conditions, such as stroke (39,76,77).

Verhoef and colleagues (70) looked at the effectiveness of 30 multicomponent vocational rehabilitation interventions for workers with chronic physical conditions (excluding chronic back pain), such as rheumatic diseases, musculoskeletal disorders and HIV. They found half applied a monodisciplinary approach and the other half used a multidisciplinary approach, with more high-quality trials showing positive impacts on work status for multidisciplinary programmes. Bernaers and colleagues (20) exclusively studied multidisciplinary interventions (including health professionals from at least two different disciplines) for subacute low back pain, and found that interventions resulted in fewer days of work absence or sick leave, while having benefits in terms of improved pain and functional status in the short term. However, they did not increase the rate at which people returned to work fully, without limitation from pain.

RTW coordinators: providing coordinated care and advocacy

Dol and colleagues (78) systematically reviewed the impact of RTW coordinators on the RTW process for multiple work-limiting conditions, ranging from psychological to MSK conditions. According to the Dol's review (78), RTW coordinators often have titles such as case managers, disability prevention specialists, or rehabilitation counsellors. They found strong evidence across 14 studies that sickness absence was reduced in duration when employees were given opportunity to have face-to-face contact with a RTW coordinator. Interventions that included training of RTW coordinators along with other key intervention aspects, such as RTW coordinators developing a RTW plan, also had moderate impact on reducing work absence (78). RTW coordinators may also improve integration between health care teams and help promote cultural sensitivity, alongside having specialised knowledge about workplace processes.

A qualitative review by Hajendijk and colleagues (38) also found the importance of a 'clear and continuous process' focusing on early access to support, continuity in support, interdisciplinary teamwork and coordination, and information about rights and regulations – functions that can be provided by a RTW coordinator.

Referral to supported employment and Individual placement support services

Several studies included in our search (79–84) found that non-healthcare interventions, such as supported employment, were highly effective, particularly in working-age people with severe mental health conditions. Supported employment is characterised by a 'place and train' approach that places an individual in a work setting, with most of the intervention provided in that setting to ensure success in the workplace (85). Individual placement support (IPS) is a type of supported employment that is highly structured and involves close integration of occupational and health services (86). Bond and colleagues and de Winter and colleagues (79,80) found IPS to be effective in improving employment outcomes, particularly in young people and in those with severe mental illnesses, such as schizophrenia.

Cost-effectiveness of RTW interventions






Evidence on cost-effectiveness of RTW interventions is in its infancy, with key methodological challenges in part due to various perspectives taken (i.e. health provider versus societal) and huge variability in costs, both direct and indirect. Furthermore, many economic analyses have been undertaken outside the UK which limits the transferability of evidence. The best evidence we found for cost-effectiveness came from two studies (17,87). In a Swedish review (17) of 95 studies, ten looked at cost-effectiveness of healthcare-based RTW interventions for sick leave. The findings showed a small positive effect on return to work (> 5 days relative reduction in one year per person), though the certainty of this was limited. Dewa and colleagues (87) examined the cost-effectiveness of ten RTW interventions for mental illness-related sickness absence and found that it was highly dependent on the subgroup of employees being targeted, with mixed evidence revealing that the more complex the condition is, the less likely it is for the interventions to be cost-effective.




Limitations

The heterogeneity and variable quality of RTW studies meant that we were limited in making definitive conclusions about what interventions were the most effective. Furthermore, a large majority of studies originated from Scandinavian countries or North America which may limit the generalisability of our findings. There is a clear lack of RTW research around some subgroups of the working-age population, particularly those suffering from acute complications of chronic diseases such as cardiovascular disease and inflammatory bowel disease. Most of the RTW literature did not comment on or provide disaggregated data across different groups based on race or ethnicity, and socioeconomic determinants of health. Therefore, the evidence that we present on what works to support disadvantaged groups in returning to work is limited.

What works: key recommendations

The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) framework has been adopted to grade the quality of the evidence and support recommendations.*

Recommendation	Target audience	GRADE certainty
RTW programmes should be informed by the biopsychosocial model of care and adopt a holistic and individualised approach.	NHS England, ICBs, PCNs, Trusts, Occupational health services, community allied health	 Moderate
RTW programmes should be culturally tailored to support people from diverse ethnic and cultural backgrounds.	NHS England, ICBs, PCNs, Trusts, Occupational health services, community allied health and other health disciplines	 Moderate
RTW programmes should be multicomponent, containing at least two or more elements, such as work-focused psychological therapies, reasonable workplace adjustments, co-ordination of care and behavioural interventions.	NHS England, ICBs, PCNs, Trusts, Occupational health services, community allied health and other health disciplines, industry	 Moderate
RTW programmes should consider targeting and delivering their services to populations with work-limiting conditions that are linked with disadvantage, such as severe mental illness.	NHS England, ICBs, PCNs, Trusts, Occupational health services, community allied health and other health disciplines	 Low
RTW programmes should involve multidisciplinary teams, including occupational therapists, psychologists, RTW coordinators and counsellors.	NHS England, ICBs, PCNs, Trusts, Occupational health services, employers, industry	 Moderate

Recommendation	Target audience	GRADE certainty
RTW programmes should include improved co-ordination between NHS organisations and employers, such as the use of RTW coordinators.	NHS England, ICBs, PCNs, Trusts, Occupational health services, employers, industry	 Low
NHS organisations should identify and refer suitable patients to Individual Placement Support schemes, and advocate for workplace modifications, flexible working and phased RTW plans through reasonable adjustments.	NHS England, ICBs, PCNs, Trusts, Occupational health services, employers, industry	 Low
Health care commissioners should work with cross-government departments to evaluate the economic benefits of RTW across multiple sectors.	DHSC, NHS England, ICBs, local authorities	 Moderate

*GRADE certainty communicates the strength of evidence for each recommendation. Recommendations which are supported by large trials will be graded highest whereas those arising from small studies or transferable evidence will be graded lower. The grading should not be interpreted as priority for policy implementation – i.e. some recommendations may have a low GRADE rating but are likely to make a substantial difference.

Useful links

- Guidance for implementation of WorkWell Service – UK Gov <https://www.gov.uk/government/publications/workwell>
- Support for mental health at work | Able Futures Mental Health Support Service <https://able-futures.co.uk/>
- Making workplace adjustments to support disabled staff | NHS Employers <https://www.nhsemployers.org/publications/making-workplace-adjustments-support-disabled-staff>
- Sickness Absence Toolkit | NHS Employers <https://www.nhsemployers.org/toolkits/sickness-absence-toolkit>
- Returning to work after absence – Acas <https://www.acas.org.uk/returning-to-work-after-absence>
- Thrive into Work London – Shaw Trust <https://shawtrust.org.uk/thrive-into-work-london/>
- A guide for employers – Crohn's and Colitis UK <https://crohnsandcolitis.org.uk/info-support/information-about-crohns-and-colitis/all-information-about-crohns-and-colitis/employment-and-education/employment-a-guide-for-employers>

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About the Health Equity Evidence Centre

The Health Equity Evidence Centre is an academic collaboration hosted by Queen Mary University of London which seeks to build the evidence base of what works to address health and care inequalities. Decades of evidence has shown that the structures and systems within society lead to health inequalities. We believe that it is only by tackling the unequal distribution of the social determinants of health will we achieve health equity and that the benefits of health care should reach the most marginalised in society.



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